MUCKAMORE Abbey Hospital Inquiry
Witness Statement Addendum

Statement of Brendan Whittle, Director of Hospital and Community Care, Strategic Planning and Performance Group, Department of Health
Date: 3 November 2023

Further to my evidence session at the Inquiry on Wednesday 17 May 2023, I, Brendan Whittle, make this addendum statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry. This addendum is to provide the Panel with additional information on a number of the queries that arose during my evidence session. The statement is made on behalf of the Strategic Planning and Performance Group (SPPG) of the Department of Health (the Department).

In this addendum statement I will continue to exhibit any documents using my initials "BW", and will number these sequentially to follow on from my first statement dated 10 February 2023, so the first document exhibited in this addendum statement will be "BW/231".

During the course of my evidence session on 17 May 2023, in response to a number of questions I undertook to provide further information or clarification. This addendum statement provides the Strategic Planning and Performance Group's response to these queries. For ease of reference, I have included the relevant page number where each of the queries arose in the transcript of my evidence session.

As with my first statement, this addendum statement contains information that is cross cutting across a number of Directorates of SPPG. I have sought assurance from the current Directors of SPPG and the SPPG Deputy Secretary that the information set out in this addendum statement is factually accurate to the best of all knowledge and records.

Query 1 - Did the Donaldson Report specifically mention the HSCB and that it should be closed? (pg 12)

1.1. In April 2014 the former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement of governance arrangements across Health and Social Care (HSC) in Northern Ireland.

1.2. The overall aim of the review was to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses, and to make proposals to strengthen them.

1.3. The outcome of this work was finalised in December 2014 in the form of a report titled 'The Right Time - The Right Place', otherwise referred to as 'The Donaldson Report' [BW/231]. This report was published by the then Health Minister Jim Wells on 27 January 2015 in conjunction with an oral statement to the Assembly.

1.4. The final report set out ten recommendations, one of which related to the strengthening of commissioning arrangements which were undertaken by the Health and Social Care Board (HSCB). The report did not specify that the HSCB should be closed, however it did recommend that '*the commissioning system in Northern Ireland should be re-designed to make it simpler and more capable of reshaping services for the future'*.

1.5. A proposal to close the HSCB was subsequently announced by the then Health Minister Simon Hamilton on 4 November 2015, which referred to the recommendations from the Donaldson Report. A copy of the statement made by Minister Hamilton is included at [BW/232].

Query 2 - Did the performance management function become broader when the HSCB came into existence than the previous boards? (pg 23)

2.1. The performance management functions did not significantly change when the HSCB came into existence as compared to those that were undertaken by the Department prior to 2009.

2.2. As detailed later in my evidence session of 17 May 2023 (refer pg 25 of transcript), prior to the establishment of the regional HSCB on 1 April 2009, performance management was a function of the Department of Health, Social Services and Public Safety (now the Department of Health).

2.3. The Department had established a Service Delivery Unit (SDU) in April 2006 to take forward a programme of reform and modernisation across a wide range of healthcare activity, e.g. outpatients, diagnostics, A&E, fractures, hospital discharge. The functions of the SDU included performance management.

2.4. As part of the implementation of the Review of Public Administration, the SDU and its functions were absorbed into the Performance Management and Service Improvement Directorate (PMSID) in the HSCB when the regional organisation was established.

2.5. The performance management functions did not significantly change from those that were undertaken by the SDU prior to 2009.

Query 3 - Performance metrics reported from HSC Trusts to HSCB which would have been reported to the HSCB Board meeting and were publicly available (pg 28)

3.1. At the evidence session it was agreed to provide a sample of the performance information that would have been shared at the HSCB's public Board meetings. Sample copies of performance reports from across the period 2009 to 2021 have been included as exhibits, namely from April 2010 [BW/233], October 2015 [BW/234], and May 2021 [BW/235]. These performance reports do not specifically make reference to Muckamore Abbey Hospital (MAH).

3.2. Furthermore, Dr Maxwell had enquired if there was a minimum data set that the HSC Trusts were required to return in relation to the contract. Whilst there is no minimum data set that the Trusts routinely returned to HSCB, the relevant data set is set out in the metrics of the Ministerial Targets and Commissioning Plan Directions. These were referenced at paragraph 4.3 of my original Statement dated 10th February 2023 and the relevant exhibits appended were as follows:

- **Department of Health's annual Priorities for Action document [BW/24]** – this sample document for 2010/11 highlights the key priority areas set by Minister, with the high level targets summarised in Annex A of the document. By way of example, the resettlement target (which would be the most relevant metric in respect to MAH) stated at that time was as follows:

  "Resettlement of learning disability patients (PSA 6.4): by March 2011, the HSC Board and Trusts should resettle 120 long stay patients from learning disability hospitals to appropriate places in the community compared to the March 2006 total."

- **Annual Commissioning Plan Direction [BW25]** – these replaced the Department's Priorities for Actions document from 2011 and an example is provided at exhibit BW/25 in respect to the 2014/15 year. This includes a schedule that outlines the high

level Ministerial targets. By way of example, the resettlement target stated at that time was as follows:

"*32. By March 2015, resettle the remaining long stay patients in learning disability and psychiatric hospitals to appropriate places in the community.*"

- **Indicators of Performance Direction [BW/26]** – An example for 2015 is provided at exhibit BW/26. As outlined at my evidence session of 17 May 2023, an indicator of performance is established when a target date (as set out in the Commissioning Plan Direction) had passed. These indicators of performance were for the Trusts to deliver and were monitored by the HSCB. The Indicators of Performance Directions included a schedule that outlines the high level Ministerial indicators. By way of example, the resettlement indicator stated at that time was as follows:

  "B12. Number of long stay patients in learning disability and psychiatric hospitals to appropriate places in the community"

3.3. As outlined at paragraph 3.66 of my original Statement dated 10th February 2023, in response to the HSCB's annual Commissioning Plan the Trusts were in turn each required to produce a Trust Delivery Plan (TDP). The TDPs required HSCB agreement, in consultation with the PHA, before being presented to the Department for approval. By way of example, a copy of the 2018/19 TDP prepared by the Belfast Trust in response to the HSCB's 2018/19 Commissioning Plan is provided at [BW/236].

3.4. Furthermore, the HSCB would also agree a Service and Budget Agreement (SBA) with each Trust on an annual basis. This document was essentially the contract held between the HSCB as commissioner and the Trust as provider. SBAs set out the services to be provided and link volumes and outcomes to costs. The SBA is a contractual document; and the TDP is the Trust's description of how it will deliver its

commitments. The last SBA between the HSCB and the Belfast Trust from 2018/19 is attached [BW/237].

3.5. As outlined at paragraph 3.67 of my original Statement dated 10th February 2023, the SBA is a contractual document and the TDP is a description of how the Trust will deliver its commitments. One is dependent upon the other.

3.6. By way of further clarification in respect to the monitoring of resettlement metrics, at the outset of each financial year during the period of the resettlement programme, Trusts were advised of the target number of long-stay patients to be resettled in that year – see attached example Definitions and Guidance document for 2011/12 (pages 12-15) [BW/238]. To enable progress to be monitored, Trusts were required to provide monthly information returns to the HSCB setting out the number of resettlements concluded; number of resettlements commenced; number of long-stay patients deceased; and, number continuing to receive hospital inpatient treatment in that month and cumulatively.

Query 4 - Minutes of HSCB / Trust performance meetings (pg 28)

4.1. An example of a record of the HSCB / HSC Trust performance meetings that were chaired by the HSCB Director of Performance Management and Service Improvement is attached as [BW/239]. From review of these records in the time period of the HSCB this was the only meeting where there was a specific reference in the record to MAH.

4.2. In my Statement dated 10 February 2023 I outlined the arrangements that were in place from 2012 to manage the performance of the resettlement agenda at paragraphs 13.12 to 13.14.

Query 5 - What was reported by the Trusts to the HSSBs prior to 2009 in respect to performance management? (pg29)

5.1. As noted against query 2 above, prior to 2009 the performance management function rested within the SDU in the then Department of Health, Social Services and Public Safety (now Department of Health).

5.2. Department of Health colleagues have conducted a search for any relevant hard copy files related to the work of the SDU retained by the Department. While this identified a number of hard copy files relating to the work of the SDU during its existence from April 2006 to March 2009, these have since been destroyed in line with the routine Record Management procedure. A search of the electronic record system has identified a limited number of records which confirms that resettlement targets were subject to monitoring by the SDU. Any relevant Departmental records relating to the performance management arrangements established to oversee the resettlement programme can be provided to the Inquiry by the Department on request.

5.3. Following the establishment of the HSCB in 2009 the DHSSPS agreed to a transfer of all SDU electronic files to a HSC server in 2010. An Agreement for the Management of DHSSPS SDU records was subsequently prepared in May 2012 [BW/240]. Within the agreement it is stated that: "…it is proposed that one disposal schedule is applied to the records created before 1 April 2009. On that basis, considering legislative requirements for minimum retention periods, it is agreed that HSCB should hold the records until 31 March 2016, at which time all records created before 1 April 2009 should be destroyed". BSO have confirmed that the HSC server which stored the SDU files has subsequently been replaced and it has not been possible to locate any of the SDU files.

Query 6 - What were the decision-making arrangements and authority of the Local Commissioning Groups (LCGs) and did the LCGs have any role in performance management? (pgs 34 to 35)

6.1. LCGs were committees of the HSCB and did not have the authority to act independently of the HSCB. Details of the remit and constitution of the LCGs were set out as an appendix to the Standing Orders, which were previously exhibited at BW/5 to BW/16. The Chairperson of the LCG attended the public board meeting of the HSCB to provide an

update on LCG activities. Any significant decisions of an LCG needed to be approved by the HSCB's Senior Management Team (SMT) or at the HSCB Board.

6.2. The LCGs did not have a direct role in performance management. The main interface with HSC Trusts on performance management was via an established performance management process. This process was led by and was the responsibility of the HSC Board's Performance Management and Service Improvement Directorate through quarterly monitoring meetings with HSC Trusts. This holding to account process dealt with scrutinising key performance areas or escalated performance issues.

6.3. The LCG Assistant Directors of Commissioning, who were the local commissioning leads in the HSCB, attended their respective HSCB/Trust quarterly performance monitoring meetings and provided input based on their local intelligence as to how local investments commissioned by the LCGs would have influenced specific performance areas. By way of example, the local commissioning leads were involved in the review and approval (or otherwise) of service development proposals submitted by the Trusts for funding. Where it would reasonably be expected that these funded developments should have had a positive influence on particular performance targets within a given time period, the local commissioning lead was well placed to feed this intelligence into the HSCB/Trust quarterly performance monitoring meetings and raise challenge where necessary.

Query 7 - Were commissioning plans issued by the legacy boards? (pg 37)

7.1. Commissioning Plans were issued by the regional HSCB from the 2010/11 financial year. Prior to that, the four legacy local area Health and Social Services Boards (HSSBs) issued Health and Well Being Investment Plans (HWIP) for their locality from the early 2000s.

7.2. These HWIPs replaced the legacy Purchasing Plans produced annually throughout the 1990s. Based on the records available, it is understood

that the HWIPs were developed annually by each HSSB. It is unclear from the records exactly when the legacy Purchasing Plans were replaced by the HWIPs. However, the earliest HWIP that has been identified through our records search to date is 2005/06. A HWIP for the Eastern Health and Social Services Board in 2007/08 is provided as an exhibit at [BW/241].

Query 8 - Did the HSCB itself have any powers to impose any penalty on the Trust? (pg 44)

8.1. In regards to the position of the HSCB prior to its migration to the Department of Health on 1 April 2022, the HSC Framework Document, which was previously exhibited at [BW/18], includes a specific reference to 'sanctions' at paragraph 2.7 under the description of the Performance Management function as follows:

"Performance management and service improvement *– this is a process of developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary,* ***the application of sanctions*** *and identifying and promulgating best practice. Working with the PHA, the HSCB has an important role to play in providing professional leadership to the HSC."*

8.2. Having consulted with colleagues it is understood that the HSCB did not have a 'penalty process' that it can impose on HSC Trusts. Where under-performance was identified the first action that the HSCB could take was to raise the issue with the particular HSC Trust.

8.3. If the issue could not be resolved by the HSCB it could have been escalated to the Department of Health who could raise the issue with the HSC Trust through the twice-yearly Arm's Length Body (ALB) accountability meetings.

8.4. If the matter required further escalation this could be raised between the Permanent Secretary and the Chief Executive of the HSC Trust, or ultimately between the Minister and the Chair of the HSC Trust by way of further escalation.

8.5. There are other mechanisms that the HSCB could use by way of financial divestment, namely that it could retract funding from one HSC Trust and

apply that funding to another HSC Trust to effect a change in provider. However, that is not something which could have been done in isolation by the HSCB but was required to be undertaken in conjunction with the Department of Health.

8.6. This was in accordance with the provisions of Section 10 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (the 2009 Act) which provided that the HSCB may give directions or guidance to an HSC Trust as to the carrying out by that HSC Trust of any of its functions, however prior to giving out any such direction the legislation stated that the HSCB must first consult the HSC Trust concerned and obtain the approval of the Department of Health.

8.7. Following the dissolution of the HSCB and the migration of the majority of its functions to the Department of Health from 1 April 2022, Section 10 of the 2009 Act is no longer in place. The power to give directions from 1 April 2022 onwards is a power conferred on the Department of Health pursuant to Section 6 of the 2009 Act.

Query 9 - Are you aware of whether the HSCB ever did raise issues in respect of service provision at MAH with the Trust first of all, and also with the Department? (pg 45)

9.1. We have no record that the HSCB raised issues about service provision at MAH to the HSC Trust or the Department, outside of the regular performance management arrangements described in response to query 4 above or through the annual Delegated Statutory Functions reporting arrangements, which are set out in paragraph 4.10 to 4.29 of my original statement

Query 10 - You reference an approval process in respect of Trust Delivery Plans, can you tell the Panel any more about the HSCB's process for the approval of those documents? (pg 47)

10.1. The role of the HSCB, as set out in the HSC Framework Document (previously exhibited at [BW/18]) was to provide the Department with

assurance regarding the quality, safety and financial viability of services. The HSCB discharged this responsibility in-part through the consideration and approval of Trust Delivery Plans (TDPs).

10.2. Trusts were asked to prepare TDPs that adequately responded to the Ministerial Targets and the Commissioning Priorities for that year as outlined in the Commissioning Plan.

10.3. On receipt of draft TDPs, an assessment of the TDPs was carried out by HSCB commissioning staff and HSCB Finance Department at a local and regional level, as well as the PHA. This included an assessment of:

- The service elements of the plan; in particular details of key deliverables in response to Ministerial Targets and Commissioning Priorities. This would have been undertaken by those HSCB commissioning and PHA staff that were involved in the development of the Commissioning Plan, with the assessment being based on their professional understanding of the requirements set out within the Commissioning Plan and the reasonability of the Trusts proposed plans to deliver the targets. Draft TDPs were received from Trusts and circulated to Directors within HSCB and PHA for dissemination to their teams to provide comment on the relevant commissioning priorities pertaining to their area of expertise. Comments were provided to the relevant local commissioning lead who would collate and meet with the Trust to inform the next/final draft of the TDP.

- The financial elements of the plan; in particular the forecast financial position at end-of-year, associated financial assumptions and components of savings plans etc.

10.4. As outlined above, the draft plans were shared with HSCB and PHA staff to provide comment. The final drafts were submitted to the HSCB SMT meeting for consideration. The plans were subsequently brought to the HSCB public Board meeting for consideration and approval. The HSCB Board had access to the HSCB Executive Directors, the PHA Director of

Public Health and the PHA Director of Nursing in reaching the decision to approve or not.

Query 11 – Provision of the Regional Surge Planning Strategic Framework

11.1. At the evidence session on 17 May 2023, it was noted that in lieu of the commissioning plan for financial year 2019/20 a regional surge planning strategic framework was developed and subsequently published in October 2020. I advised that a copy of this would be made available to the Inquiry and this is included as exhibit [BW/242].

Query 12 – Learning Disability Service Framework (Pgs 56 to 57)

12.1. At the evidence session on 17 May 2023 I referred to the evidence provided by Roy McConkey where he referenced the Learning Disability Service Framework (LDSF) and the standards and associated key performance indicators (KPIs) contained therein. I noted that I would come back to the Inquiry with further details on how the HSCB had considered each of these standards and KPIs as part of its monitoring role.

12.2. Many of the KPI's listed against the standards in the LDSF had not previously been measured and while some information systems were available, these were limited and only provided a fraction of the quantitative data required. There was relatively little HSC data collected routinely that reflected the largely qualitative data required for the LDSF's standards.

12.3. A range of audit tools to identify baseline information were developed to help inform performance indicators and monitoring. The audit tools / data collection methods used were as follows:

- Available data sets
- Organisational Audit - HSCB worked with Guidelines Audit and Implementation Network (GAIN) to develop and implement an organisational audit (survey) to gather baseline data.

- Case Note Review - A case note review was carried out between November 2014 and January 2015 to determine baselines for several of the KPI.
- Self-Assessment Audit Tool online survey - the Leadership Centre designed an online excel survey to establish baselines.

12.4. The Organisational Audit referred to above was used to identify baseline / KPIs for a range of standards, including Standard 26 and 27. This involved a survey being developed with the assistance of GAIN and the LDSF Project Steering Group which was sent to the five HSC Trusts, the Public Health Agency and the HSCB to complete and return. The returned survey responses were populated onto an excel spreadsheet for analysis and a report was produced. By way of example the report for July 2014 is attached at exhibit [BW/243].

12.5. It should be noted that not all of the Standards were applicable to the Trusts / Organisations, therefore the report is divided into two sections. The first section is in relation to the five HSC Trusts and the second section relates to the Public Health Agency and the HSCB.

Query 13 – Review of DSF Action Plans (Pg 68)

13.1. At the evidence session on 17 May 2023 I agreed to come back to the Inquiry with copies of any Delegated Statutory Function (DSF) Action Plans that specifically noted delayed discharge as being an issue at Muckamore Abbey Hospital.

13.2. In reviewing both electronic and paper files the following DSF Action Plans have been identified as containing reference to delayed discharge and the relevant extracts have been included as exhibits to this addendum statement as follows:

- April 2010 – March 2011 - Action Plan [BW/244]
- April 2011 – March 2012 - Action Plan [BW/245]
- April 2012 – March 2013 - Action Plan [BW/246]

- April 2013 – March 2014 - Action Plan [BW/247]
- April 2015 – March 2016 - Action Plan [BW/248]
- April 2016 – March 2017 - Action Plan [BW/249]
- April 2018 – March 2019 - Action Plan [BW/250]
- April 2019 – March 2020 - Action Plan [BW/251]
- April 2020 – March 2021 - Action Plan [BW/252]
- April 2021 – March 2022 - Action Plan [BW/253]

Query 14 - What is the penalty that the Board can impose for a failure to meet a requirement of a Delegated Statutory Function (DSF) action plan? (pg 70) Does it have any additional powers under the new process (as outlined at paragraphs 4.28 and 4.29 of your Statement), e.g. to impose penalties for failure to comply with the action plans? (pg 74)

14.1. The Circulars referred to at paragraph 4.15 of my original Statement dated 10 February 2023 outline the roles and responsibilities of HSC organisations in regards to the discharge of delegated statutory functions in the period prior to the dissolution of the HSCB.

14.2. The equivalent current circulars (effective 1st April 2022 following the dissolution of HSCB and the transfer of functions to DoH, SPPG) are referred to at paragraph 4.16 of my Statement dated 10th February 2023.

14.3. In terms of powers, the escalation of concerns and the potential revocation of delegated functions are outlined in both the Circular OSS 04/2015 (previously provided at [BW/45]) and the replacement Circular OSS 02/2022 (previously provided at [BW/49]).

14.4. In terms of escalation process the 2015 Circular [BW/45] advises:

'*The HSCB may, with the approval of the Department, revoke an authorisation to a Trust to exercise relevant functions, should circumstances warrant such action. Decisions for revocation of an authorisation will be made to the Permanent Secretary, Department of*

Health by the HSCB Accounting Officer based on recommendation and advice from the HSCB Director'.

14.5. Overall authorisation for revocation of statutory functions is by the Permanent Secretary upon advice from the Chief Social Work Officer (CSWO).

14.6. The review of the DSF process in 2020 referred to in paragraphs 4.23 to 4.29 of my Statement dated 10th February 2023 was concerned primarily with a revision of reporting and governance processes. There were no additional powers granted to the HSCB / SPPG as compared to those that were in place prior to 2020 as described above.

14.7. Under the current Circular OSS 02/2022 [BW/49] the Director of SCCD has responsibility to advise the Deputy Permanent Secretary of SPPG and the Chief Social Work Officer of any concerns and matters for escalation. It advises:

'*The SPPG consider and make determinations on recommendations and advice from the Director of Social Care and Children's Directorate (SCCD), after consultation with the CSWO, for the revocation of Delegation Directions to HSC Trusts and recommend and advise Permanent Secretary on same'*.

Query 15 - The escalation from the Complaints Group upwards to the full HSCB Board – are you aware of that happening in respect of complaints that related to MAH? (pg 81)

15.1. Quarterly complaints reports went to the HSCB's Senior Management Team and the Governance and Audit Committee, as did the HSCB Annual Complaints Report. These reports summarised some examples of complaints, however none of these examples related to MAH. An example of a quarterly complaints report has been included as [BW/254]

15.2. The quarterly reports did not progress to HSCB Board level and are not available on the website. There is no record of any specific MAH

complaints being discussed at HSCB Board level during the time period.

Query 16 - Where is the complaints report published? Is it accessible and provided to patients and staff? (Pg 82)

16.1. HSCB published an Annual Complaints Report and within that are various statistical presentations of complaints. An example of an annual complaints report has been included as [BW/255].

16.2. The HSCB Annual Complaints Report was approved at the HSCB's Senior Management Team and Governance and Audit Committee and was available on the HSCB website. The reports summarised some examples of complaints where learning or service improvements had been identified, however none of the reports from April 2009 to June 2021 included examples related to MAH.

Query 17 - SAI reporting pre 2009 (Pg 88)

17.1. At the evidence session on 17th May 2023 I agreed to come back to the Inquiry to confirm if there was any requirement for the legacy HSSBs to be notified of Serious Adverse Incidents (SAIs) prior to the 2006 Circular (previously provided as [BW/93]).

17.2. This was the first circular that required Trusts and GP Practices to report SAIs to their commissioning HSS Board. This drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also advised that *'Trusts and Practices should note that all SAIs should be reported to their HSS Board as a matter of course'*.

Query 18 - Would those persons identified as Designated Review Officers receive additional training specifically directed to the DRO role? (Pg 90)

18.1. Anyone taking on the role of a Designated Review Officer (DRO) would receive an induction or guidance from their respective line manager. A copy of the DRO Protocol 2017 is attached [BW/256] which sets out the role of the HSCB/PHA in the SAI Process, the HSCB/PHA Safety and Quality Structures relating to SAIs and the role of a DRO.

18.2. Further the HSCB Governance Team provided co-ordination, administrative support to individual DROs throughout the SAI process.

18.3. Regular training has been specifically provided directed to DROs within HSCB and PHA. Additional training has also been provided following each revision of the SAI Procedure.

18.4. Training was facilitated by the HSCB Governance Team in December 2013 [BW/257], October 2015 [BW/258], February 2017 [BW/259], January 2019 [BW/260] and November 2022 [BW/261]. Sessions covered:

- Key changes in Policy / Procedure
- SAI Process – How SAIs were managed with HSCB/PHA and the Governance Structures in place to support the Process
- Role / purpose of the DRO
- Learning Process
- Service User / Family Engagement Process
- Early Alert Process

18.5. Training by the Leadership Centre for all DROs across HSCB/PHA was undertaken in March 2021, covering the following aspects:

- Role of the DRO
- Role of the Trust
- PCC Family Experience

- Reviewing SAIs
- Writing a Review Report

The training was recorded and an interactive software package named PageTiger available for DROs through an online forum.

18.6. Extensive Significant Event Audit (SEA) and Root Cause Analysis (RCA) Training was also provided by Clinical Leadership Solutions (CLS) in March 2019 (Programme attached [BW/262]). The training covers the following aspects:

- Investigation Approach / Team
- Fact finding and Analysis of information
- Incident Chronology
- Interview approach / engaging with staff
- Involvement with patients / service users and their families / carers
- Analysis tools and techniques

Query 19 - So is it right to say then that prior to this change in 2016 the Trust itself could just review at SEA level and decide to close it at that level, is that right? (Pg 98)

19.1. Prior to the 2016 revision of the SAI Procedure (previously provided as [BW/100]) there were 3 levels of review. Level 1 required a Significant Event Audit (SEA) which could be undertaken for less complex SAI Reviews. Level 2 and 3 reviews were reviewed using Root Cause Analysis (RCA) methodology.

19.2. Therefore, for Level 1 reviews prior to 2016, a full SEA Review was undertaken and the full detail within the SEA report submitted to HSCB. If the outcome of the level 1 review determined the SAI was more complex and required a further more detailed review, the Trust would still submit the SEA Report advising that a more in-depth level 2 or 3 RCA review would be undertaken. A copy of a template report is provided at [BW/263].

19.3. A level 1, level 2 or level 3 review could only be closed formally by HSCB following review, with e-mail approval then given to the Trust if content to close.

Query 20 - How did the Board monitor patterns that were reported in respect of SAIs? (Pg 99)

20.1. A Serious Adverse Incident (SAI) Review Sub Group provided assurances that appropriate structures, systems and processes are in place within the HSCB and PHA for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation /Special Agency or commissioned service (ToR dated September 2018 were previously provided as [BW/200]). Earlier copies of the Terms of Reference for the SAI Review Sub Group are provided as follows:

- February 2014 [BW/264];
- May 2015 [BW/265]; and
- March 2016 [BW/266].

20.2. The SAI Review Sub Group also has responsibility to ensure that trends, best practice and learning is identified and disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

20.3. Terms of Reference for the QSE dated September 2015 were previously provided as [BW/199]. An earlier copy of the Terms of Reference for the QSE Group dated December 2013 have also provided at [BW/267].

20.4. Terms of Reference for the SQAT dated March 2017 were previously provided as [BW/118]. An earlier copy of the Terms of Reference for the SQAT dated January 2015 has also been provided at [BW/268].

20.5. The process for the review of SAIs has evolved over the years. Initially, individual DROs were responsible for the surveillance of SAIs to identify patterns / clusters / trends and onward reporting to the SAI Review Sub

Group. By May 2021 a more streamlined approach was introduced whereby all SAIs were reviewed by a SAI Professional Group. Generic Terms of Reference for the SAI Professional Group were previously attached as [BW/201].

20.6. The introduction of the weekly multidisciplinary Incident Review Group in March 2020 has enabled SPPG / former HSCB and PHA to review all notifications received into the SAI mailbox in a timely manner. Any urgent action required is identified and areas of concern or importance are highlighted to weekly Safety Brief meeting attended by both SPPG and PHA directors with responsibility for safety and quality. The terms of reference for the weekly Safety Brief was previously provided as [BW/202].

20.7. For the years to 2019/20, the HSCB produced a 6-monthly SAI Learning Report which included data in relation to SAIs. Since 2020/21 the SAI Learning Report has been published on an annual basis. Edition 18, covering the period April 2020 to March 2021 was redesigned to be more public facing. The report has always been available on the website and will continue to be.

20.8. All SAIs are recorded on an IT system known as Datix using regional generic codes which allows the identification of patterns / trends. The Governance Team has and continues to support DROs and SAI Professional Groups in running SAI reports when a potential theme / data / trend is identified.

Query 21 - Are you able to say whether any learning letters were issued to the Belfast Trust in respect of MAH arising from any SAIs? (pg 104)

21.1. Following review of a SAI (ref: SET3982) regarding a choking on food incident resulting in death of a service user on trial resettlement from MAH to a residential home, together with other similar SAIs from other facilities, a Reminder of Best Practice on the 'Risk of serious harm or death from choking on foods' was issued by the HSCB on 1st October 2015 to HSC Trust Chief Executives and RQIA Chief Executive

[BW/269]. HSC Trusts were requested to share the correspondence with relevant staff and the RQIA was asked to disseminate this to relevant independent sector providers. An assurance was not requested from Organisations at this time.

21.2. A further reminder of best practice relating to choking was issued in February 2021 [BW/270] (reissued in June 2021 to include all Programmes of Care). In October 2021, following concerns regarding further choking related SAIs (including MAH related SAI ref: B5385), which sadly resulted in patient/client deaths, HSC Trusts were asked to provide an urgent assurance to HSCB/PHA to ensure actions as detailed within the SQA have been taken forward to prevent and mitigate the risk of this type of incident recurring.

Query 22 – EHSSB – A Model of Community Based Services for People with Learning Disabilities'

22.1. At the evidence session on 17 May 2023 I noted that the HSCB has located a copy of the final draft of the document that Roy McConkey had referred to in his evidence titled 'EHSSB – A Model of Community Based Services for People with Learning Disabilities'. A copy of this has been provided at [BW/271].

22.2. I had also agreed to confirm if there was any reference in this report to the community based teams including psychologists and behavioural support therapists. The vision set out in this report (page 6) specifically refers to the following individuals within community based teams:

'*Community support to people with learning disabilities would be provided by Psychiatrists, Nurses, GPs, Social Workers, and the Primary Care Team. Where necessary, other specialists would be involved*'.

22.3. The document goes on to set out life stage and appropriate responses and specifically references a role for psychologists for children from pre-birth to 5 years (page 11), and 5+ to 19 years (page 13). Appendix 4 of the document further indicates a role for psychological support for all life stages.

22.4. The commissioning framework section of the report further notes the community learning disability teams as comprising the following membership:

'*Community learning disability nurses, specialist social workers, a consultant psychiatrist, a clinical psychologist, physiotherapists, occupational therapists and speech and language therapists'*.

Query 23 - Are you able to assist the panel with the type of data that the NI Adult Safeguarding Partnership (NIASP) received from Trusts? (Pg 124)

23.1. NIASP received data returns from each Trust on a monthly basis. The profile of information requested is outlined in the blank template [BW/272].

23.2. The information gathered was considered and reviewed by the then HSCB Head of Service for Adult Safeguarding and NIASP, who provided analysis of the data sets for each Trust, highlighting the significant issues locally and regionally in the annual Delegated Statutory Function Overview Report. An example of the BHSCT returns from 18/19 contained within the Belfast Local Adult Safeguarding Annual Report is attached for reference [BW/273]. It gives clear evidence in respect to issues raised regarding MAH on page 8 and pages 29 to 36.

Query 24 – Medication and Auditing of Medication - are you able to tell the Panel who the Designated Officers in the Board are or were, and how those Designated Officers would have exercised their functions in respect of MAH? (Pgs 130 to 131)

24.1. As set out in paragraph 10.10 of my original Statement dated 10 February 2023, the Trusts and the HSCB, as Designated bodies under controlled drugs legislation, appoint an Accountable Officer to assure the governance of controlled drugs management in the organisation.

24.2. During the period from 2009 to 2022, Mr Joe Brogan, the Head of Pharmacy and Medicines Management, was the HSCB's Controlled Drugs Accountable Officer (CDAO). Following the transfer of the HSCB's

functions to the Department on 1 April 2022, the CDAO role undertaken by Mr Joe Brogan has transferred to Dr Lisa Byers, Senior Principal Pharmaceutical Officer in the Department.

24.3. The general requirements of the CDAO are as set out in paragraph 10.11 of my original Statement dated 10 February 2023. The HSCB CDAO did not have a role in regards to the use of controlled drugs at MAH as this responsibility rests with the Belfast HSC Trust i.e. each Health Trust has its own CDAO responsible for the governance arrangements for controlled drugs in their organisation. The Belfast HSC Trust is therefore best placed to answer the specific question around how they exercised the functions of their appointed CDAO in relation to MAH.

Query 25 - Is there anything in the Pharmacy Controls Assurance processes that would monitor the administration of medicines rather than the prescription and dispensing of them? … One of the things we are interested in is how there is some control of the administration of medicines, what happens at the ward level – does it come under the Pharmacy Controls Assurance Standards? (Pg 131 to 132)

25.1. Reference is made at paragraph 10.20 of my original Statement dated 10 February 2023 to the Controls Assurance Standards which were in place from 2004 to 2018.

25.2. Criterion 7 of the Medicines Management Controls Assurance Standards states:

'*Supply and administration of medicines is safely, securely and cost effectively carried out by appropriately qualified, trained and competent staff and in compliance with all legislative requirements, professional standards and good practice guidance and in a manner which safeguards patients and the public*'.

25.3. There is an expectation that each HSC Trust has corporate assurance around each Standard. The Department of Health sought assurance from HSC Trusts in respect of the compliance with these standards. The

HSCB did not receive copies of such assurances that were provided directly from the HSC Trusts to the Department. Attached is a self-assessment form [BW/274].

Query 26 - In relation to Legacy HSSB you say at para 16.3 that they had a risk register but that searches are ongoing for the legacy risk management policies in the EHSSB – is there any progress on those searches? (Pg 147)

26.1. Following a further search the following documents have been located:

- 2003 – Risk Management Strategy for the Eastern Health and Social Services Board [BW/275]
- 2006 – Working draft of EHSSB Governance & Risk Management Strategy and Framework Document [BW/276]. A final version of this document has not been located at this time.

26.2. To provide an example of the out-workings of this, a copy of EHSSB risk registers have been provided as exhibits, namely the EHSSB Corporate Wide Risk Register for 2006-07 [BW/277] and the EHSSB Risk Register for the Social Care Directorate 2004 [BW/278].

Query 27 – HSCB Risk Registers - In terms of the decision about whether a risk should be held at a Directorate Level or a Corporate Level, was there any guidance given to those individuals as to the type of risk that constituted a Directorate level or a Corporate level? (Pg 148)

27.1. The HSCB Governance Framework includes an appendix on the Management of Board wide risks which provides guidance and overview on the management of both corporate and directorate risks.

27.2. In broad terms, risks that are low or are manageable within the control of a single Directorate are held at Directorate risk register level. Risks that that are Extreme or Medium / High and cross cutting over a number of Directorates are held at Corporate risk register level.

27.3. Copies of the HSCB Governance Frameworks, which have previously been shared with the Inquiry as exhibits to my original Statement dated

10 February 2023, set out the detail and process. The Frameworks are as follows

- BW/208 for the HSCB Governance Framework (Dec 11) - Appendix 1 covers the process for the management of risks;
- BW/209 for the HSCB Governance Framework (Jan 15) - Appendix 2 covers the process for the management of risks;
- BW/210 for the HSCB Governance Framework (Feb 19) - Appendix 2 covers the process for the management of risks.

27.4. A revised risk management policy was developed for HSCB in its transitional year 2021/22 in line with DoH business planning, risk management and assurance framework (previously provided as [BW/211]). This provided guidance on the allocation of risk at Directorate and Corporate levels. The guidance referred above was shared with Directorates to assist in their assessment of risks for the Directorate and Corporate level risk registers. The rationale for updating the policy was to ensure that when HSCB migrated to the Department of Health, that SPPG were using the same risk management policy as the rest of the Department of Health. To this end, a number of workshops were held across Directorates to ensure the Risk Register was aligned with DoH Framework in preparation for dissolution of the HSCB and the transfer of its functions to the Department of Health.

Query 28 – Details of risks registered with regard to MAH (Pg 149 to 150)

28.1. At the evidence session on 17 May 2023 I noted that I could provide copies of any risk registers where there have been risks identified with regard to MAH.

28.2. I can confirm that all Corporate and Directorate level risk registers which contain reference to MAH have previously been provided to the Inquiry as part of the document disclosure process. A sample of these, providing the relevant extract of the MAH related risks, are exhibited to this addendum statement as [BW/279 to BW/283].

I note there are a number of additional abbreviations that have been used in this addendum statement that were not included in the list previously exhibited in my original statement dated 10 February 2023 [BW/1]. An updated list of abbreviations has therefore been included as [BW/284].

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 3 November 2023

List of Exhibits - Addendum statement (Brendan Whittle)

BW/231 – The Donaldson Report – The Right Time, The Right Place (Dec 2014)

BW/232 – Minister Statement re proposal to close the HSCB (4Nov15)

BW/233 – Performance Monitoring Report - HSCB meeting 29 April 2010

BW/234 – Performance Monitoring Report - HSCB meeting 8 October 2015

BW/235 – Performance Monitoring Report - HSCB meeting 13 May 2021

BW/236 – Belfast Trust – Trust Delivery Plan 2018/19

BW/237 – Belfast Trust – Service Budget Agreement 2018/19

BW/238 – CPD Definitions and Guidance document for 2011/12

BW/239 - HSCB-NHSCT Directors Meeting - 30.3.21 (final)

BW/240 – Agreement for Management of the DHSSPS Service Delivery Unit (SDU) Records now held by Business Services Organisation (BSO)

BW/241 - Health and Well Being Investment Plan for the EHSSB 2007-08

BW/242 - Surge Planning Strategic Framework 06.10.20

BW/243 - LDSF Guidelines Audit and Implementation Network report Jul14

BW/244 - BHSCT LD DSF Action Plan 2010-11

BW/245 - BHSCT DSF LD Action Plan 2011-12

BW/246 - BHSCT DSF LD Action Plan 2012-13

BW/247 - BHSCT DSF LD Action Plan 2013-14

BW/248 - BHSCT DSF LD Action Plan 2015-16

BW/249 - BHSCT DSF LD Action Plan 2016-17

BW/250 - BHSCT DSF LD Action Plan 2018-19

BW/251 - BHSCT DSF LD Action Plan 2019-20

BW/252 - BHSCT DSF LD Action Plan 2020-21

BW/253 - BHSCT DSF LD Action Plan 2021-22

BW/254 - HSCB Quarterly Complaints Report - Jan to Mar 2021

BW/255 - HSCB Annual Complaints Report 2020-21

BW/256 - DRO Protocol 2017

BW/257 – DRO Training Presentation 2013

BW/258 – DRO Training Presentation October 2015

BW/259 – DRO Training February 2017

BW/260 – DRO Training January 2019

BW/ 261 – DRO Training November 2022

BW/262 - RCA Training Programme

BW/263 - Appendix 4 & 5 - HSCB Procedure for the reporting and follow up of SAIs - Oct 2013

BW/264 - TOR for SAI Subgroup Feb 2014 – Final

BW/265 - TOR for SAI Subgroup May 2015- Revised

BW/266 - TOR for SAI Subgroup Mar 2016

BW/267 - Revised Draft TOR QSE- Dec 2013

BW/268 - Protocol and ToR for SQAT (as at 29.1.15)

BW/269 - Reminder of Best Practice - SQR-SAI-2015-015 - Management and advice for patients clients with swallow dysphagia problems

BW-270 - Reminder of Best Practice - SQR-SAI-2021-075 (OPSMHSAS) (issued 03.02.2021)- Risk of serious harm or death from choking on foods

BW/271 - EHSSB - A Model of Community Based Services for People with Learning Disabilities - Aug96

BW/272 – Adult Safeguarding Return - CURRENT DATASET

BW/273 – Belfast Local Adult Safeguarding Annual Report 18/19

BW/274 - CA Medicines Mgt 06_07

BW/275 - EHSSB Risk Management Strategy April 2003

BW/276 - EHSSB Working draft of a revised Gov and Risk Mgt Strategy

BW/277 - EHSSB Risk Register - Corporate Wide 2006-07

BW/278 - EHSSB Risk Register - Social Care Directorate 2004

BW/279 – HSCB Corporate Risk Register - Jul 2009 - Extract CR4

BW/280 – HSCB Corporate Risk Register - Sep 2019 - Extract CR18

BW/281 – HSCB Corporate Risk Register - Nov 2020 - Extract CR17

BW/282 – HSCB Directorate Risk Register - Dec 2018 - Extract SCQS18

BW/283– HSCB Directorate Risk Register - May 2021 - Extract DSC05

BW/284 – Updated List of abbreviations used in this addendum statement and the original statement dated 10 February 2023