

**DEPARTMENTAL AND GENERAL GOVERNANCE**

**Name:** John McGrath

**Title:** Mr

**Present position and institution:**

Deputy Secretary, Department of Education

**Previous position(s) and institution(s):**

*[in 1995, 1996, 2000, 2001, and 2003 respectively]*

1995 Director of Provider Development DHSSPS

1996 Director of Trusts and Human Resource DHSSPS

2000 Director of Planning and Performance Management DHSSPS

2001 Director of Planning and Performance Management DHSSPS

2003 Deputy Secretary Urban Regeneration and Community Development DSD

**Membership of Advisory Panels and Committees:**

*[Identify by date and title all of those since 1995]*

**Previous Statements, Depositions and Reports:**

*[Identify by date and title all of those since 1995]*

**OFFICIAL USE:**

**List of previous statements, depositions and reports:**

Ref:	Date:	



**IMPORTANT INSTRUCTIONS FOR ANSWERING:**

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

**DETAILS OF YOUR CAREER HISTORY, QUALIFICATIONS AND EXPERIENCE**

(1) From organisation charts provided to the Inquiry by the Department of Health, Social Services and Public Safety ("the Department"), [Ref: 323-027e-016 , 323-027f-043 and 323-027h-017], it appears that you were head of the Planning and Performance Management Directorate of the Department for a period before August 2001 until after July 2002. Arising from that:

(a) State the dates on which:

(i) You became head of the Planning and Performance Management Directorate

I took up the post of Director of Planning and Performance Management on 6 December 1999.

(ii) You ceased to hold that post.

I ceased to hold the post on 20 January 2003.

(b) Provide your job description and detail the duties and responsibilities of that post. If the duties/responsibilities changed when you were in the post, please give details of the changes and when they occurred.

I attach a Job Description.

(c) Identify to whom you were accountable in carrying out the duties of the post.

I was accountable to the Deputy Secretary Paul Simpson.

(d) The organisation chart at Ref: 323-027e-016 identifies teams/units within your Directorate, including "Quality and Effectiveness Unit" "Provider Performance Monitoring Team 1" , "Provider Performance Monitoring Team 2" and "Strategy and Performance Review Branch." Arising from this:

Ref 323-027e-016 reflects a Directorate Structure pre August 2001.

(i) Describe the purpose, duties and responsibilities of each of these units/branches.

The Provider Performance Monitoring Teams monitored the relevant business in the 19 Trusts and smaller agencies. Team 1 covered the Eastern Board area plus oversight of the entire capital programme. Team 2 covered Trusts in the other Board areas. The work covered bilaterals with the Trusts, oversight of Recovery Plans, alongside Finance Division, plus handling of Business Cases.

The Public Appointments Unit handled all public appointments in DHSSPS in line with Guidance from the Commissioner for Public Appointments.

The Quality and Effectiveness that took the lead in developing policy on the quality agenda and the progressing of "Best Practice : Best Care".

The Strategy and Performance Review Branch led on holding Boards to account for delivering on Ministerial priorities and service targets and the Accountability Review system.

- (ii) Who was in charge of each of these units/branches between 1995 and 2003?

This was the structure in Planning and Performance Management Directorate post 1999. Prior to that the responsibility was spread across pre-existing Directorates. Going back to 1995 the Quality and Effectiveness team would not have existed. I am not in a position to identify who would have led these functions going back that far. In terms of Ref 323-027e-016 the officers in charge were Ray Martin (PAU), Eileen McBrinn (Quality and Effectiveness), Alan Gault (Strategy and Performance Review) Denis McMahon (PPMT1) and John Townson (PPMT2).

- (iii) How did the individuals in charge of those branches account to you for the performance of their duties and responsibilities?

The officers reporting to me would account for their performance through the NICS Performance Management system built around an annual review.

- (iv) Describe any changes to the name, purpose, duties or responsibilities of each unit/branch and the dates of any such changes.

There were changes to the Directorate structure to the extent that in 2002 the structure was:-

2 x Performance Management Team. One led on all accountability issues for the Eastern Board and the Trusts in that area including the Accountability Reviews with that Board. (David Galloway).

The other discharged the same role for the other 3 Board areas and the smaller agencies. (Margaret Rose McNaughton).

Public Appointments Unit. (Cathy Cooper).

Capital Investment Unit. Capital Planning prioritisation and major schemes. Capital Investment Strategy. Estate Rationalisation Allocation of Capital. (Heather Robinson).

Quality and Performance Improvement Unit. The Performance Management Framework roll out of "Best Practice : Best Care" and related legislation: Clinical and Social Care Governance (Fergal Bradley).

Planning and Priorities. Input to Regional Strategy and Public Health Strategy Health and Wellbeing Improvement Programmes, Spending Review/Public Services Agreement, New TSN. (Ray Martin).

(2) Describe your career history prior to becoming head of the Planning and Performance Management Directorate. In particular;

(a) Give full details of the duties, responsibilities and accountability of any posts held by you in the Department from 1995.

I joined DHSS as an Administrative Trainee in 1977. After postings in Child Care Social Security Policy, Establishment, the Office of the Head of the Civil Service and the NIO in London I was promoted to Deputy Principal in Planning Division in 1982. I was subsequently promoted to Principal Officer (Grade 7) in 1987 again in Planning Division. In 1997 I was promoted to Assistant Secretary in charge of HPSS Review responsible for implementing the internal market and community care reforms in the HPSS in Northern Ireland. In 1993 I became Director of Provider Development and in 1995 Director of Trusts and Human Resources. The post had responsibility for oversight of a range of provider related functions in the HPSS including human resources, capital investment, Trust Business Plans and also some of the smaller Agencies in the HPSS.

With the arrival of devolution the rigidity of the internal market had been diluted and the emphasis had shifted from competition to co-operation in a system working to Ministerial objectives. In 1999 I became Director of Planning Performance Management with a remit to provide an integrated accountability system across the HPSS. Within this the primary accountability line for service delivery was from the Department through Health and Social Service Board (Commissioners) to Trusts (Providers). Trusts would not normally account for service delivery issues direct to the Department.

While I became Director of Planning and Performance Management in December 1999 and technically divested myself of HR related functions I still had effective responsibility for their range of functions until the newly appointed Director of HPSS Human Resources took up post in 2000.

The central focus of the Directorate was largely the same during my oversight but the profile on a number of areas was enhanced reflecting Ministerial and Departmental priorities. The Planning and Priority Unit developed to reflect the strategic focus of the Minister on the new Priorities for Action approach to service planning across the HPSS. The Quality and Performance Unit reflected the developing quality agenda and the emergence of Clinical and Social Care Governance as a concept. The Corporate Governance work within the Public Appointments Unit expanded to reflect the wider emphasis on strengthening Corporate Governance both within and without Government in Northern Ireland and beyond.

- (3) Describe your career history since you ceased to hold the post of head of the Planning and Performance Management Directorate, stating the posts held and the dates between which the posts were held.

In December 2002 I was successful in a competition for Deputy Secretary, Urban Regeneration and Community Development in DSD and moved to that post in January 2003. In February 2008 I transferred to my current post as Deputy Secretary DE.

- (4) State any relevant qualifications that you hold and the date(s) on which you obtained them.
- BA Honours 2:1 QUB 1976.

#### KNOWLEDGE OF THE DEATHS OF THE CHILDREN

- (5) State when and how you became aware of the deaths of:

- (a) Adam Strain
- (b) Claire Roberts
- (c) Lucy Crawford
- (d) Raychel Ferguson.

State what action, if any, you took when you became aware of each death

I have no recollection of being made aware of the deaths of the four named children at any stage.

- (6) Would you have expected, as head of the Planning and Performance Management Directorate, to be made aware of serious adverse incidents such as the deaths of these children?

No I would not have expected to have been made aware of these issues. The primary focus of the Directorate was strategic system management and the corporate performance of HPSS organisations. Individual clinical incidents I would not have expected to have been alerted to in that role. As I have indicated the primary accountability for service delivery was through Commissioners.

- (7) What would you have done if you had been made aware of any of the deaths as a serious adverse incident?

I have no recollection of how serious adverse incidents, which could cover a wide range of settings were handled at that time. As such I cannot indicate what I might have done. I would most likely have passed the matter on to medical colleagues in the Department. This eventuality did not arise.

- (8) Would you have expected, in the period 1995-2003 that serious adverse incidents, such as the deaths of these children, would be reported to the Department? If so,

- (a) To whom in the Department would it be reported?
- (b) What action, if any, would you have expected the Department to take?

I have no recollection of the arrangements if any, for reporting serious adverse incidents and indeed what the definition of these might be. Given the number of patient and client episodes in the HPSS in any given year careful judgement would have needed to be applied in determining what was serious. When senior management or medical colleagues in the HPSS were concerned about incidents which may have related to professional conduct and competency they may have brought this to the attention of DHSSPS medical personnel.

(9) Would you have expected the Department to have been informed of the statement produced by the RBHSC following the Inquest of Adam Strain? [Ref: 011-014-107a]

(a) If so, what action, if any, would you have expected the Department to take?

Without any professional expertise to interpret the importance of the statement by the Royal Hospital trust I am in no position to judge what action, if any, the Department might have been expected to take.

(10) Were you aware of the establishment of the Hyponatraemia Working Group?

(a) If so, please give details of when, how and for what purpose you became aware.

(b) Please state what you considered to be the purpose of the establishment of the Working Group.

I have no recollection of being made aware of the establishment of the Hyponatraemia Working Group. I had therefore no thoughts on its purpose.

#### **MONITORING AND ACCOUNTABILITY ARRANGEMENTS IN THE HPSS**

(11) Describe the accountability arrangements in the HPSS in the period between 1995 and 2003. In particular, describe your role and functions in those arrangements.

The accountability arrangements in the HPSS evolved between 1995 and 2003 reflecting in part differing political steers. The advent of the internal market from 1992 under the Conservative Government and Direct Rule in Northern Ireland radically reformed the previously integrated HPSS governance. There were clear separation between the role of purchasers - responsible for assessing need and buying services from providers - and providers who responded to purchasers and in theory competed for business with the aim of driving up quality and efficiency. The fundamental aim was to ensure the services were not provider dominated but needs driven. The main accountability line in the HPSS was from the Department through purchasers, later termed commissioners to providers. Commissioners held primacy. At the same time the provider side evolved to separate management as Trusts with their own Boards and in theory the power to set their own terms and conditions of services. Apart from senior management the last was largely theoretical as there was not sufficient funding to enhance terms and any diminution would have encountered fierce resistance.

Thus the main accountability mechanism was the Accountability Review system for Health and Social Services Boards and the framework for Trusts summarised in METL 2/93.

Between 1995 and 1999 my role was to exercise the appropriate oversight of Trusts to complement the main oversight of HPSS performance, as I have indicated, via Commissioners which was discharged by colleagues in the Department.

By 1999 with the advent of devolution and greater emphasis on co-operation and whole system working, as opposed to competition, the new Planning and Performance Management Directorate provided a unified focus for oversight and accountability within the HPSS. Within devolution and the new established institutions there was more central direction from the Programme for Government and the Minister, through 'Priorities for Action', on service priorities and less discretion for Commissioners. At the same time the Department continued to hold Commissioners primarily to account for service delivery and performance across the HPSS.

- (12) Describe the specific arrangements by which the performance of the Royal Group of Hospitals HSS Trust was monitored by the Department and by which the Trust was held accountable by the Department for the discharge of its functions in the period 1995-2003. In particular:

I have described above the framework for accountability pertaining between 1995-2003. In the case of the Royal Group of Trusts Hospitals HSS Trust in terms of its performance in delivering services required by Commissioners and meeting relevant targets it would account initially to its Commissioners. As a regional provider it provided services to varying degrees to all four Boards and also in the early years to GP fundholders. Its financial performance and capacity to live within its means would be monitored by the Department. It would also report to the Department on the funds provided to support teaching and research (STAR and later SIFT).

- (a) Were there meetings to monitor performance and hold the Trust to account?

Within the context of the above description and the general framework of METL 2/93 these would routinely be meetings between Commissioners and the Trust and, as appropriate between the Trust and the Department.

- (b) Where and how often did such meetings take place?

I have no information on how often Commissioners met the Trusts. Meeting between the Trust and the Department would take place regularly on different issues, not least because:

- i) The Trust had a range of strategically important capital projects which were the subject of continuing dialogue;
- ii) The financial position of the Trust was a thorny issue through the mid 1990s and at times required Ministerial involvement. The venue for meetings would be either the Department or the Trust.

- (c) Who attended such meetings on behalf of:

- (i) The Trust
- (ii) The Department?

Attendance at such meetings would be dictated by the seriousness and the subject matter.



- (d) Were the meetings minuted?

Some discussions would be quasi formal which might merit a minute or a subsequent letter summarising points agreed or not as the case might be. Others would be less formal.

- (e) Were you personally involved in monitoring the performance of the Trust and/or holding the Trust to account?

As I have indicated above where issues were not of a routine nature I was likely to be involved particularly on the two issues highlighted at (b).

- (f) Describe your involvement in monitoring the performance of the Trust or holding the Trust to account.

My involvement would be looking the DHSSPS input, possibly in conjunction with Finance colleagues on matters which fall within the Trust Accountability Framework. Equally given that there were 19 Trusts in existence that had to be balanced with competing priorities. Routine discussions with the Trust would be led at Grade 7 level.

- (g) Were issues concerning patient safety, clinical care or the quality of care raised by or with the Trust in the course of monitoring the performance of the Trust or holding the Trust to account? If so:

(i) Please provide details and examples.

(ii) What action was taken by the Department?

The primary relationship around issues of patient safety, clinical care on the quality of care was between the Commissioners and the Trusts, particularly since resource consequences would be involved. The Trust was work to express concerns about such issues in meetings with my Directorate, particularly in the early days of Trust status when relationships between the Trust and its lead Commissioners were particularly fraught. Notwithstanding this the Trust would be steered back towards dialogue with Commissioners in line with the agreed line of accountability.

- (h) Were issues concerning the deaths of any of the children who are the subject of this Inquiry ever raised by or with the Trust in the course of monitoring the performance of the Trust or holding the Trust to account? If so:

(i) Please provide details.

(ii) What action was taken by the Department?

No.

- (13) Describe the specific arrangements by which the performance of the Altnagelvin Hospital Trust was monitored by the Department and by which the Trust was held accountable by the Department for the discharge of its functions in the period 2001-2003. In particular:

(a) Were there meetings to monitor performance and hold the Trust to account?

(b) Where and how often did such meetings take place?

- (c) Who attended such meetings on behalf of:
  - (i) The Trust
  - (ii) The Department?
- (d) Were such meetings minuted?
- (e) Were you personally involved in monitoring the performance of the Trust and /or holding the Trust to account?
- (f) Describe your involvement in monitoring the performance of the Trust or holding the Trust to account.
- (g) Were issues concerning patient safety, clinical care or the quality of care raised by or with the Trust in the course of monitoring the performance of the Trust or holding the Trust to account? If so:
  - (i) Please provide details and examples.
  - (ii) What action was taken by the Department?

The arrangement for oversight of Altnagelvin Hospital Trust and the mechanisms involved were similar to that pertaining to the Royal Trust as indicated above under (12). There were likely to be less frequent engagement reflecting the less central role of the Trust. Nevertheless it had a pivotal role in delivering sub-regional and local hospital services with multiple Commissioners and significant capital investment priorities.

- (h) Were issues concerning the death of Raychel ever raised by or with the Trust in the course of monitoring the performance of the Trust or holding the Trust to account? If so:
  - (i) Please provide details.
  - (ii) What action was taken by the Department?

I have no recollection of any issues concerning the death of Raychel Ferguson being raised with or by the Trust in the course of monitoring the performance of the Trust.

- (14) Dr Paddy Woods told the Inquiry [Ref: 323-001a-001] that formal accountability meetings took place between the Department and Sperrin Lakeland HSS Trust twice per year usually mid-year and end of year. He has advised that individuals who might have had responsibility for the oversight of Sperrin Lakeland in 2000 and who might have received reports of issues affecting the Trust would have included yourself, Clive Gowdy, Paul Simpson and Alan Gault. Arising from this:

I have described the nature of the relationship with Trusts earlier. The approach adopted by the Department throughout the period from 1993 was that there was a hierarchy of accountability, Department, the HSS Board then Trusts. While all statutory bodies within the HPSS Boards were charged with determining priorities within Ministerial guidance and deciding who would be commissioned to deliver. There was a clear determination to avoid accountability arrangements for Trusts on a par with those for Boards. Thus there would be regular, mainly biennial, Accountability Reviews with Boards led by the Minister and

Permanent Secretary on one side and the Chairman and Chief Executive on the other. The arrangement for the 19 Trusts as described above did not have this status or regularity. There was no programme of formal accountability meetings with Trusts before my departure from DHSSPS. The principal reason for this was not to undermine the primary role of Commissioners in delivering service priorities and holding Trusts to account for service delivery. My recollection is that before I left we were however contemplating perhaps an annual formal meeting with each chaired at my level.

- (a) Describe the specific arrangements by which the performance of the Sperrin Lakeland trust were monitored by the Department and by which the Department held the Trust accountable for the discharge of its functions.

I have already described the nature of engagement with Trusts in general in the period under consideration.

- (b) Please confirm whether you were involved in accountability meetings with the Sperrin Lakeland Trust during the period 2000-2002.
- (c) Where did those meetings take place?
- (d) Who represented the Trust at those meetings in the period 2000-2002?
- (e) Please give examples of matters discussed during those meetings.
- (f) Were the meetings minuted?

(b) to (f) not applicable since the formal accountability meetings suggested by Dr Woods were never held.

- (g) Outside of formal accountability meetings, did you personally receive reports of issues affecting Sperrin Lakeland Trust in the period 2000-2002? Please give examples of the sorts of issues which were brought to your attention.

I can be reasonably certain that I would have received information on issues affecting Sperrin Lakeland trust in the period 2000-2002. I cannot recollect details but capital investment and financial viability were regular issues under review.

- (h) Were issues concerning clinical care or patient safety ever raised by the Trust or discussed with the Trust either within or outside the formal accountability meetings? If so:

The Trust would raise occasionally issues in the same way or described at 12(g) for the Royal Group of Hospitals Trust. Again it would be pointed back to dialogue with Commissioners.

- (i) Please give examples and details.

I have no recollection of being made of these issues in my role of Director of Planning and Performance Management. I cannot comment for other areas of the Department.

- (ii) What action did the Department take?

- (i) Did the Sperrin Lakeland Trust at any time during the period 2000-2002 make you or the Department aware of any of the following:
- (i) Lucy Crawford's death
  - (ii) The allegations of clinical incompetence made against Dr O'Donohoe by Dr Asghar in June 2000 [Ref: 036a-099-212 to 036a-099-214 and 036a-004-009 to 036a-004-010]
  - (iii) The Trust's decision to request the Royal College of Paediatrics and Child Health (RCPCH) to assist in investigating those allegations [Ref: 036a-009-016 to 036a-009-018]
  - (iv) The first report of the RCPCH representative Dr Moira Stewart [Ref: 036a-025-052 to 036a-025-060]
  - (v) The meeting between the Trust's Medical Director Dr Kelly and Dr Moira Stewart on 1<sup>st</sup> June 2001 [Ref: 036a-027-066 to 036a-027-068]
  - (vi) The external review report of the RCPCH by Dr Stewart and Dr Boon [Ref: 036a-153-318 to 036a-153-323]
- (j) Would you have expected that the Trust would have made you and/or the Department aware of any or all of the events set out in (h) above? Please give reasons for your answer.

No I would not have expected the Trust to make me aware of any or all of the events of the events set out in (i). This is because they appear largely to relate to matters of clinical practice and competency rather than corporate issues within the Trust. It is outside my competency to judge whether for example the Trusts should have made medical colleagues within DHSSPS aware of some or all of them.

- (15) Describe what arrangements were in place in the period between 1995 and 2003 to enable you personally and/or the Department to know what was going on in the HPSS and of issues affecting the HPSS.

The Department operated as the Government Department in this period which included the first period of devolution, and also effectively as the regional health authority responsible for strategic oversight of the HPSS. Because of the latter dimensions the Management Executive was established for a period to provide a particular focus as management and delivery as opposed to policy making. This dichotomy proved difficult to sustain in a relatively small Department responsible for the biggest component of the Northern Ireland Block Equally the onset of devolution brought added pressure with the need to work under the direction and control of a local Minister and to support the institutions of Government. At a personal level as far as possible I made it my business to get out and about and liaise with HPSS colleague as time permitted, to tap into what was happening on the ground. Other colleagues did likewise. Outside the formal accountability arrangements there remained a high reliance, rightly, on HPSS organisations bringing issues of importance or concern to the Department's attention particularly to ensure that Ministers were not unsighted on key matters of public concern. This was not always effective.

- (16) Paragraph 18 of METL 2/93 [Ref: 323-001a-007] under the heading "*Ground Rules For Intervention*" states, so far as relevant, as follows:

*"Intervention by the ME in the affairs of a trust should be exceptional, in line with the principles of maximum delegation. It may be judged necessary in certain circumstances eg-*

*Items of concern relating to patient safety or client care;..."(a number of other examples of circumstances in which intervention may be judged necessary is also provided)*

In Line with the policy at the time METL 2/93 describe what was viewed as a 'light touch' approach. Para 18 makes it clear that intervention by the then Management Executive would be exceptional. Circumstances may include "items of concern relating to patient or client care."

Arising from this:

- (a) What arrangements did the Department have to become aware of "items of concern relating to patient safety or client care" in the period 1995 -2003?

There exists a number of mechanism through which "items of concern relating to patient safety or client care" could be flagged up. These include the role of Boards as Commissioners; Trusts, which were expected to flag up issues of concern about patient/client safety; individual members of staff; the Health & Social Services Council; inspection by relevant professional bodies (which had the power for example to withdraw training recognition); inspection by the Social Services Inspectorate as well perhaps as individual reviews, commissioned by Boards or Trusts or in some cases jointly. The public, service users and public representatives were a continuing channel for concern about patient or client safety.

- (b) How did the Department expect to become aware of "items of concern relating to patient safety" in the period 1995-2003?

As at (a).

#### CLINICAL GOVERNANCE/QUALITY OF CARE

- (17) Detail all steps taken by the Department between 1995 and 2003:

- (a) To encourage or require trusts:
- (i) To manage and improve the quality of care which they provided.
  - (ii) To implement and improve clinical governance.
  - (iii) To implement and improve clinical audit
  - (iv) To implement and improve a system for dealing with clinical complaints.

I am not in a position to provide first hand information on these issues. Before I became Director of Planning and Performance Management I had no responsibility for this matter. I am aware that medical colleagues led considerable work on clinical audit. Boards as Commissioners would have been expected to build in improvement in the quality of care into the commissioning process year on year. As Director of Planning and Performance Management I took on responsibility for quality but the whole concept of clinical governance as a robust and rigorous system was still in its infancy. I oversaw the work which led to the publication in April 2001 of the major policy document "Best Practice : Best Care" which set out proposals for improving quality and standards within the HPSS.

- (b) To satisfy itself as to the steps taken by trusts to progress the matters at (a).

In line with (a) I cannot comment on the matters at (a) beyond (ii) where matters were taken forward in the context of "Best Practice : Best Care."

- (18) Departmental Circular PRSC (PR) 2/99 beginning at Ref: WS-066/1, page 105 refers at paragraph 6.1 [Ref: WS-066/1, page 119] to a document "*Promoting Quality: a Framework for the HPSS*" which was to be issued in the autumn of 1999. Arising from this please answer the following:

- (a) Was "*Promoting Quality: a Framework for the HPSS*" issued in autumn 1999 or at all?

I have no recollection of such a document being published. I believe it was an aspiration at that time which eventually manifested itself as "Best Practice : Best Care" published under the regis of the devolved Minister of the day.

- (b) If it was not published, what were the reasons for that?

As at (a).

- (c) Can you provide a copy of this document, or any drafts thereof to the Inquiry?

As at (a).

- (d) What steps did the Department take to emphasise that "*high quality services is everyone's business*?

Through issuing "Best Practice : Best Care" and taking that work forward.

- (e) What did the "*existing good practice*" refer to?

In aspiring to raise the quality of care and professionalism it was important not to imply that all current practice was less than optimal. Hence it was appropriate to recognise that there would be 'existing good practice' without necessarily specifying where and what that was.

- (f) When did the Government in Northern Ireland first set the objective that "*everyone has fair access to effective prompt high quality health and social services*"?

It should be noted that this Circular was issued in advance of the devolution of responsibility to the NI Executive. As such the reference is to the UK Government not the Executive as the Minister. The approach to quality management was developed under the new Minister and articulated in "Best Practice : Best Care".

- (19) Were there communications between you and your Directorate and the Chief Medical Officer and her team, or the Chief Nursing Officer and her team about the performance of trusts in any of the following matters:

- (a) Patient safety and care;  
(b) Quality of care;

- (c) Clinical governance;
- (d) Clinical complaints;
- (e) Clinical audit.

I am unclear as to the period covered by this. My Directorate of Planning and Performance Management worked closely with professional colleagues on a day to day basis on a range of issues. Development of the "Best Practice : Best Care" agenda involved close multi-disciplinary working. Assessment of capital projects and capital priorities would have always quality of care at its heart and major studies and reviews eg Renal Services, Cardiac Surgery, Children Matter Taskforce would have issues of quality and safety at their core.

(20) If there were communications of the kind mentioned:

- (a) Please give examples of the matters which were the subject of the communications;

Already covered in (19).

- (b) Were there established systems/forums in the Department for such communications?

Such communication could be in daily contact in person or on paper or in established Working Groups, Review Groups or ad hoc meetings.

#### ADDITIONAL QUERIES

(21) Between 1995 and 2003, what policies were there for the dissemination of guidelines / protocols from the Department down to Boards / Trusts?

Depending on the subject matter the Department would issue circulars/guidelines to Boards and Trusts and other Agencies. I am not aware of specific policies for the dissemination of guidelines/protocols.

(22) How was the implementation of such guidelines and protocols by Boards and Trusts examined / assessed / monitored?

It would depend on the nature of the guideline/protocol. They could range from commending good practice on an issue to setting specific requirements and/or setting targets. As such there might be no follow up action with the matter left to the organisations' discretion or at the other end of the spectrum clear and explicit reporting requirements. It should be noted that the range of issues on which DHSSPS would issue guidance was diverse and complex.

(23) How would the Department be made aware of issues / areas that required dissemination of information / protocols? In particular, how would Boards / Trusts make the Department aware of such issues?

This again is a complex matter. The driver for such guidance could be manifold: developments in clinical practice; read across of UK/international learning; changes in financial standards; changes to health and safety requirements; changes to estate standards; implications of legislation; implementation of new policy. This is illustrative and is not intended to be comprehensive. Similarly HPSS interests could flag up issues on which there was uncertainty and seeks a clear steer from the Department.

- (24) How would the Department be involved in the dissemination of materials amongst Boards / Trusts?

The Department would normally issue guidelines to Board and Trusts (and other Agencies interests as necessary eg GPs) and expect each organisation to ensure appropriate dissemination. In certain cases there might be a follow up with workshops etc but this was not necessarily standard or indeed appropriate in all cases.

- (25) What do you consider to have been the main impetus behind the creation of a formal adverse incident reporting system from 2002?

I am not in a position to comment authoritatively on this. It is a fact however that there was growing recognition of the need to introduce and formalise clinical governance in the HPSS in the wake of "Best Practice : Best Care". In the light of the 1998 survey by Healthcare Risk Resources International it is perhaps not surprising that a formal system was introduced from 2002.

- (26) Why was a formal approach not adopted for adverse incident reporting prior to 2002?

I am not in a position to comment on that.

- (27) Prior to 2002, what would you have expected Trusts / Hospitals to have done (if anything) in regard to informing the Department when cases involving deaths due to possible medical mismanagement were involved in:

- (a) Formal complaint procedures
- (b) Coroner's Inquests
- (c) Medical negligence actions?

I am not in a position to comment on this. There may be many instances where cases involving death due to possible medical mismanagement were involved in:-

- Formal complaints procedure
- Coroner's inquests
- Medical negligence actions.

I might reasonably have had an expectation that the Department would be alerted once negligence or some other deficiency was established.

- (28) The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis Q.C. was published on Wednesday 6<sup>th</sup> February 2013. One of its key recommendations was that of 'openness and candour', namely that: *"Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful."*

- (a) What were your expectations of how the Trusts dealt with the deaths of Adam / Claire / Raychel / Lucy, and how did their actions meet or fail to meet your expectations?



I had no reason to have any expectation of how the Trust would deal with the deaths of Adam/Claire/Raychel/Lucy;

- (b) What were your expectations in situations where the Trust(s) withheld relevant documents on grounds of privilege?

I have no recollection of having to address such an issue at that time so I had no reason to have any expectation;

- (c) What were your expectations in situations where the Trust(s) did not make public acceptance of liability in medical negligence actions?

Again I had no cause to have any expectation on these issues.

- (29) Mr. Clive Gowdy, former Permanent Secretary, DHSSPS, stated in his Inquiry Witness Statement [Ref: WS-062/1, page 4] as follows:

*"In December 1998, the Department commissioned Healthcare Risk Resources International consultants to undertake a survey of risk management in all HPSS organisations. The terms of reference for the survey were to determine the level of application of risk management methods and the implementation of best risk management practices within these organisations. Incident reporting was one of the items included in the survey. [...] There was a general perception that there might have been a significant level of under-reporting of adverse incidents."*

- (a) Were you aware of this report and its findings? Please provide a copy of the report if you are able to do so.

I have a vague recollection of the survey but no detailed knowledge of it.

- (b) What was done as a result of the report's finding that *"there might have been a significant level of under-reporting of adverse incidents"*?

I was not responsible for commissioning the report nor therefore for follow up. I have no knowledge of what was done as a direct result of this finding which is somewhat tentative. The introduction of a formal adverse incident reporting system in 2002 did address the issue to a degree.

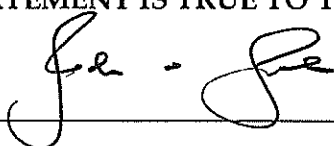
- (30) Provide any further points and comments that you wish to make, together with any relevant documents.

I have endeavoured to address the Inquiry's questions to the best of my ability some 10 years plus after I left DHSSPS with no reason in the interim to revisit the subject matter or refresh my memory. Beyond the Job Description I have no relevant documents to offer.

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THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:



Dated: 14/10/2013

**JOB TITLE: DIRECTOR OF PLANNING AND PERFORMANCE MANAGEMENT**

**PURPOSES AND RESPONSIBILITIES OF JOB**

1. To take the lead in developing and implementing strengthened planning and performance management arrangements within the HPSS to meet the expectations of the Minister, the Assembly and the Executive Committee.
2. The Director's responsibilities cover: HPSS planning and priorities in the context of the programme for Government; planning and prioritisation of capital investment; policy and legislation for quality management in the HPSS; policy on service user involvement and experience including the Charter and complaints procedure; performance management of Boards, Trust and Agencies; policy and oversight of procurement in the HPSS; corporate governance in the HPSS; public appointments within the HPSS.

**ORGANISATIONAL POSITION**

3. The postholder reports to the Deputy Secretary, Management Group. The Directorate structure is as follows:

Director

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Deputy Director

Capital  
Investment Unit

Deputy Director

Planning and  
Priorities Unit

Deputy Director

Performance  
Management  
(Northern,  
Southern,  
Western)

Deputy Director

Quality &  
Performance  
Improvement  
Unit

Deputy Director

Performance  
Management  
Unit (Eastern)

Asst Director

Public  
Appointments  
Unit

## CONTEXT

4. The Directorate was established on the creation of DHSSPS with devolution in December 1999. It was intended to provide a focus for clearer direction to, strengthened performance management of and more rigorous accountability from the HPSS, particularly Boards and Trusts, to enable the Department to fully support the Minister in discharging her portfolio and reporting to the Assembly and the HPSSPS Committee. In particular this would involve promoting greater co-operation within the HPSS, removing any remaining mechanisms or behaviour appropriate to the internal market and instilling, across the range of organisations with still a substantial degree of delegation and autonomy, a clearer sense of common purpose and readiness to work within the parameters set by the Executive Committee, the Minister and the Assembly.
  
5. In this context the following are key priorities for the postholders to lead on:-
  - Monitoring implementation of Priorities for Action, the Minister's agenda for the HPSS in 2001/2002;
  - Putting in place arrangement for new planning arrangements based on Health and Well-being Investment Plans to be prepared by Boards and supporting Implementation Plans by Trusts, from 2002/2003 onwards;
  - Leading the consultation process on the proposals for better quality management in the HPSS set out in "Best Practice – Best Care";
  - Developing the consequent legislative proposals to go forward in the planned HPSS (No 2) Bill, in the autumn of 2001;
  - Supporting Minister in taking these proposals forward into legislation in 2002;
  - Developing a new Accountability Framework for the HPSS, reflecting closer and more regular monitoring and oversight of the new 30 bodies, particularly 19 Trusts;
  - Implementing these new arrangements in the 2001/2002 financial year to support the Minister in achieving how aims of consolidating services, achieving financial stability and delivering key priorities;
  - Developing a Performance Management Framework for the HPSS to provide a clear focus for monitoring and target-setting and to enable more objective assessment of the

efficiency, effectiveness and outcomes provided by the HPSS, in accounting to the Minister, the assembly and the community at large;

- Producing for consultation a Capital Investment Strategy for the HPSS;
- Monitoring major capital schemes and providing advice on the handling and priorities of other substantial and sensitive Business Case looming up eg Ulster Hospital, BCH Cancer Centre, RVH Phase II;
- Contributing to the resource acquisition process in general in relation to the determination of priorities but also specifically for capital funds and for Executive programme Funds;
- In close conjunction with Finance Division, assessing and 'signing off' Recovery Plans for a range of HSS trusts facing income/expenditure deficits;
- Developing the Department public appointment procedures to widen the 'pool' of candidates to be more reflective of the community in line with Minister's wishes;
- Leading an audit of these procedures to ensure that the Department continues to be regarded as setting the standard within NICS;
- Developing proposals for greater user participation in the planning and delivery of services;
- Participating in a range of corporate exercises, eg Needs and Effectiveness Study with DFP; Community Care Review; Cardiac Surgery Review; Children Matter Taskforce;
- Providing high quality support to Minister in discharging her duties particularly in relation to the Assembly and the Executive Committee;
- Leading the Departmental input in one of the five areas of co-operation highlighted in Good Friday agreement.

#### ALLOCATION OF TIME

- |  |       |
|--|-------|
| 6. - Internal Departmental activities (desk-time, internal meetings, phone calls, meeting staff) | - 25% |
| - Formal meeting with HPSS   | -15%  |
| - Corporate Departmental work  | - 20% |
| - Supporting Minister (legislation, consultation activity, etc)                                  | - 40% |

## MANAGEMENT OF PEOPLE /

7. The Directorate has 30.5 staff located in Dundonald House at present. Challenges on this front are:

- Continuing to promote and transmit the 'vision' of the new Directorate, its role and its responsibilities to staff;
- Developing some stability in the light of significant turnover at senior level in the Directorate lately and creating a greater sense of ownership and corporate identity;
- Ensuring that the Directorate operates on as 'devolved' a basis as possible consistent with maintaining quality support for the Minister;
- Putting in place job description and objectives for all staff and establishing a development programme aimed at enabling staff to adjust better to the rising and more complex workload generated under devolution;
- Putting in place and maximising vehicles for regular communication with staff to achieve a greater sense of ownership and involvement, particularly with the split location between Castle Buildings and Dundonald House.

## ACCOUNTABILITY 2

8. The postholder is responsible for a DRC budget of £1.01m. He is also responsible for programme funds as follows –

- :- the HPSS capital Budget £65m in 2001/2002;
- :- £300,000 for development work.

9. Within the oversight of the Permanent Secretary and Deputy Secretary, and the parameters of Ministerial accountability the postholder is required to make independent decisions and provide advice such as:

- Acceptability and handling of proposals for major capital investment, including priority for funding;
- The overall allocation of the £60m + capital resources available to the HPSS;

- Advising the Minister on the development of proposal and their presentation for consultation, to the Executive Committee, the Assembly Committee and the public on quality management;
- Advising Minister and the Departmental Board on the performance of HPSS bodies;
- Chairing selection panels for non-executive posts in the HPSS and offering advice to the Minister in the context of the Commissioner's guidance.
- Providing on a continuing basis, advice to Minister on sensitive issues attracting criticism in the Assembly or the community at large eg service priorities, capital investment, Trust performance;
- Advising Minister, with Finance Division, on the robustness and feasibility of Recovery Plans from Trusts in deficit.

## JUDGEMENT ?

10. The postholder is required to provide high quality resolve advice to the Minister, the Permanent Secretary and the Deputy Secretary. He is required to have a sharp awareness of the 'political' environment within which the HPSS operates and to be in a position to identify strengths and weaknesses in policies and proposals and the potential for opportunities to be exploited or risks to be avoided. Increasingly under devolution he is required to address issues for which there is no suitable guidance or precedent because of the changed and evolving political context locally and also because of the new constraints and requirements flowing from the operation of the Assembly, the Executive and the requirements of the Ministerial Code. The quality, depth and complexity of thinking may be exemplified as follows;

- Judgement on the handling of the BCH Cancer Centre. Despite increasing public expectation and impatience about the perceived delay, the postholder judged that the Trust needed to redo the core Business Case because of the rising estimates of costs. Failure to do so could have exposed the Minister's criticism about breaking Government guidelines on investment and ignoring VFM.
- Shaping the content of Priorities for Action ensuring that it represented a challenging agenda for the HPSS but avoiding aspirational targets which could only be achieved at the risk of financial instability. This means that key areas of development had to be excluded.

The judgement was that criticism over this was more manageable and less damaging than falsely raising expectations or promoting unsupported investment.

- Striking the correct balance between direction and persuasion in dealing with HPSS bodies, and in resolving disputes between such bodies eg Capital Investments – Recovery Plans.

## INFLUENCING 2

11. This is a key component of the post. The postholder is expected to exercise a high degree of influence and persuasion, covering both formal and informal contacts within NICS, with the Assembly, within the Department and within the HPSS. In particular as a central 'corporate' post within the Department the postholder is expected to demonstrate particular persuasive and networking skills in securing corporate consensus and brokering solutions.

12. The following encapsulate the influencing skills required of the postholder;

- Brokering consensus between 4 Boards and the RGH Trust on the cost implications of commissioning Phase I of the RVH redevelopment;
- Leading similar exercise to agree way forward on handling of Cancer Centre at BCH;
- Leading, with Finance Division, negotiations with Boards and Trusts on formulation and agreement of Recovery Plans;
- Explaining and communicating to Boards and Trust Chief Executives and colleagues the Minister's and Department's expectations of them in implementing new service and financial planning arrangements;
- Liaising with departmental colleagues including professional colleagues in securing agreement to input in Priorities for Action which reflects sea change in the Department's management of the HPSS;
- Appearing before the Assembly Committee in conjunction with colleagues, to explain Ministerial policy and proposed legislation;
- Continuing liaison and networking with Chairmen explaining Ministerial expectations of them and their bodies;
- Persuading Chairmen of the desirability of the Minister's new inclusive approach to public appointments and the implications of this for the make-up of their NED team ;

- Brokering solutions to long-standing and apparently intractable problems eg CSA accommodation.

### ABILITIES/PROFESSIONAL EXPERTISE D

13. There are no requirements for the postholder to be professionally qualified. It is essential, however, that the postholder possess the following key abilities:

- The ability to take a strategic overview and determine priorities taking account of political and resource constraints;
- The ability to identify challenges, opportunities and risks to Ministerial policy in the local political context;
- The ability to maintain a watching brief across a wide range of diverse subjects and to set the appropriate strategic framework for other staff to work to;
- The ability to respond flexibly to work pressures, particularly Ministerial, while still maintaining the overall Directorate momentum;
- The ability to prioritise work between a range of pressures, all competing for priority;
- The ability to represent the Minister, and the Department, in formal and semi-formal settings where one might be tested on issues of policy or funding;
- The ability to work in a collective manner with professional and administrative colleagues to recognise the importance of the collective goal over individual Directorate priorities; and
- The ability to empower and motivate staff to deal with an increasing workload and cope with continuing DRC pressures.