Terms of Reference for the statutory Public Inquiry established to review matters related to the Neurology Service provided by the Belfast Trust

This Public Inquiry has been converted from the original non-statutory Independent Neurology Inquiry (INI). The Chairmanship and panel for the inquiry will remain unchanged from the INI.

The work will form part of a series of actions which have been initiated by the Department in response to the recall of patients. This includes work being taken forward by the Regulation and Quality Improvement Authority (RQIA) as follows:

- A review of the governance of outpatient services in the Belfast HSC Trust, with a particular focus on neurology services. This review will then be extended to cover all four remaining HSC Trusts over the subsequent 12-18 months;
- An expert review of the records of all patients or former patients of Dr Michael Watt, who have died over the past ten years; and
- A review of the corporate and clinical governance of health services delivered in the independent sector in Northern Ireland.

The clinical practice of Dr Michael Watt is being investigated by the General Medical Council (GMC) and employer led processes under Departmental Guidance on "Maintaining High Professional Standards in the Modern HPSS", it would, therefore, be inappropriate for the Public Inquiry to encroach on the GMC's remit or employer led processes. However, the Panel will consider the role of the Trust as an employer in terms of professional practice in the context of the Trust's system of Governance during the period covered by the Public Inquiry.

The Terms of Reference of the Public Inquiry remain unchanged and are outlined below:

a) In relation to the circumstances which led to the recall of patients in May 2018 (for the period from November 2016 until May 2018), to evaluate the corporate governance (with particular reference to clinical governance) procedures and arrangements within the Belfast Trust. This specifically includes the

communication and escalation of the reporting of issues related to potential concerns about patient care and safety, within and between the Belfast Trust, the HSC Board and Public Health Agency, the Department and any other areas which directly bear on patient care and safety and the general public, including an assessment of the role of the Board of the Belfast Trust;

b) To review the Belfast Trust's handling of relevant complaints or concerns, identified or received prior to November 2016, and participation in processes to maintain standards of professional practice, including appraisals. The Panel are asked to determine whether there were any related concerns or circumstances which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and the existing complaints procedure; and
c) To identify any learning points and make recommendations to the Department in relation to points (a) and (b) above. In particular to consider the application of any learning arising from the Inquiry to the framework for clinical social care governance, the current balance between problem sensing and assurance seeking in the extant system and its underpinning processes.

The Public Inquiry Review Panel will be chaired by Mr Brett Lockhart QC working together, and in partnership with Dr Hugo Mascie-Taylor.

The methodology to be used by the Public Inquiry Review Panel is outlined below:

There are 2 main phases envisaged of the Panel's work; to submit a preliminary report as soon as practicable to the Department and at that stage advise the Department as to when the final report and recommendations will be provided to the Department. Should the Panel, as part of their Review, establish any issue of concern, which they believe needs to be brought to the Department's immediate attention, then this will be done.

The Public Inquiry will be an inquisitorial inquiry. The Panel has a legitimate expectation of full cooperation by all parties involved, as affirmed by the Department, reflecting the professional duty of candour and HSC Code of Conduct. The Chair will determine how further they wish to conduct the review.