Thursday 2nd July 2026

RQIA Authority Meeting

Speaking Rights: Save Our Acute Services (SOAS)

Deputation: Helen Hamill (Secretary)
Jimmy Hamill (Chairperson)

In Relation to: Pathways Inspection Report (RQIA):
Emergency General Surgery in the Western Trust Following the Temporary Suspension of Services at South West Acute Hospital

Attachment: Letter
From: Robert Francis QC, Inquiry Chairman - Mid Staffordshire NHS Foundation Trust Public Inquiry
To: The Rt Hon Jeremy Hunt MP, Secretary of State for Health
On: 5th February 2013

'An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern'.
(Sir Robert Francis QC, 2013 Report of the Mid Staffordshire NHS Foundation Trust)

Sent to RQIA on 7th May 2024 – Attachment #48

[1] INTRODUCTION

Thank you for the opportunity to speak today.

We want to be clear at the outset. We are genuinely dissatisfied with this report. We believe the report inappropriately presents a picture of these pathways as having improved, while important and significant evidence in the report itself points in a very different direction. The unannounced inspection report states:

> *"In conclusion, RQIA acknowledges improvement in a number of areas across the Pathways"*
> *"Notwithstanding improvements in the EGS pathways, further measures are recommended to sustain and continue improvements." (p6)*

We directly challenge this suggestion of improvements to the pathways. Staff statements recorded in the same report describe worsening conditions in emergency departments, no significant changes to improve the system despite concerns being raised at every level, and continuing operational failures across the pathway.

This 'disconnect' matters. Senior management in the Western Trust stated:

> *"Senior managers based in Altnagelvin believed the EGS pathways were working well. They did however acknowledge that challenges were encountered when the pathways were first introduced, but believed these had resolved over time" (p10)*

In contrast, frontline staff comments describe delays, uncertainty, conflict, broken relationships, poor morale and patients coming to harm. In our view, that is not a minor difference of emphasis. It is a central problem with the report.

We want to retain a working relationship with the regulator and that should allow for respectful challenge. Our honest view is that this report does not reflect the seriousness of what staff, patients and families have been saying for a considerable period of time.

We should also acknowledge that we had a constructive and open meeting with the regulator on Monday of this week, and we welcome the opportunity for that kind of direct engagement.

[2] THE 'UNANNOUNCED INSPECTION' REPORT

2.1 Overall assessment

Our overall assessment is that this report is overly reassuring and sidesteps the hard conclusions that the frontline staff evidence requires.

It consistently gives greater weight to senior management assurances than to frontline testimony. Senior managers are recorded as believing the pathways are working well and that early challenges have resolved, while staff describe worsening conditions in ED, repeated delays, uncertainty over clinical ownership of patients and sustained tension between services.

That is the central disconnect in this report: a calm management narrative set against a much more troubling frontline reality. In the context of past public inquiries such as Mid Staffordshire, where exactly this kind of contradiction between management messaging and staff experience was identified as a key warning sign, this should have been treated as a serious concern rather than smoothed into a narrative of "improved pathways".

2.2 Audit failure and lack of meaningful data

One of the clearest warnings in this report relates to the ongoing failure of the Western Trust to produce audit information that enables the regulator to be actually able to assess these pathways properly. The regulator states:

> *"Overall, the Cycle 1 and Cycle 2 audits highlighted that current data collection is not capturing the wider scope of the extent of the pathways, nor process or outcome measures, to meaningfully assess performance, quality of decision-making, or the wider system impact."*

That is a very serious finding. It means that even now, after all of this time, the Trust still does not have the basic audit evidence needed to show whether these pathways are safe, effective or sustainable.

What makes that even more concerning is that this is not new.

In the original January 2025 RQIA Review, the regulator had already said:

> *"The review findings demonstrate that there is a need for clinical evaluation / audit."*
> *"The effectiveness of the clinical pathways put in place cannot be fully determined without this evidence."*

So, we are now in a position where, 18 months later, the same fundamental weakness remains. That should have been treated as a major red flag and much more prominently reflected in the overall findings.

This is not a minor issue. As SOAS set out in its detailed response to the 2025 Review, failures in audit, patient recording and governance go to the heart of whether any claim about improved pathways can be trusted at all. In our view, this failing alone should have prevented any positive statement from the regulator about pathway improvement.

2.3 Staff evidence and red flags

One of the most important problems here is that the staff evidence should have triggered a much stronger response from the regulator.

The report states that during the inspections, staff on both sites and in the ambulance service reported ongoing challenges with the implementation of the pathways, including:

- Long transfer delays – with an extra 12.8 hours in transfer time for surgical SWAH patients,
- Statement from NIAS senior management that it is "not uncommon for the Enniskillen area to have no ambulances",
- EM consultants stating patients have come to harm directly contradicting senior management claims,
- No diagnostic availability over weekends,
- Breakdown of ED to NIAS staff relationships, and
- delays in handovers on arrival at Altnagelvin.

In our view, each of those points is a red flag. Taken together, they show a pathway that is failing in practice and putting patients at risk.

The report says that relationships between SWAH ED staff and NIAS crews had broken down, and that a concerted effort was required to restore and improve relationships and communication. We think the language here still understates the seriousness. The phrase we heard from RQIA at our meeting on Monday is that relationships are "very, very fractured", and that this should have been recognised as a red flag in its own right.

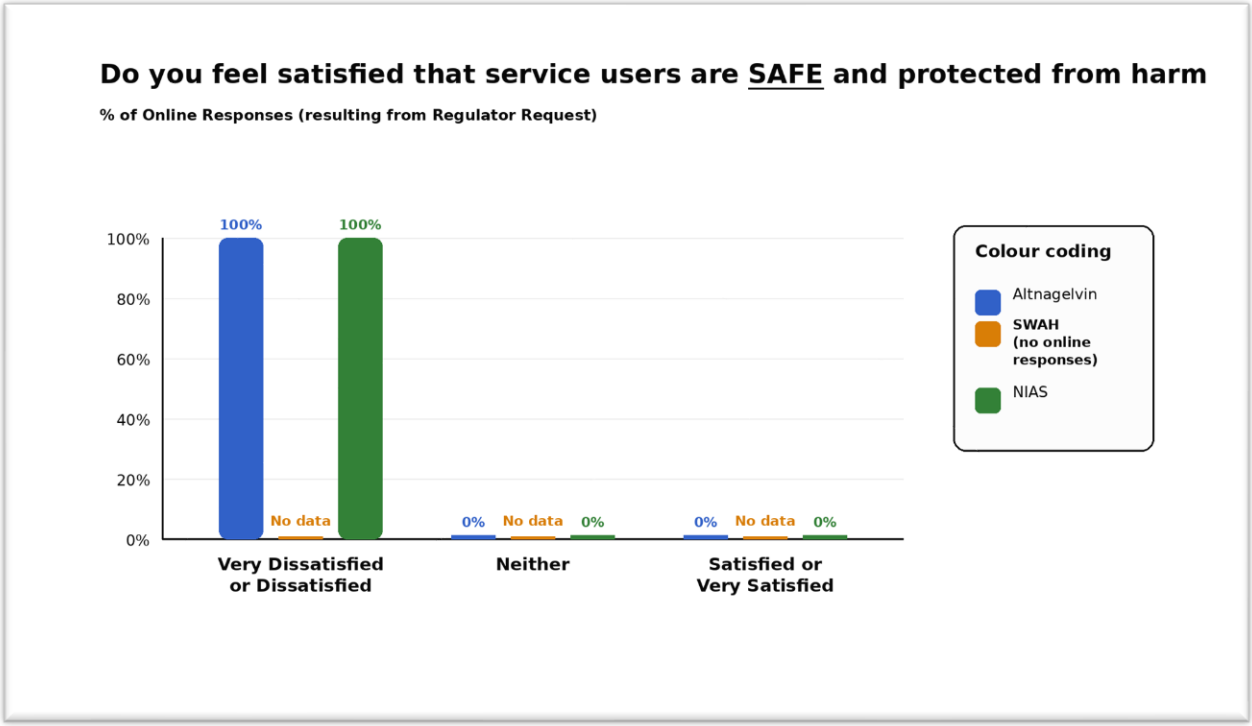
Later in the report, staff said professional relationships had broken down since the implementation of the pathway, and NIAS staff separately described a breakdown in communication and said that adverse incidents raised through Datix were not acknowledged or addressed. Again, those are not routine operational problems. They are serious warnings about system dysfunction.

There should have been much more emphasis throughout the report on the fact that there were multiple red flags from staff comments alone. Instead, the report often acknowledges the concern, but then moves quickly back to reassurance.

2.4 Survey findings

The staff survey findings are among the most striking parts of the report, and they deserve far more prominence than they were given.

In the online staff survey response to the regulator request, 100% of respondents felt service users were not safe and protected from harm, 91% believed the care delivered was not effective.



Those are extraordinary figures. They should have been front and centre in any balanced assessment of whether these pathways are safe and effective. Instead, they are buried in the body of the report - the graph above is from SOAS, not from the report. This sits uneasily beside the more reassuring tone of the summary and the wider RQIA media messaging around improvement in the pathways.

The same section records that 73% of staff believed service users were not treated with compassion and 77% believed the service was not managed well.

These findings should have influenced the outcome of the report much more significantly. We believe that the regulator should not describe pathways as improved while also recording that 100% of frontline staff online respondents said care was not safe.

2.5 Ongoing communication with the regulator

We also need to evidence more clearly that these concerns did not appear out of nowhere.

There has been ongoing, detailed communication between SOAS and the regulator over a long period of time. We also presented to the RQIA Authority in April 2025 when we pointed out that there had been close liaison with the regulator since April 2023, focused in particular on patient safety issues related to the pathways after the suspension of emergency surgery at SWAH. That matters because many of the issues now appearing in staff comments are issues that had already been raised in detail by us.

Those concerns included patient safety, delays, transport problems, adverse incident handling, governance concerns, and the wider consequences of pathway changes. So, when the current report presents several of these matters as if they are newly noted issues to be managed through workshops, further audit or future plans, it does not reflect the depth or duration of the concerns that had already been communicated to the regulator.

That history should have informed a tougher report and stronger conclusions, particularly when the regulator itself stated:

> *"This inspection was undertaken in response to increasing intelligence received by RQIA from patients and relatives, highlighting concerns about patient safety in relation to the temporary EGS pathways."*

2.6 Staff voices from face-to-face interviews

The reality of the pathways described by staff is straightforward.
We include a small sample of the many statements below:

> *"EM consultants refuted suggestions that patients had not come to harm and cited cases where requests for external review were not supported." (p15)*

> *"NIAS senior management reported that there was a knock on effect for all these transfers and advised it is not uncommon for the Enniskillen area to have no ambulances." (p22)*

> *"in SWAH ED where staff reported that relationships with ambulance staff had come under increasing pressures to the extent where it was felt that professional relationships had broken down since the implementation of EGS pathway." (p20)*

> *"NIAS staff commented on the pressures on the provision of emergency ambulances and expressed concerned that the demand on emergency vehicles for transfers*

affects the overall availability of emergency ambulances therefore leaving the rural community vulnerable." (p22)

Staff report that patients wait too long, transfers take too long and they are left dealing with delays, shortages and disputes while patients and families carry the consequences.

These concerns came face-to-face from staff in both EDs and from NIAS. NIAS senior management appeared more willing than the Western Trust to acknowledge the scale of those concerns, including the impact on ambulance cover in rural areas.

Taken together, this section describes a service under constant strain, with frontline staff saying clearly that conditions are worsening, not improving:

"Staff reported no significant changes have been made to improve the system or address the issues despite concerns being raised at every level of the Trust's management structure with worsening conditions prevailing over a number of years." (p31)

2.7 Relationships and system failure

Frontline staff confirm broken professional relationships, regular breakdowns in communication, NIAS staff saying they are experiencing burnout and that long-standing issues are affecting their wellbeing. That is not a healthy system under pressure. That is a very fractured system.

We say plainly, again, that the voices of the frontline staff should have been treated as a major red flag by the regulator. In healthcare systems, when staff say relationships between core teams have broken down and senior management present an opposite view, patient safety is put at risk because communication, trust and shared decision-making begin to fail exactly where they matter most.

The proposed answer in the report in its 4 Areas for Improvement are insufficient. Proposals including documentation of years-old pathways, workshops and reciprocal shadowing, feels far too limited for a problem of this scale. After three and a half years, the fact that such basic repair work is still needed is itself evidence of how serious the failure has been.

2.8 Medical wards and palliative surgical patients

Taken together, the report's references to palliative care point to a serious concern.

A distinct pathway now exists for some emergency surgical patients at SWAH, excluding them from the transfer pathway and instead directing them to be managed medically in SWAH as palliative patients.

This is a direct consequence of the temporary pathways created after surgery was suspended. It is not a normal service model, and the public has never been clearly told that it exists.

Our key concern is that decisions about palliation may be taken in a hospital without emergency surgery on site and without direct consultant surgeon involvement at the point it is most needed. We are also concerned that the reported issues around availability of diagnostic imaging, particularly at weekends, will further direct decisions on whether a patient should be considered as palliative.

EM consultants questioned the interpretation of mortality trends – if these patients are managed medically and excluded from the surgical cohort, then claims of improved surgical mortality become much harder to accept.

[3] WHAT'S NEXT?

Our position is clear - we are genuinely dissatisfied with this report. It understates the seriousness of the evidence, overstates improvement, and under-represents frontline staff warnings about safety, effectiveness and worsening conditions.

This is not just a flaw in one report. It reflects a wider problem in Northern Ireland healthcare, where independence and accountability remain deeply unconvincing despite repeated scandals and reviews. Staff and patient evidence should be central, yet again it appears secondary to institutional reassurance.

On Tuesday, the Minister of Health said that "too many stark examples of concerns not being heard" characterise current inspections and reviews in Northern Ireland. One of the missed opportunities here is the treatment of staff testimony. Staff were courageous enough to come forward face-to-face and give honest accounts of what is happening. When evidence of that strength is then underrepresented in the summary, confidence in the regulator's independence is inevitably damaged.

We do not want to reach a point, years from now, where another public inquiry is needed to confirm what staff are saying today. RQIA should now make clear to the public and the minister that these pathways are not shown to be safe or effective, and that serious consideration must be given to a funded emergency surgical service at SWAH aligned with the clinical interdependencies set out in the 2022 Review of General Surgery.

If that does not happen, then the warning already set out at the start of this letter from the Mid-Staffordshire Public Enquiry will fit this report exactly:

"an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern".

ENDS

Letter to the Secretary of State

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The Rt Hon Jeremy Hunt MP
Secretary of State for Health
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5 February 2013

Dear Secretary of State

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

As you know, I was appointed by your predecessor to chair a public inquiry under the Inquiries Act 2005 into the serious failings at the Mid Staffordshire NHS Foundation Trust. Under the Terms of Reference of the Inquiry, I now submit to you the final report.

Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even

after the start of the Healthcare Commission investigation, conducted because of the realisation that there was serious cause for concern, patients were, in my view, left at risk with inadequate intervention until after the completion of that investigation a year later. In short, a system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system.

The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

I have made a great many recommendations, no single one of which is on its own the solution to the many concerns identified. The essential aims of what I have suggested are to:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;

- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

In introducing the first report, I said that it should be patients – not numbers – which counted. That remains my view. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary. But it is not the system itself which will ensure that the patient is put first day in and day out. Any system should be capable of caring and delivering an acceptable level of care to each patient treated, but this report shows that this cannot be assumed to be happening.

The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed. This does not require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it.

Yours sincerely

Robert Francis QC
Inquiry Chairman