

Oral Hearing

Day 9 – Tuesday, 15th November 2022

**Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)**

Held at: Bradford Court, Belfast

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

Gwen Malone Stenography Services

1 THE INQUIRY RESUMED ON TUESDAY, 15TH DAY OF
2 NOVEMBER, 2022 AS FOLLOWS:

3
4 CHAIR: Morning, everyone. Morning, Mr. May.

5 MS. McMAHON: Today we will be hearing evidence from 10:12
6 Mr. Peter May, who is the current Permanent Secretary
7 for the Department of Health. I believe Mr. May is
8 going to affirm.

9
10 THE WITNESS, HAVING AFFIRMED, WAS EXAMINED BY 10:12
11 MS. McMAHON AS FOLLOWS:

12
13 MS. McMAHON: Good morning, Mr. May.

14 A. Morning.

15 1 Q. You have already provided a detailed written witness 10:13
16 statement to the Inquiry, that was dated 18th August
17 2022. I don't think you have your bundle in front of
18 you, but in the bundle it runs from page 11 to 79. If
19 I could ask that to be called up, at WIT-42367. Can
20 I ask you just do you recognise that statement? 10:13

21 A. There's nothing showing on my screen at the moment.

22 2 Q. I have it on my screen. Still nothing there?

23 A. No.

24 CHAIR: It seems to be there's a problem with
25 technologies on Tuesday mornings in the Inquiry, but 10:14
26 hopefully it's easily sorted.

27 MS. McMAHON: Do you have a copy of your statement in
28 front of you?

29 A. As it happens, I don't have it, I'm afraid. I can go

1 and get it. It's in the car.

2 3 Q. We can get you one that's a little bit closer.

3 A. It might be switching it on was the trick. Okay.

4 4 Q. You have it now?

5 A. I can see it now, thank you. 10:14

6 5 Q. You recognise that statement?

7 A. Yeah.

8 6 Q. If you go to the last page of that, WIT-42427. Actually

9 I think your signature is at the very first page?

10 A. I have seen my signature and I recognise my signature. 10:14

11 7 Q. Do you wish to adopt that as your evidence to the

12 Inquiry?

13 A. Yes. Can I make two comments on it, of fact? The

14 first relates to paragraph 88 of the statement, where

15 I refer to the Southern Trust having completed the MHPS 10:15

16 process. I think it's fair to say the timings are not

17 accurate, are not correct in that respect.

18

19 The second is in relation to paragraphs 132 and 142

20 relating to Early Alerts and SAIs. Those two 10:15

21 paragraphs have got swapped somehow and each should be

22 in the other place, so I would ask that that be

23 corrected.

24 8 Q. Thank you for that. We will disregard paragraph 88 and

25 then read those paragraphs as though they were swapped? 10:15

26 A. It's just that the paragraph 88, the timings are wrong

27 in paragraph 88, so...

28 9 Q. The reason why you are here today is you are the

29 current Permanent Secretary of the Department of

1 Health. Your predecessor was Richard Pengelly, from
2 2014 to 2022. Then before Mr. Pengelly was Andrew
3 McCormack?

4 A. That's correct.

5 10 Q. You only took up post in April of this year?

10:16

6 A. Correct.

7 11 Q. So most of the key events had already occurred, so the
8 Panel is aware of that. I am grateful for you coming
9 along to give us an outline of the role of the
10 Department. In your role you are the principal adviser
11 to the Minister for Health and the Accounting Officer
12 for the Department. You say in your statement that
13 you.

10:16

14

15 "... are required to ensure that the Department, and
16 any subsidiary of it, or arm's length body sponsored by
17 it, operates effectively and to a high standard".

10:16

18

19 You have also indicated that your personal knowledge is
20 limited, just as a caveat from the outset, and in
21 preparing your statement, you relied on a review of the
22 documents held by the Department, and the recollections
23 of your staff who had first-hand experience?

10:16

24 A. That's correct.

25 12 Q. There are four broad topics that I wish to discuss with
26 you today. Before moving on to that, is there anything
27 you would like to say, in general terms, before we move
28 into the detail of your statement?

10:17

29 A. Thank you for that opportunity. I would just like to,

1 firstly, apologise, on behalf of the Health and Social
2 Care Services, and acknowledge the concerns, distress
3 and anxiety for all the patients and families affected
4 by both the Urology Lookback Review, and the matters
5 relating to this Inquiry. I'm sure this has been
6 a very anxious time for the patients and families
7 concerned.

10:17

8
9 More broadly, the Inquiry is one of a number of public
10 inquiries, which has been established by the
11 Department. Some have been completed but there are
12 a number that are similar in nature due to serious
13 concerns raised relating to patient safety issues, and
14 I do want to stress how important it is that we learn
15 how we arrived here and improve the way these vital
16 services are delivered. Finally, just to assure you
17 that I am here to assist the Inquiry in any way I can
18 with the genuine commitment to do all I can as
19 Permanent Secretary of the Department of Health to
20 ensure that the confidence in our healthcare systems
21 can be restored. Thank you.

10:17

10:17

10:18

22 13 Q. Thank you for that. The general approach to your
23 evidence we will take today, probably the most brief
24 will be your involvement with the issues regarding
25 Urology since taking up your post in April 2022. Then
26 a broad outline of the healthcare structures and the
27 general relationship between the Department and the
28 Trusts. Then I would like to look at a number of
29 issues that emerge from your evidence, most

10:18

1 particularly because those are the issues by which the
2 Department and other bodies attain assurance from the
3 Trust about Clinical Standards and governance in
4 general, and then really just a mop-up of other
5 miscellaneous issues that have arisen that I would like 10:19
6 to give you the opportunity to comment on.

7
8 Finally, as the conclusion at the end of all of this,
9 I will be asking you what observations you have about
10 how the Department's systems and their processes are 10:19
11 operating in general, and that will be out of the
12 evidence I know you are going to give, and you have
13 given in written form to the Inquiry about developments
14 to date.

15 10:19
16 Just before going into that, so the Panel are aware of
17 your experience. You have set out your previous roles
18 in your statement. You were the Permanent Secretary in
19 the Department of Justice. What when did you hold that
20 post? 10:19

21 A. Between 2018 and 2022.

22 14 Q. Then you'd also been the Permanent Secretary for the
23 Department for Infrastructure?

24 A. Between 2014 and 2018.

25 15 Q. How long, in general, have you been in the Civil 10:19
26 Service?

27 A. 35 years.

28 16 Q. Your involvement since April 2022, I understand from
29 your statement, is you Chair the Urology Assurance

1 Group?

2 A. That's correct.

3 17 Q. Could you just set out in terms what that group is and
4 what it does?

5 A. Yes, certainly. It's a group that was established in 10:20
6 had 2020. I think there have been 18 meetings so far.
7 It draws together colleagues from a number of different
8 parts within the Department and from the Southern
9 Trust. It's got a series of Terms of Reference that
10 have been set out. Its primary function has been to 10:20
11 look at the review in relation to the lookback, to look
12 at what more needs to be done in terms of any patient
13 safety issues that arise. It's very much looking at
14 what else needs to be done in order to provide
15 assurance that we have addressed any harm that may have 10:20
16 been caused by the circumstances.

17 18 Q. How often does the group meet?

18 A. I think initially it met very regularly. It meets less
19 frequently. It's actually meeting later this week. So
20 I think it meets based on need rather than on a fixed 10:21
21 pattern, but as I said, there have been 18 meetings.
22 It was meeting very regularly at the very start at the
23 end of 2020, and less frequently since then.

24 19 Q. Would it be fair to describe that as a rolling review
25 of issues that are emerging through the different 10:21
26 processes the Trust have undertaken to get a full
27 picture of what the current circumstances are as well?

28 A. Yes. So the Trust would provide an update at the start
29 of each of the meetings, drawing out what further it

1 had discovered through the various pieces of work that
2 have been set out, obviously looking also at work done
3 by the RQIA and others, one of the Royal Colleges in
4 terms of the lookback, so trying to draw together all
5 of that information and then, as I said, to make
6 assessments about were there any further intervention
7 or action is needed; whether, for example, there is
8 a need to extend the Lookback Review in any shape or
9 form, and how best to do that.

10:21

10 20 Q. We will go on and look later on in your evidence at the
11 developments with RQIA and things that they have
12 undertaken for the Department, reviews they have
13 undertaken and how that may inform governance. First
14 of all, if I could set out in broad terms what the
15 Department's role is. Obviously being a public
16 inquiry, not everyone may understand there are
17 a separation of roles and responsibilities. The
18 function of the Department is to really formulate and
19 implement policy and legislation, and oversee the
20 allocation of healthcare resources. In doing that, the
21 Department then doesn't provide healthcare as such,
22 that is the role of the arm's length bodies beneath the
23 Department. I understand, in our documentation, we
24 refer to the Health and Social Care Board as being one
25 of the key players, along with the Public Health Agency
26 as being commissioners for healthcare, but I understand
27 that that HSCB no longer exists in that format. Could
28 you just explain the change that has occurred around
29 that and what implications there may be for governance

10:22

10:22

10:22

10:23

1 in general?

2 A. Okay. The Health and Social Care Board ceased to be an
3 entity in April 2022 as a result of legislation passed
4 by the Assembly. The functions performed by the board
5 have been subsumed within the Department of Health, 10:23
6 within a group called SPPG, the Strategic Planning and
7 Performance Group of the Department, so all of the
8 functions that were performed by the Board are now
9 performed by the Department.

10 21 Q. In that change-over, is there any change in governance 10:23
11 structures how they communicate with the Trust or
12 feedback generally to the Department, or is it the same
13 framework in place?

14 A. It's essentially the same framework, albeit that
15 inevitably the Board used to be an arm's length body of 10:24
16 the Department, so that was a different relationship.
17 Now it's within the Department, so it's changed the
18 nature of that relationship. Like with all
19 organisational changes, the full impacts take some time
20 to work their way through. 10:24

21 22 Q. The Inquiry have received a statement from the HSCB (as
22 was) under the new guise of the -- obviously our Terms
23 of Reference cover a different period so it's important
24 for the Inquiry to understand if it is to make
25 recommendations around any of the governance 10:24
26 structures, if there have been any fundamental changes
27 within that, so I can take that up with, I think it is
28 Ms. Gallagher from the HSCB. Just by way of further
29 understanding of where accountability lies and where

1 the lines of governance are, the Department is
2 required, under Section 5 of the Reform Act, to prepare
3 a framework document, and we have a copy of that at
4 DOH-35616. What that document does is set out the
5 roles and responsibilities of each of the Health and 10:25
6 Social Care bodies. I want to look at that very
7 briefly so that we can understand then, first of all,
8 the way in which information was expected to be
9 provided to the Department and what may have gone
10 wrong, but also to understand what other organisations 10:25
11 may have done had they been given information, or what
12 they did do when they were given that information. Is
13 your screen working okay?

14 A. I've got the front page of the document up at the
15 moment. 10:26

16 23 Q. If we go to page DOH-35622? I don't want to spend an
17 awful long time on this, but I think it is important to
18 set it out for both your evidence and future witnesses.
19 You will see on that page there is a diagram setting
20 out the Department as the overarching body responsible 10:26
21 for healthcare. Beneath that we have the HSCB, Public
22 Health Agency, RQIA, and the Patient and Client
23 Council. Then the Trusts sit under the HSCB, and then
24 other agencies as relevant. If I ask you to go to the
25 preceding page of that, at paragraph 1.8 -- I am just 10:26
26 going to read this out:

27
28 "To all of the Health and Social Care bodies referred
29 to in this document that we have just looked at, remain

1 ultimately accountable to the Department for the
2 discharge of the functions set out in their founding
3 legislation. The changes introduced by the Reform Act
4 augment but do not detract from that fundamental
5 accountability".

10:27

6
7 So I don't think there's anything contentious about
8 that, the Department has the overall responsibility.

9
10 Page DOH-35624 in that document refers to Performance
11 Management and Service Improvement. This is described
12 as:

10:27

13
14 "A process of developing a culture of continuous
15 improvement in the interests of patients, clients and
16 carers, by monitoring Health and Social Care
17 performance against relevant objectives, targets and
18 standards, promptly and effectively addressing poor
19 performance to appropriate interventions, service
20 development and, where necessary, the application of
21 sanctions and identifying and promulgating best
22 practice, working with the PHA, the HSCB has an
23 important role to play in providing professional
24 leadership".

10:27

10:28

25
26 Then again at DOH-35627. In relation to the six
27 Trusts, they are:

10:28

28
29 "... established to provide goods and services for the

1 purpose of Health and Social Care and, with the
2 exception of the Ambulance Trust, are also responsible
3 for exercising, on behalf of the HSCB, certain
4 statutory functions which are delegated to them by
5 virtue of authorisations made under the Health and 10:28
6 Personal Social Services (Northern Ireland) Order 1994.
7 Each Health and Social Care Trust also has a statutory
8 obligation to put and keep in place arrangements for
9 monitoring and improving the quality of Health and
10 Social Care which it provides to individuals and the 10:29
11 environment in which it provides them."
12

13 Again, I'm just setting this out so we know what is
14 expected from each of the bodies.

15 10:29
16 Page DOH-35629 mentions the RQIA, that's the
17 enforcement authority, and its job. You can ask it to
18 provide advice, reports or information on such matters
19 relating to the provision of services or the exercise
20 of its functions as may be requested by the Department. 10:29
21

22 In general terms, the Department utilise the HSCB to
23 commission healthcare services that is then provided by
24 the Trusts?

25 A. Yeah, the SPPG, or the Board as was, commissioning is 10:29
26 one of its three functions. Performance management and
27 resource management are the other two.

28 24 Q. In relation to the actual delivery of healthcare, the
29 lines of how that is delivered in Northern Ireland pass

1 through HSCB, they commission and the Trust provide.
2 That will become important for the Inquiry when they
3 look at what was done at various times, what the Health
4 and Social Care Board may have known.

5
6 The other important document, I suppose, for the
7 purposes of the understanding of roles, is the
8 Management Statement between the Department of Health
9 and the Southern Health and Social Care Trust, which
10 can be found at TRU-01864. I think this document was
11 in your bundle as well, Mr. May. It's the only copy
12 that we have and it's dated, I think, 2017. What this
13 document appears to do is it sets out the relationship
14 between the Department and the Trust in the healthcare
15 provision. Is it a document that you are familiar
16 with?

- 17 A. Yeah. I haven't spent a lot of time studying it but
18 yes, all our arm's length bodies will have a Management
19 Statement. They will all follow a very similar
20 template, and then there will be adjustments made
21 depending on the nature of the individual organisation.
22 It's a document on which often alongside the Management
23 Statement, there would then be a series of delegations
24 provided to each arm's length body that would specify,
25 for example, the amounts of money that could be spent
26 without seeking departmental approval and the nature
27 of, at what point, so if something is novel and
28 contentious then it may need to come to the Department
29 for approval before it can proceed. It's the core

1 document that defines the accountability arrangements
2 for each of the arm's length bodies and is regularly
3 reviewed at the moment. There's a proposal to move to
4 something called a Partnership Agreement to change the
5 way in which Management Statements operate to clarify 10:32
6 better the nature of the relationship between
7 Departments and their arm's length bodies as
8 recognising the delivery part in the nature of much of
9 the roles in many of our arm's length bodies.

10 25 Q. You have mentioned about it being reviewed. Is that a 10:32
11 process of review is that's undertaken in conjunction
12 with the Trust Board?

13 A. Yes, well with the trust including its Board, yes.

14 26 Q. Is there a plan to review that?

15 A. There's a proposal that all of the Management 10:32
16 Statements -- right across government we're looking to
17 move from management statements to partnership
18 agreements, and there have been some documents produced
19 that inform the principles that should be used. We are
20 still at a relatively early stage of that work. Covid 10:33
21 has, as in a number of areas, it's delayed the speed at
22 which we have been able to progress that.

23 27 Q. Is it anticipated that that will result in any
24 fundamental change in the accountability lines or the
25 governance lines that currently exist? 10:33

26 A. No, I don't think -- it won't fundamentally change.
27 That would need to go into primary legislation rather
28 than the Management Statement.

29 28 Q. It isn't a case of something has been identified as

1 being absent or a problem that has resulted in the need
2 for change?

3 A. No, I think it's more that, to caricature, the
4 Management Statement might envisage a kind of
5 parent-child relationship between Department and arm's 10:33
6 length body and a partnership agreement might recognise
7 there's more a partnership involved, so it's
8 a different way of way of looking at the relationship
9 rather than fundamentally -- there will still be an
10 accountability line from the arm's length body to the 10:34
11 Department in recognition, just as the Department is
12 accountable to the Assembly for all of its functions.

13 29 Q. Just in relation to the accountability, I just want to
14 highlight a couple of matters in this document as well.
15 TRU-01867. This deals with responsibilities and 10:34
16 accountability at paragraph 3.1.

17
18 "The Minister is accountable to the Northern Ireland
19 Assembly for the activities and performance of the
20 Southern Trust." 10:34

21
22 Over the page, TRU-01868, at 3.2.3, it gives reference
23 to you:

24
25 "The Departmental Accounting Officer is also 10:34
26 responsible for ensuring that arrangements are in
27 place to continuously monitor the Southern Trust's
28 activities to measure progress against approved
29 targets, standards and actions, and to assess

1 compliance with safety and quality, governance, risk
2 management, and other relevant requirements placed on
3 the organisation, and to address significant problems
4 in the Trust making such interventions as he/she judges
5 necessary to address such problems".

10:35

6
7 And just over the page:

8
9 "Periodically carry out an assessment of the risks,
10 both to the Departments and the Trust's objectives and
11 activities, and bring concerns about the activities of
12 the Trust to the full Southern Board requiring
13 explanations and assurances that appropriate action has
14 been taken".

10:35

15
16 If I can just pause there and bring that home, as it
17 were, and ask: in reality, what does the Department do
18 to fulfil their role in overseeing the Trust and the
19 quality of care, safety, governance and the risk
20 management?

10:35

10:36

- 21 A. There are a range of different mechanisms that the
22 Department will employ. Obviously the Department
23 appoints the Chair and the Board of the Trust. In
24 addition to that, it will seek reliance from the way in
25 which the Board goes about its business, including the
26 way internal audit and external audit functions
27 operate. There are twice annual assurance statements
28 which each arm's length body completes, including the
29 Southern Trust, and while that process and the one I am

10:36

1 about to describe was stood down during Covid they are
2 being restarted this year, so there's also then an
3 accountability meeting that will be held twice annually
4 with the Chair and the Chief Executive of each of the
5 arm's length bodies, and that is designed to go over 10:36
6 any issues that have been identified in relation to the
7 way in which the Trust, in this case, has carried out
8 its business. I think it's important to note that
9 Clinical Governance is not a responsibility of the
10 Department; that sits outside of the remit. The 10:37
11 Department doesn't have the skills or the capacity to
12 do Clinical Governance, so that's a separate aspect,
13 and is managed in a different way.

14 30 Q. When you say Clinical Governance sits outside the remit
15 of the Department, where do you say it sits? 10:37

16 A. Again, there are a range of different ways in which
17 Clinical Governance is managed. Partly there are
18 professional bodies that oversee individual clinicians.
19 Then there is the RQIA that will look at how the actual
20 operation of various aspects of Clinical Governance 10:38
21 operates and make recommendations as a Regulator.

22 31 Q. Would they make recommendations if there is clinical
23 risk, just so I can understand precisely the issue
24 around Clinical Governance. When RQIA make
25 recommendations around areas of clinical risk they have 10:38
26 identified, who do they then go to for action on that?
27 Who do they see as being responsible for that?

28 A. The Trust would be responsible for responding to any
29 inspection done in relation to the work of that Trust,

1 and the Department would then -- its oversight role
2 would kick in to demonstrate that, would ask the Trust
3 to demonstrate it had actually taken the steps that are
4 necessary in order to comply with any recommendations.
5 Obviously there may or may not be a dispute about 10:39
6 whether the recommendations are accepted, but if those
7 recommendations are accepted, then there would be
8 a record kept as to the extent to which those
9 recommendations have been implemented.

10 32 Q. Is it the case that the Trust can ask the RQIA to 10:39
11 oversee their governance risk? Can they actually
12 independently ask them to get involved in oversight or
13 does that come from the Department?

14 A. I confess to not knowing the answer to that
15 specifically, and I can find that out and come back to 10:39
16 you, as to whether there is a statutory requirement
17 that the Department has to technically sign off on any
18 request. I know informally the Trust could ask the
19 RQIA to assist them, but I don't know whether there's
20 a formal loop that requires the Department's 10:39
21 intervention or not, I would need to check that.

22 33 Q. That would be helpful. It would would be helpful to
23 understand if it is the Department who must trigger the
24 RQIA's involvement, how they might be expected to know
25 about the existence of clinical risk or governance 10:40
26 concerns, if the Department doesn't have direct
27 involvement in that, so it's just to give another layer
28 of understanding --

29 A. Okay.

1 34 Q. -- in relation to that. The Inquiry have received
2 a statement from Sharon Gallagher from the Health and
3 Social Care Board (as was). We don't need to go to the
4 statement, but I am just struck by the same language
5 that has been used. She says also that: 10:40
6
7 "The SPPG does not have a role in evaluating the
8 effectiveness of the Corporate and Clinical Governance
9 procedures within the Trust".
10 10:40
11 Just for the Inquiry's note, that is at WIT-66188,
12 paragraph 39 and 40.
13 A. The corporate governance aspect of that would be
14 addressed by the Department through the Management
15 Statement, and the various mechanisms that I have 10:41
16 described. Just to clarify, it would have been done by
17 the policy side of the Department, as it is now.
18 Obviously it gets more confusing, the Board doesn't
19 exist and is part of the Department, but its remit is
20 to look at the commissioning and the performance of the 10:41
21 Health and Social Care system rather than its Corporate
22 Governance arrangements.
23 35 Q. In taking your evidence and Ms. Gallagher's, is it the
24 case that the Trust self-regulates its own Clinical
25 Governance? 10:41
26 A. As I said, the Regulator is the RQIA and I think that's
27 the key aspect. You showed previously a diagram
28 showing the Regulators on the diagram as to how the
29 structures work, and that's how there's oversight

1 provided in relation to those aspects. Then, as I
2 said, there are independent, the Royal Colleges and
3 other statutory -- sorry,. The GMC and other bodies
4 provide oversight in relation to clinicians, and there
5 are various processes which doubtless we will come on
6 to in respect of that. 10:42

7 36 Q. Just while we are on the RQIA, I wonder if we could
8 just deal with that particular issue now? You begin
9 your evidence on the RQIA at WIT-42412, and it's
10 paragraph 144 for your note. 10:42

11
12 Just to run-through this, to get to the final point
13 about the forthcoming review. At paragraph 146 you say
14 that:

15
16 "In 2014, the RQIA was tasked to undertake inspections
17 of acute hospitals." 10:42

18
19 I don't think there's been an inspection of the
20 Southern Trust. We haven't got anything on the papers
21 as far as I'm aware. To follow that up, if you have
22 information on that that would be helpful. 10:43

23 A. I can check.

24 37 Q. Over at paragraph 149, you say:

25
26 "The RQIA's hospitals programme team had planned to
27 undertake a series of inspections to Outpatients'
28 Departments during 2021 and 2022 as part of the
29 follow-up of the RQIA Review of Governance Arrangements 10:43

1 in the Belfast Trust."

2

3 I don't think that happened, did it?

4 A. No. As I said, it's been deferred. It's one of those 10:43
5 things that, because of Covid, it wasn't considered the
6 appropriate time to do that work.

7 38 Q. I wonder if you could just explain a little bit more at
8 paragraph 151, the first sentence:

9

10 "Hospitals are not regulated in Northern Ireland, RQIA 10:43
11 can however issue improvement notices where they find
12 non-compliance with the 2006 quality standards".

13

14 Just for purposes of understanding, when you say 10:44
15 hospitals are not regulated in Northern Ireland, what
16 does that mean, for the purposes of governance? The
17 reason why I ask you that is because we spoke about
18 RQIA having the oversight of governance.

19 A. I think it is the Trust is seen as the unit to be 10:44
20 regulated rather than the individual hospital.

21 39 Q. At the moment, the RQIA don't go into hospitals and
22 carry out assessments that they would, for example, in
23 nursing homes? Just in language people can understand,
24 for the purposes of investigation, the RQIA's function
25 doesn't extend to Acute Services? 10:45

26 A. I'm afraid that's something that I would need to
27 explore further. I don't want to say something I don't
28 know to be accurate so I'd rather respond more fully
29 when I've had the chance to explore that.

1 CHAIR: Mr. May, in ease of yourself, we are very
2 conscious that you are new to your current role and
3 there's a lot of information that you wouldn't have at
4 your fingertips, so we do appreciate you won't have all
5 of the answers here today.

10:45

6 A. I have done my best to - as best as I can, but I'm
7 conscious I may not know all the answers, apologies.

8 MS. McMAHON: Yes, I am just trying to establish the
9 framework so we understand where we can look for
10 further information. If we go to the last paragraph in
11 that section on the RQIA at WIT-42415? I just want to
12 tentatively ask you about the review of RQIA. Is that
13 something you can provide information on?

10:45

14 A. So there's a fundamental review of regulation, and
15 there's been a good deal of work already done in
16 relation to that. I can give you a little bit more
17 information in relation to that. A new regulatory
18 policy has been drafted which would widen the scope of
19 the services to be regulated and give the Regulator
20 wider powers of enforcement. We are at the stage where
21 that draft policy would be presented to an incoming
22 Minister and we would seek their approval to launch
23 a public consultation about the work that's been done
24 in order to -- fundamentally that would need to lead to
25 new primary legislation, because you could not give the
26 Regulator new services to regulate or wider powers of
27 enforcement without primary legislation to support
28 that. It's part of a process that we are going
29 through. We have done the first stage, which is review

10:46

10:46

10:46

1 of the policy. There would then be a consultation.
2 There would then be a drafting of the legislation and
3 passage of the legislation with any amendment the
4 Assembly chose to make on its way to completion.

5 40 Q. That might be something we hear periodically throughout 10:47
6 your evidence, the issue of things getting so far and
7 perhaps not then getting across the finish line, in the
8 absence of an Executive and a Minister. Could I ask
9 you, just in general terms, what you can do about
10 developments and recommendations? we will talk about 10:47
11 the hyponatraemia recommendations, and obviously
12 recommendations from this Inquiry, how far can you take
13 that when there is no Minister in place?

14 A. It's difficult to answer that in abstract because the 10:47
15 reality is that you need to look at the individual
16 recommendations. In relation to, for example, the
17 Hyponatraemia Inquiry, there's a well-established
18 approach where the Minister has accepted or otherwise
19 the recommendations, work is proceeding to
20 implementation, that would not be affected at all by 10:48
21 the absence of a Minister, save for where primary
22 legislation is required. Clearly there's no means of
23 passing primary legislation in the absence of
24 a Minister or an Assembly to oversee that. The general
25 rule of thumb in the absence of ministers is that civil 10:48
26 servants should not take decisions that would normally
27 have gone to a Minister. It is conceivable, certainly
28 at the end of the last interregnum between 2017 and
29 2020, towards the end of that period, the UK Government

1 passed some legislation giving limited powers of
2 decision-making to civil servants, and we wait to see
3 whether that is something that's going to be
4 reinstated on this occasion or not. There's always
5 a judgment to be made about how far it's sensible or 10:49
6 possible to go. There's a question about whether we
7 could launch, for example, a public consultation or not
8 because that's not -- it's a decision but it's not
9 taking a final decision, it's merely enabling the
10 public to comment on something and other interested 10:49
11 parties, and those sort of decisions will be taken on
12 a case-by-case basis.

13 41 Q. Just another couple of examples from that, while we are
14 on that topic. For example, the Duty of Candour issue
15 that was one of the recommendations from the 10:49
16 Hyponatraemia Inquiry. Is that a recommendation that
17 perhaps will fall short in the absence of a Minister?

18 A. That's an area where the Minister had the chance to
19 consider that issue and the policy direction that he
20 set was he asked that further work be done before 10:49
21 reaching a final decision on whether a legislative Duty
22 of Candour should be introduced or not, and that work
23 is being taken forward at the moment. We are trying to
24 develop something called a 'being open' framework and
25 some work is being done. We are using the Belfast 10:50
26 Trust as our pathfinder, and the Belfast Trust
27 volunteered to be the pathfinder for that work, so will
28 involve an engagement with Clinicians about there being
29 open framework, the development of that framework with

1 a view to them being able to advice to an incoming
2 Minister around whether a legislative Duty of Candour
3 would be the right way to proceed or not. There are,
4 as so often in these areas, contrasting views with --
5 obviously the Hyponatraemia Inquiry recommended 10:50
6 a statutory Duty of Candour on individual
7 practitioners. That would be in advance of where the
8 rest of the UK is currently, although recently there
9 was a report done in relation to health matters in east
10 Kent that have made some recommendations that are not 10:51
11 dissimilar in relation to Duty of Candour, so we keep
12 in close contact with our counterparts in England,
13 Scotland, and wales to understand how that is being
14 developed. The initial work is around it being open
15 framework in order to inform the final decision about 10:51
16 whether a legislative Duty of Candour would be a good
17 idea or not.

18 42 Q. If it is the legislative framework that is required to
19 bring that recommendation into effect, it does, in
20 short terms, require a Minister in post? 10:51

21 A. It does. It would, of course, have been conceivable
22 for a Minister to have brought that forward when we did
23 have a Minister and that wasn't a decision that our
24 outgoing Minister took.

25 43 Q. One of the other matters that requires a Minister is 10:51
26 one of the other recommendations from the
27 Hyponatraemia, is the introduction of the independent
28 medical examiner whose role would be to scrutinise
29 hospital deaths not referred to the Coroner. It's at

1 WIT-85756, just so you can see it on your screen. You
2 will see there's a non-statutory prototype at the
3 moment. If you can speak to that?

4 A. There are non-statutory prototypes operating across all
5 five of our Trusts, so when a doctor completes 10:52
6 a medical certificate of cause of death, an independent
7 examiner reviews the certificate, together with the
8 patient's clinical record, and has a discussion with
9 the certifying doctor about the circumstances of the
10 death. I have actually visited and seen that in 10:52
11 operation. The purpose is to ensure that deaths
12 occurring in hospital are appropriately reported to the
13 coroner when there's a need to do so. It should also
14 reassure the family that the death certificate is
15 reasonable and accurate, and that if any safety or 10:53
16 governance issues are identified these are brought to
17 the attention of the relevant Trust in order that
18 immediate action can be taken if it's required. What
19 we are now looking at, or the non-statutory office of
20 the independent medical examiner is looking at is the 10:53
21 most appropriate way in which a statutory service might
22 interact with bereaved families, and how the system can
23 include reviews of those deaths occurring in community
24 settings which are usually certified by GPs. That's
25 logistically a much more complex challenge. The 10:53
26 prototype should provide all of the required
27 information to inform the development of a statutory
28 service for Northern Ireland.

29 44 Q. Has that again found itself in the same area as the

1 Duty of Candour, in that there is a statutory framework
2 required to make real that recommendation?

3 A. In order to move it from being a non-statutory to
4 a statutory service there certainly needs to be
5 legislation. That's stating the obvious. I think it's 10:54
6 fair to say there's some further work to be done about
7 how the community settings could be incorporated. It
8 would be desirable, and probably preferable, to make
9 a decision on the scope of the IME work at the
10 beginning of the policy work to develop the 10:54
11 legislation, and while we can see how it would work and
12 does work in relation to Trusts, we don't yet have as
13 clear a view as to how it would work in a community
14 setting. As I said, the extra complexity with GPs is
15 more significant. 10:54

16 45 Q. I think there's no doubt that there's a bit more work
17 to be done in the operational outworkings of these
18 issues, but the point, I suppose, for our purposes in
19 understanding recommendations that this Inquiry may
20 make and the reality of those taking effect, is that 10:54
21 issues are percolating up from various inquiries, from
22 recommendations, and in the absence of a Minister they
23 are really not going anywhere else?

24 A. The work is proceeding to try to implement those that
25 we have had a policy steer on, and we would look at any 10:55
26 recommendations this Inquiry or any other Inquiry made
27 to see what we could sensibly take forward. Any
28 recommendations that require primary legislation would
29 need to await a Minister coming into office.

1 46 Q. Just at the bottom of that page, WIT-85757. This is
2 the update from your Department to the Inquiry on your
3 website. There's the recommendation of RQIA review of
4 series adverse incidents?

5 A. Yes. 10:55

6 47 Q. The recommendation, I think, has been taken forward and
7 a report is now published in June of this year. Do you
8 have an update on what's happening with that report and
9 the recommendations made by the RQIA, given that SAIs,
10 Serious Adverse Incidents, have played such a key role 10:56
11 in the documentation leading to this Inquiry, and will
12 be subject to significant analysis by the Inquiry and
13 various witnesses who will be called?

14 A. When the RQIA review was published on 7th July, the
15 Minister gave a commitment to support the redesign and 10:56
16 implementation of a new regional SAI procedure, to
17 ensure HSC staff, service users and their families were
18 all supported as active participants in the review
19 process. We are currently scoping the systems in other
20 countries and drawing together Terms of Reference to 10:56
21 take forward the implementation of those
22 recommendations, so that is not something that needs to
23 await an incoming Minister because we have a policy
24 steer from our outgoing Minister. We will continue to
25 follow that policy steer until such time as we have 10:57
26 a new Minister. In this area I would assess it
27 unlikely that an incoming Minister would come in and
28 want to change the approach that has been recommended
29 by RQIA, so we will proceed at the moment with this

1 work.

2 48 Q. Can you proceed to final conclusion with those
3 recommendations or is it again another potential
4 roadblock in that?

5 A. Obviously it's something we keep under review, but, on 10:57
6 the face of it, I don't see why we couldn't proceed to
7 take this work forward. I don't know whether there
8 would come a particular point where a decision is
9 needed that I would feel was beyond, would normally
10 have been taken by a Minister, I would need to reflect 10:57
11 on that, but a number of these things look as though
12 they are things that could be developed in the absence
13 of a Minister.

14 49 Q. Anything that falls into that particular criteria could
15 have been made by a Minister, then it's effectively 10:58
16 hands off?

17 A. As I said, subject to any decision that the UK
18 Government may take to reintroduce some modest
19 decision-making powers for civil servants.

20 50 Q. Just the assurance that you received by arm's length 10:58
21 bodies you have referred to in paragraphs 11 and 12 of
22 your statement, at WIT-42369. I just wonder if you
23 could just explain them just a little bit more?
24 Paragraph 11 refers to the period of 2003/2004 where:
25
26 "... the Department utilised controls, assurance
27 standards as a means of arm's length bodies' boards
28 providing evidence and assurance that they were doing
29 their reasonable best to manage themselves in meeting

1 their objectives and protect stakeholders against
2 risk".

3
4 I think that's even further back than you need to go.

5 Paragraph 12:

10:59

6
7 "The current system from the 1st April 2018 is
8 a revised approach of proportionate assurance was
9 introduced whereby arm's length bodies provide
10 assurance to policy leads in the Department with
11 respect to their compliance with Departmental policy".

10:59

12
13 I just wonder if you could tell us how that actually
14 operates?

15 A. Yeah. I think the pre-existing mechanisms were seen as
16 being too cumbersome and placing a disproportionate
17 burden on some of the smaller ALBs. The new
18 arrangements were designed to be more proportionate, to
19 streamline the approach, reduce duplication and provide
20 clarity on the level of assurance required by the
21 Department. So the key method by which the
22 proportionate assurance is provided is through the
23 midyear Assurance and Governance Statements that
24 I referred to earlier, and that accountability process
25 is the way in which exceptional issues are highlighted,
26 that would then feed into the accountability meetings
27 that are held twice a year, in addition to any
28 performance concerns and other wider issues that may be
29 relevant. That doesn't stop Chief Executives from

10:59

11:00

11:00

1 putting in place other arrangements within their own
2 organisation to give them the assurances as Accounting
3 Officer of their own organisation that they require.

4 51 Q. Just in general terms, when you receive assurances from
5 arm's length bodies, is there any way that you test 11:00
6 those assurances, how robust they may be or how strong
7 they may be before you can take assurance from them?

8 A. You are continually taking an overview of the work of
9 an arm's length body and you are drawing on the various
10 different methods that you have. I would talk to the 11:01
11 Chairs of the Trusts on a regular basis. I would have
12 meetings with the Chief Executives, usually

13 collectively, but obviously on specific issues on
14 a one-to-one basis. As I said, there are then the
15 internal and external audit arrangements are put in 11:01
16 place and the Department reviews the way in which the

17 Board goes about its business on a regular basis, so
18 there are a range of different ways in which you build
19 a picture up of an organisation. What we don't have
20 the resource or the time to do is to drill down into 11:01
21 each individual assurance that's provided in order to

22 assess whether or not that is accurate. There is
23 a very small team that would act as what's called the
24 sponsor branch within the Department for all of the

25 Trusts, and its role could not be to perform that very 11:02
26 detailed checking role. Indeed, I'm struck by the fact
27 that if you worked in Whitehall at the moment the
28 amount of checking and assurance done in relation to
29 arm's length bodies is massively less than it would be

1 in Northern Ireland, and some people inevitably are
2 seeing that that is a potential way that a resource
3 could be saved in Northern Ireland compared to
4 Whitehall counterparts. Against that, there's always
5 a challenge that if something goes wrong in an arm's 11:02
6 length body, what did the Department know, how did it
7 oversee? You are forever trying to manage and reach
8 the right balance, and almost inevitably if something
9 goes wrong then the balance is seen to be wrong and you
10 should have intervened more, but by intervening more 11:02
11 you create more bureaucracy, you create more stickiness
12 in the system that actually makes it harder for high
13 levels of performance to be achieved. That is always
14 the balance and, as I said, you always try to look at
15 what the risk profile for each ALB is and how much 11:03
16 confidence from the interactions you have collectively,
17 because it's very rarely the case that there's
18 a problem in one specific area and it's not, you know,
19 if you're looking at the Corporate Governance aspects
20 that it's not then something that should be looked at 11:03
21 more widely in that context.

22 52 Q. Thank you for explaining that, and an interesting point
23 about the position in England. There is a tension
24 obviously between providing the Service and overseeing
25 it, in trying to maintain that tension and also meet 11:03
26 the expectations of both the legislative requirements
27 of the Department, the Framework, the Management
28 Statement, the Policy and Procedures, but I think what
29 the documents from this morning would indicate is that

1 effectively the buck stops with the Department as
2 regards accountability. Would you agree with that?

3 A. Yes, the system of governance we have is that the
4 Assembly is responsible for everything that happens
5 within the devolved sphere in Northern Ireland, and the 11:04
6 Department and the Minister are the key building block
7 by which they then hold to account for the delivery of
8 all of those aspects of Service that fall within that
9 Department.

10 53 Q. I know you are not long in the job, but I wonder if 11:04
11 I could just ask you some general questions about how
12 you perceive things to operate at the moment?

13 A. Sure.

14 54 Q. Is it the case, from what we have said already, that
15 the Department doesn't know what's wrong unless someone 11:04
16 tells them? Is that too general a statement or do you
17 have to wait until information makes its way to the
18 Department? There's no proactive way of you seeking
19 that information out.

20 A. I think, and I refer back to the diagram you helpfully 11:05
21 showed at the very beginning, and I don't know if that
22 can be brought back up on to the screen, but there are
23 multiple ways in which the Department can gain
24 information and knowledge, in addition to the more
25 informal ways that I described just now. The work of 11:05
26 the Regulator is the work of the various audit bodies,
27 and so on, all are ways in which you gain wider
28 information on a regular basis.
29

1 I'm just going to wait for this to come back up, if
2 I may, to see if there's anything further that occurs
3 when I see it again.

4 55 Q. I think what that does show is it shows where everyone
5 sits in relation to each other, and you are relying on 11:05
6 that to say that information can come from all of those
7 sources; is that right?

8 A. There's a variety of different ways in which we get
9 information, is the point. We haven't mentioned the
10 PCC, but the Patient Client Council is another way in 11:06
11 which information flows to the Department, as it does
12 through RQIA. I think it felt too bald a statement to
13 say that we need to be told something wrong in order to
14 know there's something wrong. There's a number of ways
15 in which there are designed to be checks and balances 11:06
16 within the system, so if something is not working the
17 way in which it should -- and I'm talking here in the
18 corporate governance space, not the Clinical Governance
19 space for the reasons I have described -- the
20 Department doesn't have the same remit in relation to 11:06
21 Clinical Governance, then there is a means by which
22 things will come to the Department's attention and
23 decisions can be taken about what is required.

24 56 Q. I think you have mentioned in your statement as well
25 and Mr. Wilson indicates that the Department didn't 11:07
26 know anything about what had happened in Urology until
27 31st July 2020?

28 A. Yes.

29 57 Q. None of those systems operated to bring that to the

1 Department's attention until that point. Is it your
2 position, your view that that was proper, given that
3 the issues that did eventually come to the Department
4 were Clinical Governance issues?

5 A. I'm not saying that it was proper, I think it's a fact 11:07
6 that it didn't come to the Department's attention until
7 that date. I think there's always questions about
8 whether there are things that could or should have been
9 done differently and whether connections could or
10 should have been made that would would have identified 11:07
11 some of these challenges more quickly. I think that's
12 obviously fundamentally part of the work the Inquiry is
13 doing. I think we'd all think there are, would there
14 be scope there for us to learn some lessons going
15 forward. 11:08

16 58 Q. Just following on from that then. Do you think that
17 the information that did become available in July
18 should have been made available to the Department
19 before that date, now that you know what you know about
20 that information? 11:08

21 A. I think that the area it seems to me that, you know,
22 could it, should it have been the case that a number of
23 different pieces of information would have been brought
24 together and that might have resulted in the issues
25 being elevated earlier, so there were some SAIs, as 11:08
26 I understand it, running in tandem with the MHPS
27 process and so on, and I don't know whether -- I think
28 that's the area where there could have been more, you
29 might have hoped there would have been more of

1 a connection made, and that might then have identified
2 it as more of an issue. I think that's probably the
3 area I would suggest.

4 59 Q. When you said earlier that the Department don't get
5 involved or have no role in Clinical Governance, does 11:09
6 that mean that the Department can't intervene if
7 required, or is the Department's power sufficiently
8 broad to intervene where it sees fit to do so, if
9 patient care and safety are an issue?

10 A. You can see from the way that the Urology Assurance 11:09
11 Group has worked in relation to defining the -- looking
12 at whether the scope of the Lookback exercise, Lookback
13 Review exercise was sufficient, whether the SCRR
14 process and overseeing all of that, so at a system
15 level, the Department can intervene and require actions 11:10
16 to be taken or work with, requisition RQIA to do work
17 in relation to specific actions. What the Department
18 doesn't do is to get involved in the individual
19 decision-making of a clinician in relation to
20 a patient, that's taking you into a different space. 11:10

21 60 Q. Just in your experience to date, what's your view of
22 how effective the oversight mechanisms in place are
23 generally, in general terms?

24 A. I think that's a very general question. Can you say
25 a little bit more about what you're referring to in 11:10
26 relation to oversight mechanisms?

27 61 Q. In relation to information making its way to the
28 Department that may be a cause for concern and the
29 robustness of that information, the frequency and the

1 time at which it's provided, and your ability to follow
2 up on any concerns that you have, do you feel that you
3 are satisfied that all of those issues are working as
4 they should be?

- 5 A. I mean, the way in which information of concern flows 11:11
6 to the Department is, broadly speaking, through the
7 Early Alert System, and that's a system that is
8 currently going to undergo a review. I think the Panel
9 will have evidence around the number of Early Alerts,
10 and there's been a significant growth in recent years 11:11
11 around Early Alerts. I think some of that can be
12 explained by Covid and the need to report outbreaks of
13 Covid, and so on, but there is inevitably a risk that,
14 over time, the filter that is supplied in relation to
15 Early Alerts can get broader more things than go 11:12
16 through the filter and more Early Alerts are raised.
17 There's then a question: Does that mean that there's
18 more to be worried about in the Health and Social Care
19 system or more is being reported than was being
20 reported previously? My sense is that, and then, as 11:12
21 you say, a question about is there capacity to do
22 something about all of those Early Alerts and so on.
23 I think because one of the grounds for the early alert
24 is that it may generate media interest and, at the
25 moment, you'll not have to go very far in order to 11:12
26 identify media interest in health issues. It may be
27 that we need to look again at how we draw that filter
28 in order to make sure that the Early Alerts are -- we
29 are confident that we are only things that are of real

1 significance that need to be looked into. There's
2 always going to be a risk that something doesn't come
3 forward because people don't feel it does meet the
4 terms, or perhaps is not recognised for the
5 significance that it has when it appears. I think 11:13
6 anyone sitting here would be foolish to say that they
7 have absolute confidence in a system of that nature.
8 It's all down to human judgment and prone to human
9 error in relation to how systems of that nature work.
10 My sense is that if we develop a new Early Alert 11:13
11 policy, try and make sure that we then do some work to
12 make sure the guidance is well understood, because
13 often words on a page can mean different things to
14 different people. I think we are not clear at the
15 moment that the policy is being implemented 11:13
16 consistently so that's, I think, the reason why we need
17 to get to that point. Again, I think that a review of
18 the nature of that sort is something that I could
19 advance in the absence of a Minister. I don't think it
20 takes a decision by a Minister. What we are trying to 11:14
21 do is make an existing policy work properly, as it
22 were, rather than create a new policy.

23 62 Q. The Inquiry will have heard about the RQIA review of
24 SAIs. The RQIA itself being reviewed or looked at the
25 powers. The Early Alert System is subject to review 11:14
26 and possible change. The other matter you'd mentioned
27 was Maintaining High Professional Standards, and that
28 was mentioned as a way in which you receive information
29 or seek to look at the robustness of governance in

1 Trusts?

2 A. I don't think I made reference to something that we
3 looked at. I think it was in relation to your question
4 about how Clinical Governance is exercised, although
5 I'd need to go back and review the transcript. 11:15

6 63 Q. I stand corrected on that point. If we look at it now,
7 MHPS, there were two reviews of this procedure by which
8 the Trust in considering the standards in relation to
9 practice of Clinicians, and you referred to it in your
10 witness statement in significant detail, but I think, 11:15
11 for our purposes, we only need to note that there was
12 a review due to start in 2011, and then one again in
13 2018, and neither of those reviews, for a variety of
14 reasons, actually took place. You do say in your
15 statement at paragraph 109, which is at WIT-42400, and 11:15
16 you say:

17
18 "Turning to the future action to strengthen the MHPS
19 policy, it is my view that a rapid but fundamental
20 review of MHPS must be started and, most importantly, 11:16
21 completed as soon as possible and as a matter of
22 priority."

23
24 I wonder if you could just speak to that statement and
25 give us a little bit more detail? 11:16

26 A. First perhaps to give a little bit of context around
27 how I see MHPS is sitting. It's part of a number of
28 different mechanisms that exist, all of which have some
29 bearing, and it may be useful to the Inquiry at this

1 stage. There's a professional appraisal process and
2 job planning process that I understand was introduced
3 in 2003. That was then supplemented in 2012 by the
4 revalidation process that all clinicians go through on
5 a three-yearly basis that is run by the GMC, and then 11:16
6 MHPS is something that sits, as it were, on top of and
7 alongside those various mechanisms. The first review
8 was in 2009. The second started in 2018. As you say,
9 neither of those was completed. Before the Minister
10 left, the outgoing Minister left office he agreed to 11:17
11 proceed with a review of MHPS. We are hoping that
12 review will commence early in the New Year. We are
13 currently looking at identifying suitable individuals
14 with an expertise who could come in and assist with
15 that process. I think there were already some issues 11:17
16 that were identified previously about the length of
17 time it takes to get through the various steps, the
18 clarity on roles, the need for clarity about which
19 professional groups are covered by the MHPS process,
20 including, for example, whether GPs and pharmacists are 11:17
21 within the scope or not. But alongside that we have
22 also more recently received the Neurology Inquiry
23 report which makes further recommendations around MHPS,
24 and obviously we'd want to take that into account. One
25 of the things that I'm keen to do is not to see 11:18
26 individual recommendations from Inquiries and do a kind
27 of tick box thing but we have to kind of join it all up
28 together because they are all part of a wider piece.
29 We have already talked about being open, and that's

1 a classic case where Hyponatraemia and Neurology both
2 say things about being open, and we need to join those
3 together, rather than seeing them as two separate
4 enterprises. Obviously with whatever recommendations
5 this Inquiry makes, we would look to follow the same 11:18
6 sort of broad approach. You need to be able to
7 demonstrate that you have, or haven't, fully
8 implemented what the Inquiry asked for, but also that
9 it's part of that wider view of what's being done in
10 the space to make sure that, as I said, we are not just 11:19
11 getting focused on individual aspects but we are seeing
12 this as a systemic issue.

13 64 Q. It's clear from your statement that there were some
14 confusions or uncertainties around where responsibility
15 for MHPS lay. I think that was in the previous 11:19
16 potential review in 2011?

17 A. Yes, that's been resolved. There's a clear lead within
18 the Department, and it's also clear who will provide
19 support to enable that work to be done.

20 65 Q. Do you have any view as to whether that confusion may 11:19
21 have contributed to the delay in getting MHPS reviewed
22 and changed as needed?

23 A. So far as I can assess, I think that it was much more
24 a question of prioritisation. There were multiple
25 things going on and inevitably an Inquiry looks at one 11:20
26 particular thing, and so on, but there's always lots of
27 other things going on, and the MHPS was seen, I think,
28 as perhaps being a bit clunky but not fundamentally
29 flawed, and, on that basis, the priority was to do some

1 of the other things. For example, I know there was
2 quite substantial work done in the 2009 review, but
3 then at the point when that was getting near to
4 a conclusion, the Revalidation issue was being
5 negotiated with the various medical associations, trade 11:20
6 unions, for want of a better word, and it may well be
7 that Revalidation was given priority as something that
8 was new and additional. MHPS can't be done on its own.
9 Even after the review it needs to be negotiated because
10 it relates to the kind of terms and conditions of 11:20
11 service for Clinicians. In 2018/2019, I think the
12 challenges were more, there was a major industrial
13 relations issue with the nursing strike, and then Covid
14 came in, and those were things that kind of prevented
15 that review from, I think that review was never as 11:21
16 fully taken forward as the 2009 one. I think it was
17 wider issues rather than the confusion that caused the
18 problem. Confusion doesn't help, but I don't think
19 that that was the fundamental problem.

20 66 Q. One of the other things, just before the break, 11:21
21 I wanted to mention, was the current involvement of
22 RQIA in looking at the Urology Services at the moment.
23 If I could ask for WIT-85746, the letter from the
24 Urology Services Inquiry to your Department. Following
25 the RQIA review of the Urology structure case record 11:22
26 review carried out by the Southern Trust, and in that
27 they made a recommendation number 13:
28
29 "That the Department of Health should commission the

1 RQIA to undertake a review of governance arrangements
2 within Urology Services in the Southern Trust and on
3 terms the Chair of the Inquiry sought information from
4 you to make sure that roles were clarified in relation
5 to the" terms of this Inquiry and that recommendation. 11:22
6 You wrote back, WIT-85748, by letter 9th November 2022.

7 A. I received a further letter this morning, I think
8 indicating that this issue is resolved at this stage.

9 67 Q. Yes. It's just to indicate to the public that there is
10 a current review being undertaken by the RQIA and the 11:22
11 Terms of Reference have been set by the Department to
12 look at the current systems in place.

13 A. Yes.

14 68 Q. I just wanted to acknowledge that in passing.

15 A. Okay, thank you. 11:23

16 MS. McMAHON: Perhaps this would be a convenient time?

17 CHAIR: Yes. Say 15 minutes, so, 20 to.

18

19 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

20 11:30

21 69 Q. MS. McMAHON: Mr. May, I just have two other very brief
22 areas to ask you about, and the first one is in
23 relation to the Department's relationship or oversight
24 or scrutiny of the Trust Board. As I understand it,
25 the Chair of the Board, the appraisal is carried out, 11:39
26 is that by the Department?

27 A. Yes.

28 70 Q. Is that done on an annual basis?

29 A. Yes.

1 71 Q. Is there a designated person in the Department who does
2 that?
3 A. Yes.
4 72 Q. Who is that?
5 A. It depends on the arm's length body but I think for the 11:39
6 health trusts, the appraisal is carried out by Jim
7 Wilkinson, one of the grade 3s in the Department, and
8 then I see all of the appraisals and sign them off or
9 my predecessor would have done. Again, I'm not certain
10 whether the appraisal process continued during Covid 11:39
11 but it has restarted this year.
12 73 Q. When you look at those appraisals, if anything arises
13 would it be your first port of call to speak to the
14 Chair?
15 A. First port of call would be to speak to the person who 11:39
16 had done the appraisal probably, and thereafter to the
17 Chair.
18 74 Q. The other issue I just wanted to ask you about was in
19 relation to Mr. O'Brien. In his counsel's opening
20 address to the Inquiry he raised concerns generally 11:40
21 around the funding of Urology and the way in which the
22 Department has been organised. Specifically for you to
23 consider, if you wouldn't mind, was the shortness of
24 notice he received in relation to the calling of the
25 public inquiry. Mr. O'Brien I think was given 30 11:40
26 minutes, roughly 30 minutes' warning in advance of the
27 announcement. I think the Trust was told within the
28 hour that the announcement was imminent. I wonder if
29 you have any comment to make on that?

1 A. Maybe to start with the more general point you made
2 about funding in relation to Urology Services. It's my
3 understanding and belief that as need grows, so
4 Commissioners are faced with decisions about how to
5 apportion scarce resources accordingly. I think 11:41
6 a number of steps have been taken over a number of
7 years to try to increase the resource provided in
8 relation to Urology Services more generally across
9 Northern Ireland and for the Southern Trust, but we do
10 face challenges in relation to demand outstripping 11:41
11 capacity in a whole range of services at the moment,
12 and there's no easy resolution to that in the absence
13 of a substantial additional investment of money to
14 Health in order to seek to manage that. We are looking
15 at how we can maximise what we do with what we have got 11:41
16 in terms of maintaining a core quality standard, but
17 alongside that, maximising productivity and efficiency
18 so that the system meets the needs of as many of the
19 Health and Social Care needs of our population as
20 possible. I think it's commonly understood that there 11:42
21 are challenges and that those challenges have existed
22 for a number of years. I understand, and we have made
23 some specific investments to support the Service
24 provision in the Southern Trust in the last couple of
25 years, there have been some reductions in the level and 11:42
26 extent of those waiting as a consequence. That's
27 largely by supplementing the Southern Health Trust's
28 own resources with the independent sector resources.
29 Just to give some background to that. I know there

1 have been challenges in terms of recruitment of
2 Consultants to the Southern Trust Urology Department
3 which I don't claim to be an expert on.
4

5 In relation to the calling of the Inquiry, the 2005 Act 11:43
6 does not specify any time that needs to be provided for
7 individuals. I think there are always competing
8 challenges in relation to timing, because a Minister
9 will always feel he or she needs to be accountable to
10 their peers in the Assembly, and if news of what is 11:43
11 being announced becomes known too far in advance,
12 through whatever means, whether, you know, because
13 there are a raft of different people who have an
14 interest in an Inquiry, obviously Mr. O'Brien and the
15 Trust, but patients and families also have an interest, 11:43
16 so trying to define and decide precisely who gets told
17 when is a judgment-call. I would just offer that
18 there's a series of things to be thought about, not
19 simply how much, you know, not simply the time scales,
20 but how it all fits within the wider piece. 11:44

21 75 Q. Just finally, you have mentioned about the funding and
22 structuring of the Health Service. We have had reports
23 like the Bengoa Report delivering together initiatives
24 from the Executive seeking to restructure Healthcare to
25 try and optimise patient care and standards. Is that 11:44
26 another stream of work or developments that can't be
27 taken forward because of the absence of an Executive?

28 A. There are some aspects of the work that relates to the
29 Bengoa Report which can be progressed and others which

1 are more challenging. There have already been a number
2 of reviews of major services in the areas of Stroke,
3 Adult Social Care, Urgent Emergency Care, Cancer
4 Strategy, and there's been a number of other things
5 that have been done and can continue to be done. The 11:45
6 area which is most difficult is that if there needs to
7 be a reconfiguration, particularly of hospital services
8 in order to deliver more efficiently and more
9 effectively for the people of Northern Ireland, then
10 the nature of those decisions they would definitely 11:45
11 normally be taken by a Minister, and there would be
12 a very high public profile and there would be a lot of
13 public interest in relation to those, and it's not easy
14 for me to see how those could be progressed in the
15 absence of a Minister, save for the unfortunate 11:45
16 circumstances where the service can't be continued to
17 be delivered safely, in which there's an inevitable need
18 to make a change. In our past I would reflect we have
19 seen pretty much all the changes that have been
20 forced rather than planned, and that's not a good way 11:46
21 to manage services.

22 CHAIR: I have no further questions for you. I think
23 the Panel may have some, so stay where you are, please.
24
25
26
27
28
29

1 THE WITNESS WAS THEN QUESTIONED BY THE PANEL AS
2 FOLLOWS:

3
4
5 76 Q. DR. SWART: I was interested in your comments about 11:46
6 the proposed changes to the Regulatory Framework which
7 you referenced in your statement and again today. Can
8 you tell me what, in your view, the drivers for the
9 need for change has been?

10 A. I think there's a number of drivers. I think that the 11:46
11 changes would essentially involve both giving the RQIA,
12 potentially giving them more teeth -- this is all
13 subject to public consultation I should say -- but also
14 broadening the scope. The Neurology Inquiry made
15 a series of recommendations, for example, around the 11:47
16 independent sector and the need for -- and while RQIA
17 has the scope and the remit to do work in relation to
18 the independent sector, it's a question about whether
19 that's sufficient. One of the issues that I'm sure
20 will come up in this Inquiry is around those employed 11:47
21 by Health and Social Care who then see private
22 patients, and that seems to be a lacuna in the RQIA's
23 remit doesn't stretch to cover that. You know, it's
24 one of those areas where obviously we would be
25 interested to see the Panel's recommendations and 11:47
26 observations. It will take some time to get to the
27 point of legislative change, there's a question of
28 whether something more immediate is needed in that
29 space, but I would be very interested in whether you

1 have observations or views when you feel that you've
2 done enough to reach them in that space because, you
3 know, we are open to receiving suggestions before you
4 reach your final report.

5 77 Q. Another thing that you have drawn attention to a couple 11:48
6 of times this morning is the distinction between
7 Corporate Governance and Clinical Governance. My
8 experience in hospitals, for example, are very much
9 concerned with measuring and providing safe quality
10 care, and it's quite difficult to differentiate these 11:48
11 because the Board, as a whole, has responsibility for
12 everything?

13 A. Yeah.

14 78 Q. Do you think that ongoing separation is helpful, and, 11:48
15 if so, how could that be resolved, do you think?

16 A. I mean, I think we always have to see the quality of
17 the service as intrinsic to the service, and it comes
18 down to who has the skills and the expertise to
19 properly oversee that. I'm loathe to make suggestions
20 that would require my Department to grow substantially 11:49
21 in size when I'm not confident that that would
22 necessarily be the right answer, so it may be there
23 needs to be some way of better aligning the methods of
24 governance, but I'm not just sure saying it's the
25 Department's responsibility, and please create a big 11:49
26 function to do it makes sense, if that's an answer to
27 your question.

28 79 Q. I get that. Just finally, I wonder, having looked at
29 the previous inquiries and the materials so far here,

1 and from my own experience, there's a huge value in
2 involving patients and families, and you have referred
3 to it already in the context of being open, and in the
4 death reviews, both of which there's a lot of learning
5 in England and Scotland, and so on. Has the Department 11:50
6 given any thought to the greater involvement of
7 patients in Northern Ireland in terms of things like
8 copying them into clinical letters, and initiatives
9 like that, which have been in place in other countries
10 for some time, and to try to assess the value of that 11:50
11 in the patient being, in effect, a monitor of their own
12 quality of care through that mechanism?

13 A. Yeah, and I think the other thing, the RQIA review of
14 SAIs also makes reference to patient involvement as
15 well. 11:50

16 80 Q. It does.

17 A. I think strategically giving individuals a greater
18 sense of agency over their own healthcare has to be
19 a good thing and we should be looking at ways in which
20 we can achieve that, so I can't claim to be over the 11:50
21 detail of what those specifics might look like, but
22 I think, in overall terms, that's the right way to go,
23 and that might include, for example, allowing
24 individuals to decide themselves whether they need
25 a review appointment in some cases rather than it being 11:51
26 on an automatic recall basis. So, there's a range of
27 different ways, and again I'm interested in any
28 observations you reach in that space.

29 81 Q. Thank you, that's all from me.

1 CHAIR: Do you have any questions, Mr. Hanbury?

2 MR. HANBURY: No questions.

3 CHAIR: One thought that occurs to me is that you talk
4 about the Department being responsible for the policy,
5 the Healthcare policy, and the fact that you would 11:51
6 issue, we do know that you issue Circulars to the
7 various Health Trusts periodically. I just wondered
8 what level of training on that policy is available to
9 the Leadership within the Trusts? Because it seems to
10 me that a lot of the Leadership, current Leadership, 11:51
11 for example, in the Southern Trust is someone who comes
12 from a Clinical background but may not have the
13 training in Corporate Governance that is required to
14 put into effect some of the policies, and I just
15 wondered does the Department provide Leadership 11:52
16 training? If so, what level of Leadership training
17 and, if not, has any consideration been given to doing
18 so?

19 A. The Department doesn't directly provide training.
20 There is a Leadership centre within Health and Social 11:52
21 Care that does provide and contracts with each Trust
22 for services. Those services, there may be some they
23 provide to everybody, but there is certainly some that
24 are specific. Each Trust senior team should be
25 designed to have a range of different skills and 11:52
26 expertise with, for example, the Finance Director and
27 the HR Director being able to support whoever the Chief
28 Executive is, whatever their background, whether it be
29 a Clinical or a management background. I think your

1 wider point about whether we do enough in relation to
2 Leadership training for our service is a good one, and
3 one that certainly I have begun to turn my mind to.
4 I can't claim to have a complete answer yet, but I do
5 think there is a need for us to think about that and 11:53
6 there are different sorts of training. My version of
7 Leadership training, yours might be more of a Corporate
8 Governance training you were describing there, I don't
9 know, but I know the two are linked, and it can be
10 about what is reasonable to expect of an individual and 11:53
11 what that individual ought to be looking out for in any
12 given set of circumstances. I think another aspect to
13 that is how do we encourage people to take a systemic
14 view as opposed to merely an organisational view when
15 they reach the most senior levels. Again we need to 11:54
16 think about how we can do more, I think, in that space,
17 so that there's a regional perspective being taken in
18 relation to some issues, and the idea of regional
19 learning becoming much more embedded as a result.
20 CHAIR: Thank you, Mr. May, I have nothing further 11:54
21 I want to ask you today. Thank you very much for
22 coming along on what I know is a very busy media-heavy
23 day.
24 A. I would like to say that that's unusual, but it's not.
25 CHAIR: Thank you very much. We won't keep you any 11:54
26 longer. Thank you.
27
28 I think then 2 o'clock, Ms. McMahon.
29

1 THE WITNESS THEN WITHDREW

2 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

3
4 CHAIR: Good afternoon everyone.

5 MS. McMAHON: Ryan Wilson, who is the Acting Director
6 of Secondary Care within the Department of Health.

14:03

7
8 MR. RYAN WILSON, HAVING AFFIRMED, WAS EXAMINED BY
9 MS. McMAHON AS FOLLOWS:

10
14:03

11 82 Q. MS. McMAHON: Mr. Wilson, you have provided a very
12 detailed statement to the Inquiry. If I can ask that
13 to be called up. WIT-50710, and it runs through to
14 50767. Do you have that on the screen in front of you?

15 A. Yes.

14:04

16 83 Q. If we just go to the last page of that statement, do
17 you recognise that statement as yours, that's your
18 signature on the last page?

19 A. Yes.

20 84 Q. It was made on 1st September 2022?

14:04

21 A. That's correct.

22 85 Q. Do you wish to adopt that statement as your evidence to
23 the Inquiry?

24 A. Yes, please.

25 86 Q. At this stage, are there any corrections you wish to
26 make or amendments, additions to the statement before
27 we go to it in detail?

14:04

28 A. There is one, in fact. I would just like to draw the
29 Inquiry's attention to paragraph 38, an update to the

1 position that I outlined in that statement around the
2 Department's request for a project evaluation of a 2009
3 review of Urology Services. At the time of my
4 statement I had stated that the Department didn't hold
5 a record of a response from the Health and Social Care 14:04
6 Board. I have since found out last week that the
7 Health and Social Care Board did, in fact, submit
8 a response to a request in 2019. It appears not to
9 have been filed by the Department, but has now been
10 received. So we may come to that later in the 14:05
11 proceedings.

12 87 Q. I will take you through. What I propose to do with
13 your statement is really to start off with your role,
14 what that involves, and then take you through your
15 statement and highlight the main points along the way 14:05
16 as they are relevant to the Inquiry. Mr. May gave
17 evidence this morning and we have covered quite a bit
18 of ground with him. I don't intend to go over that
19 with you, except where relevant to your role, or if you
20 have anything to add in relation to any of that. If 14:05
21 you do at the end feel we haven't covered anything,
22 please just say and you will have an opportunity to
23 fill in any gaps.

24
25 You indicate that you took up your role, in paragraph 1 14:05
26 of your statement, on 3rd August 2020 as Acting
27 Director of Secondary Care. I wonder if you could just
28 explain what Secondary Care is?

29 A. Secondary Care Directorate is a Policy Directorate

1 effectively within the Healthcare Policy Group of the
2 Department of Health. It's one of a number of Policy
3 Directorates which generally provides policy advice to
4 the Health Minister and has policy oversight for the
5 Clinical Services which underpin, broadly speaking,
6 hospital services and ambulance services. 14:06

7 88 Q. You have been in the Healthcare Policy Group since
8 2013?

9 A. I have, yes. I have been in the Department since 2005
10 and in the Healthcare Policy Group since 2013. 14:06

11 89 Q. In paragraph 4 at WIT-50711, you say your role:

12
13 "As the Director of Secondary Care is an Assistant
14 Secretary and the Department's Senior Adviser to the
15 Minister of Health on Secondary Healthcare Policy with
16 responsibility for developing and reviewing 14:06
17 Departmental policies which underpin the delivery of
18 Healthcare mainly within hospital settings and the
19 Clinical specialties to which these services are
20 delivered." 14:07

21
22 So in layperson's terms, is it possible to translate
23 that into layperson's terms, Mr. Wilson?

24 A. I will make an attempt. The broad area of Secondary
25 Healthcare Policy, as I said, covers almost every 14:07
26 aspect of clinical services that take place within
27 a hospital setting, so the agenda or the priorities for
28 Secondary Care are generally set by the Health
29 Minister. While we cover, broadly speaking, all areas

1 of Secondary Healthcare, there are, at any time,
2 a number of high priorities within that service which
3 may be under review or which may be the subject of
4 interest by the Assembly or by the media. For example,
5 a number of areas, prior to my current position as 14:08
6 Director, I have worked in and around Secondary Care on
7 areas such as Paediatric Healthcare, Children's Heart
8 Surgery, the establishment of a major trauma service
9 centre, Organ Donation and Transplantation, Fertility
10 Services, those type of broad clinical areas each have 14:08
11 a policy position from the Department, or a policy
12 statement of some kind. That is our role as Policy
13 Leads within the Department to keep those policies
14 under review in accordance with the priorities set by
15 the Minister, or in accordance with the needs of the 14:08
16 system at any time.

17 90 Q. When you talk about the agenda being set by the
18 Minister, we don't have a Minister at the moment but,
19 in the absence of that, is it the case that the policy
20 work that was ongoing under that Minister continues 14:08
21 until a new Minister is appointed and perhaps stays in
22 that direction or takes a different direction; is that
23 the way it works in real terms?

24 A. Yes. I can maybe illustrate that with an example. In
25 2016 when the previous Minister published what is 14:09
26 currently the Department's ten year Healthcare Strategy
27 "Delivering Together", that essentially set the policy
28 agenda for the Department so while we had then a period
29 of three years without any Minister or any Executive in

1 place, in effect the policy priorities in the strategic
2 direction for the Department had been set, and that's
3 what we worked to up until 2020 and continued
4 thereafter, although we did have Covid then to contend
5 with from early 2020. The policy position generally
6 set by previous ministers, in the absence of any
7 current Minister, are what we continue to work to.

14:09

8 91 Q. We have spoken to Mr. May this morning about that and
9 the difficulty then of taking things any further, but
10 it is the case that the Department is still working
11 away, as it were, on what's considered priorities at
12 the moment, even though there's no-one at the helm, as
13 it were?

14:09

14 A. That's correct, yes.

15 92 Q. You speak about the Departmental policy in relation to
16 the Urology Services at paragraph 11, WIT-50712. You
17 have exhibited to your statement the standard policy
18 brief in relation to Urology dated September 2019, and
19 that's an internal brief that sets out the issues
20 around Urology and for internal use giving, for
21 example, the location of the Services, Clinical
22 Guidelines and other information, sort of
23 a one-stop-shop that if anybody wants to know within
24 the Department about Urology I presume that's the
25 function of that document?

14:10

14:10

26 A. That's right. There would have been a similar document
27 in place across most or all of the Clinical
28 Specialities that is covered by Secondary Care and, as
29 you said, there's a reference document that gives

1 a high level easily accessible information for the
2 purposes of being able to pull off-the-shelf, as it
3 were, the key facts and current policy position around
4 any of the Clinical Specialities, and that's used by us
5 as officials for briefing requests or for Assembly
6 questions as they arise. 14:11

7 93 Q. One of the things you have referred to is the regional
8 review of Urology Services in 2009. I am not going to
9 spend any great time on that, but that was a result of
10 increasing demand and issues with capacity, and 14:11
11 resulted effectively in three teams, a Team South with
12 the Southern Trust being one of them. You have just
13 said at the bottom of that page, at WIT-50713, you have
14 quoted from the policy document that there was to be
15 a Secondary Care Directorate for the next policy review 14:11
16 of Urology Services was 2019. Do you see that?

17 A. I have it in front of me. It's not on my screen
18 currently but I do have it in paper format.

19 94 Q. I will read over the page while you're looking for it:

20 14:12
21 "A further review has not been completed since policy
22 brief document was revised in September 2019".

23
24 I know you weren't in post at the time, but do you have
25 any information about, firstly, why that was planned 14:12
26 and, secondly, why it didn't occur?

27 A. My understanding of that date is that it would have
28 been an estimation of an appropriate timeframe in which
29 to revisit a regional review of Urology Services on

1 account of the fact they had previously been reviewed
2 ten years prior, but that estimation would have been
3 subject to any number of factors, including what an
4 incoming Minister might prioritise or what the
5 Department was currently prioritising under the
6 Delivering Together priorities in the absence of
7 a Minister. It serves as an estimation of what we, as
8 Secondary Care Officials, would have considered an
9 appropriate timeframe, but doesn't represent the
10 decision as such to prioritise that.

14:13

14:13

11 95 Q. I think an example of that you give later on is the
12 interjection of Covid in healthcare plans, or you had
13 to meet the demands at the time, and we will come on to
14 that.

14:13

16 I just want to slightly jump ahead to point out some of
17 the key features of why the 2009 Review was important
18 for the Panel to note. If you go to WIT-50716,
19 paragraph 21. You have said in paragraph 21 that the
20 Department has been unable to locate any records in
21 advance of the initiation of the review, but,
22 nevertheless, at the end of that paragraph you quote
23 from Michael McGimpsey who was then the Health Minister
24 who stated that the rationale for the review was:

14:14

14:14

26 "This was in response to concerns regarding the ability
27 of HSC Urology Service to manage growing demand, meet
28 cancer and elective waiting times, maintain quality
29 standards and provide high quality elective and

1 emergency services. "

2
3 Then just over the page at WIT-50717, paragraph 24:

4
5 "The Terms of Reference set the overall purpose of the 14:14
6 review to develop a modern, fit for purpose in the 21st
7 century reformed service model for Adult Urology
8 Services which takes account of relevant guidelines,
9 NICE, good practice, Royal College, British Association
10 of Urological Surgeons, British Association of 14:15
11 Urological Nurses. The future model should ensure
12 quality services are provided in the right place at the
13 right time by the most appropriate clinician through
14 the entire pathway from primary care to intermediate to
15 secondary and tertiary care". 14:15

16
17 The context of the review at paragraph 25 was:

18
19 "The evolution of the field of Urology from being the
20 provenance of a general surgeon into a separate 14:15
21 surgical speciality, and the growth in the number of
22 urologist appointments in Northern Ireland hospitals
23 from ten in 1999 to 17 in 2008 and 2009. "

24
25 Paragraph 26 says: 14:15

26
27 "The review was completed in March 2009, it contained
28 26 recommendations. "

29

1 If we jump forward again to WIT-50719 at paragraph 33,
2 we see:

3
4 "Dr. Miriam McCarthy, then the Director of Secondary
5 Care in the Department wrote to the HSCB on 2nd April 14:16
6 2010 to communicate the decision to request that the
7 HSCB implement the recommendations as soon as
8 possible."

9
10 That was the commencement of the Urological Service 14:16
11 provision in Craigavon and in outlying areas.

12
13 I would just like to go back very briefly, because you
14 have mentioned the guidelines, WIT-50714. The Inquiry
15 will hear and has received evidence that there are 14:16
16 quite a considerable number of guidelines, standards,
17 policies, that are filtered through from various
18 bodies. Firstly, can I ask do those guidelines emanate
19 from your Department or come through you before
20 eventually making their way down through each of the 14:17
21 Trust?

22 A. Can I just clarify you're talking about NICE guidelines
23 broadly?

24 96 Q. Yes, NICE guidelines broadly, generally, yes.

25 A. That process into which the Department entered into 14:17
26 2006 with NICE was the formalisation of a relationship
27 between the Department and the National Institute.
28 They don't come through my Directorate routinely.
29 There's a branch within the Department which serves as

1 the host branch effectively for receiving and
2 processing any new NICE guidelines. They will inform
3 me as the Policy Lead where that NICE guideline is
4 relevant to my policy area. Generally that process is
5 one whereby the Chief Medical Officer would endorse any 14:17
6 NICE guideline that's produced. That's the Policy
7 position that the Department adopted in 2006 was that
8 we looked to NICE as the body that provides us with the
9 assurance around the cost-effectiveness and the
10 clinical-effectiveness of any treatment or medication 14:18
11 or any new technology. Once that has been through the
12 robust process within NICE, that effectively is the
13 assurance that the Department leans upon, and where the
14 Chief Medical Officer's endorsement of that NICE
15 guideline is based upon. It then undergoes a period of 14:18
16 quality screening and consultation by colleagues in the
17 Department who look after that, and then it's formally
18 issued effectively to the Health Service via the former
19 Health and Social Care Board and to Trusts for
20 implementation. At that point, implementation is often 14:18
21 subject to availability of funding, so it's not
22 necessarily implemented automatically, but the Policy
23 position will have been set by the endorsement by the
24 Chief Medical Officer of any particular guideline.

25 97 Q. Just to clear it up for my understanding. When you say 14:19
26 it's not always implemented because of perhaps funding
27 or an issue like that, if a NICE guideline is in
28 existence but not implemented are those standards to be
29 adhered to anyway, or are you referring to guidelines

1 specifically in relation to technology or something
2 new?

3 A. In relation to anything, it will be subject to
4 availability of funding, so the standards may not be
5 able to be applied. For example, just to try and 14:19
6 illustrate that point, we have a policy position in
7 effect in relation to Fertility Services where we agree
8 in principle with the policy of providing up to three
9 cycles of IVF, and that's been the policy position of
10 the Department for a number of years, but as yet the 14:19
11 funding and the capacity to provide that has not been
12 in place, so it's not a standard to which Trusts can be
13 held to account yet, although work is in progress in
14 that example to get us to that point. I mention that
15 by way of example to show that the endorsement of any 14:20
16 NICE guideline doesn't automatically become the
17 standard that Trusts can automatically implement.

18 98 Q. Yes, thank you for that. And once the guideline makes
19 its way from, we will just call it the Department
20 generally, and finds its way through to the Trust, the 14:20
21 Trust then are responsible for implementing that. Do
22 you have any or any of the Department bodies have any
23 oversight of those guidelines; any review or any
24 responsibility around assurance of them, to see if they
25 have been implemented? Do you have any role in that? 14:20

26 A. Sorry, just to be clear, on the implementation of NICE
27 guidelines?

28 99 Q. Yes.

29 A. Generally once the policy position has been established

1 and Trusts have been asked to implement it, provided
2 that there is funding and capacity in the system, then
3 that would be one of the functions of the former Health
4 and Social Care Board, now the SPPG in the Department,
5 to ensure that the Service is being delivered to that
6 standard. 14:21

7 100 Q. That oversight role passes through to what we will call
8 the HSCB for our purposes?

9 A. Yes. It's effectively delegated but as Policy Lead in
10 any of those areas covered by NICE, we would have an
11 interest in drawing assurance from the Commissioner 14:21
12 that the Service is being implemented in accordance
13 with NICE.

14 101 Q. If we just move on then. In paragraph 34, WIT-50719,
15 again in relation to implementation, this is about the 14:22
16 Urology Review Recommendations in a response to an
17 Assembly question in 2010. There was a question about
18 how many of the recommendations had been implemented,
19 and just four lines from the bottom:

20
21 "The time scale for full implementation is being guided
22 by the Health and Social Care Board and is subject to
23 the approval of implementation plans by Commissioners
24 to fully deliver all of the recommendations." 14:22

25
26 I suppose just to tie that up with the previous point
27 I was making about the guidelines, does the Department
28 have any role in oversight or seeking assurance or
29 monitoring in any way any recommendations from a Review

1 such as that?

2 A. Effectively once a review has been completed on any
3 service and a set of recommendations have been accepted
4 by the Minister -- I will take you back to the previous
5 paragraph, 33, where my predecessor Dr. McCarthy wrote 14:23
6 to the Health and Social Care Board. That is the point
7 at which the implementation responsibility is
8 effectively handed over to the Health and Social Care
9 Board to oversee, and then Trusts, as the delivery
10 organisations, would work closely with the HSCB to 14:23
11 deliver that in accordance with or in line with the
12 allocation of additional funding. The Department, in
13 effect, has handed that over to the Health and Social
14 Care Board but will draw its assurance from the HSCB
15 and now from the new SPPG group in the Department that 14:23
16 there's structures in place to make sure that the
17 implementation is being delivered.

18 102 Q. The only thing then the Department would have been
19 involved in then would be if the HSCB came looking for
20 funding to make good some of the recommendations? 14:23

21 A. Yes, the funding process or the funding that's
22 associated with any new recommendations or any new
23 service model effectively goes into a new process, and
24 in the context of finance being extremely constrained
25 as it is at the moment, it's always a constraining 14:24
26 factor. Funding will have to be prioritised in normal
27 circumstances where a policy has been set by the
28 Department or by a Minister. There is an expectation
29 that that funding would be prioritised to allow the

1 implementation of those recommendations to proceed, but
2 that is in the context of an extremely constrained
3 budget so it's not always automatic that funding is
4 available.

5 103 Q. It's difficult to look back, and I know you weren't in 14:24
6 post at the time, but just so we understand exactly how
7 that works. would it ever be the case that HSCB would
8 come back to the Department and say we can't
9 implementation that recommendation or the anticipation
10 of the Department that we would meet this service can't 14:25
11 be met because, for example, we can't secure the staff,
12 we don't have the capacity? Do those things happen in
13 real life?

14 A. Yes, they do. I can answer that generally and then
15 maybe speak specifically about the Urology 14:25
16 recommendations. That is a common constraint. I would
17 say policy is formulated with those constraints in mind
18 and policy generally isn't formulated by the Department
19 in isolation. It's routinely clinically led. That
20 means there's clinical representation from across 14:25
21 Health and Social Care Trusts, from the Public Health
22 Agency and from Commissioning within the former HSCB,
23 so it's a collective effort to develop policy, and that
24 will be informed by the relevant NICE guidelines, all
25 of which is the context in which the policy is 14:26
26 developed. So while any policy review or set of
27 recommendations will attempt to raise the bar
28 effectively for a service, it then, once that's
29 accepted as a reasonable set of recommendations that

1 can feasibly be implemented, it goes into a process, as
2 I referred earlier, of prioritisation and
3 identification of funding. So, in reality, it can
4 often be the case that either funding is not
5 automatically available. For example, if the Executive 14:26
6 collectively has set a priority for a particular
7 initiative, it doesn't necessarily follow that
8 additional funding has come into the Department's
9 budget to deliver that, so effectively it creates a new
10 pressure which means something else probably needs to 14:27
11 be de-prioritised for that to happen. Setting aside
12 the funding, there is, in many Specialities,
13 a recruitment challenge whereby there is a relatively
14 low number of qualified specialists for a particular
15 role. So while there may be a desire to grow the 14:27
16 workforce in a lot of areas, it isn't always the case
17 that recruitment into any speciality is successful.
18 Those are the real life constraints to any policy being
19 implemented once it's been set by the Department.

20 104 Q. That's very helpful. The Inquiry will hear evidence 14:27
21 and suggestions that from the time of the Review there
22 were existing problems that perhaps weren't grappled
23 with, and they will want to look at whether there's any
24 merit in that in light of what subsequently emerged, so
25 that's useful background. Thank you. 14:28
26

27 I think we are close to the paragraph where you wanted
28 to add something, paragraph 38, WIT-50721, just the
29 next page. I think the preceding paragraph -- does it

1 follow on from that, Mr. Wilson? There was
2 a stock-take. The paragraph you wanted to amend
3 relates to January 2019? Okay. So you had indicated
4 in that paragraph that you wrote to the HSCB asking
5 them to update on the implementation of the Review 14:28
6 recommendations, which was ten years post review. You
7 had indicated at that time, as you said, you hadn't
8 been aware there was a response and you said that there
9 wasn't. You haven't yet provided that, because I think
10 you have just received it, to the Inquiry, but I know 14:29
11 you have a copy. Would you be able to give us just an
12 idea of highlights from that, from the HSCB?

13 A. Yes, I can, and I apologise for the confusion. At the
14 time of preparing my statement for the Inquiry, myself
15 and colleagues performed a thorough search of the 14:29
16 Department's records and, unfortunately, we don't
17 appear to have filed the Post Project Evaluation when
18 it was requested in 2019, but I did find out last week,
19 and subsequently received a further copy, that the HSCB
20 did, in fact, submit that to the Department in March 14:29
21 2019. I received that Post Project Evaluation last
22 week. Essentially it confirms what the HSCB did
23 following the receipt of Dr. McCarthy's letter at
24 paragraph 33, and in line with what the Department
25 would have expected at that time, the HSCB set up the 14:30
26 necessary structures to oversee the implementation of
27 the review recommendations, and that was an
28 Implementation Board known as the Urology Review
29 Project Implementation Board, and we will submit a copy

1 of this PPE to the Inquiry after today. It confirms
2 that £3.5m of additional recurrent investment was made
3 available through the HSCB to Trusts to establish the
4 three team model. That was to, among other things,
5 increase the Consultant workforce within Urology across 14:30
6 the region from 19 whole time equivalent Consultants to
7 23. That was in recognition of the increasing
8 projected demand for Urology Services and the pressures
9 that the service had been under. It goes on in the PPE
10 just to describe how that funding was allocated across 14:30
11 the three teams. There was Team East comprising the
12 South-Eastern Trust and the Belfast Trust, Team South
13 comprising the Southern Trust and a part of the Western
14 Trust, and Team North comprising the Northern Trust.
15 So the 3.5m was allocated across those three teams to 14:31
16 increase the workforce and also to adopt the working
17 model whereby there were more Clinical Nurse
18 Specialists incorporated or recruited into those
19 Urology teams to support the Consultant workforce.

20
21 The PPE then goes on to summarise, and it's a fairly
22 high level summary as you would get with PPEs
23 generally, but there is a section asking about value
24 for money. The purpose of the Implementation Board was
25 to ensure that the Urology Service was designed to meet 14:32
26 the needs of patients, to recommend to the
27 Implementation Board how the £3.5m should be allocated
28 and to establish appropriate performance indicators.
29 It then goes on to summarise the problems that were

1 encountered during implementation of the Review
2 Recommendations, saying that:

3
4 "The main problems pertain to the vulnerability of the
5 Consultant teams where sick leave, vacancies and 14:32
6 recruitment challenges impacted upon service
7 provision", and goes on to describe a few examples of
8 that.

9
10 That's hopefully answered your question, just to give 14:32
11 a flavour of what's in the PPE, and we will submit
12 a copy of that after today.

13 105 Q. Thank you. There's mention of the Bengoa Report at
14 paragraph 39 and we spoke to Mr. May about that this
15 morning, that there is work behind the scenes, and you 14:33
16 had mentioned yourself about the Delivering Together.
17 Is there any part of that particular policy -- I think
18 you had said that the Delivering Together, there was
19 policy work continuing on that; is that correct?

20 A. On Delivering Together generally? 14:33

21 106 Q. Yes. Is that still a live project as it were?

22 A. Very much so. It remains the Department's ten-year
23 strategy for Health and Social Care. I mentioned
24 earlier that that was published in 2016. The
25 Department, through the period of there being no 14:33
26 Assembly between 2017 and 2020, the Department oversaw
27 a programme of work to review what Delivering Together
28 had identified as the top priority areas for review and
29 progressed those as far as possible essentially without

1 a Minister being in place to take the necessary policy
2 decisions at the end of that work. There was work
3 initiated to review Urgent and Emergency Care, Stroke
4 Services, Paediatric Services, Breast Assessment
5 Services, and a number of other high priority areas. 14:34
6 So when I say "work initiated", what I mean by that is
7 essentially those Services were reviewed with
8 recommendations as to how those Services should be
9 delivered and configured under the broad model that
10 Delivering Together had recommended. 14:34

11
12 The core theme of Delivering Together, if you like, was
13 that the Health and Social Care is being delivered on
14 a burning platform and is in urgent need of reform in
15 terms of how Services are configured and delivered. 14:34
16 When the Assembly was restored in 2020, I think it's
17 fair to say that the plan would have been then to begin
18 to bring these policy reviews and recommendations to
19 the incoming Minister for consideration by him and,
20 where necessary, by the Executive. Covid-19 did 14:35
21 obviously impact on the ability to do that, and
22 essentially paused a lot of that work. To varying
23 degrees, that work has been picked up, particularly in
24 2022, but it hasn't been possible to fully resource
25 those through 2020 and 2021. In the last year, the 14:35
26 Department has concluded some of that work in terms of
27 publishing the Cancer Strategy, the Elective Care
28 Framework, the Review of Urgent and Emergency Care, for
29 example, and a Stroke Implementation Plan, so the

1 direction that was set by Delivering Together still
2 remains the overarching strategic direction for the
3 Department. There will be further work taken forward
4 under that, albeit that there is a rebuilding job to do
5 in terms of the impact that Covid-19 has had on waiting 14:36
6 lists and that is an additional challenge to what would
7 have been the Delivering Together programme.

8 107 Q. In paragraph 41 you have talked about the priority 1
9 and priority 2, and we see at the top of page WIT-50722
10 that Urology Services would be among a number of 14:36
11 priority 2 services for review. Later in your
12 statement I think you indicate that post Covid you
13 weren't going to reach Urology anyway, any time soon,
14 I think. Perhaps if you explain what Priority 1 is and
15 why Urology falls within Priority 2? 14:37

16 A. I'm not sure if I used the term post Covid, because
17 I don't know if we are post Covid just yet. The
18 prioritisation, my understanding it's not that Urology
19 was de-prioritised, it's those areas that were listed
20 as Priority 1 were regarded as essential, requiring 14:37
21 urgent review. I am referring to urgent and emergency
22 care, unscheduled care, in particular, and general
23 surgery, and those areas where we have systemic
24 problems that contribute to long waiting lists.
25 I think it was in the summer of 2021 that a further 14:37
26 look was taken and a submission sent to the Minister
27 just to check in on where the prioritisation of those
28 reviews stood at that point in time. Effectively,
29 there was no change to what had previously been

1 identified in terms of Urology. There wasn't a reason
2 to elevate it to a Priority 1 status at that point.

3 108 Q. Just to go back slightly. When you spoke about
4 Delivering Together, is there anything specific, the
5 governance, in the plan in Delivering Together, is it 14:38
6 anticipated that restructuring will impact in some way
7 to bring about change to the way in which healthcare
8 delivery is governed or overseen by the Department or
9 the HSCB?

10 A. I have to confess that I would need to go back and 14:38
11 study Delivering Together to see if that is
12 specifically referenced. My area of interest in
13 Delivering Together really is around the Service Model
14 and the Delivery of Services and which ones ought to be
15 prioritised for transformation. It doesn't spring to 14:39
16 mind that there's anything particular around governance
17 issues within that.

18 109 Q. Paragraph 44, WIT-50722, I have referred to post Covid
19 but you were quite right in correcting me. There was
20 a publication at that time in June by the then 14:39
21 Minister, Robin Swann, when he published the Strategic
22 Framework for Rebuilding Health and Social Care
23 Services. Was that a document that was aimed
24 specifically to address the state of the Health
25 Service, as it were, in light of what had happened as 14:39
26 a result of Covid?

27 A. Yes. At that time just to revisit what the context
28 was. We had just emerged from the first wave or the
29 first surge of high Covid admissions, and there was

1 a recognition of the impact that that had had.
2 Effectively a lot of staff within Health and Social
3 Care were redeployed to Critical Care roles or to
4 supporting the Covid response and that meant their
5 normal services were largely down turned or paused 14:40
6 entirely, so that contributed to longer waiting lists
7 for diagnosis, and for treatment, and for surgery. The
8 Framework that was published by the Minister in June
9 2020 was a recognition of that impact. It was
10 a snapshot of the impact at that time and a request for 14:40
11 Trusts then to bring forward three-monthly rebuilding
12 plans, subject to prevailing Covid-19 conditions. At
13 that point, it was expected, I think it's fair to say,
14 that there may be further waves of Covid-19, but while
15 we were in a lull, as it were, there was a desire to 14:41
16 ramp up as much activity as possible, so each Trust was
17 asked to bring forward a set of rebuilding plans and to
18 keep those under review in order to return, as far as
19 possible, to activity levels. Those activity levels,
20 it was acknowledged, could not return to pre-Covid 14:41
21 levels at that time because we were still operating, or
22 the service was still operating with full social
23 distancing and hygiene measures, so that impacted the
24 number of patients that could come through services.
25 Also, there was an inevitable impact on staff absence 14:41
26 due to Covid from that time, from early 2020 onwards.
27 The capacity was not able to be restored to pre-Covid
28 or to commissioned levels, but the aim of the Strategic
29 Framework and the action plans that flowed from that

1 was to maximise the activity that Trusts could deliver,
2 and to keep that under review on a three-monthly basis.

3 110 Q. would it be fair to say that that represented
4 a landscape change in how things were approached
5 because of the impact on Services, were the priorities 14:42
6 moved down?

7 A. Yes. It may be worth saying from early 2020 until the
8 summer of this year effectively the Department and the
9 Health and Social Care system was in a business
10 continuity mode and that meant that at any time the 14:42
11 priority was to respond to the Covid-19 situation as it
12 was at that time. Other Services inevitably had to be
13 down turned or paused, but the landscape essentially
14 was changed because of that for over two years.

15 111 Q. I think that's reflected in paragraph 47 where you have 14:43
16 quoted the reference you made in your oral evidence
17 that:

18
19 "No progress will be made on any of the extant planned
20 projects between the 9th March and 30th June 2020. The 14:43
21 HSC and all of Hospital Services Reform Directorate and
22 Regional Health Service Transformation Directorate
23 Resources have been redirected towards planning for and
24 managing the impact of Covid".

25
26 Your evidence is that essentially that remains the
27 position?

28 A. No, I'm not saying that that remains the position
29 currently.

1 112 Q. Sorry, in relation to Urology. Sorry, I should have
2 said the Priority 2 Urology, just at the beginning of
3 that paragraph, it's not going to move at all and move
4 up the list, as it were?

5 A. As things stand at the minute there hasn't been any 14:44
6 decision to elevate it to a Priority 1 or to the next
7 set of priorities for review. There's a lot of review
8 work underway within the Department and that draws on
9 the Health and Social Care system in terms of Public
10 Health Leads and Clinical Leads from across the Service 14:44
11 to provide their input and expertise to those reviews,
12 so there is a limit to the amount of reviews that can
13 be undertaken at any one time. As things stand, there
14 isn't an intention to look at a regional review of
15 Urology services at this point in time. 14:44

16 113 Q. You cover that again in the proceeding paragraphs,
17 paragraph 52, where you have already given evidence
18 about the prioritisation of certain services at the
19 moment. Paragraph 55, WIT-50726, we will move on from
20 that background information to the Early Alert, which 14:45
21 I think you were directly involved in that. Almost
22 your first day in the office I think was the phone
23 call. You have summarised the position that you found
24 at that time, at paragraph 56, WIT-50727, and one of
25 the first things you mentioned: 14:45

26
27 "My response will show that" -- and this is in response
28 to the statement 21 that the Inquiry sent to you --
29 "that the Trust led Lookback Review was already

1 underway when the Department became aware of concerns
2 relating to Urology Services in the Southern Trust,
3 after which the Trust progress with the Lookback Review
4 was guided by ongoing discussion with the Department,
5 HSCB and PHA, both prior to and subsequent to the 14:46
6 establishment of a Department Led Urology Oversight
7 Group in October 2020".

8
9 we will lead up to that in a moment. Can I just ask
10 you generally had you been involved in anything to do 14:46
11 with Lookback reviews before?

12 A. No.

13 114 Q. Had you been involved in Early Alert process?

14 A. Yes. Prior to taking up my current position on 3rd 14:46
15 August 2020, as I said, previously I have worked either
16 in Secondary Care in related roles within Healthcare
17 Policy Group, so the normal protocol with Early Alerts
18 is that a senior member of staff within the Department
19 can receive a phone call from anybody within the Health
20 and Social Care that meets the criteria. On occasions 14:46
21 where a senior civil servant is not available, somebody
22 of the next grade below, which I would have been prior
23 to August 2020, can receive that call and pass on the
24 necessary details to colleagues. I had some experience
25 over several years of receiving Early Alert calls on 14:47
26 a range of different issues, from across Health and
27 Social Care Trusts.

28 115 Q. When you mention that the Lookback Review was already
29 underway, is that merely just a factual statement or

1 was there an element of surprise for you that things
2 had come so far before the alert to the Department?

3 A. It is a factual statement that the Early Alert, when
4 reported on 31st July 2020, indicated that the Trust
5 had begun to look back at issues that they had concerns 14:47
6 around from early June of that year. As I said,
7 I wasn't familiar with the Lookback Review process or
8 guidance at that point, but I understood the rationale
9 that the Trust had taken to try and quantify those
10 concerns before raising an Early Alert with the 14:48
11 Department.

12 116 Q. I'm going to take you through the dates of the Early
13 Alert and the increasing knowledge. I think you talk
14 about your information elevating as time went on. If
15 I could just ask you in general terms, given what you 14:48
16 now know about the information over that short window
17 of time, would you have expected or do you think the
18 Department should have been informed at an earlier
19 stage about what was happening in Urology?

20 A. I think the Lookback Review guidance has subsequently 14:48
21 been revised to provide more clarity in that regard,
22 essentially saying that when a Trust recognises the
23 need to even begin a lookback exercise, that they
24 should definitively raise an Early Alert, even if it's
25 not something that they can quantify at that point in 14:49
26 time. I think the previous Lookback guidance left
27 a bit of flexibility for Trusts to try and ascertain
28 more information before raising the Early Alert with
29 the Department. I mean, having reflected on this,

1 I think had the Trust raised an Early Alert sooner,
2 i.e. in June 2020 when they first began to recognise
3 that there were concerns, I think that the process
4 would have been similar in that the Trusts still needed
5 to undertake a large intelligence-gathering exercise in 14:49
6 order to be able to quantify, and that obviously has
7 continued on in the intervening period.

8 117 Q. I suppose that begs the question then: why was the
9 Lookback Review criteria changed to try and make things
10 happen a bit sooner? 14:49

11 A. The purpose of the Early Alert is a notification
12 essentially to make sure that senior members of the
13 Department, senior officials and the Minister are aware
14 that there's an issue, even if the issue can't be
15 completely defined at that time. I think the purpose 14:50
16 of tightening that part of the Lookback guidance is
17 really just to ensure that the existence of an issue is
18 known as early as possible.

19 118 Q. If you take the Lookback Review issue out of it, would
20 you accept the proposition that if patient standards 14:50
21 are in question or if there's a potential for patient
22 risk, then really the earlier the Department know about
23 that, the better?

24 A. That's the underlying purpose of the Early Alert
25 system. I understand that the Early Alert process 14:50
26 itself or the protocol is under review and will be
27 revised to provide more clarification on the criteria
28 or the process through which Trusts should notify the
29 Department.

1 119 Q. Just again for my clarity, so it's not my
2 misunderstanding. It's not the case that commencing
3 a Lookback Review serves to, if I can put it in very
4 general terms, give the Department more time before it
5 has to notify, or give the Trust more time before it 14:51
6 has to notify the Department?

7 A. Sorry, I'm not sure I picked that up.

8 120 Q. We were talking about the Early Alert and I said if you
9 take the Lookback review out of it, and you agreed that
10 the earlier the better, that under the criteria for 14:51
11 a Lookback Review there are defined times when you
12 inform the Department, so is it possible that the Trust
13 instigating a Lookback Review can serve to extend the
14 time for them to get their numbers together or to get
15 their facts together, where if they didn't instigate 14:51
16 that they might have to tell the Department a bit
17 sooner?

18 A. My understanding of the revised lookback guidance is
19 that it clarifies that, so the notification comes as
20 early as possible, in effect as soon as the Trust has 14:52
21 confirmed that there is something that meets the
22 requirements for a Lookback. I'm not sure that it
23 necessarily buys the Trust more time because in any
24 instance a Lookback Review can be relatively small or
25 it can grow in accordance with what the Trust 14:52
26 determines. Whatever that period of time is, it's an
27 intelligence-gathering exercise and it really needs to
28 be assessed on a case-by-case basis, I believe, because
29 it depends where the information is located or who

1 needs to be involved in ascertaining the full picture.

2 121 Q. Just while we are on this topic, was there any sense at
3 all, at this time or any of your dealings with the
4 Trust, that they were reluctant at all to escalate
5 matters, or that they sought to not go public, that 14:53
6 they wanted to delay things; was there any sense of
7 that at all in your interactions with them or from
8 anything anyone might have said to you?

9 A. My recollection of the period of time between the
10 receipt of the Early Alert and the early establishment 14:53
11 of the Urology Assurance Group, is that there would
12 have been some debate or discussion around the timing
13 of public communications around the issues. That is an
14 issue that does require discussion and consensus
15 because there is a need to get the balance right 14:54
16 because if you're making any type of public
17 announcement, the information needs to be well-informed
18 to the extent that it answers any questions that might
19 arise, and also assuages any concerns that might be
20 from members of the public who are affected. I think 14:54
21 that was a necessary discussion.

22

23 My recollection is that the Trust reported to the
24 Assurance Group that this issue had been discussed
25 internally within the Trust. I believe there may be 14:54
26 some differences of view expressed as to whether the --
27 it was accepted that the Minister was going to have to
28 make a statement to the Assembly at some point.
29 Collectively between the Department, the HSCB and the

1 Trust, there was discussion with a view to reaching
2 consensus as to when that date should be. My
3 understanding was that the Trust was reporting some
4 discussion within its ranks internally as to whether
5 that should be sooner rather than later, or a desire to 14:55
6 essentially continue the lookback exercise and acquire
7 more information in order for the Minister's public
8 statement to be more fully informed.

9 122 Q. I wonder just on that point, if you could go to
10 WIT-50734, paragraph 78? I think I partially quoted 14:55
11 this about the evolution of the picture, but I will
12 just read out what you have actually said in your
13 statement. This is a time when there were weekly Zoom
14 calls before the establishment of the Urology Assurance
15 Group. So that's the time frame. You have said: 14:56

16
17 "Over the course of these weekly calls, a clearer
18 picture evolved of the full scope of issues needing to
19 be investigated and the number of patients within
20 different cohorts about whom the Trust had identified 14:56
21 concerns and potential SAI cases. The Trust advised
22 that it was developing a comprehensive communications
23 plan for the purposes of handling communications and
24 call-backs with any patients impacted, their families,
25 GPs, elected representatives, and the media. 14:56

26 Discussions took place over the course of these calls
27 regarding the relative merits of making a public
28 announcement while the Lookback exercise was ongoing,
29 or alternatively endeavouring to make further progress

1 to fully understand the scope and scale of issues in
2 order to make a more informed public announcement at an
3 appropriate time in the near future. My recollection
4 is that the Trust advised that the Trust Board had
5 taken the view that there was insufficient information 14:57
6 available for a public announcement to be made at that
7 time, i.e. during September and into October, and that
8 the Trust would need time to further establish facts,
9 confirm the cohorts of patients potentially affected or
10 who otherwise would be assured that there were no 14:57
11 concerns about their care and prepare for the opening
12 of public advice telephone lines."

13
14 Obviously the last sentence indicates operational
15 things that needed to be put in place. If I can just 14:57
16 ask you, you were obviously involved in these
17 conversations at this time around that. Was there any
18 risk assessment carried out by you and the others in
19 the group, HSCB, PHA, into whether or not there was
20 a potentially increased patient risk by delaying making 14:57
21 the announcement?

22 A. To my knowledge, there wasn't a Risk Assessment carried
23 out within the Department. It may have been something
24 that the Trust undertook. I can't recall whether that
25 came up in our discussions at that time. 14:58

26 123 Q. Did you have any discussions around risk and the
27 potential between giving the Trust more time and people
28 perhaps being exposed to sub-optimal care?

29 A. I think risk was at the heart of all of those

1 discussions, leading up to and after the establishment
2 of the formal assurance group. Early on in that
3 period, the Department was assured that the Consultant
4 had retired essentially or had effectively left
5 employment with the Trust, and the remaining consultant 14:58
6 body within the Trust had concerned or prioritised that
7 they would seek to ensure that no patients had come to
8 harm or would come to further harm, so there was
9 certainly a priority coming from the Trust in their
10 discussions with the Department that they would want to 14:59
11 identify any cohorts of patients and contact them as
12 soon as possible. I think at that time, while there
13 were a number of SAIs, serious adverse incidents,
14 identified, and I believe that contact had been made
15 with the patients with the families involved and those 14:59
16 individual SAIs, there had not been a public
17 announcement, firstly, and there had not not been
18 a confirmation given to those families that there were
19 similar or related cases identified, so essentially
20 each patient involved would have been contacted as 15:00
21 necessary or as deemed clinically necessary, but would
22 not have been aware that there were wider issues being
23 looked at or wider cohorts at that point in time. That
24 essentially was what those discussions centred around,
25 was: at what point or when would it be appropriate for 15:00
26 a fuller announcement to be made in the knowledge that
27 there's always a chance that information could make its
28 way into the public domain and cause further anxiety
29 among patients and families. So there was a desire to

1 try and acquire as much information as possible in
2 order for any public announcement and any patient
3 communications to be as comprehensive as possible.

4 124 Q. The changes to the Early Alert system and the Lookback
5 Review, the procedure I'm not sure if they do, but do 15:01
6 you consider it might be helpful if they expressly
7 import the requirement that a balance of risk is part
8 of the assessment when considering the timing of such
9 announcements? Do you think that would be something
10 that would be a beneficial factor to include in that? 15:01

11 A. I personally think that it would be. I think in our
12 discussions risk was a factor and it was a theme of the
13 discussion. I am just not sure that a formal risk
14 assessment was carried out.

15 125 Q. I am not sure we have them but are there notes of the 15:01
16 discussions that took place around issues like risk?

17 A. Prior to the formal establishment of the assurance
18 group in October 2020, the Department doesn't have any
19 written records of those discussions. They were
20 settled into a pattern of more or less weekly telephone 15:01
21 calls or video conference calls, hosted by the Southern
22 Trust, involving myself and other officials from the
23 Department, the Health and Social Care Board and Public
24 Health Agency along with the relevant Trust Leads.
25 They were more or less weekly calls where the Trust 15:02
26 provided a verbal update as to the emerging
27 intelligence that it was gathering through its various
28 strands of investigation or of Lookback. As that
29 picture developed, that led to the decision then for

1 the formal establishment of the assurance group, but we
2 don't have Departmental written records of those calls
3 prior to the establishment of the formal group.

4 126 Q. I wonder if I could just ask you a little bit about
5 that. The first meeting was on 10th September. Then 15:02
6 I think the meetings were weekly up until 29th October,
7 and the Urology Assurance Group then was set up on 30th
8 October. Just for the Panel's note that's paragraph 76
9 of Mr. Wilson's evidence at WIT-50734. These meetings,
10 were they set up at the behest of the senior officials 15:03
11 from the Department or was it another one of the arm's
12 length bodies that decided that this would be a good
13 idea? what way what did that start, that process?

14 A. I can't say definitively whose decision it was or whose
15 direction it was to establish those. To my 15:03
16 recollection, the immediate days following the receipt
17 of the Early Alert, as I said in my statement, I had
18 a number of telephone conversations with relevant Leads
19 from within Commissioning from the Health and Social
20 Care Board and from the Trust. The purpose of that 15:03
21 was, as I say, to try and ascertain what level of
22 intelligence or knowledge there was around the Trust's
23 concerns. Over that period, between August, September
24 and into October, the Trust was still developing its
25 knowledge around the concerns and attempting to 15:04
26 quantify the number of patients in each of the cohorts
27 around whom they may have concerns or need to look back
28 at their care. I don't recall whether it was directed
29 by the Department that we should have weekly calls.

1 I think there was a recognition that the picture was
2 unfolding and emerging and that a weekly call would be
3 beneficial. I think it's fair to say that there was
4 consensus between the Department, the Health and Social
5 Care Board, the Public Health Agency and the Trust
6 Leads that a weekly call would be useful to check in
7 and hear from the Trust what the current position was.

15:05

8 127 Q. For an audit of that decision-making if one were
9 needed, were any notes taken of the telephone calls
10 that you had with various individuals, apart from these
11 weekly meetings? 15:05

12 A. No, I didn't retain a note other than my two
13 submissions that were sent to the Minister around the
14 Early Alert. While the intelligence picture was
15 developing weekly, it wasn't until the Trust was asked
16 to submit a formal report around the middle of October
17 of its progress to date that I then sent a further
18 update submission to the Minister in October. 15:05

19 128 Q. You have provided those submissions to the Inquiry.
20 I suppose what I'm looking for is the information that
21 forms the basis for those submissions, the notes and
22 minutes that you might have used to take a view as to
23 what way the Minister might want to look at the
24 information that you were providing him so that he
25 could be informed of that. If there are no notes or
26 minutes leading up to that or available, then that's
27 the way it is. I'm not going to keep asking you the
28 same question. I'm just interested to know if there
29 are any and where we might ask for them? 15:06

1 A. The information would have been formalised essentially
2 when the Trust sent an updated version of the Early
3 Alert notification and then submitted its report, its
4 progress to date report. All of the information
5 gleaned through the weekly calls was a changing 15:06
6 picture. The report, as requested in mid-October,
7 provided a further snapshot at that point in time of
8 where the Trust had got to, so that formed the basis of
9 a formal submission then to the Minister around which
10 the decision, at that point, was taken to establish the 15:07
11 formal oversight assurance structures.

12 129 Q. I just want to, because we will be hearing from other
13 people who were likely at these meetings, just so we
14 are clear, there wasn't a formal notetaker. These were
15 informal conversations effectively set up to, if I can 15:07
16 use the word react in a neutral way, react to the
17 information that was coming from the Trust, in order to
18 devise a plan and provide advices to the Minister by
19 way of a submission. We don't have the information
20 leading to the decision-making up to the submission, 15:07
21 but we have the factual information provided by the
22 Trust that informed that submission. Is that fair?

23 A. Yes.

24 130 Q. A fair reflection. Because from 1st October from the
25 first Urology Assurance Group meeting, we have notes 15:08
26 for every meeting since then, and I think more or less,
27 bar one or two individuals, I think it's the same
28 people involved in those meetings, so there will be,
29 hopefully for the Panel, a corporate memory perhaps of

1 the decision-making that resulted in the Minister
2 making the announcement?

3 A. I think there should be. The difference, I suppose, is
4 the purpose of the weekly calls as the rhythm became
5 was for the Department and Health and Social Care Board 15:08
6 to agree what the appropriate assurance mechanism or
7 oversight arrangements should be as this picture
8 unfolded. Those calls were hosted by the Southern
9 Trust, so I'm not sure, I don't believe that there has
10 been a minute submitted by the Trust of those weekly 15:09
11 calls. Once the Urology Assurance Group was
12 established then from late October, with the Permanent
13 Secretary as the Chair of that group, that's when the
14 Department essentially assumed responsibility for the
15 conduct of those meetings and would have had a formal 15:09
16 minute taker in place from that point onwards.

17 131 Q. Because one of the issues raised by Mr. O'Brien, if we
18 could just deal with it at this juncture, is that he
19 questions the integrity of a strength, and the strength
20 of the information that was relied on in order to 15:09
21 commence a review of his practice effectively. He says
22 that was an erroneous basis. That does lend itself to
23 the question of, if at all, did you or anyone in the
24 group seek to test the information that the Trust was
25 providing you with, and which ultimately led to the 15:10
26 ministerial submission? Did you seek to ask questions
27 about it or interrogate it in any way so that you were
28 assured that your response to it was based on a sound
29 basis?

1 A. Can I clarify? Are you referring to the submission to
2 the Minister that I sent in October or the subsequent
3 submission around the --

4 132 Q. I think if we look at this as a chain of events.
5 Everything led to that point, and certainly from the 15:10
6 Trust on your actions -- your involvement from 3rd
7 August, everything subsequent to that was layer upon
8 layer which ultimately led to that. The information
9 that Mr. O'Brien takes issue with was the information
10 that subsequently triggered the Lookback and the SAIs, 15:10
11 and he questions that. That was the start of what
12 could be considered the particularly intense look at
13 his practice, and he sees that as a sort of a false
14 start.

15 A. Okay. 15:11

16 133 Q. The Inquiry will have to take their own view on that
17 and hear evidence, but just from your perspective and
18 your position in the Department and the other
19 professionals you were working with, is it the case
20 that you do question the robustness of information 15:11
21 given to you or do you take the Trust at face value?

22 A. I think that my position, and the Department's position
23 on that is fairly straightforward. The Trust raised
24 concerns initially using the Early Alert process as the
25 mechanism to raise those concerns, but at that point 15:11
26 onwards any concern raised by a Trust then becomes
27 a matter of judgement as to what the appropriate
28 response to those concerns should be. The period of
29 August, September, October that followed was very much,

1 from the Department's perspective, one of trying to
2 build a full picture of the nature of those concerns
3 and to have those quantified, which the Trust was doing
4 through its various work streams and the cohorts of
5 patients that were being looked at. Those concerns 15:12
6 were escalated when the Trust submitted an update to
7 the Early Alert in the middle of October, I can't
8 recall the exact date, but when the Trust began to look
9 at the prescribing practices, the nature of those
10 concerns took on, from my perspective, a greater degree 15:12
11 of seriousness. The Department does take what Trusts
12 report at face value, there's no reason to doubt what
13 Trusts report, especially when they are concerns around
14 patient safety. Patient safety is paramount in
15 everything that the Department does, especially when 15:13
16 reacting and responding to an issue that arises. We do
17 have to take what Trusts report to us through senior
18 management and through medical directors very
19 seriously, but the discussions that ensued leading to
20 the more formal process were not designed to test the 15:13
21 robustness of the Trust's information, but to seek
22 assurances that the concerns were being investigated
23 and that the appropriate interventions were being put
24 in place, firstly, with regard to patient safety and,
25 secondly, with regard to the Trust's overall response 15:13
26 to those issues.

27 MS. McMAHON: I wonder if that's a convenient time, I
28 am just about to move on to the last section?

29 CHAIR: 15 minutes, Ms. McMahon. We will take a short

1 break and we will come back at half past three.

2
3 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

4
5 134 Q. Mr. Wilson, I just have a couple of other topics to discuss. I will discuss the learning bit at the end. There is a couple of mop-up bits that will come up in evidence and I want to give you the opportunity to comment on them. If I just ask, before asking the question I want to ask, what involvement do you have, or your Department have, in relation to targets that a Trust has to attain? Do you have any involvement in monitoring or overseeing any targets or liaising with the Trust about targets? 15:31

6
7
8
9
10
11
12
13
14
15 A. In a general sense, yes, but the function around the monitoring of Trust performance and the reporting of that was a function of the former HSCB, and has now come into the Department to colleagues in the Strategic Planning and Performance Group, so the function remains the same essentially. It is of interest and importance to me as a Policy Lead what waiting time targets are set and how Trusts are performing, because that, obviously, has a bearing on how patients experience it, and how they come through the service. The Department generally sets those targets normally through a commissioning plan direction issued to the Commissioners, now to SPPG, and Trusts are expected then to deliver upon those. I don't have a direct role in the setting of those targets or in the monitoring of 15:33
16
17
18
19
20
21
22
23
24
25
26
27
28
29 15:34

1 them, but they are important and relevant to my work.

2 135 Q. I just want to read an extract from Section 21 Response
3 from Martina Corrigan, who was the Head of Service of
4 Urology. She refers to the word "Department", it may
5 be she is referring to the Department or, having 15:35
6 listened to your answer, she may be referring to the
7 HSCB. Given that she makes this comment, I just want
8 to give you the opportunity, if you have any comment,
9 to make on it. There are just other names on this so
10 I am just going to read it out rather than bring it up 15:35
11 on the screen, I will just read the relevant part:
12

13 "It was apparent that the Trust was being held to
14 account by the Department of Health and I am aware of
15 the monthly meetings chaired where comparison with 15:35
16 other Trusts on how well they were or were not doing
17 was presented with all Trusts being present. I am
18 aware, through others, of fractious conversations with
19 the Department of Health personnel and feel this
20 impacted on the operational teams as they didn't want 15:36
21 the Trust to look bad in front of the other Trusts.
22 While I believe this was introduced for the benefit of
23 the patient, I also believe that the patient's needs
24 were at risk of getting lost in the need for the Trust
25 to be seen to be best performing in the eyes of the 15:36
26 Department of Health. In short, it was all about
27 figures and the patient needs, risk getting lost in the
28 midst of these figures."
29

1 If you just hold on to that thought at the moment and
2 just, out of balance, I will finish off the next part
3 of the second paragraph on the next page. She also
4 said:

5
6 "In my opinion, the Urology Unit was not adequately
7 staffed but I can confirm that was not due to funding
8 from the Department of Health to implement the
9 recommendations of the review."

10
11 Those are the two particular references. Just in
12 relation to the first reference where she talks about
13 pressure for targets, the notion that Trusts were maybe
14 being played off each over, first of all, is that
15 anything you recognise at all?

16 A. Back to my previous comment, I don't have a direct role
17 in the performance monitoring or in holding Trusts to
18 account on how they perform against targets. I have to
19 say I don't recognise that is what is being described
20 as the Department's primary focus, and I want to be
21 careful not to take those comments completely out of
22 context. I would recognise that it's maybe a concern
23 that's expressed at times, but ultimately I would say
24 that from the Department's perspective the monitoring
25 of Trust performance is a really fundamental and
26 important function. The service is provided through
27 public funding, and there's a Statutory function upon
28 the Commissioners where are now in the Department to
29 monitor how that funding is used, and that is done

1 primarily through the process that we generally call
2 Performance Monitoring, so the performance targets are
3 set by the Minister and they are what Trusts are
4 measured against, among other indicators. It's not
5 accurate, I think, to say that would be the sole focus 15:38
6 and I would say in my almost 18 years in the
7 Department, and nine years working in healthcare
8 policy, I think that patient safety and patient
9 experience would be paramount. I am saying that from
10 the perspective of a policy maker rather than somebody 15:38
11 who is tasked directly with performance management.
12 But the focus really is across both; both are extremely
13 important and fundamental parts of how the system
14 operates.

15 136 Q. To be fair to Ms. Corrigan she will give evidence. The 15:38
16 reason why I read that out is because there are other
17 examples in the evidence before the Inquiry of other
18 individuals in different levels, including more senior
19 to Ms. Corrigan, who say the same thing effectively;
20 that there was not so much the Department playing 15:39
21 Trusts off, but there was an over-focus on outcomes and
22 perhaps less of a focus on patient quality, the
23 standard of care. Just on that point, I know you have
24 said you are not directly involved in targets but you
25 have quite a considerable experience in the Department. 15:39
26 Are you aware of particular targets or assessments that
27 relate to the quality of patient care rather than data,
28 rather than just the numbers?

29 A. I can't say, it's not something that comes into my

1 direct responsibility. I think it's worth saying that
2 whilst performance monitoring in general is really
3 fundamentally important, there is probably a constant
4 debate about the nature of how those metrics are set
5 and whether the current performance indicators are the 15:40
6 most appropriate, or whether they they can improved
7 upon. I think that's something the Department is
8 looking at, and will look through the work on the
9 integrated care system. So there is ongoing work to
10 look at how and what performance indicators should be 15:40
11 set for the Health Service and maybe to relate that
12 more to things like patient experience and overall
13 population health outcomes. But the fundamental data
14 as you describe around actual throughput, if you like,
15 and again, I want to be careful not to make this 15:40
16 completely about numbers, but that is still an
17 important consideration. We need to know how is the
18 system is performing, both internally within Northern
19 Ireland across five delivery Trusts and also by
20 comparison to other regions and countries. It's 15:41
21 a really important means of assessing where our system
22 is at and how it could be improved.

23 137 Q. Just before moving on to the last part in the learning,
24 I just wanted to raise with you the issue of -- I'm not
25 sure if you address it. I don't think you address it 15:41
26 in your statement, I don't think you were directly
27 involved but because you were part of the Early Alert
28 process, Mr. O'Brien appears to have only got around
29 half an hour's notice of the announcement by the

1 Minister, and I think the Trust got just under an hour.
2 Do you have any view as to the appropriateness of that
3 short period of notice, or was there a reason that
4 those involved in the decision thought that that was
5 appropriate?

15:41

6 A. I should clarify, I didn't have any direct involvement
7 in the advice or the timing around the Minister's
8 announcement about the Public Inquiry, so my view is
9 a general one. I think it's probably fair to say that
10 when a decision like that is taken that something is of
11 a seriousness or a magnitude that the Minister wants to
12 make an announcement to the Assembly, that there's
13 a certain degree of caution needs to be exercised
14 around the handling of that announcement in order that
15 members of the Assembly don't find out through another
16 means. It's an important part of giving the Minister
17 his or her place in the making of that announcement. I
18 am aware of the details around timings of who was
19 informed about that just prior to the Minister's
20 announcement, but I can't speak to the rationale other
21 than just to say generally that there's a reason to
22 exercise some caution around the timing of that.

15:42

15:42

15:42

23 138 Q. If we move onto the learning part of your statement.
24 It's WIT-50764, paragraph 168. A lot of these issues
25 we discussed with Mr. May this morning so I'm not going
26 to go over them again. He has updated us as to the
27 current position with the Department. You, in
28 paragraph 170 at WIT-50766, have indicated that --
29 after referring to all of the various developments and

15:43

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

planned reviews:

"It is envisaged that the implementation of any learning identified through the various processes and reviews outlined in this statement include any recommendations from the USI itself will be taken forward at an appropriate juncture."

15:43

I think that last part of your sentence reflects your evidence today, that this is a fluid position for the Department and you have to prioritise. Certainly the issues that were discussed with Mr. May this morning would indicate that the reviews currently undertaken have a certain level of commitment, that they will be followed through once the recommendations are made.

15:43

Paragraph 171 where you were asked by the Inquiry:

15:44

"Does the Department consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?"

15:44

You have said:

"It is clear from the issues identified and actions underway to date that opportunities to improve processes and prevent or mitigate risks exist at a Policy and Oversight Level for which the Department accepts it has direct responsibility as well as at an

15:44

1 operational level."

2

3 If I could just ask you, when you refer to the risks in
4 that paragraph, what sort of risks are you referring
5 to?

15:45

6 A. I think I'm referring to the risks around the concerns
7 that the Trust raised in the first instance around
8 patient safety.

9 139 Q. Reading that into the sentence then that:

10

15:45

11 "There is opportunities to improve the processes and
12 prevent or mitigate patient safety risks at a policy
13 and oversight level"?

14 A. Mm-hmm. I'm referring there to some of the processes
15 that we have touched upon around primarily the SAI
16 process, the Early Alert process and the Lookback
17 Review process, all of which have been revised or are
18 undergoing a revision at present. These are all
19 essentially protocols and processes through which
20 Trusts identify where there are potential risks or
21 improvements to be made or clinical learning that could
22 be drawn from any incident as it arises and
23 disseminated through the region, through relevant
24 clinical specialities.

15:45

15:46

25 140 Q. You are referring to the systems by which you hear of
26 patient safety risks rather than the patient safety
27 risks themselves?

15:46

28 A. I think that's one aspect of it. I mean, I don't think
29 there's an inherent risk in when the Department hears

1 about an incident; it's more about the timing of when
2 it's identified in the first instance and the
3 appropriateness of the response to that. Once the
4 Department becomes aware that any Trust has identified
5 concerns about any issue, as I mentioned earlier there 15:47
6 then needs to be an assessment and a judgement taken as
7 to the appropriate response to that. Quite often
8 Trusts will have already taken the appropriate action
9 or will have initiated at least the action that's
10 needed to mitigate those risks. 15:47

11 141 Q. When you are looking at these issues it's sometimes
12 quite difficult to distinguish between Clinical
13 Governance and Corporate Governance whenever you are
14 providing an oversight and ultimate accountability role
15 which the Department has and the distinction between 15:47
16 those types, there's certainly a point at which they
17 almost crystallise. Would you accept that, that it can
18 be difficult at times to separate those two notions of
19 governance out?

20 A. I know the Permanent Secretary touched on this in his 15:47
21 evidence earlier. It's not a question that comes up
22 regularly in my role, so I haven't given that great
23 consideration but I think they are two separate issues.
24 The Corporate Governance to me relates to how the Trust
25 management and its board functions and how it 15:48
26 translates to assurance through the Department's
27 Standard Assurance Process. Clinical Governance to me
28 means more around how the medical side of the service
29 is delivered and the structures that exist and the

1 processes around individual clinicians and clinical
2 teams and the role of Trust Medical Directors in
3 providing an oversight to that. Essentially, you know,
4 maybe the role of Trust Medical Directors and their
5 teams is where those two functions essentially converge 15:48
6 because you have a role that is part of the Trust's
7 Corporate Governance structure as well as part of the
8 Trust's Clinical Governance structure. They are both
9 important and I'm not sure if I'm qualified to comment
10 further on the importance or the convergence of those 15:49
11 two functions.

12 142 Q. Just when you look at your statement in the round, it's
13 clear that there's been significant work or effort put
14 into looking at the Healthcare system and certainly in
15 the systems of Governance that the Department rely on, 15:49
16 it's also evident that there's quite a bit of work to
17 be done to adjust those systems so they operate in
18 a way that enhance patient care - the RQIA, the SAI,
19 the Lookback Review, the Early Alert, all the things
20 that are on the list for review. The Hyponatraemia 15:49
21 Inquiry recommendations, the Neurology Inquiry, and
22 then this Inquiry. Is it a source of frustration for
23 you that you can take the work so far but in the
24 absence of a Minister to take most of it over the line,
25 then improvements may not take place as quickly as they 15:50
26 might do?

27 A. In the time that I have been in this current role, as
28 I said, we have been in a business continuity mode of
29 operation essentially with the Minister until recently.

1 Prior to that, yes, we, I think, became accustomed to
2 working as a Department without a Minister and with
3 civil servants having limited decision-making powers,
4 so, in a sense, there is a space in which to develop
5 policy and to review policy and develop 15:50
6 recommendations, but there is always a point at which
7 ministerial decision will be needed to advance those.
8 The main source of frustration that arises from that
9 really is around the inability to set a budget for the
10 Department, because inevitably any Policy that we 15:51
11 review or any service that we seek to transform will
12 require some degree of additional investment and on
13 a recurrent basis. Even with Ministers in place for
14 the last eight or nine years, we have been living with
15 a situation of single year budgets and often injections 15:51
16 of nonrecurrent funding into the system which helps on
17 a temporary basis, but I think the frustration from us
18 as policy makers and I probably can speak on behalf of
19 delivery organisations and Trusts and Clinicians, is
20 that there, as yet, has not been a a multi-year budget 15:51
21 that allows us to undertake any meaningful long term
22 planning so it makes it difficult to put good policies
23 into effect.

24 143 Q. I have no further questions, Mr. Wilson. The Panel may
25 wish to ask you some questions, so if you would just 15:52
26 wait there for a moment.

27
28 THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:
29

1

2 144 Q. DR. SWART: I just want to bring you back to your
3 comments about Delivering Together and the
4 prioritisation, and the work plan, and the current
5 situation where there is a huge backlog of work, the 15:52
6 fact that you have been operating under business
7 continuity. On the one hand, you can regard that as
8 a huge problem, but to what extent has the Policy Group
9 looked at what has really been learned during Covid in
10 terms of the ability to rapidly transform services with 15:52
11 good Clinical Leadership, because surely that's an
12 opportunity to actually do things differently. Has
13 that been built into your current thinking?

14 A. Yes, and for the duration of the Covid response, I have
15 been part of the Department's what we refer to as the 15:53
16 Gold Command Structure, which has been stood up or met
17 with increasing frequency during periods of high surge
18 in Covid. Those structures would have brought together
19 the leaders from across the Department's Arm's Length
20 Bodies, including Trust Chief Executives. There's very 15:53
21 much a sense that it is possible to introduce rapid
22 changes to the way of working and to break down I think
23 what were previously perceived as organisational
24 barriers or silos across the five regional Trusts, and
25 my sense -- as we have continued and hopefully are now 15:53
26 emerging from the height of the pandemic -- my sense is
27 that the leaders from right across the system want to
28 capitalise on that sense and there seems to be, from my
29 perspective, a very good spirit and determination to do

1 that. There are, as I said previously, constraints to
2 do that, because it still takes time to develop policy
3 and when we do it properly there is a need to fully
4 involve stakeholders and that inevitably slows things
5 down a little bit. I don't think the system can 15:54
6 constantly react in a rapid sense. I think the proof
7 of concept has been delivered by Covid in lots of ways
8 that a lot of services could be stood up rapidly and
9 the extent of cross-Trust collaboration, seeing
10 Services as Regional Services where they previously 15:54
11 weren't maybe perceived in that way, and
12 a centralisation of waiting lists becomes much more of
13 a reality that people can work towards, so I think
14 there is an opportunity in that that has begun to be
15 capitalised upon, but I think there's possibly scope 15:55
16 for more of that.

17 145 Q. Within the Trust, they will no doubt be embarking or
18 are embarking on a huge programme of work to improve
19 things in urology, and there will be quite a cost
20 attached to all that in terms of the transformation 15:55
21 work. Does the Department recognise and sponsor that
22 or does the funding for that come through another
23 vehicle?

24 A. Can I just ask you to clarify what type of funding or
25 what type of initiative? 15:55

26 146 Q. I'm talking about people to oversee improvement
27 projects, additional managerial support, expertise, and
28 so on, which the Trust will incur on a practical way on
29 the ground, I imagine, in order to transform things at

1 the Southern Health care Trust?

2 A. Yes.

3 147 Q. How does the Department's Policy Group assist with
4 that?

5 A. I think the Department will be open to any requests and 15:56
6 discussion around additional funding that's required.
7 It's obvious that funding is extremely constrained this
8 year, and looking into the next one or two financial
9 years, with the budget as it currently is. So there
10 isn't a guarantee. Quite often when Trusts want to 15:56
11 initiate a programme or a project within their Trust
12 locality, it will be funded or the additional resource
13 to put in place the core programme team will be
14 identified from within the Trust's own baseline, so
15 there isn't necessarily a need for additional 15:56
16 investment on top of that, and that might be a result
17 of other projects coming to an end and project managers
18 becoming available, and there are other projects and
19 programmes that take place at a regional level and that
20 are sponsored by the Department in any case because 15:57
21 they are recognised as regional priorities. I'm
22 involved in some of those around the regional approach
23 to transforming Pathology Services, for example, or
24 Imaging Services where you do need need a regional
25 approach of all Trusts working together as a system. 15:57
26 In the past we have been fortunate that initiatives
27 like that have been able to attract additional admin
28 funding, and it's not often a huge amount of funding
29 but putting together a core team of three to four

1 people to manage and run projects and programmes, in my
2 experience, makes a huge amount of difference for
3 relatively small investment.

4 148 Q. It's really a question about whether you recognise the
5 pressure this puts on cultures and the need for 15:57
6 investment to support the Trust in whatever they think
7 needs to be done as part of your Department Policy role
8 and a part of these big Inquiries?

9 A. To bring it back to my role, if that is something that,
10 in this case the Southern Trust or if any Trust 15:58
11 identifies a clear need to have or to identify
12 additional investment, my role as a Policy Lead
13 overseeing that particular service would be to, I would
14 often be asked for policy support for a bid to go
15 forward to the relevant Finance Leads. It would be 15:58
16 a matter of myself and my team assessing the proposal
17 and getting an understanding of what it seeks to
18 achieve. If that's in line with what the Department
19 would see as a Policy priority we would usually support
20 that, and then the bid or the proposal might go forward 15:58
21 for consideration by the relevant Finance Or Economy
22 Leads.

23 DR. SWART: Thank you.

24 CHAIR: Mr. Hanbury have you any questions?

25 MR. HANBURY: No. 15:59

26 CHAIR: Just one left field question perhaps. One of
27 the issues that there seems to have been certainly in
28 the Urology Department and in the Neurology Inquiry,
29 I think identified this also, there's an issue with

1 recruitment in Northern Ireland. It may be not just
2 particular to Northern Ireland, but I wondered had the
3 Department any policy initiatives, if I can put it that
4 way, to help to recruit more bodies for our healthcare
5 system here?

15:59

6 A. The Department has an overarching workforce strategy
7 and the responsibility for that sits with one of my
8 neighbouring Directorates under Healthcare Policy and
9 Workforce Directorate, and it essentially sets
10 a framework for the future planning for the workforce
11 needs within clinical specialties looking at projected
12 future demand and demographic change. The purpose of
13 those workforce plans is to prepare in advance or to
14 begin to identify the training needs and the succession
15 planning that's needed to sustain and grow those
16 services in line with demand. But inevitably there is
17 always, and across most of the areas where we face long
18 waiting lists, we have a recognised gap between growing
19 demand and the system's current capacity. Often that
20 comes down to recruitment difficulties or workforce
21 shortages and Services, by and large, try to address
22 that gap by adopting different models of care or
23 identifying opportunities to work more efficiently, but
24 inevitably there is a need across most Services to grow
25 the workforce. One of the areas I oversee is in the
26 Imaging Service, the overall provision of Radiology and
27 Radiography workforce, so there's an exponentially
28 growing demand across all specialties for Imaging. We
29 have an initiative underway to radically try to grow

15:59

16:00

16:00

16:00

1 the amount of trainees coming through as radiologists
2 and radiographers recognising what the future demand is
3 likely to be, that needs to be met with the appropriate
4 investment, and it comes back to the point that I made
5 about multi-year budgets and issues like that. Part of 16:01
6 my role is to lobby effectively, or to ensure that
7 those types of needs are prioritised because across
8 most of the long waiting lists, one of the underlying
9 factors is workforce, and the succession planning and
10 the growth of the workforce. It's recognised as 16:01
11 a major constraint and a major factor in the current
12 waiting list situation that we face. The response to
13 that is being taken forward at the level of individual
14 Clinical Specialties regionally and also within
15 individual Trusts with the Department's oversight. 16:02
16 It's definitely not a quick fix, but there is an eye on
17 the future, to the extent that it's possible with our
18 current budget, trying to put in place the necessary
19 resource and training places to address that.

20
21 Another aspect of that, it's not my area of expertise,
22 is the Nursing workforce, which I think was exposed
23 during the Covid crisis, that we simply aren't training
24 and producing enough nurses. Although there were
25 decisions taken immediately prior to Covid to increase 16:02
26 the number of trainee places for nurses, it will
27 obviously take a few years for those changes to come
28 into effect.

29 149 Q. I mean I can understand the need to plan long term

1 about that, but one of the points that my colleague was
2 making was in relation to the agility that was shown
3 when there is a will among the medical workforce and
4 the Commissioners and the Department and the Trusts to
5 work agilely, if I can put it that way. I am just 16:03
6 wondering is there learning from that that can be
7 applied to this long term planning? Is it possible to
8 cut out some of the fat, as it were, in order to be
9 more agile?

10 A. I think in relation to the training and growth of the 16:03
11 workforce, I think that is a difficult one because it's
12 accepted it's going to take time to firstly increase
13 the number of training places that are funded and
14 available, and then for the trainees to come through
15 those programmes in order for there to be more feet on 16:04
16 the ground, effectively. The notion of agile working,
17 I maybe want to clarify if you are talking about the
18 ability to deploy resources across the region as they
19 are required using the staff resource that's currently
20 in place, is that more the sense? 16:04

21 150 Q. That would be part of it, yes.

22 A. Yes. I think it's maybe a question that the Trusts can
23 address more directly, but I think there's a desire to
24 do that, and essentially to map the current workforce
25 to where it's needed. I think during Covid it was done 16:04
26 in a crisis, and staff responded to that, but I think
27 it probably has to be recognised that staff who were
28 involved in that response were stretched. I probably
29 can't speak on behalf of different sections of the

1 workforce as a whole, but that's my sense that, yes,
2 there's a will to do that where it's possible and where
3 there's enough resilience in the system, but I think
4 the first challenge is to build the resilience, and
5 that's not a quick fix.

16:05

6 CHAIR: Thank you very much, Mr. Wilson.

7 MS. McMAHON: That's the end of today's evidence.

8 CHAIR: Thank you very much, Mr. Wilson, ladies and
9 gentlemen. We will reconvene in the morning at 10.00.

10 Mr. Wilson, I think you were scheduled for tomorrow
11 morning to continue on, so our next witness doesn't
12 come until 2:00 then. See you all tomorrow at 2:00.

16:05

13
14 THE WITNESS THEN WITHDREW

16:06

15
16
17 THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 16TH
18 NOVEMBER 2022 AT 2.00PM

19
20
21
22
23
24
25
26
27
28
29