Urology Services Inquiry

Oral Hearing

Day 19 – Wednesday, 25th January 2023

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

THE INQUIRY RESUMED AT 10.15 A.M. ON WEDNESDAY, 25TH JANUARY 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Hughes, Mr. Gilbert, welcome back. 10:15

MR. WOLFE KC: Good morning. As you can see, we have back before us this morning Dr. Hughes and Mr. Gilbert. We last heard from them on 29th November; that was Day 13 of the Inquiry. There is obviously a full transcript of their evidence for Days 12 and 13 of 10:16 their evidence available on the Inquiry website.

You may recall that when we finished - and this is for you as well, Dr. Hughes - when we finished on 29th November, we were examining what Dr. Hughes had 10:16 described in his Section 21 statement as the key themes which had emerged from his, Dr. Gilbert's and the SAI team's consideration of the nine cases. Amongst the key themes that we had looked at on the afternoon Of Day 13 were the issue of a professional delivering 10:17 care without multi-disciplinary input; the failure of onward referral to oncology or palliative care, and in one particular case we looked at failure to refer to a specialist oncology setting in the case of a penile cancer. We also looked at the issue of prolonged 10:17 treatment pathways, and we looked at care which varied from regional and national best practice.

We ended the evidence on Day 13 by commencing with an examination of the theme that care varied from the

recommendations set out in the decisions of the urology MDT. We will now conclude on that theme this morning before examining some of the other key themes, which include a lack of resource to adequately track cancer patients; a lack of a quorum in MDT; lack of assurance audits, and the lack of a coherent escalation structure. So, that's our task for today. 10:18

Dr. Hughes and Mr. Gilbert, when we were looking at the theme of care varying from the recommendations set out in the decisions of the MDT, I was asking you, Dr. Hughes, whether a clinician was locked into implementing the MDM recommendation for his patients in the sense of it being a contract, and you may remember that. I was asking you whether there was any entitlement to deviate from that recommendation. You were saying, you may recall, that your language of the contract, which you had mentioned, I think in a meeting with the family of Patient 1, your language of a contract was merely intending to emphasise that the MDT recommendation is what should be offered to a patient if the circumstances continued to justify that, and that any deviation from the recommendation - and there may be good reasons for a deviation, and I think you accepted that - they should be rediscussed as part of a multi-disciplinary process. You have said that the change should be described, noted and explained, and you said it can't be explained very well without input from, for example, a cancer specialist 10:18 10:19 10:19 10:19

nurse as a supporting mechanism.

Mr. Gilbert, I think you agreed with that analysis. You commented that even in an emergency situation where a decision has to be taken quickly, there are structures and processes available to avoid unilateral decision-making. 10:20

I want to pick up, then, this morning with some of the views expressed around this by Mr. O'Brien. If we can open, if we could and have up on the screen, some extracts from Mr. O'Brien's Section 21 statement, starting at WIT-82508. If we go to paragraph 314. Thank you. 10:20

Mr. O'Brien is seemingly explaining that in the urology MDT at the Southern Trust, other members of the multi-disciplinary team were generally not subsequently informed of a deviation from an agreed recommendation as there was an understanding that the clinician and patient have the right, and indeed the responsibility, to deviate from the agreed recommendation if the latter was declined by the patient or if the recommendation was concluded by the clinician and patient to be inappropriate. 10:21 10:22

As a principle, Mr. Gilbert, if I could ask you first of all, is that, in your view, an appropriate way of working within a multi-disciplinary format?

MR. GILBERT: I'd say it is not my understanding of the way an MDT should work. The MDT it a meeting to arrive at a consensus in the best interests of the patient. That discussion and its outcome should relate to the patient. 10:22

Now, ultimately, the clinician looking after the patient is most intimately knowledgeable about the particular and peculiar circumstances of that patient which may lead to the need for some deviation, but the 10:22 discussion of that between the clinician and the patient should be entered into the notes, the reasons. I would still hold that the MDT should be informed of the deviation and the reasons for that deviation.

MR. WOLFE KC: Any observations from your side, 10:23 Dr. Hughes?

DR. HUGHES: Yes. The reason why this should be fed back to the MDT is it is not multi-disciplinary care if they don't know about the care that's being given. It is in the interests of the patient, it is in the 10:23 interests of the professional, that those decisions are supported. These variances from recommendations should be the minority of the cases. Also, the Trust has a reasonable expectation that they would know about the care that's given. If changes are made unilaterally 10:23 in, say, the outpatient setting with nobody else knowing, the Trust cannot simply know about the care that's been delivered. That's not an appropriate setting for any healthcare setting.

MR. WOLFE KC: Is there any distinction to be drawn, Mr. Gilbert, say between a decision to deviate from the recommendation which the clinician might know is never going to be controversial, it's a straightforward decision to deviate from the recommendation; you should only do it in more complex cases? 10:24

MR. GILBERT: Normally, if there is any possibility of variation, that would have been discussed in the consensus and arrived at in the consensus of the MDT. Those options would have been put to the patient. The reason for a patient selecting one or other option could then be recorded in the notes and there would be no need to go back to the MDT because the MDT had agreed different options as a consensus. 10:24

If, however, an individual clinician and a patient, for good reasons, decide to offer an option not discussed at the MDT, then the patient has the right and should expect that discussion to be relayed back to the MDT so that it becomes a multi-disciplinary team decision. 10:25

MR. WOLFE KC: That's very clear.

Can we look, if we scroll down to paragraph 316. Here Mr. O'Brien gives us an example. An example, Mr. Gilbert, that you had, I suppose, some input on. 10:25 He says:

"I can refer to one example which has been provided in the disclosure".

He doesn't have the benefit of the full record, scrolling down, but he's able to make the following comments:

10:25

"The patient presented to haematologists in March 2019 with lymph node enlargement, and the biopsy in April 2019 which confirmed follicular lymphoma".

Scrolling down, please. 10:26

"Staging of the lymphoma revealed the presence of a right renal lesion. While it was considered that this legion was probably a primary renal cell carcinoma, it remained a differential possibility that the lesion may 10:26 have represented lymphomatous infiltration of the kidney. If that was confirmed by percutaneous biopsy, that alone would have been an indication for treatment of the lymphoma. Percutaneous biopsy with prophylactic factor VIII was recommended at urology MDM on 27th June 10:26 '19".

Scrolling down. When he subsequently reviewed the patient - and just paraphrasing here - he decided because of a risk of infective complication, it 10:26 wouldn't be appropriate to conduct the biopsy and he made the decision to defer consideration of the biopsy to later. You concluded that that was a reasonable change of plan.

Just if we can go to your observations on that. You were asked to provide advice to The Trust, you may remember, in respect of that case. Your observations are at TRU-09829. You're writing to Patricia Kingsnorth. You say: "This case does not raise any alarms in my head". Just scrolling down. Go on down, please. 10:27

I think in a nutshell, Mr. Gilbert, you're agreeing that it was not necessary for Mr. O'Brien to pursue the MDM recommendation. In other words, it was a correct or a reasonable decision to deviate from it; is that fair? 10:28

MR. GILBERT: Yes, but I'd qualify that by saying that it should have been discussed in the MDT in a timely fashion. 10:28

MR. WOLFE KC: You see that there, it is 09830.

"My only observation is that the reasonable change of plan should have been discussed in the MDT in a timely fashion. I don't think the patient suffered any harm as a consequence of this omission". 10:28

You don't think it amounts to an SAI. But the important procedural consideration is, doing it properly, you have to bring it within the multi-disciplinary regime. 10:29

MR. GILBERT: Yes.

MR WOLFE KC: And let the MDT have its say so that there's ownership of the decision by the entire team?
MR. GILBERT: Well, so that a consensus opinion could arise for the best interests of this patient in the light of what was going on at the same time. I think it was perfectly reasonable to defer the biopsy in the light of the co-morbidities, but the MDT should have been informed of that because that was a significant variation or deviation from the original consensus. 10:29
MR. WOLFE KC: That principle of returning it, re-referring it to the MDT, is that one that you think holds good for all cases? 10:29
MR. GILBERT: Yes.
MR. WOLFE KC: Presumably a factor that you would rely on to support that analysis is that operating on a unilateral basis may risk you not taking all of the factors into account that might be seen as relevant by your colleagues, your multi-disciplinary colleagues? 10:30
MR. GILBERT: Yes. But broader than that, when Improving Outcomes Guidance was originally devised by Mike Richards, who was then the Cancer Tsar, I understand, the whole principle was to ensure that individuals who practised outside normal guidelines without reasonable justification could be brought into the fold. So, specifically to support clinicians in making sure that practice was according to guidelines, hence the title of the document "Improving Outcomes Guidance". That can only be done by consensus. 10:30 10:31
MR. WOLFE KC: Let's go back to Mr. O'Brien's comments

on the issues arising from a deviation from recommendations. If we turn up WIT-82591, at paragraph 564, he argues that:

"I don't believe that any failure on my part to follow MDM recommendations would have or did impact on patient care and safety. In any case where there may have been a departure from an MDM recommendation, a detailed review of the individual case would be required in order to comment on the rationale for departing, as there can be many appropriate reasons to do so. For example, it would not be appropriate to follow such a recommendation if, following discussion with the patient, the patient didn't wish to follow the treatment recommended at MDM. That would be a more serious patient care and safety issue in that it would amount to providing medical treatment without the patient's consent". 10:32 10:32 10:32

I suspect the last part of that is uncontroversial, albeit that you would add the caveat, as you have done so already, that deviation requires a return to the MDM. 10:32

I want to focus for a moment on the first part of that paragraph. Mr. O'Brien doesn't accept that any failure on his part to follow MDM recommendations would have an impact on patient care and safety. Dr. Hughes, I'm conscious that the focus of the SAI process isn't on 10:33

any, I suppose, causation issues per se. It's not about working out whether a person suffered, in legal terms, a causative injury. Is it fair to say that your reports in the round found that patients had suffered serious and significant deficits in care - I think four 10:34
patients were identified under that heading - and all received suboptimal care?
DR. HUGHES: Yes, that's correct. An SAI process is a patient safety process. It is really about systems and processes and about how to improve it to make sure 10:34
these outcomes don't happen again.

Changing MDM recommendations, for whatever reason, should be fed back to the MDT for a multi-disciplinary input. That has been NHS guidance since again Mike 10:34
Richardson in 2010. That allows people to have input into that, and oversight and again the Trust, as governing body, to have knowledge of it.

What we identified was delays in care. Care that 10:34
varied from best regional, acknowledged regional best practice; care that varied from the actual MDM recommendations, and care supported by both locally clinical nurse specialists and expected onward referral to other professions. So there are multi-layers and 10:35
multiple reasons for the deficits.
While this comment is really in discussion between a single professional and a single patient, but best care in cancer care is delivered by

a multi-disciplinary area team. To go down this route without involving a multi-disciplinary team is, in my view, inappropriate and potentially risky.

MR. WOLFE KC: If I was to ask the question directly, putting what Mr. O'Brien has said into a question, did you find that any failure on his part to implement MDM recommendations impacted on patient care and safety? 10:35

DR. HUGHES: Yes. Patient 1 should have been referred earlier to oncology for potential curative treatment. Patient 2 should have had referral in a time-sensitive manner, and didn't achieve his chemotherapy in an appropriate time. Patient 3 was referred down an inappropriate pathway and not a super-regionalist pathway. 10:36

MR. WOLFE KC: Sticking specifically to the example, and I think maybe Patient 1 is a good example of deviation from the recommendation as opposed to other causes of harm to patients. Patient 1 is an example where there is a clear recommendation, which included provision for onward referral to oncology. Whether we call it simply not implementing the recommendation, for whatever reason, or deviating it, the conclusion in that case was the patient developed metastases while being inadequately treated for high-risk prostate cancer? 10:36 10:37

DR. HUGHES: Yes.

MR. WOLFE KC: In terms, then, do you consider Mr. O'Brien correct in his assertion here?

DR. HUGHES: I do not. In terms of Patient 1, there

was a clear recommendation for early and urgent referral onward to oncology for a consideration of potentially curative therapy. That did not happen over a prolonged period of time, and Patient 1 was eventually referred to oncology at a palliative stage of his illness.

MR. WOLFE KC: You deal in your Section 21 statement, Dr. Hughes, with the issue of consent. If we could turn up WIT-84169. You say that: 10:37 10:38

"Patients were not aware that the care given varied from regional standards and MDM recommendations",

and if that was the case, they could not have given informed consent to this. 10:38

Could you explain that to me and to the Inquiry in terms of your understanding of the consent process? If you are suggesting that it's a key factor in the consent equation to be told about what the MDT has said about you as a patient, can you explain how that arises? 10:39

DR. HUGHES: Consent in cancer care is critical for good care. It is a supportive process in virtually all instances. It is to ensure patients who are maybe - I think all these patients were - on their first cancer journey, through a difficult time, to fully understand the options that are available to them. Some of the options vary from active and potential curative therapy 10:39

or active surveillance, which to a lay member is complete polar opposites. Those discussions need to be supported. That's the essence of having a clinical nurse specialist there, who can explain this in detail over a prolonged period of time so people have a deep knowledge and understanding of what they are deciding to do. 10:39

The second issue, it should be based on the MDM recommendations. If there's a reason for it to vary from that, that should be clearly documented in the notes, and it should be clearly documented that that has been discussed with the patient. That second issue was not present. When we talked to the patients who had received care and to the families of those sadly bereaved, they had no understanding of that conversation happening. So, they presumed the care they were getting was the agreed care from the MDT. In several of the cases, what was suggested should happen from the MDT meeting either didn't happen at all or was very slow in happening. 10:40 10:40

MR. WOLFE KC: Mr. Gilbert, again this transaction normally takes the form of a conversation clinician and patient. To what extent do you say that it is necessary as part of the consent process to inform the patient of what the MDM has determined or recommended? 10:41

MR. GILBERT: It is mandatory.

MR. WOLFE KC: In what sense?

MR. GILBERT: The patient's care has been discussed by

a multi-disciplinary team, a consensus, again, has been arrived at; either options for treatment or a specific treatment has been recommended. The clinician should document the discussion, the options, the reaction of the patient, and any reason why the options offered by the MDT have been declined and another variation is put in place. Without that documentation, we must assume that the patient was not informed of the various options available to them and, therefore, they could not have given consent. It's only through information and education of the patient that a decision about treatment can be arrived at between the professional and the patient. 10:41 10:42

MR. WOLFE KC: I want to ask you about this issue of documenting that process. We can see in a number of examples -- I'll pull one of them up but just going through some of the examples. Patient 4, there's a reference at DoH-00108, the need to document informed consent. With Patient 1, a similar reference at DoH-0010. 10:42 10:42

If I can pull up Patient 6 and the report concerning him at DoH-00079. Just scrolling down. You say at recommendation 3:

10:43

"The rationale for any decision to diverge from the MDM plan must be explained to the patient, documented in the communication with their GP, and subsequently validated by further MDM discussion".

The reference to documentation here in the context of writing to the GP, but presumably also in the patient notes?

MR. GILBERT: I think the best record is in the letter sent to the GP and preferably copied to the patient. Very often a great deal of information is given during a consultation regarding management options, which the patient may not be able to retain in detail. Therefore, it is best practice and good practice to ensure that the letter explains the options available to the patient and the reasons for selecting a particular course of action. That letter should be sent to the GP, and it would be best practice to send that to the patient as well so that they have a record of the discussion. If they feel that it doesn't actually represent the points that were raised and talked about, the patient will have an opportunity to try and correct or qualify whatever has been written. 10:44 10:44 10:44

MR. WOLFE KC: Dr. Hughes, I suppose in the world or in the industry of medicine, if I can put it in those terms, is it, I suppose, the expectation or the norm that if you don't see a record explaining the consent process - what was said, the explanation given, the options - then is it your understanding that in that world of medicine, a conclusion can be fairly reached that that discussion didn't take place, or the consent process wasn't properly or effectively followed? 10:45 10:45

DR. HUGHES: In terms of professional guidance for

doctors on GMC guidance, you are required to make notes on all pertinent issues. Making notes about consent is really an essential issue. All doctors are strongly advised if it is not written down, it cannot be regarded as happening. That is a clearly well-understood principle for many, many years, both in the medical and in the legal world. 10:46

Critical issues, where you're suggesting that advice has been given for one pathway but a separate decision has been made to do something different, that's an incredibly complex decision for somebody who is maybe on their first journey in a cancer journey. It is an even more complex discussion for somebody who is not supported by the appropriate professionals, which would have been a clinical nurse specialists who could have had a detailed discussion. The fact that that's not even noted in the routine documentation is a significant issue. 10:46

MR. WOLFE KC: Obviously there are other ways of proving that a process happened or a consent was properly taken but, judging from what you're saying here, you could only go on the basis of what was available to you in the notes and in the correspondence? 10:47

DR. HUGHES: Expected best practice is that variation from MDT recommendations should not be the majority of cases but if it happens, it should be documented, the discussion with the patient should be documented, and

the case should be rediscussed to support the professional and to support the patient back at the MDT.

MR. WOLFE KC: Let me move on then to the next theme set out in your Section 21 response, Dr. Hughes. If we could have up on the screen, please, WIT-84169. Here we looked at the issue of lack of resource as it was reported to you within the Trust to adequately track cancer patients through their journey. What you are reporting here was what is contained in the reports, or some of them and certainly in the overarching report; that it was reported to you that there was no resource for a whole system and whole pathway tracking process; that the focus was simply on what I think you have referred to already as the ministerial imperative of a 31/62 day compliance. You said that there should be a three-prong tracking approach; the MDT will have its tracking people or processes; the availability of the nurse, the CNS, and the consultant and secretary element. I think what you are commenting here through the reports is that all three were inadequate in some respects. 10:47 10:48 10:48 10:49

Can I ask you, when you talk about the need - and your recommendations deal about this - when you talk about the need for adequate tracking, can you give us some examples of what should be tracked? 10:49

DR. HUGHES: I think it is really important that they have a process to check that actions are taken; scans

that are being ordered, have they been completed, have they been reported, have they been read? Infrastructure that knows that onward referrals to oncology, has the referral been made, has it been received, has it been completed? 10:50

That is a normal process of tracking the system. I think it is very unfair that we use the word "trackers". These are essentially professionals who run the infrastructure of cancer services. They will 10:50 have knowledge in the system who can make sure people get their investigations and results in a timely fashion. It has to be a dynamic system but it has to be respected and resourced, and I don't believe it was. I think there was too much focus on did we meet the 10:50 31-day diagnostic timeline, did we meet the 62-day treatment timeline, as opposed to the important infrastructure around that and the safety issues around that, and that was clearly deficient. 10:50

I think the other issues is the professional secretary. Unfortunately, that was a known problem within the Trust from 2016. The first around patient triage of red flag referrals was one of the issues. There were known deficits there. Red flag deferrals, maybe 15 to 10:51 20 percent will result in a cancer diagnosis, yet they didn't think to look at the actual cancer pathway where everybody actually has cancer, and to see if there were deficits in that pathway. So, I think that was an

issue.

Again, I don't think your clinical special nurses, their sole job is to be a safety check. They are part of the multi-disciplinary team and everybody has a responsibility to do patient safety and quality of care. Part of that would be supporting patients through their complex diagnostic pathways, to explain what an MRI is, to explain what a CT scan is, to know the dates, and to able to take them through in an informed way the results. When they are removed from that, you're increasing the greater risk of incidence; you're making the system unsafe. When you add that on to a secretarial process that was dysfunctional and overworked, you increase the risk. Then if the tracking is not as it should be, you increase the risk. Throughout this process, we have seen lots of trips and slips. We have seen things that --

MR. WOLFE KC: Let's look at a specific example, perhaps, one that's maybe fresh in our minds after yesterday's evidence. We recall the case of Patient 5. Patient 5 had a history of renal cancer which was the subject of ongoing review. There were scans in the summer of '19, and then a scan in December of '20 which was available and reported in January '20 -- sorry, I should say December '19 was the scan, into January 2020 it was available to be read and actioned. We don't need to go into the fine detail. It wasn't actioned until late July/August of 2020.

In a case like that, when you talk about tracking and the need for tracking and the fact it wasn't available for this MDM, or not effectively available, what would tracking mean in practical terms in a case like that, if it's applicable? 10:53

DR. HUGHES: Well, first and foremost, radiology usually send an alert e-mail to say there's an issue with this, please review. The MDT trackers, somebody whose in a follow-up, should be informed of that as well. The patient should have been allocated a Clinical Nurse Specialist, who would have supported them through their aftercare and they could also have been identified. What we have here is results going to a single person. Irrespective of who that could be, that is not an appropriate safety net for a complex pathway. Unfortunately, lots of our IT systems are not currently joined up so you need these multiple professionals being involved in the care. But, first and foremost, the alert e-mail to a consultant and the report going to the consultant is the first point of tracking. 10:54 10:54 10:54

MR. WOLFE KC: In a system of tracking, as you might imagine it or construct it, where does the alert ring with or chime with -- the failure, say, to read that report and take the necessary action and return the case to MDM, the omission or the failure to do that, where does that sit within an effective tracking regime? 10:55

DR. HUGHES: Irrespective of the quality of the tracking regime, the responsibility lies with the responsible consultant. That's always as is.

MR. WOLFE KC: Yes, that's fine, but we all know that consultants can be busy, they can be sick, they can be distracted. I think on the last occasion, Mr. Gilbert maybe illustrated that quite well. 10:55

If tracking is to mean anything, it takes the distracted consultant as a given, and presumably tracking is to deal with the effects of the distracted or forgetful consultant. Who in the system should be receiving the alert and making sure that these things are done? 10:56

DR. HUGHES: The lead tracker for the urology team should receive it. I should say the responsibility for having an appropriate tracking system and having an appropriate resource lies with the cancer services. It is not an administrative process, it is a patient quality and safety process. There were known deficits. There were deficits with the consultant secretary. I'm not saying it is the consultant secretary's fault, I mean they can be swamped with lots of work. But nobody took a step back to say how is this whole process working? They were clearly aware that they weren't resourced appropriately but there was no escalation and no action on that. 10:56 10:56

MR. WOLFE KC: Yes, indeed. You'll recall that you spoke to the urology MDT and they all attended to hear

what you had to say. Mr. Glackin, if we could turn up WIT-84349. Just a third of the way down, Mr. Glackin suggested there was an issue with resources at MDM. He recalled his experience in the West Midlands where MDM is better resourced. The follow-up and tracking was more robust, more a priority, and had admin support. He advised there were weekly trackers who would liaise with consultants enabling them to meet their timelines, adding here they're never able to meet timely care. 10:58

Is that what you were hearing from him and others about the safety of this process? 10:58

DR. HUGHES: Mr. Glackin and other consultants, especially those who are trained and/or worked in England, they were used to a different resource and a different structure. Urology cancer is high-volume MDMs, six cancers; it needs to have an appropriate infrastructure to deal with that volume and deal with that volume in a safe and appropriate way. That requires a proactive resourced tracking system. It needs a system that checks that when actions are agreed, they are actually completed; that when actions are not achieved, there's an escalating mechanism to expedite them, and that there's a knowledge of the ongoing problems within the system. Every MDT should have a twice yearly business meeting to actual review where the problems are and drill down deep and seek changing how they work to improve patients' outcomes. 10:58 10:58 10:59

This MDT was not resourced to have that knowledge and to effect meaningful change. When we did the SAIs, while we started off on a pathway of inappropriate prescribing, we started finding a lot of things that were I would call were unknowns and undones. I don't think anybody had a clear understanding of lack of timely onward referral, because the system is not joined up to know that. Some people were unaware of the presence or absence of Clinical Nurse Specialists. Unless you have an appropriate infrastructure to know about your system, you won't and can't improve it. I think this MDT was inappropriately resourced to have that baseline knowledge. 10:59 11:00

MR. WOLFE KC: I want to go back to the issue of resources in a minute. Mr. Gilbert, going back to the example that I deployed, which was Patient 5, a consultant doesn't action the results report, how would your forgetfulness, if it was you in your home place, how would that be picked up on and addressed within your MDT structures? 11:00 11:00

MR. GILBERT: This case is not entirely typical of MDT from my perspective. I mean, it depends how your MDT operates, which, I'm sorry, is a slightly mealy -mouthed way of answering your question but if I can illustrate. This patient had gone through an MDT and had their definitive treatment for renal cell carcinoma. This was now a follow-up situation. My experience and practice has been that that is the responsibility of the person who requests the test, 11:01

which is ultimately the consultant leading the team. However, MDTs have moved on from that process of just moving up to giving the definitive first treatment and now, as part of the rolling improvements, broadening and deepening of the process will include follow-up protocols as well. It is only with those protocols that you can ask people who are nonclinical to help with the tracking process; so, the MDT coordinators if you have them. If you don't have them, then it relies on simply the clinician and whatever administrative support. 11:01 11:02

There is less and less time for secretaries across the Health Service these days. They seem to have been diverted into other activities. So, for example, when I started as a consultant, I had two and a half secretaries to cover my work. When I finished at Cheltenham, I had half a secretary. What's happened is that more administrative duties have fallen to the clinicians, and that can be overwhelming. Unless you have an MDT which is developing and has set up follow-up protocols as well as the preoperative decision-making protocols, then mistakes will happen. 11:02 11:02

So, the way I now avoid that is by having these results flagged up by the MDT coordinators, because we have evolved into that comprehensive, continuous scrutiny and oversight of the patient's journey. That's supported by a multi-disciplinary team - the clinician, 11:02

the Clinical Nurse Specialist, and the trackers. It is those three people working cooperatively and together that avoid problems.

MR. WOLFE KC: I quite take your point that Patient 5 may not have been an ideal example for this scenario because, as you say, he was out of the MDT process by that point, but I suppose the general point is that there are steps to be taken in respect of a patient's care pathway, whether that's a timely referral to oncology, the appointment of a nurse, or whatever it might be. 11:03 11:03

Your point is a broad one, Dr. Hughes, is it not, that a tracking facility for any of those factors or indices simply wasn't available in this MDT? 11:04

DR. HUGHES: It wasn't available, and the focus is very much on the targeted returns. When you take out a critical patient support role, which is the Clinical Nurse Specialist, that makes the situation worse. As we had already discussed, the overburdened consultant-secretary situation would be a problem. 11:04

I think as things have evolved, part of the multi-disciplinary working, lots of other professionals take on the role of follow-up. Specialist nurses will do a lot of prostate cancer follow-up. That's how people work through their MDTs in a twice yearly business meeting to see how can we improve, how can we make this better? Part of the way of doing that is 11:04

to change the roles of professionals and change who actually does the follow-up.

MR. WOLFE KC: The point that is made to you, I suppose loudly and clearly by, for example, Mr. Glackin, and it is the point which you reflect into your Section 21 statement, is that this was a resources issue; they weren't resourced to deal with that. Is that to oversimplify it or, perhaps from the other side of the coin, overcomplicate it? Mr. Gilbert has explained the need, the important first step is to develop a protocol, to have a recognition that tracking is important; in fact vital, I think you would say. There were people around that table who had the experience of tracking earlier in their career. This issue didn't even seem to be on this MDT's agenda. It hadn't been, I suppose, spoken about or sold to the managers that "we need this"? 11:05 11:05 11:06 11:06

DR. HUGHES: No. The issues that were on the agenda were lack of oncology, quite rightly; a second radiologist for pre-MDT review of cases, quite rightly. But the actual functioning of the MDM, where they could have meaningful data to review the problems in their group in an evidence-based way, did not seem to be on the agenda. I should say, to be fair to professionals, they felt there was a major disconnect between them and the cancer management team, and they felt they weren't being heard and they felt they weren't being resourced. They felt there was quite a disconnect, and there clearly was a disconnect. 11:06 11:07

MR. WOLFE KC: I think I'll not bring it up on the screen. Mr. Glackin makes the point at WIT-84349 during his meeting with you that there was no input from outside of the multi-disciplinary team, no support from the Cancer Services Management. We'll come to look at that in a moment.

In resource terms, whether that's the number of personnel you need or the cost of it, without putting a figure on it, this isn't a terribly expensive or complicated thing to implement? 11:07

DR. HUGHES: No. They're usually incredibly vital staff and incredibly important to patient care, but they are usually Band 3, 4 clerical staff. I suspect that if management is only focused on 31/62 day targets and don't see the patiently safety deficits and the clinical deficits, the tracking will not be an issue. 11:08

MR. WOLFE KC: Let me move on to the theme of quorum or inquorate MDT meetings.

Can we have up on the screen, please, WIT-84169, the bottom half of the page. Here, you reflect that in the period with which you were most interested, 2017 to 2020, only in, I think, one year, 2018, only in 2018 does the quorate rise above 20 percent. I take it that's 20 percent of the meetings? In 2019 it was never a quorate. You explain that the clinical medical oncology and attendance by cancer specialist radiologists, that that was the problem. 11:09

In broad terms, what are the implications or what can be the implications of an inquorate meeting? Maybe I'm direct that question to Mr. Gilbert. If you happen to a meeting where the medical oncologist isn't available, 11:10
does the meeting proceed?
MR. GILBERT: I've never really faced that situation, I'm afraid. But yes, if there were -- if a medical oncologist wasn't present, if a clinical oncologist wasn't present, then I really haven't ever encountered 11:10
that situation. Would we go ahead with discussion? No, the patient would be -- if one of the reasonable treatment for a patient involved either of those specialists, then no, the discussion would have to happen at some other time. 11:10

The point of the multi-disciplinary team is that you have every opinion the patient needs for their treatment to be considered and agreed upon. It just seems to me that this particular MDT was not 11:11
well-served. I'm trying to avoid commenting on the MDT itself because my only role was to look at these particular cases, so I don't want to fall into conjecture. But it did surprise me that the attendance of the clinical oncologist, let alone a medical 11:11
oncologist, was very deficient and, therefore, couldn't really lead to a comprehensible or all-encompassing discussion of the patient's management and care.
MR. WOLFE KC: I think it is helpful to deal with it

broadly and generally perhaps in the sense I'm anxious to understand, and I'm sure the Inquiry is anxious to understand, if you don't have these valuable inputs from these other disciplines, if it's simply a urological and nursing discussion, in general terms is it inevitable that, in their absence, issues are not discussed, there's a risk that key factors aren't picked up on, and that the patient's treatment pathway may miss or may be absent key discussion? 11:12

MR. GILBERT: It has to be said that in most cases, the discussion falls into a very stereotypical pattern according to which cancer you are dealing with. The purpose of having expert opinion there is to spot those that lie outside the normal stereotyped pattern. So, for example, somebody with localised prostate cancer, the decision would normally be all options available, so active surveillance, radical prostatectomy, or external beam radiotherapy, and that would be a stereotype. We deal with maybe 50 cases in an afternoon, of which maybe 40 will be that sort of straightforward, shall we say, discussion. 11:12 11:13 11:13

But every so often there's a patient that comes along with some variation, either particular and peculiar to them or particular and peculiar to their disease, that requires reflection and thought. Unless you have expert opinion there, then you're not going to be able to have that comprehensive discussion. So, it is absolutely mandatory to have a clinical oncologist 11:13

present at these discussions.
MR. WOLFE KC: Dr. Hughes, you received evidence or information from Mr. Glackin. I needn't bring it up on the screen but the reference for your note, Chair, is WIT-84349. When you met with him and the MDT team, he talked about the fact that he had suggested suspending the Trust MDM due to attendance issues. Can I turn that into a question? What should he have been doing as the Chair and what should the Trust have been doing? Is it as bad as they should not have put up with this and should have stopped their MDT? 11:14 11:14
DR. HUGHES: I think there's a very clear pathway. I think that should have been escalated to the Cancer Services and the Associate Medical Director For Cancer Services. This should have been taken to the Chief Executive or the Medical Director in the first instance. 11:15

When I was Medical Director and had issues around how quorates or people's attendances at meetings, if it required discussion with the Central Oncology Service in Belfast, we had those discussions, and sometimes they were frank discussions. I think the Southern Trust were badly served, but they had been badly served over a long period of time. I know a slight bit of background knowledge in that the jobs were not attractive. Urology was twinned on the same day with a respiratory lung cancer sort of contribution in the afternoon, so it was impossible. While there 11:15 11:15

may have been oncology staff there coming from Belfast, they were probably unable to attend this MDM.

That said, I think the right action is to escalate it on the basis of their patients are not being served promptly, and the patients are not getting the same service that is happening elsewhere. I actually went back to look at the peer review of my own Trust's urology services at the same time as the Southern Trust, and their quorate rate was 98 percent, and I presume it would be the same in Belfast, the other third team. 11:16 11:16

So, I think known problem, not resolved and not appropriate equal share of resource. 11:16

MR. WOLFE KC: By definition, I suppose, if you don't have the attendance of these three specialties, then it is not a Multi-Disciplinary Meeting?

DR. HUGHES: No.

MR. WOLFE KC: I've looked at the findings across the nine cases. In many of the cases you make, I suppose the general observation. For example, Patient 1 at DoH-00010, "The MDT meeting should be quorate and all participants must be able to contribute to the discussion". Now, that general remark inserted into many of these cases, it didn't seem to me when reading that - and I would be grateful for your comments on this - that you were making any specific or focused point that the absence of quorum, the absence of these 11:17 11:17

three key members perhaps, was having a direct impact that there was any particular shortcoming in the recommendation. But is there something in general about the attendance that improves the MDM, even if it isn't necessarily relevant to a particular issue in the patient's case? 11:18

DR. HUGHES: Well, I think with attendance quorate levels at that level, it is a nonfunctioning -- it doesn't meet the definition of a multi-disciplinary meeting. That was largely driven by the absence of oncology, clinical oncology, and that is critical to the care of many urological cancers. So, people were probably working to protocols and then referring on. But without oncologists embedded in the team, it is not a functioning team. As Mr. Gilbert has already said, while you can function for the majority in that way perhaps, there may be deficits. 11:18 11:18

There's also an issue about the cultural issues. You have to take a step to refer people to another institution. That other institution doesn't have a lot of ownership for what is going on in the Southern Trust. You saw that in the governance issues where people knew about prescribing issues but didn't escalate it to the Southern Trust. So it is not simply about having them in the room to have the meeting, it is about feeling they belong to the team and feeling that they have some governance responsibility for that. 11:19 11:19

Part of the problem with a peripatetic service coming down is that you feel you belong to another Trust and not deliver the same level of governance oversight. I suspect at that time not only was it low levels of oncology cover, I know for a fact it was a variable 11:19
rotational group, because I know at times my own Trust in the northwest were sending professionals down to help to cover. It's not just the numbers, there was no stability in the service and there was no real input. I think that's a critical issue when there are issues 11:20
within the service.

MR. WOLFE KC: Can I ask you then just to turn to one, what appears to me to be a more specific concern about the quorate problem. It concerns again Patient 5, DoH-00042 and recommendation 2. You'll recall the 11:20
circumstances of this patient's case, that the primary or the initial problem had been dealt with by nephrectomy in the previous year. That was dealt with by the MDM and into treatment and all of that. The problem that concerned you in this SAI was more 11:21
specifically the failure to action the scan in January '20. It's in that context that I want to ask you about this recommendation.

"The Trust must ensure that patients are discussed 11:21
appropriately at MDM and by the appropriate professionals. In this case, it would be essential to approve on radiological resource".

I must confess, I didn't understand what that was driving at. Can you help us with that?

DR. HUGHES: Part of the non-quorate issue was there were not two radiologists with some specialist interest in urological cancers who do a high proportion of the work in that field and have a specific component of their continual professional development in that field, they had only one. So, the radiological scans were not appropriately double read in advance of meetings. It is the same standard that applies to pathology. They have stringent rules in the quality of the images and the quality of the pathology that input into the MDM. It was in relation to that. 11:21 11:22

It was again another sense of a reasonable request from the urology team of management, and it hadn't been addressed. 11:22

MR. WOLFE KC: But in this case, factually it hadn't got to the MDT or the MDM in respect of that radiological output, it was still sitting as unactioned. My query was how would radiology have assisted -- how would additional radiological assistance within the MDT have assisted in that particular context? 11:22

DR. HUGHES: The issue is of patients are appropriately discussed at the MDT. If you do not have double reading of radiological scans in advance of MDT, it is not meeting the qualified standard. So, that is the deficit in the MDT. 11:23

MR. WOLFE KC: If we could turn up DoH-00097. This concerned Patient 3. Within his report, just look at the second bullet point.

"If the MDM is not quorate, an accountable chair should ensure through appropriate quality assurance that every patient's potential management options are fully discussed and that the MDM's decisions are documented as having been communicated with the patient, their family and their GP". 11:23 11:24

Could you break that down for us? What are you expecting of the Chair? How can these actions replace a fully quorate meeting?

DR. HUGHES: These actions cannot replace a full quorate meeting, but it is a sense to ensure that all the appropriate options were discussed and they were fully documented. 11:24

MR. WOLFE KC: Does that mean perhaps if, say, a clinical oncologist is not available and it is necessary to have that view or that input, that you would adjourn that patient's consideration or seek to speak to him or her outside of the MDT? 11:24

DR. HUGHES: What the practice was, that they would refer onwards, usually to the oncologist in the Cancer Centre in Belfast. It is the Chair's responsibility to make sure that that has happened, but they didn't have an infrastructure to do so. 11:25

MR. WOLFE KC: Again, it was your information that the

issue of quorum and the lack of supply of these key professionals was known to the Cancer Services Management Team. Their view of it was what?
DR. HUGHES: Their view of it was they actually knew about it and had been trying to resolve it over a prolonged period of time, and they thought they had improved the situation. I did respond with them to say that wasn't factual due to the figures that we had. So, they had struggled in getting a resource from the regional service to the Southern Trust. 11:25 11:26
MR. WOLFE KC: I thought I said Patient 3; maybe I didn't. This report concerns Patient 3.

The next theme in your Section 21 statement, Dr. Hughes, concerns the issue of assurance audits and the lack of them. If you could turn up your Section 21 again at WIT-84169. You say that the assurance audits of patient pathways within urology cancer services were limited between 2017 and 2020, and they could not have provided assurance about the care delivered. 11:26 11:27

I think you received some information that audits on the nursing side were reasonably mature and helpful but there was none at all focused on the workings of the urology MDM? 11:27
DR. HUGHES: There were nursing audits on the very good work they do in Trust biopsies. There was a patient experience audit as well, but that was only given to patients who had met with a Clinical Nurse Specialist

and really had the major fault that it wasn't sent out to all. There is other work ongoing around patient experience across the region, and that has been reported on as well.

11:28

In terms of the local urology MDM, one would expect, where there are areas of concerns, that there would be whole-system patient pathway audits, perhaps done by trainees for presentation. If you are going to have twice-yearly business meetings, you have to have it on 11:28
the basis of data and information, and you have to focus on your known areas of concern. So, there were areas of concerns but they weren't audited. So back to my prescribing.

MR. WOLFE KC: I know you are not intending to be 11:28
proscriptive. By way of, I suppose, broad example, the MDT is supposed to have an annual business meeting. At that annual business meeting, for example, there was a discussion that nurses aren't appointed in every case or that patients aren't being referred within the 11:29
appropriate timeframe to oncology; any known risk. What, without being overly prescriptive, would you expect to see flow from that?

DR. HUGHES: Twice annual audit, sometimes people look at their very delayed cases to see what went wrong in 11:29
the system, so you may have exception audits just to see what was going on. They would have that information in the 31 and 62-day targets. So, if someone has a very prolonged patient pathway, it might

be worthwhile to drill down into that and see how they can improve the systems.

I don't think there was an appetite to look at possible known problems. I think that's a cultural issue. To 11:29
do this well, it has to be an open and transparent environment, and it must be an environment where everybody feels their input is welcomed and essential. I didn't believe that was the impression I got from the MDT. That said, I think if you are going to make 11:30
returns, not simply for your service improvement but people have to make returns for cancer peer review - and some of the returns they made were opinion-based as opposed to data-based or evidence-based - I think they could have started with the questions that peer review 11:30
will ask us, and have significant audits in that work.

MR. WOLFE KC: If we look at what you have said here, "In the absence of audits, this Trust, this MDT, could not have provided assurance about the care that was delivered". That's a pretty damning indictment, 11:30
I suppose, of the known -- there were known risks and there were, as you have discovered, unknown issues. Are you saying that audits would reasonably have picked up on some of that stuff and brought it together for action purposes? 11:31

DR. HUGHES: Yes. I mean cancer service is a structured healthcare delivery process which should have internal assurance and external assurance through peer review. People should have self-knowledge and

intelligence in terms of incidence, complaints, delayed in care. They should have a matrix of things that trigger specific audits. They should be doing that on a regular basis. I mean if your infrastructure is poor, I can understand the difficulty in that, but you 11:31
should be doing proactive work around assuring yourself about your cancer pathways. Normally, people would look at their bladder cancers, would look at prostate cancers or look at some aspect of it. It might be triggered by some soft information of it or prolonged 11:32
pathways. Simply waiting for people to find issues or reacting to DATIXs or reacting to SAIs, it's not the best way to manage or provide a safe service. That's why you have a structured process within Cancer Services, so that you can do that. 11:32

MR. WOLFE KC: Obviously this MDT had been working, by the time you looked at it, for a period of ten years or so. It had been, certainly when you get to look at it, working without appropriate audit. We'll come to look at resources in a moment but what would be the benefit 11:32
of an appropriately functioning audit process for the MDT and its work?

DR. HUGHES: Appropriate audit should be into areas of potential known problems, and I have suggested some triggers for that. But it should be aimed at quality 11:33
improvement and see how we can do this better, or differently. If you look around urology services, they have changed remarkably over ten years. You can see how the enhanced role of Clinical Nurse Specialist, in

the Southern Trust especially; into diagnostic processes that would have previously been done by consultant staff. There's other ways of doing the follow-up and taking off the burden off professionals and working in a truly disciplined. But you have to have the evidence, you have to have the data. 11:33

I think if you only do governance from the process of SAIs or when things go wrong, that's a terribly negative way of looking at your service. People have a natural heart-sink moment when they are dealing with difficulties through a deficit in patient care. 11:33
I think it is much better to do this proactively in an open and transparent way from the basis of known difficulties and improvement methodology. 11:34

MR. WOLFE KC: What you are suggesting here in respect of audits, is this blue sky thinking? Is this new thinking at 2020, or is it well-embedded in other places?

DR. HUGHES: It is Improving Outcomes Guidance; you are required to have these business meetings. Business meetings are about the service you provide. It is about the professionals' multi-disciplinary team owning the service. That has to be supported by management, it has to be supported by resource at times. But it is to ensure that the service improves and changes as needs changes and as demand increases. 11:34 11:34

I didn't believe that the MDT felt they were supported

enough and I didn't believe they felt ownership of that problem, because they frequently talked about resource problems, frequently talked about volume activity problems. They are all correct, but I didn't see them being resourced to see how they could do that differently. 11:35

MR. WOLFE KC: In your place, Mr. Gilbert, is audit a feature of the MDT process and, if so, what kinds of things are audited?

MR. GILBERT: If you remember there are five cancer that we largely deal with. Usually what happens is once every six months for each business meeting, one of the pathways or part of the pathway will be reviewed, usually by a junior who is very keen to get a presentation at a local meeting because that helps their CV. They are sent off to review an appropriate number of cases, a representative sample, usually of timings and of the patient experience, either together or separately, in order to ascertain those areas which could be improved upon. That is then used as a tool to persuade the people with the money to cough up when they need to. 11:35 11:35 11:36

MR. WOLFE KC: It doesn't sound, Dr. Hughes, that it's terribly resource heavy. That's a no?

DR. HUGHES: I don't think so, no. 11:36

MR. WOLFE KC: You do suggest, for example in Patient 3's case, if we have it up on the screen, DoH-00097. If you just look at the third bullet point. You place particular onus on the MDM Chair to develop appropriate

and comprehensive quality assurance programme that ensures adequate compliance with the MDM's published guidelines. You go on at the sixth bullet down, if you just go back to that, to say that:

11:37

"The MDM should agree and audit, as part of QA, the indicative timings for the stages in cancer management". You say just above that: "The MDM should regularly revisit their guidelines and policies to ensure best practice continues to be followed. 11:37
This needs to be audited annually. This does require good leadership in the MDT supported by Cancer Services Management".

DR. HUGHES: Yes. 11:38

MR. GILBERT: Apart from resources, do you think an additional problem was either a failure to recognise the need for audit or perhaps an inability on the part of the Chair of the MDM, who I understand was Mr. Glackin, to be able to persuade or feel comfortable 11:38
persuading Cancer Services Management that this needed supported?

DR. HUGHES: I think the issues are several fold. These recommendations flow from the GMC leadership and management. It is very clear if you take a role that 11:39
you are responsible for setting up processes and policies to ensure that you can quality assure care. I don't people fully understand their roles when they take on a leadership role. I think those in the Cancer

Services were really too focused on the 31, 62-day target and didn't fully understand the need for a quality assurance process because they didn't know the detail of potential problems. Now, it is the chicken and the egg; you have to have a process in place to quality assure yourself that there are no problems.

I think it is hard to say where somebody was unable to secure resources but they simply didn't or couldn't. I think from listening to Mr. Glackin, it wasn't that he didn't try. I think you are left in a situation where professionals knew there was a better way of doing it. He certainly trained in the West Midlands. He had experience of a different situation, had explained to the Trust management or the cancer leads of the deficit, but it hadn't been addressed.

MR. WOLFE KC: As we will see shortly, perhaps the mainstay of the recommendations and action planning contained in your overarching report was the need for audit. We'll talk about that a little later.

Would it be convenient, Chair, just to take a short break?

CHAIR: Yes. I was going to suggest if we come back at 11.55.

THE INQUIRY ADJOURNED

CHAIR: Mr. Wolfe.

MR. WOLFE KC: Thank you.

Dr. Hughes, back to your Section 21 statement again for the final of the key themes that you identify for us arising out of the nine cases. 11:57

WIT-84170. Here you talk about the lack of coherent escalation/governance structures. Do I interpret that correctly to mean that while there may have been some escalation, it wasn't done coherently or in such an 11:57 effective way as to produce change, and that's coupled with an absence of effective governance structures to enable that to be done?

DR. HUGHES: Yes. It was really twofold. I think they were ineffective in escalating things they knew about, 11:58 but I think the structures were very poor. The structures were very much based on who the professional was. So, it was the responsibility of nurses one way, and responsibility for doctors in another direction, and a tendency to say "That's not my responsibility". 11:58

Whereas governance is based on patient outcomes and patient deficits. They should have had a very clear, coherent responsibility written into the cancer structures that whatever happens in cancer care on 11:58 cancer patients, there is a definite responsibility for cancer services around that. Too frequently I heard the words "Well, that's not our responsibility".

I don't think it is helpful that you have a leadership

structure which defines what they're responsible for or not, or if there is a lack of clarity. I think those leading cancer care should be responsible for positive outcomes and negative outcomes in cancer care. Without that clarity, it definitely fell between several stools. Through my interviews with the different staff, you could not get clarity about who actually owned problems. That, in itself, was a problem. 11:59

MR. WOLFE KC: You highlight, whatever else about the other concerns that you picked up on from this MDT and how it operated, you say that there were two issues that you could identify from the information coming your way that were known to the MDT. One was the nursing issue and the second one was the prescribing issue. The prescribing issue was also known externally. You had heard from Professor O'Sullivan, for example, in that respect. 11:59 12:00

Knowledge of those issues isn't enough; you suggested, it has to be escalated. How do you imagine that ought to have been done properly? What would that have looked like? 12:00

DR. HUGHES: Well, proper escalation should have been to Cancer Services then up to the board at the level of Medical Director. If there's concern about prescribing that may or may not affect patient care, I think the simplest answer to that would be to do a proactive audit or prospective audit and define the issue. This should be part of normal business within the MDT 12:00

working. I know these are difficult questions in a team. If the culture in the team is not good, they are questions that can be not had but that's not the point. If somebody is concerned there's prescribing that may affect patient care, they have to take action, they have to escalate it to the appropriate people; they have to understand it and hear it and they need to deal with it or escalate it. That could be through the business meetings. 12:01

I got the impression the culture wasn't good. There wasn't a willingness to escalate these issues and, unfortunately, a full understanding of the issues. I think until you do an appropriate review of the concern, you really don't know the extent of the issues. 12:01

The issue about Clinical Nurse Specialists, that was clearly known by the manager and there's clear documentation of how she had tried to address that through her line of management. 12:01

MR. WOLFE KC: That is Mrs. Martina Corrigan who told you - the reference is WIT-84356 - the issue of nursing was escalated to the Assistant Director and the Associate Medical Director. They never got anywhere, it is suggested. That perhaps suggests that the process for escalation was there and it was used in that instance, but the appetite to force real change was, for whatever reason, not there or not followed 12:02

through effectively?
DR. HUGHES: Yes. I think the culture was inappropriate. Too frequently. The culture was based around on a name as opposed to how does this affect a patient. If you step through saying not having an appropriate Clinical Nurse Specialist, as opposed to the vast majority of the people going through their care, what's the impact on the patient? What's the real care deficit? Nobody bothered to take that step, or nobody was able to take that step or join up the dots. 12:02 12:03

That being said, they were being asked questions about this at peer review. They gave assurances that they couldn't give and shouldn't have given. 12:03
MR. WOLFE KC: Mr. Gilbert, I don't want to go over old ground but I think you, on one of the previous occasions, talked about the difficulty of - if we individualise this - dealing with a colleague on an MDT and, I suppose, the potential for professional embarrassment around that. I think you said ultimately it is something that, if informal overtures to change aren't working, you have to grasp the nettle? 12:03
MR. GILBERT: Yes, but that isn't easy within the Health Service. 12:04
MR. WOLFE KC: Is it still not easy or are we doing it better in your experience? If we're doing better, how is that being achieved?
MR. GILBERT: It is a very difficult question to answer

for personal reasons, and because I work in a nice -- in one trust, I can't speak generically. But there are processes in place by which it should be possible for an individual with concerns to voice those concerns and for them to be heard and, if necessary, acted upon. I'm not confident that the Health Service has the appropriate structure to ensure that aim is achieved. Too often, concerns don't percolate into the right fora to be able to be dealt with properly. 12:04

MR. WOLFE KC: It may not be a problem unique to medicine, albeit we do hear regularly through the media that it is a particularly problematic issue for the medical profession. Is it simply fear of challenging, perhaps, a more senior colleague with the risk of impact on career, or is it something more specific that even that? 12:05 12:05

MR. GILBERT: I think you're asking me to -- I can't comment specifically on whatever was going on at the Southern Trust because, as I've indicated, I don't know the people involved, their personalities or their history. 12:05

MR. WOLFE KC: No, no. Just to be clear, I'm bringing to an area that, of course, you have your own confidences in your own place to protect. I'm asking - and the Inquiry can decide how helpful it is - your broad impression over a career in medicine about how, as I've said, these widely reported concerns about this kind of inability to tackle what is known, perhaps because people are not escalating effectively; what in 12:06

your broad experience? Can you help us with that?
MR. GILBERT: By broad concerns is that it becomes very difficult to raise concerns at all levels. That's not particularly about protecting your own reputation, your own income. Yes, consultants are usually appointed in 12:06
their late 30s, they have young children, they have been moving around often, apart from their families for many years, and finally they get this job that allows them to settle. Risking that is quite a big step to
take, school and children, mortgages to pay and so on 12:07
and so forth. The Health Service should have systems in place in order to protect those individuals in those circumstances when they wish to raise a concern. I am not confident that the Health Service has those
mechanisms working in place. They may be there in name 12:07
but I do not believe that they are functioning.
MR. WOLFE KC: Thank you for that.

Dr. Hughes, is there anything you can further assist us
with in that sort of particular respect, how the Health 12:07
Service can build greater confidence into its systems to encourage people to speak when it is appropriate to speak?
DR. HUGHES: We have to recognise we wouldn't be in
this place if the Health Service wasn't so 12:08
hierarchical. There are known and problematic issues, especially in Northern Ireland where 80 percent of the medical graduates come from one medical school and everybody knows everybody else, and that adds another

difficulty. I think what you need to take it back, what is an issue? It is actually a patient issue. Park the name, park the person, park whatever. If something is affecting patient care or patient outcomes, or potentially, people should be in a flat environment where they can have these difficult conversations. 12:08

For a multi-disciplinary team to have that conversation, it needs to be fully cognisant of their roles and responsibilities; it needs to know how their behaviours affect everybody else, and they need to be reminded of what their primary duty is, it is to keep patients safe. If anybody has a concern around that matter, that should transcend any other issues. 12:08 12:09

That being said, human beings being human beings, you have to deal with the human factors around that and we're not good at doing that. I think this is a case in point. People had concerns but didn't have a meaningful way of escalating them, and didn't really want to deal with them in a confrontational manner because that will not resolve anything. I think this is a much wider conversation we're having than just this issue, because how do you -- you know, a stressed environment, an MDT that's not fully functioning, is not appropriately resourced and doesn't have oncologists on a regular basis, how does that address its own internal problems? It's probably not going to 12:09 12:09

be able to do so.
MR. WOLFE KC: It appears, I suppose, that in this particular MDT, it needed to be better supported, both within the urology side of the fence and from Cancer Services Management? 12:10
DR. HUGHES: Yes.
MR. WOLFE KC: Before I turn to the recommendations that emerged from your reports, gentlemen, can I ask you just to consider your meeting, Dr. Hughes, with one of the families that were part of the nine that led to 12:10
reports. You will recall that on Monday, 11th January 2021, you met with the family of Patient 5. I want to ask you some questions about that specific case.

If we could have up on the screen, please, PAT-001954. 12:11
This is the start of a seven-page record of that meeting. PAT-001954. I gave you a hard copy of that document this morning because it didn't form part of your bundle for these hearings. I think you have had an opportunity to look at it, albeit briefly. 12:11

You say, if I could turn your attention to just over halfway down the page, "As doctor Hughes explained". This is part of a series of meetings that you were having with patient families; isn't that right? 12:12
DR. HUGHES: Yes.
MR. WOLFE KC: You say in that paragraph, beginning "The review will involve the treatment and care of nine patients". Do you see that?

DR. HUGHES: Yes.
MR. WOLFE KC: You go on to explain the kinds of cancers affecting those patients. You say to this family that you don't believe that they will be the only patients affected. Why were you sharing that 12:12
information with that individual family?
DR. HUGHES: I genuinely can't remember. At the time, full disclosure was that we told them they were part of a group of nine but I also knew there were further cases that did reach the SAI process but didn't come 12:13
into this pattern but were going to be reviewed by another process ongoing, separate to this SAI review. I think I viewed that as part of full disclosure. I'm mindful of many, many years ago a review of Organs Inquiry I'd been involved in with Mr. O'Hara, that part 12:13
of our deficient was that we didn't give full disclosure to tell the individual people that they were part of a bigger cohort of review issues. I think part of my - and I'm reflecting on this now - that I think full disclosure was about there are nine cases under my 12:14
SAI review but there may be others.
MR. WOLFE KC: The purpose of this meeting, at least in part, you were there to introduce yourselves and tell the family something of the project that you were engaged in. Part of it also was to gain information 12:14
from the family about their concerns and understanding of how their father was treated. In telling them that there were other cases and potentially more cases to come, does that not have some impact in terms of

muddying the waters against Mr O'Brien, creating some kind of bias or prejudice against him?

DR. HUGHES: I can see why you're saying that. I think this might have been the second meeting with this family. I met them on three occasions. 12:15

MR. WOLFE KC: I think it was the first. I think they were late to commit to engaging with you, for perfectly good reasons. I don't mean to sound critical. Assuming it was the first meeting, do you understand the concern that this might colour -- 12:15

DR. HUGHES: I can understand the concern but I also would say that in my defence, under my guidelines, the GMC, I have to be open and transparent. The work was about a range of patients and it was about a range of cancers. The additional statement to say that there 12:15 may be other cases going through another process was about being open and transparent.

I think part of the problem with the families, the families were totally unaware of deficits in care, so 12:15 when they came in they had little knowledge of the process. I was discharging my duties about being transparent and open. I can understand that that may be perceived by others to be different but I think that was required of me in my role as Chair. 12:16

MR. WOLFE KC: By this stage it's 11th January. From recollection, you've received Mr. Gilbert's first draft of a clinical timeline outlining his concerns, and no doubt you were building up a picture of what was

happening here.

Could I ask you to turn to 001956? Bring that up on the screen, please. It is the third page of this record. About two-thirds of the way down that page, you say and it is recorded: 12:16

"Dr. Hughes acknowledged the impact this had had on the family. He advised that Mr O'Brien is polite and personable but he gave the wrong advice. He seemed to work as an individual". 12:17

The notion of him working as an individual, it comes across, in terms of what you are telling the family here, is that that is a conclusion that you have reached, albeit that your investigation is still at a reasonably early stage. Had you formed a firm view? 12:17

DR. HUGHES: "He seemed", so it was an impression at that stage. The view was from the fact that Clinical Nurse Specialists weren't involved; from his colleagues who said that he practised very much on his own. They described him as a holistic practitioner in that he -- 12:18

MR. WOLFE KC: If you think about the dates here, by this stage you had met Mr. Glackin and you had met the cancer team management, the trio, on 29th December. You were yet to meet the MDT as a whole and you were yet to meet the nurses and Mrs. Corrigan. What was it at this stage, 11th January, that caused you to hold the view that he was unilateral in his approach? 12:18

DR. HUGHES: From memory, I think we had evidence that Cancer Nurse Specialists were not involved in the care at that stage. I talked to Mr. Glackin at length, who described him as a holistic professional and who works very much on his own. 12:19

MR. WOLFE KC: But in circumstances where the investigation isn't complete and you have yet, for example, directly you have yet to hear the nursing perspective, do you reflect that this was perhaps premature to have reached this view and to have shared 12:19 it with the family, however hesitant it might have been expressed?

DR. HUGHES: It is a balance of being open, honest and transparent. I think I was in possession of pretty certain knowledge, because it was a finding we were not 12:19 expecting. We went into this process largely on the basis of a prescribing issue and a few other issues which had been detected as potential SAIs. Then we discovered this very unique and strange thing that Clinical Nurse Specialists were not part of the care, 12:20 despite that being recorded as such. At that stage I believe I would have been pretty certain that that was the case, but I did say the word "seemed".

How do you be open and transparent with people, bring 12:20 them along in a traumatic process, while withholding information you know? This is an SAI, a process, it's a learning tool; it is not a legal process, as such. My thought about sharing that with the family was to be

open and transparent. They are very able, very capable people, and they were detailed in their questioning. So ...

MR. WOLFE KC: Can we perhaps just turn to the meeting that you had with the nurses. WIT-85142. This is a meeting that takes place on 22nd February, just over a month after your meeting with the family. If we could scroll down to the penultimate paragraph there. There is discussion about the reasons for the lack of nursing input in cases with which Mr O'Brien has carriage. You say, referring to Kate O'Neill, that you're asking her to send the information to you about the audit of nursing input. You say, "... you want to be able to say resources were available but patients weren't referred". 12:20 12:21 12:22

Can you help us with that sentence? On one view it is suggesting that you want to put forward a particular conclusion regardless of any other possible explanation. Is that what you're wishing to get across there? 12:23

DR. HUGHES: No. I'm sorry that the notes read like that. I was wanting to make a statement on the basis of evidence and that's why I asked for the audit from the nurses. We had views from the Cancer Nurse Specialists that they didn't give support reviews from the cancer manager -- sorry, not the cancer manager, the Urology Services manager, that they did not attend the oncology clinics on Friday, but I wanted a 12:23

specific audit of that. They had done patient experience audits, but only those patients who had received an interaction with a Clinical Nurse Specialist. So, I think that was an issue.

12:23

I should say that we had a clinical nurse specialist on the review team with us as we were going along, who was new to the service and would have imparted into the information.

MR. WOLFE KC: You'll recall on the last occasion that I referred you to the Southern Trust's process which in writing, in its written form, indicated it was the role of the core nurse member of the MDT to ensure that the key worker or the CNS was appointed. You, on the last occasion, reflected - sorry to be going over old ground here - that wasn't your understanding of how it worked in practice, that it was the responsibility ultimately of the consultant to make the introduction or pass on the contact details but make some effort to ensure that a nurse was offered or contact details were provided.

12:24

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12:25

That isn't a perspective that you reflected to this family when you met them. Does that suggest again that you had made up your mind that it was a consultant responsibility?

12:25

DR. HUGHES: It is the responsibility of the consultant caring for a patient to refer that patient to all professionals needed. In my view, that is a Clinical Nurse Specialist. I believe it should be the

responsibility of the Southern Trust Urology MDT to have the appropriate resource. At this stage they had five. My evidence at that stage was everybody else had access to a clinical nurse specialist but this group of patients did not, so that was concerning. You know, 12:25
nine patients who actually entered the SAI process for completely different reasons, and this was a theme that we picked out. So, I was the trying to get assurance or understanding was this just these nine patients or was it an endemic problem with this individual. 12:26

There was a statement suggesting that the nurses should be allocated by either the Chair of the MDT or the head Clinical Nurse Specialist. You have to ask the question why is it only this cohort of people with one 12:26
professional who don't have a clinical nurse specialist? It just seems perverse. My discussions with the Cancer Services Managers were very clear, and she had to escalate that through the Trust, that nurses were not being able to access the urology oncology 12:26
clinics, and she felt that that was a deficit but got nowhere with it.

MR. WOLFE KC: Could we go back to the record of the meeting; I am sorry to have come out of that. PAT-001957. Just below the entry in relation to the 12:27
patient's family member having no confidence in the Trust, you're recorded as saying that:

"Dr. Hughes will be asking why a specialist nurse

wasn't aligned to the patient and why MDT advice was not taken forward".

Thinking about Patient 5's case, this was the case which we've dealt with already this morning, where the scan wasn't read or actioned in January, between January and August 2020. Were you thinking of any particular MDT action in that case? 12:28

DR. HUGHES: No, no, that case was a general term, one of the general themes. 12:28

MR. WOLFE KC: It may read as pertinent to this particular patient but are you saying it wasn't, it wasn't intended to be?

DR. HUGHES: No. With this patient, we were very clear with this patient, Patient 5, that the care of the renal surgery was appropriate. 12:28

MR. WOLFE KC: Yes. Indeed you go on, I think if you go over the page, to say that. PAT-001958. If we go down towards the bottom of the page, you go on to say, just in the very last paragraph, that you're telling the family you were ashamed as a health professional for what their father and the family had gone through. 12:29

Now, what was the purpose in sharing I suppose your personal feelings about the case with the family? 12:29

DR. HUGHES: I don't recall saying that, I'm very sorry. I expressed my sorrow with them and my sadness that they were in that traumatic place, but I don't recall using those words.

MR. WOLFE KC: If they were used, do you think that, upon reflection, it is not particularly appropriate for the independent chair of a process to --
DR. HUGHES: Yes. I agree with that.
MR. WOLFE KC: No doubt it is important to build a rapport and a trust with families, but in terms of your concern about this case - and I'm conscious you don't think you used the word "shame" or 'ashamed" - what was the position at that time in terms of your -- perhaps a better word would be "dismay" or "concern" about how their father had been treated? 12:30
DR. HUGHES: In case 5 we were very clear that the renal surgery was an appropriate standard, and I think it may be slightly delayed. The issue was with the nonreading of the report and delayed report and delayed diagnosis of a second cancer, prostate cancer. 12:31
I certainly felt dismayed by it, I think that would be an appropriate better word. I think the issue is really about not having systems and processes in place. Again, another example of a missed report or a missed X-ray impacting on patient care. There had been a history within the Trust prior to this, prior to this set of SAIs, and still the same problem exists. 12:31
MR. WOLFE KC: In terms of your independence and open-mindedness, I suppose, in terms of the receipt of information, the analysis of information and then reaching conclusions, could you help us with this: In terms of how you and the team went about its business, was it a case that conclusions were reached at the 12:31

start of the process, or were they all reached at the end, or was it an iterative process where you felt able to reach firm conclusions at certain points?

DR. HUGHES: It was very much an iterative process. The timeline was drawn up, the timeline was examined. 12:32
The clinical report was done by Mr. Gilbert, and then we had multiple discussions and multiple iterations of reports as we went through. So it was a collegiate and collaborative approach. Conclusions were pretty straightforward and agreed, but the reports were 12:33
refined as we went along. Some of the issues, such as this case, this was clearly a follow-up scan which was ordered and not reported for months. Then there's an ancillary factor whether a prostate PSA test should have been done at the initial presentation, and that 12:33
was discussed with the families. But very much an iterative approach really, involving all members of the team.

MR. WOLFE KC: I think that you reflected before that the reports that emerge were the product of consensus, 12:33
so it wasn't you, although you were the author ultimately and had sign-off, I suppose, rights at the end. What was the, I suppose, working relationships; could you have dominated to the exclusion of others?

DR. HUGHES: I certainly couldn't dominate to the 12:34
exclusion of Mr. Gilbert's clinical opinion. In terms of knowledge and experience of governance, yes, possibly, but we had input from local governance structures. I think, and I've reflected on this, the

local cancer manager was in a very difficult position because we were actually commenting upon the service that she was managing, and there's implicit criticisms of not just the clinical deficits but in the processes and how things were done, so I think that was an issue. 12:34
The Clinical Nurse Specialist that was on the team was new to the Trust and had come from a different Trust and obviously had a different experience, and I don't think there were issues there. But I think it was particularly hard for the local cancer manager, yes, 12:35
having reflected on that.

MR. WOLFE KC: I am just going to turn back to the conclusions that you reached in the overarching report. If we could open DoH-00128. I suppose to summarise that, Dr. Hughes, what you're saying here is that a 12:35
system had been established to provide multi-disciplinary care but it was the opinion of your review that one clinician was able to disregard that in key respects, and you pointed to failing to implement MDM representations around prescribing and referral, 12:36
and exclusion of the nursing cohort. You also highlight the systems of governance which, I suppose, were quite unable or ineffective to prevent this so that a number of patients suffered significant deficits and all suffered suboptimal care. 12:36

Is that the thrust of it? Is that what emerges from this?

DR. HUGHES: I think the issue is - and I don't mean

this in any disrespect to the families - the issue is why did it happen and how did it happen. Clearly, normal mechanisms to prevent variance from best care, normal mechanisms to ensure involvement of all professionals in care, things that - we've talked about, you know - you may have seen 15/20 years ago in cancer services; there should have been structures there to ensure that that did not happen. There should have been internal governance as well as external quality assurance through peer review. Any service can have difficulties, any service can have problems, but it should have an active and agile governance structure to prevent patient harm, and it clearly wasn't there.

MR. WOLFE KC: If we scroll down and over the page, please. You set out the recommendations and action planning. You say that the recommendations, of which there are, I think, 11, that they represent an enhanced level of assurance. Just help us with that term. What does that term mean?

DR. HUGHES: The recommendations are based around returns that you would have to make, including additional returns above and beyond what a normal cancer team would expect to do. The rationale behind that, there was a major deficit in how the public viewed the service. The remaining team had to deal with this downside and patient engagement process. So it was to ensure that the service, going forward, did meet the standards, did say what they promised to do in the Cancer Peer Review and made sure there was no

exceptions to that.

The recommendations are pretty straightforward and should be how a well-functioning team should perform. It is just about demonstrating that in a detailed, 12:39
data-driven way. I think the other issue is that we asked families, and I think family 5 are one of those who volunteered, to act as patient engagement experts by experience. I think that's a bit of a challenge, you know, maybe for the local team but 12:39
I think it was important to involve the families in the outcome.

MR. WOLFE KC: I'm not sure if I heard you correctly. Did you say that these recommendations and the enhanced assurance processes are over and above what would be 12:39
normal for a cancer team?

DR. HUGHES: They are probably more detailed and more exacting than somebody would make on an annual return. The rationale for that was because of public deficit and the public damage, I think, into patient faith in 12:40
the services. It's not that I don't believe they can deliver on it, I think it is required -- well, a couple of reasons were to show what they're delivering is of high standard and quality, and also to embed a process of quality assurance and make sure the infrastructure 12:40
is available to do that going forward, because the problem was they didn't have that in the past.

MR. WOLFE KC: If we go to your Section 21 at WIT-84165, where you comment at the top of the page on

the action plan. You explain it was intended to provide evidence of a high quality service going forward. You say the recommendations were routine expectations of a functional high-quality service. Just on the point you made that they're over and above what a cancer team would normally have, I'm just trying to marry that --

DR. HUGHES: The assurance process, the data required to provide the assurance is probably over and above what is required. The actual standards are no different than what anybody else would have to attain. Part of the deficit was that they had made returns on the basis of standards to a peer review which were not proven to be factual.

12:41

MR. WOLFE KC: So, you're not suggesting that the assurance mechanisms which were to be new to this cancer team and this multi-disciplinary team, you're not suggesting that they ought to have been in place necessarily prior to your investigation. What you were saying is "I'm pushing this higher bar because I think this service reputationally and otherwise actually requires it".

12:41

12:42

DR. HUGHES: Yes, that's what I'm saying. Normally, the assurance mechanism would be a selected number of cases, just for example, to provide assurance, but because the deficits identified in the service provided by this team were a range, they needed a proportionate enhanced assurance mechanism. That could be rolled back in the fullness of time but I think because of the

12:42

reputational damage, I think that needed to be in place. Also, it needed to be in place to make sure the resources were made available to ensure that this could be done for the team.

MR. WOLFE KC: If we go back to the report itself at DoH-00129. If we stop at recommendation 2 just by way of example. 12:42

"The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients". 12:43

As you say, nothing terribly earth-shattering or new about that. It seems to me, and you can comment on this, that that's a statement of general good principle. But the key to it, if I understand your answer correctly, is what you say about the assurance, and that entrenches the need, if you can scroll down, for external benchmarking. This should be benchmarked again external standards. There's also the need for a comprehensive audit, pathway audit. That's the way, as you say, to achieve this general recommendation and make sure it is done. That concept of introducing an audit permeates, I think I counted six of the 11 recommendations. 12:43 12:44

DR. HUGHES: The urology team was flawed and a lot of the discussions were opinion based, unsupported by data and information. Governance does not function on that basis. Because there's a reputational damage and a need to provide assurance internally but assurance 12:44

externally, especially to patients and families, the infrastructure and data requirements of that was more extensive. That was going to run for a period of time with an, after a year, external cancer peer review or external review by a royal college; the Royal College of Surgeons obviously. It was very clear that whatever was said, it had to be supported by information and data as opposed to opinion, basically.

MR. WOLFE KC: I don't intend taking up any further time on the recommendations, they speak, I suppose, for themselves. The Panel might have some questions in relation to it. 12:45

It's your understanding, if we go back to your witness statement at 84171, that the recommendations and action plans were accepted by the Trust and Urology Cancer Services, and you were, in fact, invited to assist with the implementation by the Cancer Service manager but you declined that opportunity? 12:46

DR. HUGHES: Yes. They had asked me to be a critical friend and I just thought that would have been inappropriate because I think it would be better if somebody else took this on. 12:46

MR. WOLFE KC: The third bullet point on that page refers to the response of the senior clinical and managerial leadership of Cancer Services. You say they had a different view of your recommendations and action plan, and regarded many of the assurance requirements within the recommendations were based on commissioning 12:46

a questionable benefit. You responded to that. I just wanted to look at that for a moment. You shared the overarching report, or you asked for it to be shared, with the various teams that it was relevant to, including nursing, including Cancer Services, including the urology team, to explain the action plan and to ensure the delivery of outcomes? 12:47

DR. HUGHES: Yes. Yes.

MR. WOLFE KC: We can see that if we turn up TRU-255360. Mr. Wallace, who I understand is in Mrs. Kingsnorth's office, he circulates the report. If we just scroll down to 16 March, he says: 12:48

"As agreed, the draft copies of the SAI reports are now available... Mr O'Brien has asked that a copy of correspondence from his solicitors" as it turned out to be Tughans, "to the Trust should be issued". 12:48

The next paragraph:

"If you have any comments on the factual accuracy of any of the reports, Dr. Hughes would be grateful if you would provide these via Patricia Kingsnorth". 12:48

That's a perfectly acceptable invitation. 12:49

DR. HUGHES: Yes.

MR. WOLFE KC: And that's your understanding of what would happen; is that fair?

DR. HUGHES: Yes.

MR. WOLFE KC: If we turn then to WIT-85244. Scroll up to see the bottom of the page. Mr. Conway in Cancer Services is sending through Patricia Kingsnorth's office a set of commentaries on the report; isn't that right?

DR. HUGHES: Yes.

MR. WOLFE KC: He, first of all, expresses sadness and regret at the adverse impact on the nine patients, and Cancer Services, he says, would work as a priority with other divisions in acute services to implement the agreed recommendations to improve services.

Then scroll down, please. He praises the work of the reports and says on behalf of himself, Dr. Tariq and Dr. McCaul, who you spoke to in December of 2020, they have reviewed the reports and have attached a tracked version over the overarching report with their comments.

"Please note that we have not been able to involve Fiona Reddick in reviewing the draft reports as she is currently on a period of sick leave from late February".

That is just an aside, it would have been wholly inappropriate to engage with Ms. Reddick because she was a member of your team?

DR. HUGHES: Yes.

MR. WOLFE KC: In any event, that appears not to have

happened. They categorise their response in the following terms. The last paragraph:

"Our feedback is primarily focused on comments from a factual accuracy perspective. However, following recent discussions with Melanie and Maria, we have also included some of our thoughts in relation to how the current governance arrangements could be improved".

12:51

Just so we can see how they approach their work, if we open TRU-163132. Just slowly scroll down and stop when you see a tracked comment. Sorry, I should have identified a specific page. Stop there.

12:52

Mr. Conway and his colleagues have answered the call for comments on factual issues by inputting into the report their responses to aspects of your findings. I think there's maybe a total of 11 or 12 sprinkled throughout the report. I don't wish to pick on any one in particular. In terms of your view on that, Dr. Hughes, you thought their view was, to say the least, inappropriate.

12:53

12:54

DR. HUGHES: Yes. I was very concerned that they had access to editing the report. I thought that was a very negative thing because, as an independent chair, I assured the families that this would be independent of the Southern Trust. I thought it was misjudged. So, I asked them to remove the document. What I actually did myself was remove their comments

12:54

individually and paste them and respond to their comments individually. I think what they were doing was not simply a factual accuracy check, and I think it had progressed beyond that. I think that was unhelpful. I certainly responded to all the comments. 12:55

MR. WOLFE KC: Maybe just look at some of your responses. You immediately write to some of the managers. If we go to WIT-85241, you begin to express your concerns. WIT-85241. You're saying you were concerned about the use of the master copy's editing 12:56 rights and the loss of an independent process.

"I have copied you into my responses to what was described as matters of fact". "I and Hugh as externals would disagree with this assertion given that 12:56 all three individuals had limited knowledge of any of the issues that formed core of the SAI's and the deficits experienced by the nine patients.

"Our recommendations around tracking which was 12:56 referenced to my previous experience in the Western Trust is actually normal standard in the UK, and my previous cancer experience in Washington DC and the National Cancer Institute. These standards are what many urology team members would welcome and had 12:57 previously experienced in the UK.

"In any event, they are what is required to keep patients safe and provide assurances to patients'

families and the public.

"Ten matters of fact have been addressed in my response but you are still concerned about a similar number of issues raised regarding the recommendations. The recommendations have been shared with the families and are regarded by the external team as things that should be in place anyway. Assurance mechanisms could be scaled back with time but I am conscious of previous absence of meaningful audit and indeed incorrect declaration to peer review. 12:57

"The recommendations are limited, straightforward, and an opportunity to address staffing issues, improve care and move on". 12:57

Just so that we can see it, if we can go back to WIT-85178. You took the opportunity, just for the Panel's note, to, in red, set out what Mr. Conway had said and had written into the report, and you then comment in black ink. Is that the way of it? 12:58

DR. HUGHES: That's correct, yes.

MR. WOLFE KC: You appear rather cross that this was being done. Is it possible that Mr. Conway and his colleagues had simply misinterpreted or had misinterpreted what was appropriate in this context? 12:58

DR. HUGHES: I should say, I did not send them a red -- that's a draft one. That does seem bad.

Yes, I think they misinterpreted. My major concern was the lack of understanding of the issues in the first place. If you step through my responses, one of the weaknesses of this process that is those delivering 12:59
care did not meet the families who had undergone the process. I think they did not have full understanding of the nature of the problem in the first instance and they didn't have full understanding of the consequences of the problem. I think some of their statements that 12:59
they made just were not factually correct. They kept referencing that -- they were explaining why they couldn't do things and why things were unique to other Trusts, which was not my experience and I have referenced that in the letter to Melanie, I think it 12:59
was. I think the issue was their response; not, how can we do this, how can we move there; a list of reasons why we can't do things. I honestly thought that was probably the wrong approach because it was a very traumatic process, obviously, for the families and 13:00
patients, but it is a traumatic process for the urology team and the service, and you have to acknowledge that.

I felt that this was a way to address resource, make sure that the MDM was quorate, provide the service and 13:00
then, allied to that, enhanced assurance. With the resource, I believe they could deliver on a high-quality service. The assurance is there, it's for external reasons, and because of the deficits already

experienced. I just don't think they understood that.
MR. WOLFE KC: When you say -- we can pull up your witness statement, again at WIT-84171. If we scroll down to the fourth bullet point, please. You say that the clinical and managerial leadership of Cancer Services had no knowledge or insight into the problems identified within the SAI processes. There is a lack of understanding of services and how they were delivered elsewhere, and what constituted open and transparent governance. 13:01

We'll look after lunch at just a couple of the examples and we will walk through those, but were you caused to have a concern or a lack of confidence in how this team would engage with the recommendations of the action plans if these are the kind of views that were coming out of them upon receipt of the report? 13:01
DR. HUGHES: Yes. But I suppose, on reflection, the report was including implicit criticism of them as well. I think perhaps I was probably not sensitive enough to that. That being said, the report was requiring appropriate resourcing to make the team quorate so that patients would get the appropriate care. The report was asking for additional resource to make sure that we could provide assurance. I felt it was an opportunity for them to lead the team forward and move on. But they were pushing back on that, and I find that a difficult process. 13:02
MR. WOLFE KC: Helpfully your Section 21, in addition

to the document that had the, I suppose, angry red ink on it, steps through the 10 points raised by the Cancer Service managers' team. We'll illustrate your concerns after lunch by looking at two or three of them. We can get through that quickly. 13:03
Two o'clock?
CHAIR: Two o'clock. Yes.

THE INQUIRY ADJOURNED FOR LUNCH
CHAIR: Good afternoon, everyone. 14:01
MR. WOLFE KC: Good afternoon. If we could start at WIT-84161, please.

Just to orientate the Inquiry Panel, what you have done in your Section 21 Statement, Dr. Hughes, is set out - 14:02
you can see in the middle of the page - response from the Chair of the SAI process, that is yourself, to comments from Dr. Tariq, Mr. McCaul, and Mr. Conway. Sequentially you worked through each. You set out in parentheses the comment from Mr. Conway et al, and then 14:02
the response of you as Chair. Is that the way you did it?
DR. HUGHES: Yes.
MR. WOLFE KC: I just want to set through a couple of examples - the Inquiry can consider the detail of it - 14:02
to illustrate your concern and give us a flavour of that. Skip over the page to WIT-84162 and go to the bottom of the page. You'll see there point 5. Point 5, Mr. Conway and his colleagues comment that:

"Cancer trackers will track patients on the 31 and 62-pathways in line with what has been commissioned. This is confirmed to be the case in other Trusts in Northern Ireland with the exception of Western Trust. The responsibility for following up actions sits with the clinician and his/her secretary." 14:03

I suppose in a nutshell Dr. Hughes, you didn't think what was being signaled in Mr. Conway's response was any way good enough. It seemed to be accepting was the view that the norms elsewhere in this jurisdiction is 31 and 62, and that really was enough? 14:03

DR. HUGHES: I didn't accept that. The Western Trust is a reference to my previous employer. While the resource to track the 31 and 62 days may be there, what we're actually trying to do is track patients safely and make sure nobody comes to harm. That it the responsibility of the Trust and it is the also the responsibility of every professional providing cancer care. 14:04 14:04

What I would have perceived the role of a cancer Service to be is to lobby as any other lobby to reduce risk and keep patients. While the funding may not be coming line item down from the commissioners, they have a responsibility to ensure the patients are kept safe. That's how I got additional resource, and that's how you get whole patient pathway assurance processes. It 14:04

is about ensuring scans are undertaken, scans are reported, scans are actioned, you know, the whole way through. I regard it as part of their role to lobby on behalf of the service. Just to say this is what we got and this is where we are is not acceptable, especially when there have been a range of incidents and a knowledge of potentially many more incidents.

MR. WOLFE KC: Yes. You've told them in your report that the system is, in some respects, unsafe. The answer to that, at least in part, is tracking. You highlight that your concern is one that is also shared within the urology MDM. You set it out here in the response. 14:05 14:05

"This has been shared with urology MDM and welcomed, given several members have this previous experience of working elsewhere in these islands". 14:05

DR. HUGHES: Yes, that's correct. Enhancing the resource to make it a fully functioning quality assured process was welcomed by the urology team, and I think they had had those discussions prior to the investigation. 14:06

MR. WOLFE KC: If we go over the page to WIT-84163. Number 8, scrolling down, is the cancer team's response to the issue of audit. They say: 14:06

"Additional capacity for targeted assurance audits would be useful for MDMs and for cancer services".

What was your concern in that? It doesn't seem to be in disagreement with your recommendation in respect of audit but it is highlighting a capacity issue.

DR. HUGHES: I think they are emphasising a capacity issue. If you were managing a service that had problems, they should reflect on what more they could have done in the first instance. There had been ongoing discussions with the urology team on a repeated basis that they didn't have enough resource and they weren't achieving the assurance that they needed. 14:07

I think part of that is a response simply it would be welcome, but it was a question of why it hadn't been there in the first place. I think a manager isn't simply a transactional post where what comes down from the commissioners, that is what we do. If they see need or they see patient risk, they need to act upon it. 14:07

MR. WOLFE KC: So, you highlight within your response that there were some known problems or concerns?

DR. HUGHES: Yes. 14:07

MR. WOLFE KC: You are reflecting back to Mr. Conway, well, if those concerns are known, where's the response in terms of audit or thinking about audit in order to pick up the extent of the concerns and what might be done with them. Is that the thrust of your thinking? 14:08

DR. HUGHES: When talking to the cancer team, part of the issue was the cancer team were adamant they were unaware of any issues. That suggests -- audit would provide detailed evidence but that suggests there was

poor conversations, poor relationships, even for soft information. I mean, the urology service manager clearly knew about the clinical nurses, and the issue around the Bicalutamide prescribing were clearly known, but either they were not escalated or not heard. 14:08

MR. WOLFE KC: Going down just to item 9, it seems to be a broadly similar issue to the two that I have already highlighted. This is again the issue of tracking, their commission to track 32 and 61-day pathways. They are saying it is incorrect to suggest 14:09 that the scope of tracking is limited due to resources or due to the process being flawed. They're saying that the trackers perform this function in line with what is being commissioned, and to improve or expand the scope of tracking has to rely on a regional 14:09 approach and be consistent across this jurisdiction.

Again, your response to that was that that isn't indicative of a constructive or positive approach to this issue. 14:09

DR. HUGHES: This is a conceptual difference. I actually regard tracking as an intrinsic part of quality cancer care. It is to ensure patients get a timely diagnosis and staging and a timely treatment. It is a really, really important piece of quality and 14:10 safety. Now, it may have come about many, many moons ago through the 31 and 62-day targets, but to primarily focus on 31 and 62-day targets misses the issue. People need high quality care, good outcomes, good

support, and to do that you need an appropriate tracking system. I think they don't fully understand the purpose.

MR. WOLFE KC: Reflecting back on the fact that you'd received these comments at the end of an exhaustive process and one of the key components of any reform would necessarily be the people who were writing these remarks to you, obviously it is not your problem to implement it, that's a matter for the Trust, but did it leave you with any confidence issues? 14:10 14:11

DR. HUGHES: I suppose it is partly my problem because you have to have the right culture that they will accept your report and own it as opposed to receive the report and having to deal with it. I was concerned that these were changes being forced upon them without full understanding of the rationale behind them. 14:11

I don't think there's an issue with the urology team per se because they welcome the highlighting of the lack of resource, the better tracking, the oncology input they need, and they'd asked for it themselves. 14:11

I think part of the problem here was that the report was implicitly criticising the cancer team above, and I think that's a difficult issue we have to work through.

I was a bit surprised by some of the comments because they did read a bit like, well, this is what we have always done, this is what we will do going forward, when there was clearly a patient deficit and a potential patient deficit for others. I just thought 14:11

they hadn't fully thought through that.
MR. WOLFE KC: I suppose, overall, if you think that the urology team are welcoming of this and you have buy-in from them, that leaves the reform agenda in good hands. Is that a fair reflection? I mean it obviously 14:12
has to be delivered, and we will hear from The Trust in terms of delivery.
DR. HUGHES: Part of this process, it will be difficult for the team. This is traumatic for those who provide
services as well as patients and families. Building 14:12
back up confidence, building up good team working, I think they have to own it, they have to internalise it. At the end of the day, I'm an external person to them. This has to be a priority for the Trust and a
priority for the patients of the Trust. 14:13
MR. WOLFE KC: In your Section 21 you do make, I suppose, some troubling remarks about the urology team in the sense that you describe that they had a concern that the SAI process was potentially
detrimental to the public perception of their service 14:13
and their professional practice. Is that a reflection of, I suppose, a natural response to people such as yourselves coming in and poking around how they did things. But do you think that was overcome ultimately
in terms of them - that is the urology MDT - seeing the 14:13
benefits of what you were suggesting?
DR. HUGHES: I don't think it was overcome in the time period that I was there. I think things would have been difficult. I think they are struggling with a

reputational damage, which some of them have not internalised their ownership of or their responsibilities for it. I think that's an issue. How you achieve it is to appropriately resource the team and provide the assurance internally and externally on what is required. I believe they will do that but I don't want to underestimate the task. 14:14

MR. WOLFE KC: You also received some feedback, I suppose - I was going to say push back but feedback is maybe a more appropriate word - from the nursing team, if we can deal briefly with that. If we go to WIT-163161. I'm immediately thinking that's a wrong reference. It should be perhaps TRU-163161. You might recollect those as the document containing the views of the specialist nurses. I just want to pick up on one point of concern that they raised. If we scroll through to TRU-163163, they pick up an issue at the word "failsafe" and what the sentiment is, it would be wrong to describe them as a failsafe; that other people have responsibilities and it is not the role of the nurse to pull disasters out of the fire and provide a safety net. So, just to read it verbatim. 14:14 14:15 14:16

"The CNS team believe the use of the word "failsafe" in reference to the CNS team workers' role is inaccurate. There are numerous references to this term throughout the report", and they cite those examples after the red ink. 14:16

"As identified in both the NIcAn Guidelines and the

Trust MDM operational policy in place, the function is not described as the responsibility of the CNS or key worker. Neither is the assertion that the key worker has a role to ensure all key actions take place as is described in the overarching report". 14:17

I think I can leave it there. I just want to pick up on your response to that, if we can zoom out of that and go... You say:

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"The review team fully accept that it is not the sole responsibility of the specialist nurses to ensure appropriate care is delivered. This is referenced in the overarching SAI, where it emphasises the primary role of the consultant responsible for care. In normal 14:17
practice, patients are cared for through their cancer journey about by a collegiate team of consultants, specialist nurses, consultant secretarial staff and appropriate MDT tracking. This is about everyone's responsibility to ensure right care at the right time, 14:17
something the nine patients missed out on."

Did it surprise you that the nurses were coming back on this description of themselves?

DR. HUGHES: No, and perhaps we could have chosen a 14:18
better word. I think the specialist nurses were in a difficult situation. They felt very concerned about their position because they felt that the nine cases showed that Clinical Nurse Specialists were not

present, and I believe they were concerned that they would be blamed for that. I want to emphasise that I know that the care the specialist nurses deliver is of the highest order. That has been evidenced through the Regional Cancer Experience Audit. 14:18

I think "failsafe" is a short term, but part of their primary role is to support patients through their cancer journey. Part of that cancer journey is through diagnosis and staging and ultimately treatment. Part 14:18
of that is knowing about the patient's journey as it progresses. So, they do act as a failsafe, in the same way the consultant acts as a failsafe, the secretaries. Everybody has to contribute to this. The fact that they were mentioned more is because they were absent 14:19
from all the care of nine patients. It is not to denigrate what they do and it is not to emphasise the failsafe part of the work, it's about keeping patients safe. That's an intrinsic part of their job.

MR. WOLFE KC: I think, Mr. Gilbert, recalling your 14:19
evidence from the last day, I think you possibly took issue with the use of the word "failsafe" in one of your answers. What you explained was that the CNS role is specific, it has its own attributes and responsibilities. It wasn't a case of how the nursing 14:19
cadre help you, it was in many respects because your job is becoming increasingly technical over the years, it was how you could assist them. But ultimately, I think, in your answer in the round you could see the

use of the word "failsafe", while creating difficulties, does describe an aspect of the nursing role?

MR. GILBERT: Yes. I think "failsafe" is a difficult term. I can't think there is a single system in the world which is going to avoid difficult circumstances. There will always be patients that will slip through the net because of the complexity of what we're doing. Thankfully, and in normal circumstances, it should be extremely rare. The Cancer Nurse Specialist role is complementary and augments the patient experience, and is complementary to the responsibilities of the consultant, the diligence of the secretaries, and the cancer nurses' understanding of the emotional and physical journey that the patients are going through. Those have to be put together. There will still be a little gap every now and again but the gaps are increasingly small, and the chances of people slipping through the net will decrease to an absolute minimum. They do not replace the consultant, they do not replace the secretary, they have a separate, augmented role.

MR. WOLFE KC: Just if you can go back to the document and the next page, please. I think it is a further elaboration on why they would be concerned about this failsafe description. I think in the round that next paragraph on the top of the page is an indication that the nurses are of the view that they are not privy, and nor should they necessarily be privy, to certain developments within the patient pathway. So, they need

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not be expected to know that a scan report is due; that's the responsibility of the individual who requests it. In addition, they say that if a patient contacted their key worker CNS to inquire as to the date of a scan, that would be escalated to the consultant. I suppose implied within that, it is not a matter for the nurse to know when the important dates are in the process, the important response times are, that's somebody else's responsibility, so the use of the word "failsafe" in that context is problematic. 14:22 14:23

You respond to that. You say that on the contrary, it is the review team's experience that specialist nurses would have the understanding, which these nurses seemingly are lacking confidence about or suggesting that they do not have. 14:23

DR. HUGHES: Part of the primary role and responsibility of Clinical Nurse Specialists is to support patients through the myriad of staging scans and complex pathway. To do that, they would need to know the dates. My experience is that they do know the dates and times. 14:23

MR. WOLFE KC: If they are named nurse to the patient, they may not know in advance this is coming down the road but they would be told through the process of whatever communication it is that Mr. Smith, or whoever it is, is due for a scan today, and they would know instinctively or by experience that that is going to report in one week or whatever it is. Is that the 14:24

point you are making? It is the relationship that gives them the knowledge.

DR. HUGHES: Yes. If they are going to support people through their complex and diagnostic treatment pathway, they do need to know about the points of investigation and diagnosis and care. Otherwise, they can't inform and support their patients.

MR. WOLFE KC: You reflect some concern about this input from the nurses back to Mrs. Kingsnorth. Just bring up the correspondence, TRU-163160. At 8th April 2021, you have inputted your remarks in red into the document that we've just looked at. "I have drafted some thoughts in response."

You go on to say:

"I'm concerned that the CNS are not aware of critical posts" - would that be "points" - "in a patient's pathway such as staging and initiation of treatments. I am not sure how they can deliver the responsibilities detailed in the letter if they are unaware of the critical points in a patient pathway.

"I think there is a concern about the term failsafe. It is a common reference for all professionals in cancer care, my lab staff and the secretaries act in that role for me.

"Perhaps we need to think about emphasising everyone's responsibility to deliver right care right time".

The nursing response viewed against what you discovered through the nine cases, did it concern you then and do you have any lingering concern or confidence about the impact on the reform or the change that is necessary within this system? 14:26

DR. HUGHES: I have to acknowledge the language is probably clumsy. If they don't like the term "failsafe", I think that's appropriate and you have to accept that. I am concerned that we're trying to deliver right care right time, and one of the primary responsibilities of Clinical Nurse Specialist is to support patients through their cancer journey from the very start, through the diagnostic processes, scans, biopsies and whatever. To do that, they would have to know when those processes are happening. To support the patients regarding the outcomes of those investigations, they would need to know the results. That's the process I'm aware of and worked in, and I would expect that to be the present in the Southern Trust. 14:26 14:27

MR. WOLFE KC: It does seem, on the face of it, and it might seem to the Inquiry surprising, that some such remarks were being made by the nurses given what you were receiving back, I think, from other consultants who you spoke do about the quality of the nursing input and support for the patient pathway. There didn't seem to be - at least you didn't hear any 14:27

and didn't report any - concern about the use of nurses otherwise?

DR. HUGHES: No, No. To be fair, this is intrinsic in their work and their primary responsibility is not to be a tracker and their primary responsibility is not to tell people when their scans are. The primary responsibility is to say what the outcomes of their investigations were and to support them, but to do that, they need to know when they are happening. They will have a patient workload that's similar to any other professional and they should be part of that process. 14:27 14:28

MR. WOLFE KC: Thank you both for your evidence. I have no further questions today. I think I mentioned to you this morning briefly that there may be further input to be received from you in due course and the Inquiry will work that out. I understand the Chair may have something further to say about that this afternoon. 14:28

CHAIR: Yes, thank you both very much. I appreciate the time you have given to the Inquiry. Sadly, we cannot release you just yet. We have some questions as a panel to ask you. 14:28

I'm going to start but if I may start just with the last question. I wonder was there a misunderstanding on the part of the Clinical Nurse Specialists about what it was you were saying their responsibility was. It seems to be that when they are appointed, they give 14:28

exemplary service. Certainly that was the evidence we heard yesterday from Patient 5's family; that she contrasted what had happened with her father's renal treatment, where there was no cancer nurse specialist, and where there was one through the prostate and bowel cancer journey. I just wonder, did they maybe misunderstand that they were being asked to work as a tracker for all patients, not just those they had been engaged with by the consultant? 14:29

DR. HUGHES: I think I have to be conscious of when the letter was written and the circumstances. It may have seemed that a nurse specialist was the silver bullet, the complete solution to a complex process of patient care, that this would surpass their current role in terms of supporting and informing and providing direct patient care. That wasn't the intention. But it was the intention that they do know about their patients' journey and have information so that they can inform and support. The issue is that those patients who did not receive the input of a Clinical Nurse Specialist were not properly informed, were not properly supported, and had incredibly difficult journeys between hospital and primary care and community care. 14:29 14:30 14:30

CHAIR: Thank you for that. I'm going to go back to some of the earlier evidence that you gave and I'm sure my colleagues will be doing the same thing. 14:30

One - and it is a general question - about the leadership roles, and particularly maybe the Assistant

Medical Director. It seems to be a specialised job for which most professionals are not adequately trained. Would that be your view, or have I misinterpreted that?

Secondly, have you given any thought as to whether or not what support the Medical Director would need in that role in terms of training? Should it be a sabbatical role? Should there be mentoring for that person? How can the person who is in that role better perform is really my question. 14:31

DR. HUGHES: I think medical leadership roles are sometimes poorly defined, poorly understood by both the Trust and the candidates for those roles, and they're certainly poorly trained, I think. In terms of the associate medical role, it is probably much wider than just cancer. Unless they have a dispensary power or have been in a previous relationship with that service, they may struggle with that. There are training programmes which are available but they tend to be very brief and very limited. 14:32

In this case, I think culturally there was a distance between the medical leadership and the actual people delivering care on the ground. That's really, really unhelpful. You need to be embedded with one another so that they feel comfortable in escalating the really difficult stuff. It is fine when you're dealing with generic timelines or 31, 62-day targets, but the really difficult stuff is usually obviously patient safety and

interprofessional issues. If that relationship is not present, that can cause problems.

CHAIR: I think one of the difficulties that you articulated earlier was there's almost a Buggins' turn attitude to taking on these roles. You know, I have done it for so many years, it is somebody else's turn now. Somebody else applies for it because to some extent it furthers their career without actually appreciating what is involved in the role. Would that be fair? 14:32 14:33

DR. HUGHES: I think people don't realise it is a different skill from their medical training, and it is dealing with people and dealing with highly functioning, often highly opinionated, medical staff. It can be a challenge in itself. It needs particular training, and particular training in safety and quality and particular training in governance. People often assume roles because of seniority or experience. You really do need clear focus on governance and what your roles in both the local governance and the corporate governance is. I think that's not really part of the curriculum at present, and it needs to be. 14:33 14:33

CHAIR: It really needs someone with good man management skills?

DR. HUGHES: Yes. 14:33

CHAIR: Just in terms of the overall culture, we've talked a lot about that throughout your evidence; about the culture of challenge, for example, of escalating things that ought to be escalated appropriately. How

do you think that can be changed?
DR. HUGHES: I think it is best if it starts from the bottom up. I think the unit of work should be the multi-disciplinary team. It needs to be really functional, it needs to be really comfortable, it needs 14:34
to be really flat. People need to have trust in one another. It's not because they need to like one another, it's because that's how they'll deliver really good outcomes for patients, so that if people have difficult questions to say or things, that they will 14:34
accept that in the terms of a collegiate team.

I obviously was a pathologist at one time. If somebody questioned your diagnosis and things, instead of getting into a head-on argument, you need to have 14:34
policies and process in place to deal with difference. You need to have process and policies to make sure that if there's a difference of clinical opinion, there's ways to resolve it. So, let's take the heat out of this position; if we can't agree, escalate it to somebody 14:35
outside the Trust to get an opinion. I'm not saying you prioritise interprofessional behaviours but you need to realise that that's an important dynamic, and have a structure to deal with it. It has to be a flat structure to everyone in the team, be it the trackers, 14:35
be it the clinical nurses, can raise issues and are heard and are respected.
CHAIR: We know very well how resources are stretched to the nth degree. I suppose in an ideal world where

you did have the time, would there be a place for ongoing training and refresher training?

DR. HUGHES: Unfortunately, I'm old enough to know when we brought in multi-disciplinary teams, we had lots of training. We had like Michael West over regularly. 14:35
We actually valued the human dynamics part of it.
I don't think that happens as much now because time is short, money is short, and people think that's soft stuff instead of core stuff.

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I believe if you invest a lot of money in a team that's trying to provide better outcome for patients, you do need to invest some resource and you need to know where are your difficult areas. Invariably the difficult areas are not simply the throughput and the pressures, 14:36
it is about how people work with one another because once that is wrong, it is very difficult to resolve.
I think that needs to be taken on board.

CHAIR: If I can move on to a separate question now about the SAI process itself. You are very experienced 14:36
and obviously you have had experience here. This morning you were pulled as to the language, maybe, that was used in respect of some of the things recorded in the meetings. Just what would you change? If you had the opportunity to change how SAIs were conducted, what 14:36
one thing, or if there is more than one thing, please tell us what it is you would change.

DR. HUGHES: SAIs, I think they're difficult because you are dealing with a governance issue, trying to

resolve issues after something has happened or after something has potentially happened. They tend to be formulaic and they try also at the same time to resolve issues with patient and families dynamic. That's very difficult. How you would bring the family along can be very problematic and sometimes doesn't help because you are just reliving a bad situation. I think we need to think about how things can be done more efficiently, effectively, but in a non-blame culture. I think we're far from that. 14:37

I struggle at times -- I have some experience of structured judgment review where the clinical piece is taken away and is done separately and then you speak to the families. I think that worked well, but that's only available for certain sort of higher level SAIs. I would think if you ask around in, say, the urology team do they think this is a positive thing; probably not. I think probably for everybody that this has touched, it was not a positive thing. Could there be a better way of doing it? Yes, but that would take major change and we're slow to change. 14:38

There has been a review, an external review of the SAI process, but it still is problematic because I think some of the cultural things in the Health Service are challenging. Is it a non-blame culture? I don't think so. Is it hierarchical? Yes. Does that get in the way of a non-blame culture? Yes. 14:38

CHAIR: Talking about the structured review process and the SCRR cases we are looking at, as well as the Trust and the lookback, the purpose of that process is to really ensure that the care the patient is getting at present is the correct care, as I understand it. 14:39
I just wondered what your views were about the family involvement in that process. We heard from one family this week who they didn't know unless somewhat late in the day by letter from the Trust that the records had been looked at and their father's care was deemed to be 14:39
suboptimal or inappropriate, or whatever the terminology was.

You talked about being open and transparent with the families in the SAI process. I just wondered where you 14:39
believe the balance is in a lookback review; where it should be struck involving the families. Obviously, you don't want to scare them by saying there may be something wrong with your care until you know for sure, but at what stage is it appropriate to involve the 14:40
families and how should it be done?
DR. HUGHES: My past experience in a structured judgment review was with families who had concerns about the care, so they were the ones bringing it forward. We met with them beforehand and that fed into 14:40
the structured judgment review. It came back and we met them again. They were actually very grateful because a lot of their concerns were founded. I think it is different where people are unaware if there's any

issues around the care, whether you inform them and ask them if they want to discuss it in advance and then provide feedback. Simply saying to a family "we're unsure", that could be troubling in itself.

CHAIR: That's my point, where do you actually draw the line? Where is that line to be drawn? You're just saying it is a difficult judgment call, really? 14:40

DR. HUGHES: Yes. The real practical issue is the numbers. The previous issue I was referring to, that was a relative small number of 45, but it potentially could be many, many more; hundreds. How do you manage that process while delivering care? 14:41

CHAIR: Thank you. That's helpful.

Can I also ask, one of the things that you said and we heard from families was that they are surprised when they were told that they ought to have had a Clinical Nurse Specialist assigned to them through their pathway. Why do you think it is the case that they didn't know this was something they ought to have had? Where is the deficit in the information available to patients is really what I'm asking. 14:41 14:41

DR. HUGHES: It should be widely available. It should be available at outpatient clinics. I think all nine patients, this was their first cancer journey, so there's no reason to expect that they would know this is standard care unless you are in some way embedded in the service, but it is very much standard care. I'm at a loss, really, to know that fact. We obviously didn't 14:42

know that fact when we went into the process, and it struck me as very strange.

CHAIR: Just some general questions, again coming back to the culture. Why do you think the culture in this MDT was so very different to what you and Mr. Gilbert have experienced in other MDTs? 14:42

MR. GILBERT: I think there was a particularly dominant character in the MDT who exerted a certain power and wanted to -- felt he was offering the best possible treatment and didn't need the help of Cancer Nurse Specialist, and maybe eventually didn't want the scrutiny. I don't know; that's conjecture. As a clinician who has gone through the period of the last 20 years of the development and evolution of MDTs and the roles of all the people including trackers, coordinators, Clinical Nurse Specialists, all the various specialities coming through, it has become the single most supportive part of my work. Without it, I don't think I could function any longer. Now that's to do with certain changes happening in terms of the administrative support they've but it is much more than that. I look forward to the MDT. It is a chance to meet with everyone in the team, talk things through, catch up. More important than that is the clinical support and reassurance of knowing that we have consensus about what represents a good job. I don't understand why anyone would not want to be part of that. It's a glorious thing. It's great fun. 14:43 14:43 14:43 14:44

CHAIR: Change is difficult, and change is difficult

for people who have been working in a particular way for a long time and to actually recognise. I'm wondering, is there a role to bring people along to invest in that change. You were saying about the training that there was at the outset when the process was introduced, but is there an ongoing role to be envisaged, if you like, to ensure that people have, I don't know, role play or whatever? To see the benefits is really what I'm saying. 14:44

MR. GILBERT: I would have thought that that was the responsibility of the line management within the Trust. So, whoever was the clinical lead for MDT services should have experience of a good MDT and should be going out proselytising the benefits and ensuring each MDT understands the benefits and can engage. I don't think you'd have to have an external person there, you can just take somebody who doesn't believe in it and go and pop them in a different MDT and see how good MDT works, how you can get through an awful lot of meaningful work in a very short time, in a very collegiate and cooperative way. 14:45 14:45

DR. HUGHES: I think if you turn it on its head, not what a professional should do but what a patient should expect. It is very clear when a patient comes to a service that they should expects a MDT process that's fully quorate and fully functional; appropriate support from Clinical Nurse Specialists who will have their name and they will have their number, and they will be supported through the cancer journey, which is 14:46

incredibly complex and difficult for people the first time. That's the standard of care that you offer to your patients.

I mean, we spent years fighting for resources and we spent a long time. We still don't have enough resources but thankfully we have a lot more Clinical Nurse Specialists. By any metric, if you look at what people say and what the evidence is, people get much better and much safer cancer care with Clinical Nurse Specialists. 14:46 14:46

CHAIR: Just coming back to some of the things about this, the operation of this and the quoracy issue, for example. I mean, it's really striking that in 2019, not one meeting was quorate. One of the issues you were saying was that the radiologist, the cancer radiologist, had another MDT at the same time. Surely it is not beyond the reams of possibility for somebody to pick that up and say, well, let's change the day. 14:47

DR. HUGHES: I think what it was, they did the urology service, which was a very, very large service, and they did the lung cancer service in the afternoon, which is very large and very complex as well, and they simply didn't have time. As well as that, it was staffed by rotating locums, so there was no continuity. Even though it may have been quorate one or two times, it may not have been the same professional. In essence you didn't have embedded oncology within the team on a stable basis. 14:47

CHAIR: How can that be ameliorated?
DR. HUGHES: I think we need to have a hard look at commissioning. I mean, I did mention this morning, obviously in the Western Trust they could manage quoracy of 98 percent; I am sure Belfast was somewhat similar. How did it happen that one area resulted in a deficit? 14:48
MR. GILBERT: It is part of job planning as well. If it is made as an addendum to the rest of the week's work, then people are going to find other things to be doing. Whereas if it's carved out and actually pay is allocated to that particular activity, then they have no excuse, it is part of their job plan. Therefore, as part of their appraisal they should demonstrate they are fulfilling that obligation. 14:48
CHAIR: Thank you. That is helpful.

I'm just checking. Yes, just about the whole auditing issue and the metrics and the tracking and all of that. I mean, obviously if a department or a service is under-resourced and they want to seek more resources, then it is no good just simply going along and saying, well, you know, anecdotally this is the position on the ground. If they don't have the actual facts and figures, it is not going to be anywhere near as persuasive as if they have the evidence base on which to say we need these resources because, look, this is what's happening; we need these resources because we can't have a quorate MDM, or we need somebody to look 14:49 14:49

at this and change it, for example. Am I right in my understanding of why it is so important to gather this information and audit these things?

DR. HUGHES: I think it is really important to gather information because you should be in a process of biannual business meetings that you can look at the deficits in your service and improve on a quality improvement process going forward. I think this is an exceptional case where you actually need the data just to quantify the care of deficit. That's an extreme example. But the fact that there was no meaningful ongoing assurance audit concerned me. 14:49 14:50

CHAIR: Thank you both very much. I'll have something else to say to you at the end but I'm going to hand you over to Dr. Swart and then to Mr. Hanbury. 14:50

DR. SWART: Thank you very much for clear evidence. I have a few questions. They are mainly general for Dr. Hughes. Just one quick one for you, Mr. Gilbert. I think Mr. Hanbury will cover some of the more clinical aspects of it. 14:50

Dr. Hughes, going back to the very beginning you talked about your experience with serious adverse incidents at the Western Trust. You mentioned something then which was about your director oversight of serious incidents in your experience. How important do you think that is, to have somebody like the Medical Director taking a personal responsibility, and what did you learn in your time at the Western Trust about that? 14:50

DR. HUGHES: We set up a process to review all SAIs as they were coming through. We would have had early learning or early notification of major things. But the first thing you notice is the variation, and the ranges of professionalism. Often SAIs are done by 14:51
well-meaning, very busy clinicians who are not necessarily trained or experienced in this process. While we could standardise and suggest improvements, I'm not sure if the best way to do these is to get a doctor to do it a couple of times a year, because if 14:51
you don't do them frequently, you don't know the process. Part of our learning from it was that we needed to set up a better way, perhaps grow a team from the governance team who would do the process and call in appropriate medical or nursing or the 14:52
appropriate witnesses. That would be a more radical way of doing it.

I think what we all struggle with is to get appropriate patient or family engagement because you are dealing 14:52
with people who suffered deficit, are often traumatised by processes. How do you achieve resolution for people in the process? It doesn't always work. Probably, if you think about it, taking people through another detailed traumatic process is not necessarily going to 14:52
be helpful.
I think the other thing about SAIs is that they can be very time-consuming and don't make a meaningful timeframe. That can be difficult for those in service,

and also difficult for families.

DR. SWART: Can I ask you about the early learning from them. You'll be aware at Southern Healthcare Trust, some of the SAIs - not this one but a previous one - took very long times. It is difficult to find the learning and the action. Is there anything about the structure of the way that was set up at the Southern Healthcare Trust that you came across that perhaps was partly responsible for that, or are you not able to make that judgment? 14:53

DR. HUGHES: I did ask the Associate Medical Director. Ultimately, they didn't know about the initial SAI in 2016, and they certainly didn't know about any MHPS process, apart from noises in the system as opposed to being informed. That meant that potentially learning wasn't brought to the SAI or to the service in advance. Because if you are looking at the front door of the Cancer Services, red flag, triage, and there are issues - issues about timeliness of triaging and issues about missed cases - somebody needs to ask the question are there issues elsewhere in the pathway, and to get assurance around that. I don't think that happened. 14:53

DR. SWART: Do you think it can happen if it is not at director level?

DR. HUGHES: I think it needs to be at a very senior level. 14:54

DR. SWART: The over thing is this particular group of SAIs that you were responsible for, it is quite an unusual situation. Nine all together, the context of a

public inquiry. It gives you some particular challenges, I think, in terms of every aspect but particularly family engagement. How did you find that when you started off? What do you think the pluses and the downsides were of that particular set of circumstances? 14:54

DR. HUGHES: I think the positive thing was the family engagement. I need to thank the governance team from the Southern Trust, who obviously were perceived to be the Southern Trust meeting families where a potential deficit occurred, and they handled that well. We had a family liaison officer. We met with them on three occasions. All those occasions were quite difficult. They were stunned at the first meeting, needed to know a bit more at the second meeting, and probably anger by the third meeting. They had moved from the individual issues to the systemic issues you are now discussing. They were very able, very articulate. So, I think that was a positive thing. I don't necessarily think it was particularly good for them but it was a positive thing. 14:54 14:55 14:55

I think the difficulty with this process was that this Inquiry was known about so people were very anxious. People were very anxious how they'd delivered, what they could have done more, and I think they became anxious of the SAI process. So, I had to understand that. It is what it is, I suppose. 14:55

DR. SWART: What did you use as your yardstick in terms of what to tell them and what not to tell them? You

had an earlier conversation about being open, which is absolutely right, but there must have been some tension with that, with what to say, what you know and what you don't know, what they should know.

DR. HUGHES: With the staff? 14:56

DR. SWART: And with the families.

DR. HUGHES: Certainly with the families I had to be open and honest and transparent in terms of numbers and scale, especially the issues about their loved ones. 14:56

With the staff, I had to tell them about the numbers on the scale and issues because some were informed, some didn't know. We had to explain -- I think everybody probably knew about the Bicalutamide issues, everybody did not know about Clinical Nurse 14:56 Specialists. Everybody was not aware of lack of onward referral. They were not aware of and had not thought about people not being brought back to the MDT when the disease progressed. That did surprise me. I think that was early learning for the team. I think they 14:57 became anxious as the process went on because then it went from what happened to what was their role in allowing it to happen. I think that's human nature.

DR. SWART: One of the things that is evident in this is a series of cases involving one clinician. How did 14:57 you get evidential assurance that other clinicians weren't operating in the same way?

DR. HUGHES: I discussed this with the Medical Director at a very early stage because the only way I could, on

a short term basis, was to ask people. I would simply ask did they use Clinical Nurse Specialists; did they adhere to the prescribing guidelines; did they appropriately onward refer, and they did give me that assurance, but that had to be augmented by the 14:57
assurance audit process that I recommended in the recommendations. That was partially part of my pushback to the Cancer Management Team, because I really couldn't understand how they would push back on that assurance process because I think that was 14:58
critical for the service going forward. I think it would be inappropriate and unfair to say we'll investigate one professional but just accept what everybody else says.

DR. SWART: Yes, I agree. Did the families ask about 14:58
that?

DR. HUGHES: Yes.

DR. SWART: Moving on to the disconnect with cancers --

DR. HUGHES: I should say, I asked the families to be part of the assurance mechanism with the 14:58
recommendations.

DR. SWART: Yes. We heard from one yesterday, so that's good.

Moving on to the disconnect between Cancer Services and 14:58
operational services and, indeed, between Cancer Services and clinical governance in the Trust, to some extent. In your view, what is the cause of that?

DR. HUGHES: I think it is a structure where the

professionals were managed by one group and some professionals were managed by another. My previous experience was that Cancer Services was a coherent unit, and all issues arising in cancer was reported through a director, Associate Medical Director. If an issue arose in cancer, cancer dealt with it, it didn't matter who the professional was or what service they came. There was a clear ethos around Cancer Services. Cancer Services is usually a major part of the Trust and a very front-facing part of the Trust, with a lot of public awareness. I think that was a much tighter structure. 14:59 14:59

When I came to this process, it was very clear that the Associate Director and the cancer lead didn't know about some of the issues and didn't have structures to know. 14:59

DR. SWART: The other thing that has come out in questioning, I think so far, is that the Chief Executive, the board, the Medical Director to some extent, were perhaps not aware of the scale of the issues. In your experience and thinking back to the time when you were Medical Director, what enquiries should they have made, and what should they have sought to draw out that needed to come to the attention of certainly the governance committee but probably the full board? 15:00 15:00

DR. HUGHES: I think quantify things. Part of quantify things means to look at numbers. So, if it is a

prescribing thing, that should be done as an urgency. If it is about adherence, Clinical Nurse Specialists audited or get information. I think a lot of the stuff was opinion-based and not numbers. I think have an honest and transparent discussion with the multi-disciplinary team. 15:00

DR. SWART: When you were Medical Director, did you get reports as to compliance with improving outcome guidance, peer review and all those things? Would you have known about that. 15:01

DR. HUGHES: I think different specialty senior professional issues were raised by members of staff, so we immediately did a lookback exercise. We did that in the electronic care rec in the first instance; triaged it down to notes. We did that. Then eventually reviewed 39 patients, starting with 500. 15:01

When people raise concerns, you need to do it in a instructed way based on evidence.

DR. SWART: Would you have had evidence without people raising concerns? Would there have been routine information that would go to the performance committee or another quality committee of the board? 15:01

DR. HUGHES: Yes. I think you are a hostage to fortune if people feel -- if people don't escalate issues or don't feel they can escalate issues. The cultural piece is people feel they can't escalate issues. 15:01

DR. SWART: When you produced your recommendations and you had your discussions with the Medical Director, was

this well received? Was the enormity of the challenge received?

DR. HUGHES: It was very professionally received. There was no pushback, no. I think the Medical Director was reasonably new into the service. 15:02

DR. SWART: Yes, that's right.

You have been a Medical Director. What do you see is the role of the Medical Director in influencing especially the clinical governance structures in the 15:02 Trust and the culture of the response of medical staff?

DR. HUGHES: I think the issue should be not about professionals, it is about patients. Everybody should have a focus about the outcomes for patients. I think you have to be available and get involved as needed. 15:02 I think you have to encourage by example a culture of openness and honesty. You mightn't be liked but you have to be trusted.

DR. SWART: You referred, quite rightly, to the managerial responsibilities of the GMC, every doctor 15:03 but particularly doctors in leadership. If you come across an organisation where this is not understood, how would you go about changing that?

DR. HUGHES: I think you should start with the leaders in the organisation because I suspect there's lots of 15:03 leaders in our organisation - clinical leaders, I mean - that probably don't understand their roles and responsibilities. I think if you explain people's roles and responsibilities, it may put people off

taking those jobs. I think you probably need to review how we deliver clinical or medical management. I think it is often an add-on, four hours a week with limited training, and people don't understand the complexities or the responsibilities until something goes wrong. 15:03
I think you need to have really, really good data and good ways of measuring your service. We currently don't have that, and certainly the Southern Trust in their urology didn't.
DR. SWART: Just as a softer thing, do you think the 15:04
urologists viewed themselves as working as a team? Do you think they had a collegiate team culture?
DR. HUGHES: No, I think there was difficulties. I think new members in the team came in, and I think have to be commended, did try to raise this and 15:04
struggled. I think relationships were poor. People were trying to do the right thing but didn't succeed.
DR. SWART: How would you rebuild that? We already referred to the stress of the Inquiry and, you know, the difficulty in recruitment and so on. This must be 15:04
a very, very difficult team to operate in at the moment.
DR. HUGHES: I think get people refocussed on their task. Their task is to provide high-quality care which I am quite sure many of them currently do. It is about 15:05
evidencing that to the public, and have patients and clients and families with them to see that that's the journey their on. It is about supporting them and recognising that this can be achieved, and providing

resource to make sure that it is achieved.
DR. SWART: A sort of simple one in a way. I'm very struck by the lack of written information to patients, many patients. There doesn't appear to be a kind of a Northern Ireland-wide mandate for this to be done. At 15:05
your Trust, at the Western Trust, do you think that was embedded in normal practice?
DR. HUGHES: Yes.
DR. SWART: What do you think the barriers are to embedding it in a place like Southern Healthcare Trust? 15:06
They hasn't that happened; have you got any views?
DR. HUGHES: Certainly patients would have got copies of their outpatient letters. Part of the problem with new patients in Cancer Services, sometimes they get voluminous amounts of information. I think the best 15:06
people to do that is the Clinical Nurse Specialists in terms of supporting information; that there is a cancer patient experience audit. It does show that those --
DR. SWART: I'm talking specifically about the letters. So, mostly the letters are not copied to patients. 15:06
DR. HUGHES: They should be.
DR. SWART: There doesn't appear to be a rule that says they have to be.
DR. HUGHES: I did try to check that in the Northern Ireland Cancer Network and it is not there. A piece of 15:06
work I'm currently doing implementing a new system; every patient will have access to their information, so the letters will be available to them as their lab results or their scan results. So, that will change.

But there's no reason why this can't change now because that's standard practice. It's standard practice outside Cancer Services and it is standard practice in many geographies and not in Ireland.

DR. SWART: I don't understand why that isn't happening and if there were any specific barriers, really, I suppose, is the question. 15:07

DR. HUGHES: I didn't review that issue but I think it is something worth asking of the Southern Trust because I know it happens elsewhere. 15:07

DR. SWART: Mr. Gilbert, just quickly. If you were in an MDT in your hospital, or the previous hospital, and you had this kind of situation where you became aware that there was a colleague that was behaving differently from other colleagues, what would you do about it personally? 15:07

MR. GILBERT: I would talk to my other colleagues to understand whether my perception was reasonable or not. If it were, I would talk to the individual concerned to try to understand their perspective. If at that time I was not satisfied or hadn't persuaded a change in practice, then I would escalate it through the line management, which is now clearly defined in hospitals. 15:08

DR. SWART: In your Trust, what is the relationship of Cancer Services to the individual MDTs and operational services? 15:08

MR. GILBERT: I have experience of the two. My greater experience is with the Gloucestershire MDT. The relationship with Cancer Services is that -- well, what

was set up was a thing called Surgical Quality Assurance Group, SQAG. It was led by an associate Medical Director, and each MDT had to report once a month with a prescription of particular data points, complaints, compliments; audits had to be conducted twice a year. So, there was a definite schedule. Once a year the poor clinical governance lead would have to go and sit in front of four or five colleagues who would give them a hard time. If the MDT was not performing according to the prescribed milestones, there was trouble. 15:09 15:09

DR. SWART: Did that work? Did it means things --

MR. GILBERT: Yes. Well, I can only speak for urology.

DR. SWART: That's what I'm asking.

MR. GILBERT: Yes, it worked. If we were getting up to a particular threshold in terms of time, somebody would look around and say gosh, we haven't done an audit. Now, that was rarely a problem because there are lots of junior doctors who are desperately keen to do audits because it advances their CV. 15:10 15:10

The advantage of doing it in that cyclical mode is that it becomes stronger and stronger as time goes by, so you can focus in. We started with very broad audits, how long does it take for someone with blood in their urine to get their bladder removed if they need it, right down to how long is it taking for the histology to come through. There are so many little components that can be looked at, and then the overall process can 15:10

be looked at.
DR. SWART: If you weren't meeting peer review standards and you went up before your committee and things were going bad, who would know about it in the Trust, do you think? 15:11
MR. GILBERT: Well, the Associate Medical Director clearly would because -- I never quite knew but I think that would have been reported to the Medical Director overall.
DR. SWART: That's my experience, too. 15:11
Thank you.
CHAIR: Mr. Hanbury.
MR. HANBURY: Thank you very much for your evidence. It has been extremely interesting.
15:11
I would just like to go back to the oncology presence at MDM, which I know we talked a lot about. It is not just having them there, it is what they do. In your report there are three patients, I think 1, 4 and 9, all of whom had prostate cancer which was rapidly 15:11 progressive, so they were against the clock. Either the non- or delayed referral to oncology was a big part of the problem.

I guess, for Mr. Gilbert, if a clinical oncologist had 15:11 been there when these cases are discussed, how do you think that might have changed or streamlined the pathway?
MR. GILBERT: One of the advantages of the MDT, which I

am sure you have experienced, is if somebody is sitting in front of you, then the MDT outcome form constitutes a referral. If you have your tracker - I prefer not to call them trackers because I think they are so much more - coordinator, has completed the MDT. We develop MDTs on a Friday afternoon and our coordinator was often there until eight o'clock in the evening, it was not a popular job. But she was a wonderful individual who made sure that those forms were on the desk of the appropriate person on the Monday. 15:12

MR. HANBURY: So, the referral had been done there and then?

MR. GILBERT: It was done face-to-face.

MR. HANBURY: Instead of waiting for the patient to come back, see the clinician; have letters to be dictated. 15:13

MR. GILBERT: Precisely. The cancer nurse actually would telephone the patient on Monday to let them know exactly what was happening and what the outcome of the MDT was. 15:13

MR. HANBURY: Dr. Hughes, sort of hearing this and with the difficulties with the post-oncology service, do you really accept that more could not have been done to give assistance there, as an oncologist yourself?

DR. HUGHES: I think more should have been done because it was quite clear there was a persistent and prolonged deficit in oncology attendance. I think when we're commissioning services in Northern Ireland, we have an equity issue. The catchment probably for this urology 15:13

service was probably is upwards of 400,000, and those 400,000 population were differentially treated. As I said, it is not simply the oncologist not being there, it would have been staffed largely by locum oncologists so there was nobody embedded in the service. If you are going to build a proper team, you have to have permanent members in that team and a relationship with other professionals. Undoubtedly, having a professional beside you to discuss the patients and taking immediate action would have been better. 15:14 15:14

MR. HANBURY: Okay. Thank you.

Moving on to the penile cancer case, which is number 3, same point again, Mr. Gilbert. Obviously I think one of the problems here is that there was a small number, perhaps only one urologist in the room whose opinion swung the day. If a clinical oncologist would have been there, do you think that would have made a difference to the pathway? 15:14 15:14

MR. GILBERT: I would have hoped so, yes. The Improving Outcomes Guidance and its general principles have been around for 20 years. There's no doubt that penile cancer, which was a Cinderella, a Cinderella speciality so it was really down the order of the list of things, needed to be brought in to centralised referral process. That should have been in place. Penile cancer should have been referred on. The clinical oncologist needn't have been there. Any 15:15

clinician who sees a case of penile cancer who is not an expert in that particular field with extensive experience should refer the patient on. I would almost say that could happen outside the MDT because it is a reflex response. 15:15

MR. HANBURY: So in your opinion, is there a place for an inguinal lymph node dissection outwith a specialist penile cancer centre? We have discussed before the difficulties of setting it up in Northern Ireland.

MR. GILBERT: It took me an hour and 40 minutes to fly here from London this morning. I think somebody would perfectly prefer to fly to London in just 140 hours (sic) to get an expert to do their operation. The answer to your question is specifically no, I don't think it is appropriate. 15:16

MR. HANBURY: Moving on to the small renal mass case - I'm sticking to the clinical aspects - which is Patient 7, there appeared to be a delay or non-referral. There clearly had been difficulties with the NICAn guidance for the small renal mass team. Mr. Gilbert again, what implications in this case were there from that lack of referral? 15:16

MR. GILBERT: Well, I think the main concern is the anxiety created in the process of coming up to a definitive plan. The patient will have been thinking well, what's happening; have I got cancer or haven't I; have I got significant disease or haven't I; what's happening. That's where a cancer nurse specialist would have been helpful because one of the very 15:17

important roles of the Clinical Nurse Specialist is communicating information and being available to answer questions as and when they arise.

Did this affect the patient in the long term? Probably not. We don't know that. It's less than four centimetres -- I'm sorry, I can't remember the exact, so it is a small renal mass. Under many circumstances, in the past that might have been managed by certain active surveillance, by repeated CT scanning. With the advent of less invasive surgery nowadays, the balance of risks between intervention and nonintervention has swung towards the way of actually dealing with the cancer. 15:17 15:17

I'm sure we've all seen cases of renal masses of less than four centimetres metastasising, so that has been a great advance, in my view, in the last five years. 15:18

MR. HANBURY: Perhaps more treatment options for smaller --

MR. GILBERT: There are other options as well. The intervention may be less invasive surgery but there is also cryotherapy or radiofrequency ablation to consider. Those can only be provided within a centralised service which demands referral from the local MDT to an expert. 15:18 15:18

MR. HANBURY: Thank you for that.

Moving on to the low dose Bicalutamide issue. Low dose Bicalutamide 50mg monotherapy for the treatment of

localised prostate cancer. I apologise, it is a slightly specialised question but it is an issue in this Inquiry. Are you aware of this being used in your practice or in places that you've worked before, MDTs you've been involved in? 15:19

MR. GILBERT: No. In Gloucestershire, I had ten colleagues, in Bristol I have 23 colleagues, urologists, big departments. I don't know of any one of those people using that particular treatment.

MR. HANBURY: Are you aware of any guidelines that you frequently use, maybe quote a few guidelines that you use where that is recommended? 15:19

MR. GILBERT: No, I'm not. I carry the European Association of Urology Guidelines on my mobile phone. Because sometimes there's a peculiar case, you just think to yourself you want to remind yourself of things. It is very accessible information. I am unaware of the use of 50mg monotherapy as definitive treatment for prostate cancer. The only scenario, and I have some issue with this actually personally, is when it is used as the starting treatment for definitive hormone therapy to cover for the commencement of an LHRH analog. 15:20

MR. HANBURY: Prophylactic?

MR. GILBERT: Yes. 15:20

MR. HANBURY: Lastly, a slightly more technical question. Are you aware of any evidence, looking at Bicalutamide 50mg or conventional LHRH/orchiectomy in the literature?

MR. GILBERT: Not with the use of 50mg.
MR. HANBURY: Thank you. Getting there.

We've asked about oncology at MDM. What about radiology at MDM? Again, sorry, this is another one for Mr. Gilbert. Do you think actually an MDM without a uro-radiologist is viable? 15:21
MR. GILBERT: Not consistently. All radiology is double reported. Usually it is reported by A N Other radiologist initially, and then a specialist urology one who is dedicated to the MDT will come along with a blind report to confirm the original findings. Having said that, even in Gloucester with a relatively large department, we only have one radiologist available to us, and of course he would go on leave from time to time. Occasionally we would be able to have a substitute. They are never as good because the rapport between somebody you meet once a week is very valuable. But on occasions we couldn't. On those occasions, the dedicated urologist would prepare for the MDT, and one of us would read out his lines for the rest and try and demonstrate the radiology. Not always successful. 15:21 15:22 15:22
MR. HANBURY: Are you aware that system happened at Southern Trust?
MR. GILBERT: I'm not aware that it happened. 15:22
MR. HANBURY: Right.

Dr. Hughes, something for you. Pathology reports. There's comment about a safety note mechanism and many

MDTs, MDMs have the situation where pathology automatically flag up any unexpected cancer diagnosis and that gets pulled up to the coordinator. How difficult is that to set up? It seems to be a good idea which many MDTs use, but there seemed to be some resistance to this from the Cancer Services. 15:23

DR. HUGHES: It is very simple to set up and it is based on SNOMED codes. It's a safety net. It means that cases that are forgotten, they're submitted by pathology. As well as that, they can expedite the presentation of cases so that they are on for discussion at the earliest time possible. It's simple printouts on the basis of a SNOMED code. I think it had been present in the Southern Trust, but I think they thought it wasn't identifying many additional cases so they stopped. The idea of a safety net is that it shouldn't be identifying many cases, it is there for the exception. 15:23

MR. HANBURY: I should have said this refers to Patient 8. 15:24

On a similar theme, Mr. Gilbert, if an unexpected pathology did come over your desk, such as Patient 8, how would you have responded to that?

MR. GILBERT: I would have spoken to the MDT coordinator to add the patient's details to the next MDT. 15:24

MR. HANBURY: Then it would be discussed and appropriate follow-up?

MR. GILBERT: As with all other cases, yes.
MR. HANBURY: Dr. Hughes, you've obviously been involved way back in 2010 with centralisation, the early Improving Outcomes Guidance. Did you have from any other Trusts resistance to subspecialisation, giving out the big stuff, as it were? 15:24
DR. HUGHES: Yes.
MR. HANBURY: How did you handle that and was it successful?
DR. HUGHES: Oesophageal cancer, gastric cancer, pancreatic -- sorry, prostate surgery, I think there was genuine resistance because people felt validated by the service they delivered. Part of this was major change. Certainly my own Trust stopped it. While they were rather sad about that, they stopped doing this service because they knew that you needed a critical volume of service in the hands of fewer specialists. 15:25 15:25

I did meet with the Southern Trust in that time and they were slightly more resistant on the basis they were as good as anybody else. That wasn't the argument, the argument was that somebody can only be good if they are doing a sufficient throughput. 15:25
I didn't particularly pick up on the fact that that resistance -- I had similar resistance in terms of centralising oesophageal surgery or gastric surgery. 15:25
I understood it was a process.
MR. HANBURY: Thank you. Last question, national audits. It was a frustration, obviously looking at

surgical quality. BAUS, the British Association of Urological Surgeons, launched national audits in kidney pelvic surgery and complex stone operations. I think the urologists were keen to join this. Then there was a political disengagement, shall we say. What's your view on that, and did other specialties get round it in some way? 15:26

DR. HUGHES: Not all the urologists were members of BAUS in the Southern Trust. I think there was an issue about transferring patient data to the United Kingdom from Northern Ireland because we don't have appropriate legislative cover. I think we would encourage people to collate the data and benchmark the service against BAUS. I don't know if the sharing of information has been resolved yet. Obviously Northern Ireland is a very small place, and unless it shares data with larger institutions and all of the United Kingdom, you don't get meaningful data and meaningful outcomes. 15:26 15:27

MR. HANBURY: Thank you.

No more questions. 15:27

CHAIR: Gentlemen, thank you again for coming three days now. We received, as you are aware, a bundle of information from one of the core participants very late in the day on Friday last. That did not give the Inquiry team time to analyse it and look at it in any meaningful way. I know that you have looked at it but are concerned that you haven't had the opportunity to consider it appropriately or properly. 15:27

Can I ask, we will be considering what is the best way for you to engage with the Inquiry on that material. It may be that we can simply accept a written document from you once you have had the opportunity and time to look at it, or we may, unfortunately, need to call you back to address it. We are hoping to avoid the latter and go for the former, if we can. If I could ask you to look at it and maybe come back to the Inquiry with whether you feel that you can address it appropriately on paper or not and let us know and we'll take it from there, please. Thank you. 15:28 15:28

Can I just, in light of that, urge all of the core participants that if they wish to share material with the Inquiry - particularly if it is material that they want a witness to look at - they need to do so in sufficient time to allow counsel to the Inquiry time to look at it. I would remind observe about our protocol, our procedural protocol, that any questions for counsel should be submitted at least seven days in advance of a witness giving evidence. We do advise the core participants in good time as to who our time tabled witness is going to be, and there should be no reason for people not to meet the requirements of the protocol, please. It is unfair on Inquiry counsel, it is unfair on the other members of the legal team, and it is certainly unfair on the secretariat having to process information also. So, please, please, in the spirit of collaboration, get things to us quickly if 15:28 15:29 15:29

you want us to look at them.

I have been very flexible in terms of extension of time for submission of responses to Section 21s. From here on in, this year is a very tight year in terms of getting through all the work we have to get through. I will not be so flexible. We have the majority of the Section 21 responses in but from here on in, please adhere to any timeframe that is set by the Inquiry. 15:29

15:30

Thank you very much, gentlemen, for your time.

THE INQUIRY ADJOURNED TO 10.00 A.M. ON THURSDAY 26TH JANUARY 2023