Urology Services Inquiry

Oral Hearing

Day 45 – Tuesday, 23rd May 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

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THE INQUIRY RESUMED AS FOLLOWS at 10:00 A.M. ON TUESDAY, 23RD MAY 2023

CHAIR: Morning everyone. Ms. McMahon.

MS. McMAHON: The first witness is Fiona Reddick, who is the head of Cancer Services, and she's going to take the oath. 10:01

MS FIONA REDDICK, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:01

1 Q. MS. McMAHON: Ms. Reddick, thank you for coming to the Inquiry to give evidence. You have already provided evidence in written form, a Section 21 response. If we just go to that at WIT-91001. It's notice number 99 of 2022. That's the first page of that. Then if we go to the signature at the bottom of WIT-91023, you have signed the notice dated 8th December 2022. If we just look at your signature, do you recognise that as your signature? 10:02

A. Yes, I do.

2 Q. And that's your statement to the Inquiry?

A. Yes.

3 Q. And you wish to adopt that as your evidence?

A. Yes. 10:02

4 Q. Thank you. For the Panel's note, the enclosures with that statement are from WIT-91024 to WIT-91048.

Ms. Reddick, I just want to discuss briefly with you

your employment history to date, which you set out at your statement. We do not need to go to it but it's at WIT-91003. From 1999 to 2003 you were a staff nurse in the Mandeville Unit of the legacy Trust?

A. That's correct, yes. 10:03

5 Q. Then in 2003 you were appointed the clinical sister in the same department?

A. Yes.

6 Q. From January 2010 to July 2012, you were an acute oncology nurse specialist? 10:03

A. Yes.

7 Q. Is that now what would be called a cancer nurse specialist?

A. It's different; it's site specific. Acute oncology is an area in its own entity. But it ties in as a cancer 10:03 nurse specialist, it has various aspects which are consistent across the board.

8 Q. So it's specific to that unit at that time?

A. Yeah.

9 Q. July 2012 was when you were appointed the Head of 10:03 Cancer Services in the Trust?

A. That's right.

10 Q. And that's your current role?

A. Yes.

11 Q. Now, as regards what your role involves, you have set 10:04 out at WIT-91001 of your statement -- and we'll just bring that one up, 91001. You have said in the third line down:

"I have indicated in my responses that I was responsible for ensuring that cancer access ministerial targets were adhered to, and that any issues or delays were escalated as appropriate. This would have been carried out using the Trust's escalation process and completing breach reports, which would have been shared locally and at HC and Health and Social Care Board level."

10:04

Just in relation to that aspect of your role, how did you go about ensuring that ministerial targets were adhered to?

10:04

A. So, within the Trust we had regular cancer performance meetings. On a day and daily basis, we would have been monitoring patients along their pathway, and I worked very closely with the cancer tracking team and operation support lead. We worked very closely in monitoring those, where the patients were in their pathway. We had regular performance meetings within Cancer Services, and then once per month we had a monthly cancer performance meeting, where we worked with the other heads of services and assistants to directors for each of the specialties, and we looked at areas where there were issues and highlighted those; we worked our way through individual patients and shared breach reports. If patients breached their 62-day cancer performance target, then we went through the detail of where the delays were.

10:05

10:05

10:05

We also were accountable to the Health and Social Care Board. We had regular performance meetings with the Board where we were held to account for our cancer access targets, and we reported back to those as well.

12 Q. The breach reports are what they sound like, highlighting any breach in expected targets? 10:06

A. That's correct.

13 Q. Would they be completed on an ad hoc basis or would you have done that weekly or monthly anyway?

A. No, that was part and parcel of the role of the cancer tracking team. So any patient that breached, there were breach reports, and those were visible for everyone. 10:06

14 Q. Now, we'll go on to talk about the Trust's escalation processes shortly. You have mentioned there the Health and Social Care Board. How often did you provide them with the reports detailing the information you've just set out? 10:06

A. So, we would have sent that through. We would have either met on a monthly basis or bimonthly basis, and they would have requested information from the Trust prior to the meeting. Each month, they would have focused -- potentially they would have told us where they were going to focus for that ensuing meeting that was going to happen. So, we would have shared that information ahead of the meeting and then they would have went through the detail at those meetings. 10:07 10:07

15 Q. Now, the Inquiry have heard from a cancer tracker as well so there's information available to the Inquiry.

In relation to your particular role as Head of Cancer Services, if you identified information that was fed up to you to inform you whether targets were met or not, did you have any responsibility around dealing with issues that were causing problems? 10:07

A. Yes. Collectively as a cancer team, the trackers, the operational support leads, myself and my Assistant Director would have shared that information with the head of service if there was issues across a particular tumour site. That would have been shared through the 10:08 escalation process. If someone was delayed, if the first appointment was delayed, or if they were waiting on an investigative test, that would have been flagged up through e-mail.

16 Q. So was the limit - and I do not mean any disrespect, 10:08 just so we know the contours of your responsibility - the limit of what you could do when a problem was highlighted was let someone know to deal with it?

A. Yeah. You escalated it to the service because there was things within -- out of our control that we could 10:08 not do. It was up, you know, to the service. If it was theatre access, that was out of our control, it had to be flagged up to the service.

17 Q. Was there any sanction or feedback from the HSCB when targets were not met or performance was not as 10:08 expected?

A. HSCB, you know, we went through issues at our meetings. There also was the Northern Ireland Cancer Network Clinical Reference Group, site specific. A lot of

their focus would have been around performance as well. They would have looked -- they would have picked a particular meeting to look at performance across Trusts and shared that at meetings to see if there were any other ways that they could work to achieve the targets in a more timely manner. So, there would have been focus from HSCB on our performance as well.

18 Q. Just in relation to the issue of sanction or any feedback from a commissioning perspective, was there any response from the HSCB if targets or performance were consistently not met? 10:09

A. They would have tried to look at other -- you know, there would have been site specific groups set up. For example, in urology there was an implementation group. But I would not have been at that, I would not have had sight of the discussions that would have taken place at those meetings. Across tumour sites, there would have been meetings with boards to see how they could, you know, look at performance and improve it. 10:10

19 Q. In relation to clinical nurse specialists or cancer nurse specialists -- and just before I ask the question, you have set out in your statement that there is a difference between those; they're not interchangeable, the names, cancer nurse specialists are specific for Cancer Services. That is something that welcome on to discuss, about you seeking funding for -- 10:10

A. Hmm-mm.

20 Q. -- to ensure that Cancer Services were properly

resourced. In your role, did you have any oversight or management in relation to cancer nurses or clinical nurses?

A. Yes. In my role I was responsible for some tumour site specific cancer nurse specialists. However, in the context of this Inquiry, within urology I didn't. I suppose when I took up post in 2012, there weren't that many cancer nurse specialists across tumour sites. Some tumour sites didn't have any at all; some were single-handed. So within the NICaN cancer lead nurses forum, we tried to drive that forward. We actually were part of a cancer patient experience survey in 2015. As a result of that, patients were saying it was very clear that they had a better experience if they had a key worker and a clinical nurse specialist at the point of diagnosis. So, on the back of the cancer patient experience survey in 2015, we highlighted to the Health and Social Care Board that we were keen to try and recruit, and we championed that we wanted more clinical nurse specialists for cancer patients going forward. So, we approached Macmillan as well for some funding and were able to develop a bid for additional cancer nurse specialists. We scoped out across the region in various Trusts -- in all of the Trusts. We done a scoping table to see where we were, where our baseline was and where we needed to go. That, thankfully, was taken on board by the Health and Social Care Board and we expanded that over a five-year plan, starting from 2016. It was a tapered funding model,

10:10 10:11 10:11 10:11 10:12

and that was the first type of funding of its kind. We did roll it out. I worked with heads of services across various specialties to scope out what their baseline was and where they felt they needed to go over the next five years. 10:12

21 Q. Well, you have given us a lot of information in that answer. If I could just break it down slightly so we can highlight the stops along the way chronologically.

So, the 2015 patient survey highlighted the importance of the role of the cancer nurse specialists in the patient's pathway. That triggered then the 2016 request, I think to Macmillan, for co-funding for cancer nurse specialists. I think you said that you were also responsible for mapping out within the service the particular need for cancer nurse specialists throughout Cancer Services so you could identify where those posts may most helpfully be placed. 10:13 10:13

As part of that, that was something that was worked on with the board -- sorry, the Health and Social Care Board, and the Public Health Agency?

A. That's correct, yeah.

22 Q. And they were on board with that. 10:13

You said something about funding in relation to that. Was this going to be a recurrent funding post or was this going to be time-limited at that time?

A. No. So, the funding was a tapered funding model where Macmillan done the initial pick-up and then, over the years, it rolled into pick-up by the Health and Social Care Board. Those were recurrently funded beyond that point. So, they were all recurrently funded; that was the agreed model.

23 Q. So, the Board's commitment was to pick up when the Macmillan funding ended?

A. Yeah.

24 Q. And this was around 2016? 10:14

A. That's correct.

25 Q. Now, there were nurses employed around that time within Urology Services. I do not know whether you've heard the evidence of any of the nurses who gave evidence, Leanne McCourt at Kate O'Neill? Were you able to hear 10:15 that evidence? You were?

A. I was, yeah.

26 Q. And Leanne McCourt explained that she had applied for a clinical nurse specialist post as then, in 2016, which, as was explained to her because of, I think, a missing 10:15 aspect or an element of the job description, was incorrect; it became a clinical sister's post and a charge nurse post. Now, those seem to be the same sort of jobs that you're speaking about, the funding for that came from Macmillan. Were you involved at all in 10:15 that process?

A. No. I shared job descriptions as part of -- you know, within the Cancer Manager Lead Nurse Forum, the NICaN Lead Nurse Forum, we worked up job descriptions in that

forum and agreed them and signed them off. Obviously because Northern Ireland's a small place, nurses moved across Trusts; they moved, you know, to similar posts, so we wanted consistency. Those job descriptions were worked up and signed off at that forum. I shared those with the head of service to go ahead and appoint and recruit into the... But I wasn't aware of the interview process or what happened until I heard it in the evidence.

27 Q. So, just so the Panel is clear, the funding that you have secured or assisted in securing through Macmillan, the match funding that was ultimately going to be paid by the Board, is the same posts that were advertised for urology in 2016? 10:16

A. I would believe that would be the case, yeah. 10:16

28 Q. I just want to give you the opportunity to comment on Mrs. Corrigan's explanation for that to see if it is in any way familiar to you. If we could go to WIT-26197, this is Mrs. Corrigan's Section 21 reply on the nurse specialist issue. This is paragraph 16.3B. So I'll just read these points. It's B1 to 5. This is one of the aims that Mrs. Corrigan had in relation to urology in order to increase the workforce. 10:17

The clinical nurse specialist was to increase from two to four clinical nurse specialists. She says: 10:17

"In 2009 there were two clinical nurse specialists in post, Kate O'Neill and Jenny McMahon. The plan from

the review, which was the initial 2009 review, was to recruit a further two nurses who were to be aligned to cancer as per the review. It was also stated in the review that this would be taken forward by NICaN during January-March 2011, which meant that the Trust couldn't move to recruit for those two posts until this had finished." 10:18

Now, this is before your time, you came in in 2012. She then says: 10:18

"As head of service, I was not involved in this process and this was under the remit of Head of Cancer Services, Alison Porter and then Fiona Reddick, who both reported to Ronan Carroll, Assistant Director, from 2009 to 2016, and then to Heather Trouton from 2016 to 2018, and then to Barry Conway from 2018 to now. So, for this process I had no influence to speed it up, which, from a personal perspective, I felt did cause issues for the operational aspect of the service in that whilst I operationally managed the clinical nurse specialists, I had no influence over how and when they would be appointed. 10:18 10:18

In October 2014, whilst still waiting on the decision on the cancer clinical nurse specialists, I prepared and presented a paper to Mrs. Burns, Interim Director of Acute Services, in which I requested that we would appoint two Band 6 nurses so that we could start to 10:19

train them up to become specialist nurses. There were no Band 6 qualified or with the experience to become Band 7s. Funding for this proposal was going to go at risk, but I presented that these were needed to assist in tackling the increasing waiting times for outpatient appointments. Mrs. Burns agreed to go at risk with these posts and we temporarily appointed two members of staff, who were substantive Band 5s, to these and then we backfilled their posts into the unit. To note, both of these Band 6s have taken in Band 7 clinical nurse specialist roles, Leanne McCourt and Jason Young. 10:19 10:19

Furthermore, in 2020, the clinical specialist nurses have increased to five members of staff. However, the key issue here is that it took from 2009, when the recommendation was made, until 2020 when there were finally five clinical nurse specialists in post." 10:20

I just want to go back up to paragraph 4, I think it is. Paragraph 3. Now, you're mentioned in there obviously as the Head of Cancer Services, we know, from 2012. We can see from Mrs. Corrigan's statement that she expresses that she had no influence to speed up the process. Now, from your perspective in 2016, from the 2015 patient survey in 2016, did you feel that the process was unduly slow in achieving the funding from Macmillan and the buy-in from the Board and the PHA? 10:20 10:20

A. It is. When we're seeking funding, it can be a very slow process. We submit bids all the time, and it

can -- from the time you actually submit that bid to you actually get recurrent funding agreed, it can be a very slow process. In recent years we tend to get nonrecurrent funding for time-limited. You know, we get time-limited funding, which is very difficult to recruit into. You know, people want permanent posts. From experience, it can be a slow process.

But this is one route. The Macmillan funding was one route to seek funding to expand the cancer nurse specialist nursing workforce. So, you know, there are various routes that funding can be sought through, but this was one route that we, as cancer managers, took forward on the back of the cancer patient experience survey. 10:21 10:22

29 Q. Was that for one post, the Macmillan post?
A. No, that was in -- sorry, in Urology?
30 Q. Yes. Was it for two or one?
A. One post.
31 Q. One post? 10:22
A. Yes. It was one Band 7 post that was agreed.
32 Q. So when Mrs. Corrigan is speaking about October 2014, preparing a paper for Mrs. Burns, this was in advance of your seeking funding?
A. Yes. 10:22
33 Q. Did this all dovetail at one stage, because it sounds like two different processes?
A. I would not have been aware of the 2014 process with Ms. Burns. I wasn't aware of that happening.

34 Q. But it was your expectation that when the funding was received for that post, a cancer nurse specialist would be appointed?

A. Yes, that's right.

35 Q. Now, before we got into the issue of the funding for the post, we were talking about the management of the CNS within Cancer Services. Urology sits within the surgical management rather than in Cancer Services? 10:22

A. That's correct.

36 Q. Has that historically been the case, that urology and I think lung as well sits within the Surgical Directorate, does it? 10:23

A. Urology sits, and head and neck sits within the Surgical Services. Breast used to sit under my remit, I did manage the breast symptomatic service at a point in time. But that was moved in, I think it was 2016. At that time the breast care nurses then went under the surgical remit as well. So, for most other cancer nurse specialists, they sit under my remit, for example, haematology, acute oncology, lung, gynae. 10:23

37 Q. From a governance perspective, what's the difference between services that sit under your remit and those that do not, from your perspective?

A. I suppose from a governance perspective, I can monitor what the nurses are doing, what their activity's like. 10:24 We monitor their key performance indicators; that obviously patients that are on a cancer pathway have access to a key worker, that they have holistic needs assessments carried out. Some of the nurses would do

independent clinics, and some have progressed on to more advanced roles where they would free up consultants to see more complex cases.

So, you know, I suppose I have more ownership of those nurses and I can see what their performance is like and, you know, see how they're developing through their career. Some have progressed on. We actually were the first Trust to actually progress on with advanced nurse practitioners. So, they are working at a very independent level now. I think that has been very beneficial because we know that there's lots of waiting lists, and it has made great inroads to tackle waiting lists. I think that's something that we, you know, really want to move forward with and develop nurses to more expanded roles in the future. 10:24 10:24 10:25

38 Q. Obviously one of the issues for the Panel is to look at the allocation of key worker to patients on the pathway. When you speak of monitoring the ones under your remit, you know, the nurses and whether they're allocated or who the key worker is, is that something you've always done or is that a relatively new audit that's carried out now as a result of what's happened? 10:25

A. For the nurse that I'm responsible for, that would be a fairly new concept in line with the cancer nurse specialist workforce expansion plan that was agreed when nurses came into post, because bearing in mind some specialties didn't have any cancer nurse specialists at all, and some had, some were 10:25

single-handed. The key performance indicators were signed off at the NICaN Nurse Leaders Forum that that's something that we would want to monitor going forward, and on the back of the cancer patient experience survey, that patients did have access and were seen by a key worker.

39 Q. What year was that?

A. So, the start of the expansion was 2016.

40 Q. So it's something that has already been done for the past seven years? 10:26

A. Well, I would say probably more like five years.

41 Q. Five years?

A. By the time we got recruitment done and nurses trained up. Because a lot of the nurses were coming from Band 5 posts that would not have been doing some elements of the -- so, by the time they were trained up, it's more like 2018.

42 Q. From 2018 then, the KPI for the allocation of key workers has been something that's been monitored within services under your remit? 10:27

A. Yeah.

43 Q. Do you think that that is a flaw in where Urology and others sit, that there's not a standardised approach to issues such as KPIs for key workers?

A. I think the Trust is trying to move forward with that across tumour sites and have a Cancer Nurse Specialist Forum, you know, that we are consistent across the Board, no matter where nurses sit operationally. I think it's something that we -- there's more work to be

done with.

44 Q. I'll ask you it in a slightly different way then. Do you think if Urology had sat within your remit from 2018, you would have been able to identify that key workers had not been allocated? 10:27

A. Potentially.

45 Q. Do you miss any at the moment in the services under your remit? Have you identified any key workers not being allocated under any of the services you're responsible for as being an issue? 10:28

A. Not at the moment but that is an ongoing, you know, measure. I suppose, you know, there's always the risk that staff go off for one reason or another. It may not always be 100% but we try to make it that way.

46 Q. So any you've seen have been more blips in the system rather than systemic? 10:28

A. Yes.

47 Q. Just while we're on the issue of standardisation in approach, within your remit, the areas that you cover, is there a standard way in which clinical nurse specialists or cancer nurse specialists operate when they need to attend to a patient? For example, is there any priority given to people with first diagnosis that there must be a nurse around? Is there any priority given to patients if it's known that they're going to have complicated treatment pathways explained? 10:28 10:29

Does any of that currently exist to ensure that the patient does have someone there, no matter what?

A. It depends. I suppose now, you know, patients are given diagnosis at various places. Very often cancer patients are given a diagnosis in the Emergency Department. Some -- you know, obviously we have now the rapid diagnostic centres; we have outpatients. 10:29
Patients do not always get, you know, their diagnosis given at an outpatient clinic where there's a clinical nurse specialist present. However, we've done a lot of work working with Outpatient Departments, Emergency Departments, where there's some information, and then a 10:29
note is taken to give to the cancer nurse specialists. At that point then, the cancer nurse specialist would try and pick up with the patient and give them some more information and see them, you know, further along their journey. 10:30

We also have a health and wellbeing information centre at the front of the hospital. That's also been funded by Macmillan. We would find a lot of patients would call in there and get basic information. We try and -- 10:30
you know, obviously the cancer nurse specialists are there as close to the point of diagnosis as possible to give core information about their treatment plan and their management plan. Then obviously the softer things like financial worries or fatigue or side-effect 10:30
information is given by others.

48 Q. Now, the change in profile in how people get information about their health care and cancer diagnosis, does that present a challenge for you in

delivering the service; that you can't be everywhere all at once, as you say, but the information comes in to a central point that you then know if people have been allocated key workers. That puts the emphasis then on the admin support that you have, the data that you receive. Is there a greater emphasis on other systems to allow you to know what's happening?

A. Yes. We have a function on our cancer pathway system, CaPPS - I'm sure you've heard that across the evidence - and there is a field on that to record that the patient has a key worker. So, there's a field there that we can monitor as well, that patients have been identified a key worker.

49 Q. And that's irrespective of what route they come into the Cancer Services from? 10:31

A. Yes.

50 Q. Now, from your own role in governance systems for reporting and escalating concerns, you had weekly one-to-one meetings with the assistant director?

A. That's correct. 10:32

51 Q. At the moment that's Mr. Conway?

A. Yes.

52 Q. Prior to that it was Heather Trouton?

A. Yes.

53 Q. I think she was 2016 to 2018? 10:32

A. That's right.

54 Q. Before that, it was Ronan Carroll?

A. Yes.

55 Q. At these one-to-one meetings, were these more high

level meetings about performance, staffing, or was it getting beneath the data and speaking about issues that might have been impacting on meeting targets? Give us a flavour of your one-to-one meetings with Mr. Conway or Mrs. Trouton or Mr. Carroll. 10:32

A. At those one-to-one meetings, we would look at services that I'm responsible for. We would touch on performance but the main area for discussing performance would be at our -- we would have weekly head of service meetings with our assistant director 10:33 and, over a four-week period, we would focus on one week would be performance, next week would be governance, next week would be finance, and then the other week would be ad hoc.

10:33

We would, you know, spend -- those head of service meetings would have lasted on average an hour and a half to two hours, so we would focus quite a bit of time on performance. Also governance. You know, if it was a governance week, we would look at our complaints, 10:33 our IR1s, our Datixes, and we would work through those and pick out key themes and, you know, update our risk registers, see what was on our risk registers. There would have been a lot of focus from Cancer Services, you know, we would look at our divisional risk 10:33 registers and our complaints.

56 Q. When you say weekly head of service meetings with the assistant director, would that have been with Mrs. Corrigan, yourself? No?

A. No. No, it would have been the heads of service within the cancer division. So, that would not have interfaced across with surgical.

57 Q. When did you interface with surgical? How did that happen? 10:34

A. That would have been at our monthly performance meeting. We would have went through our - and I think I did include one of the dashboard, the cancer dashboard, an example of that. That would have been a report that would have been shared and discussed and 10:34 went through in great detail at the monthly performance meetings. We would have went through the breach reports and cancer access targets across all specialties. All heads of services and assistant directors would have been at that forum. 10:34

58 Q. Was it your view that the weekly head of service meetings with those within your remit provided better communication and allowed a better flow of information?

A. Yes.

59 Q. You've said about communication in your Section 21 at 10:35 WIT-91011. At 18.1, you say -- the question asked of you was "Did you feel supported by staff within urology in carrying out your role"? You have said:

"Communication from the service was not always 10:35 forthcoming. I felt there could have been better communication with me when recruiting and appointing cancer nurse specialists". We'll talk about that. "There were delays in the appointment of nurses even

though I had secured funding. Feedback from the Urology Professional Implementation Group was limited."

There's a couple of examples in that paragraph of what you think are poor communication. Why do you think the communication was poor? 10:36

A. I honestly can't answer. I just felt that in those couple of situations, it probably could have been better so that there was openness and transparency interlinked between, you know, the specialty and Cancer Services. 10:36

60 Q. Was it a case of you trying to contact people and them not getting back to you, or them trying to contact you and you not getting back; or was no one trying to contact anyone else? 10:36

A. I think in those couple of instances, it just -- you know, I had secured the funding and it just felt like a long time -- you know, I'd shared the job descriptions, and it felt quite a long time from the funding was available to the actual nurses were in post. There was poor communication as to why the reasons were for that. 10:37

61 Q. And was that a source of frustration to you?

A. It was, yes.

62 Q. Did you consider the failure to properly appoint cancer nurse specialists when the funding was available something that had an impact on patient care and safety? 10:37

A. Yes, it potentially could have.

63 Q. If we go to WIT-91020, this is a reference to the key

performance indicator. Paragraph 36.1, just halfway down, the sentence begins "level" and then the sentence I want is "At those cancer performance meetings". Can you see it?

10:38

"At those cancer performance meetings, I had also highlighted to Martina Corrigan that urology patients should have a key worker urology cancer nurse specialists as part of a key performance indicator. I would have highlighted this in other services whose patients required a CNS."

10:38

Then you talk about the funding that you'd been successful in securing. You say:

10:38

"I was disappointed that this took so long to appoint. Indeed, I was surprised that I was not communicated with or involved in the recruitment of cancer nurse specialists for urology. This was kept within the surgical directorate."

10:38

Again, you have said communication with Cancer Services was not always forthcoming.

Do you think that the poor communication allowed problems to exist and persist, such as the ones that the Inquiry are looking at? Do you think the poor communication from Urology towards Cancer Services assisted in creating an environment where problems were

10:38

not dealt with?

A. I suppose I have used a couple of examples here that I was aware of.

64 Q. Well, you were aware of the issues around Mr. O'Brien and triage from 2015, I think? Do you recall that? 10:39

A. Yes. In regard to red flag triage, yes.

65 Q. I know that's not one of the examples that you've referred to but if I go back to my initial question. When you saw those emails -- and I'll give the Panel the note for the emails. 2015-2016, referring to 10:39 Mr. O'Brien, referring to triage, referring to referral, referring to the build-up of patients who were not coming through the system and representing a blockage to get through the care pathway. Did you think that the failure for that information to be 10:40 properly communicated to you allowed problems to persist in Urology?

A. Probably, in hindsight, if it had have been more joined up communication, that everything was together, it probably would have dealt with things at a much earlier 10:40 time.

66 Q. Well, if those problems were arising in one of the areas which falls within your remit, what would you have done? If you were getting emails saying patients aren't being triaged, there's delay; if that was under 10:40 one of the other services that you cover, what would your role have allowed you to do about that?

A. Our escalation process. So, you know, we would have been escalating that back to the service where there

were delays. So, those escalations were happening.

67 Q. We'll just go to some of the emails now so the Panel has the note. WIT-14651. This is an email from Wendy Clayton on 28th January 2015 to Ronan Carroll and you, copying in Vicki Graham. It says: 10:41

"Hi, I have met with Vicki re: Urology escalations. We are going to continue e-mailing the Urology PTLs twice weekly highlighting action required and risks. Vicki is going to attend the beginning of the Urology MDM to 10:41 ensure the trackers are highlighting escalations, patients requiring dates for surgery."

Then under "Outstanding Issues", it says: 10:42

"AOB issues with triage. However, Debbie has given Martina to the end of day to revolve. Longest waiter, 23 days. Vicki or I will continue to escalate individual risks to consultants. Martina will copy you in. Regards, Wendy." 10:42

Do you recall these emails? Do you recall seeing them at the time?

A. Yes, I do. Yes.

68 Q. Then WIT-14660. This is an email from Martina Corrigan 10:42 on 1st February 2015. It's to Wendy Clayton and you're copied in, as is Mr. Carroll. The subject: Red flag triage.

"Hi Wendy, I am conscious we have had an issue with Mr. O'Brien and the delay in returning his triage. I am aware that he is the only consultant that there is a delay in getting the triage returned. I have had numerous conversations with some of the Urology team and we are going to raise this at our meeting next Thursday. In order to present the problem, I have been asked to have some information available for the meeting in that they want to find out what the turnaround time is for all the consultants. That is so we can show Mr. O'Brien that he is the only problem. Can you provide me with this information, even from the beginning of November which is when we moved to Consultant of the Week". 10:43 10:43

Then she's on leave until Wednesday. So, this information was going to you and Mr. Carroll?

A. Yes, that's right.

69 Q. You're saying that, so we understand the governance routes, because Martina Corrigan was the Head of Service within Urology, there was no one for you to escalate it to because she was actually dealing with the issue? 10:44

A. Yes. She wanted, you know -- my perception of that email is, you know, she was dealing with it at specialty level; she was having a meeting. I note there that her assistant director wasn't copied into that email. But, you know, she was wanting the information from Cancer Services to take back to the 10:44

meeting.

70 Q. When you say you note the assistant director wasn't copied in, why do you say that?

A. From an escalation point of view, that would be our process, that, you know, your assistant director is copied into that as well. 10:44

71 Q. A further email at WIT-14680. These are further emails back and forth. I think we'll go down just to the bottom. Vicki Graham to Martina Corrigan. You're not CC-ed into this one but you are CC-ed into the subsequent replies. "Missing urology RF referrals from triage". Vicki Graham says: 10:45

"Hi Martina. Please see below list of patients whose referrals have not still been triaged. The date of these referrals date back to last Wednesday and Thursday." 10:45

You will see just at the top of that page the reply that you and Mr. Carroll are subsequently copied into? 10:45

A. Yes.

72 Q. Then January 2016, WIT-14684. At the bottom of the page, it says from Angela Muldrew to Martina Corrigan and copies then to Wendy Clayton. Again, you're going to be copied into the reply. It says: 10:46

"Hi. See below referrals that we have not received back from triage. Could you please chase this up for us?"

The email just above that on 6th January 2016 copies you and Mr. Carroll in. Wendy Clayton says:

"Who is on triage? If nothing back tomorrow, can you ask one of the other consultants to triage, please." 10:46

Then Ronan Carroll says "Martina, can we leave with you to resolve, please?"

10:46

Did you ever speak to Mr. Carroll about this issue?

A. Yes, we were well aware of it. You know, this would have been discussed at cancer performance meetings. It's difficult, because you escalate back to the specialty and it's not our remit to work directly with 10:46 the clinicians. There is a process, you know, to work directly with them if there is an issue highlighted. So, the issue was highlighted from Cancer Services but it was out of our control to actually deal with it.

73 Q. Those emails, a snapshot over a period over January 10:47 2015 for a year through to January 2016, and it's a significant period of time and the same issue is coming up again and again. Was that something that you ever brought to the HSCB or to any other source to inform them that there was an underlying problem as to why 10:47 targets weren't being met in some cases?

A. No, I personally didn't take it to the HSCB. I'm not sure if -- I can't answer you if the Urology Service took it in any way or gave an early alert. I am not

aware of that.

74 Q. Or Mr. Carroll?

A. Or Mr. Carroll. I'm not aware of that.

75 Q. Do you think it might have been something that they should have been informed about, that there was an issue underneath the figures that was rumbling on and had not been dealt with? 10:48

A. Yes. Potentially, yeah.

76 Q. Well, when you say potentially, do you mean that it may have been, they may have been told or they may not, or do you think they should have been told? 10:48

A. I think they should have been told but I'm not aware if they were or weren't, in my role.

77 Q. Now, there seems to have been, if I can say, quite a few opportunities to communicate with others. You have mentioned some of the meetings, the weekly meetings, head of service weekly meetings with your AD. There was a Trust monthly cancer performance meeting that you have referred to at your statement at WIT-19010. This was a meeting where all specialties were invited and minutes, agenda and dashboard were shared. At paragraph 15.1, you say: 10:48 10:49

"From a cancer perspective we held a Trust monthly cancer performance meeting where all specialties were invited and minutes, agenda and a dashboard were shared. Martina Corrigan, Head of Service For Urology, attended these meetings and would have always received the documents. The Urology MDT was also peer reviewed 10:49

and the findings of this were shared with Martina Corrigan, Ronan Carroll, Heather Trouton and myself via the Chief Executive and also to the HSCB."

Just before we look at the peer review, when you say that Martina Corrigan attended these meetings and would have always received the documents, are you saying that she would have known exactly what the performance figures were for her specialty? 10:49

A. Yes. 10:50

78 Q. The peer review of Urology MDT, is that the review that was carried out in 2015?

A. I think it was 2017.

79 Q. 2017. You reference a peer review in a paragraph in your statement I would like to go to as well, when you talk about risk to patients. It's at WIT-91011, paragraph 17.1. You say this: 10:50

"I highlighted on many occasions at cancer performance meetings the risk to patients who had a suspect cancer and who were delayed in getting an appointment to be seen and commenced on a first definitive treatment within 62 days. I worked with the Urology MDT in order to prepare and be peer reviewed in October 2017. The serious concerns raised during this assessment were escalated by myself for including on the Acute Directorate Risk Register." 10:51

Then you say you secured the funding via Macmillan and

the HSCB Cancer Nurse Specialist Workforce Expansion Plan for an additional urology nurse specialist, and there were delays in getting this appointed.

Just a couple of things in that paragraph. When you say "I highlighted on many occasions the risk to patients", over what period of time and roughly how often did you highlight it? 10:51

A. The risks would have been noted on our dashboard on a monthly basis, you know, risks like first appointments, if we had delays in various investigations along the pathway. You know, we would have examined the breach reports, so the reasons why patients were delayed were clearly on the breach reports and they were all, you know, those were shared widely. 10:52

80 Q. So the data was there --

A. Yes.

81 Q. -- that supported that. Did you feel a sense of professional frustration that because Urology sat outside your boundaries, you couldn't get to the bottom of some of the reasons why performance targets weren't being met? 10:52

A. Yes, it is frustrating. Yes.

82 Q. Now, the peer review in October 2017, you have said that the concerns raised in that, you put in the acute directorate. We can have a look at a couple of documents that highlight that you did escalate the issue. Now, the peer review was in October 2017, and the serious concerns you've set out in your updated 10:52

information of May 2018. We can look at that at WIT-91043. This is a document -- is this a document you completed?

A. Yes. This was an action plan completed on the back of the serious concerns that were raised.

83 Q. This was updated in May 2018. Can I just ask before we go to May 2018, do you have any knowledge of what happened after the peer review when these serious concerns were highlighted in October 2017? Was there any action taken at that point?

A. Yes. From a point of view of the oncologist gaps and the radiologist, unfortunately at that time we did have deficits in Oncology. The Oncology Services obviously, it's like a hub and spoke model, the Cancer Centre was in Belfast and the oncologist came out from the Cancer Centre to the units. At that time, 2015, there was a regional roll-out of acute oncology consultants. We also were preparing to open the Northwest Cancer Centre, and there just wasn't enough oncologists to meet all of those needs. That was highlighted various times to Health and Social Care Board. Indeed, there was oncology pressures meetings regularly to see how we could cover the demand for services, and there just wasn't enough cover to meet all of the demands from a clinic provision, acute oncology, to MDT cover. There were gaps. Those were well recognised at department level.

We did have then a piece of work started in 2018 led by

the Health and Social Care Board, looking at oncology transformation and how we could try to bridge some of the gaps. That was a huge piece of work and there were lots of deficits. There was also a paper shared by the Health and Social Care Board where Cancer Research UK done a scoping exercise looking at how we could actually make our MDTs more effective. There were a few workshops here where there was suggestions looking at protocolised discussions, and we were talking about piloting some of that. However, that never really was taken forward; it didn't really go anywhere. 10:55 10:56

We were trying and we were escalating and we were trying to actually see how we could improve the quoracy within MDT. So, there were lots of regional discussions to try and address some of the gaps. 10:56

84 Q. If we just look at this plan again that's completed just seven months after the peer review. There's four serious concerns on it; three are of interest for our purposes. The first one is "No cover in place for the clinical oncologists and the consultant radiologist." 10:56

The update of May 2018:

"Clinical oncology representation core and cover provided through the regional oncology centre when possible but it is not the same person each time and is still not consistent. For consultant radiology representation, no cover for the radiologists, though 10:57

an expression of interest is being developed to recruit an additional radiologist with urology interests and expertise."

The Inquiry will hear this afternoon from Marc Williams, a radiologist, on the particular issues he experienced. 10:57

The second point is the quoracy is low due to low clinical oncology and radiology attendance. It had been, in October 2017, 25% attendance and it was now 11% by May 2018. You say that only five meetings were quorate throughout 2017 and it is perceived that this has decreased even further. 10:57

10:58

"Therefore, more patients are not benefiting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision-making process and treatment. 10:58

3. Long waits for routine referrals. Due to increasing number of referrals, services concentrating resource on meeting red flags and urgent demand. Routine referral waiting times have increased from 52 weeks to 128 weeks, present day. Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded." 10:58

The Inquiry has heard evidence that routine referrals, sitting back, not getting priority because of the red flag in urgent referrals, posed a risk to patient safety. I presume that's something that you would agree with?

A. Yes.

85 Q. In relation to the quoracy, you have identified there delays in decision-making processes in treatment. So, the level of oversight that perhaps is anticipated by full attendance at MDT for Cancer Services is absent if quoracy is not met and the right people aren't round the table? 10:59

A. That's right.

86 Q. Now, you had a role in MDT in terms of linking in with the specialties and their heads of service and their ADs. In that role, did Urology sit outside that because it wasn't in your remit, or did you also cover that within Urology MDTs? 10:59

A. No. There was interface. You know, we had interface. This action plan would have been shared because obviously there were things that were the responsibility of Cancer and Clinical Services, for example the oncologists and radiologists cover. However, you know, the waits was back to service, it was back to the Urology Service. That was out with our control, how we would deal with that. That's why the action plan was collated, you know, and all the serious concerns were brought together to see how they could be addressed collectively. 10:59 11:00

87 Q. You've also said:

"The issues of quoracy in oncology and radiology was escalated by myself under the Acute Directorate Risk Register and raised regionally with the Health and Social Care Board." 11:00

A. That's correct.

88 Q. So, were the Board aware that it was on the risk register or is that two separate things?

A. The Board would have been aware. In fact, it was the Board that funded the peer review process from 2014. So, any of the serious concerns actually would come back down through the Board to the Trust Chief Executive. That's, you know, any of the reports coming and arising out of peer review process would have gone directly to the Board before coming out to Trusts. 11:00

89 Q. The Health and Social Care Board?

A. Yes.

90 Q. Not the Trust Board?

A. No, the Health and Social Care Board. 11:01

91 Q. You have updated the risk assessment. We'll just see that. Just two pages on, I think, from that one, 45. This is an email from you on 16th December 2019 to Vivienne Toal and Barry Conway. You say:

"Hi Vivienne, please find attached updated risk assessment for Urology MDT to replace risks 3728. Regards, Fiona." 11:01

So, that was done in 2019. Had there been an updated risk assessment reflected on the Acute Directorate Register in 2017 or 2018 when the peer review findings were made?

A. No, because the action plan -- the process would have been to look at the action plan first to see what we could do before raising those risks on the risk register. 11:02

92 Q. The delay between the May 2018 action plan and updating the risk register in December 2019, a year and a half, would that be a normal lead-in time before you would mark something up as a risk? 11:02

A. No, it probably should have been reviewed. Unfortunately, I had a period off at that point, so there probably was a gap in having that reviewed. 11:02

93 Q. My question was just to try and understand the system, if the Trust do things periodically. I'm assuming if something is identified as a risk, best practice would mean that someone reports it as a risk on the register. Would that be a fair enough assumption on my part? 11:02

A. Yes.

94 Q. There are some figures. I just want to give the Inquiry Panel a note of some peer reviews rather than go to them. There was a peer review visit report from 2015 indicating a self-assessment of 70% for MDT and the peer review came in at 35%. That can be found at AOB-78513. Then subsequent to that, there was a 2017 self-assessment of 55%, which was upheld on peer review. That is AOB-78607. 11:03

I would like to go to AOB-78606. This is an email of 6th January 2017 - I'm hoping - from you to Ronan Carroll, Wendy Clayton, Martina Corrigan, Anthony Glackin, Mark Haynes, and Mr. O'Brien. Heather Trouton is copied in. Subject, Urology MDT Peer Review. 11:04

"Dear all, please find attached the external validation report from the recent validation process required for Urology peer review for circulation amongst all members of the Urology MDT. This year Urology MDT were required to undertake a self-assessment which was then externally validated by the National Peer Review Team. We have been advised by HSCB that when MDTs are self-assessing, that the feedback from National Peer Review Team will be directly uploaded onto CQUINS rather than a formal feedback report coming into Trust via the Chief Executive. As you can see, the overall self-assessment score achieved 55%, and this score of 55% was maintained by the external team. The National Peer Review Team have indicated that the Urology MDT will have to undertake a self-assessment again in September 2017, and Mary Haughey will continue to work with the Urology MDT to prepare for this process." 11:04 11:05 11:05

Just stopping there for a moment, is there a reason why Urology had to undertake the self-assessment again at that point?

A. The National Peer Review Team, depending on what

concerns were raised, they were the ones who indicated whether we needed to have a formal visit or a self-assessment. They indicated that on the back of what the previous report highlighted.

95 Q. What is then indicating that Urology have to undertake a self-assessment again; what is the reason for that? 11:06

A. I would imagine it's probably because our overall assessment score achieved 55, they wanted to review that again to see if things had improved or went the other way. 11:06

96 Q. Okay. The last paragraph:

"I'm conscious that at a business meeting prior to Christmas leave that concerns were expressed by members re inadequate quoracy of the MDT, particularly for radiology and oncology. I have escalated the concerns to Professor O'Sullivan, Clinical Director Cancer Centre, and we are due to meet Tuesday, 10th January to agree improved representation for oncology input. Dr. Gracey is aware of concerns re radiology. We will continue to attend Urology business meetings as requested." 11:06 11:07

Now, it's clear there that there are two avenues of trying to sort out the quoracy issue for oncology and radiology. One of them was to meet with Professor O'Sullivan. Did you have that meeting with Professor O'Sullivan, do you recall? 11:07

A. Yeah. Can you just scroll down to see the date of that

email, sorry? Yes, that was 2017. Subsequently, yes, the meeting happened but then subsequently, you know, there were other ongoing challenges within the Oncology Service across the region so that, on the back of that, there were pressures -- oncology pressures meetings established. Then, it was a regional forum where all Trusts were brought together to highlight where the gaps were. There was a scoping exercise to see where the gaps were across the board. On the back of that then, the Health and Social Care Board instigated the oncology transformation piece of work. 11:07 11:08

97 Q. And the result of that was?

A. Oncology transformation? So we looked at -- we had some -- from an MDT point of view, we did have an improvement where some of the oncologists tried to link in from the centre to our MDTs. Then, we appointed an acute oncology consultant with an interest in lung and urology. So, he has been in the Trust - sorry, I don't have the exact date. But that did highlight improvement. So, from an oncology perspective, there were pieces of work happening to try and improve oncology representation at MDT. 11:08 11:08

98 Q. It was a matter of people working together to try and find workarounds to cover oncology for MDTs?

A. Yeah. 11:09

99 Q. "And Dr. Gracey is aware of the concerns re radiology."

Do you recall what was done in 2017 around that?

A. I'm not close to radiology, and perhaps Marc will be able to explain that in the afternoon. I know that David did, at times, do workarounds and link in, you know, from leave and that. I'm not close, but you'll probably get more detail from Marc around that. 11:09

100 Q. There's just another email at WIT-57926. This is from Anthony Glackin to Ronan Carroll, Wendy Clayton, Martina Corrigan, Mark Haynes, Mr. O'Brien. It's on 16th January 2017. He writes: 11:10

"Dear Fiona, can I meet with you to discuss ongoing problems with quoracy at the urology cancer MDM, the urologists are coming to the view that this meeting is no longer sustainable in view of the pressures on our single-handed radiologists and the infrequent oncology attendance. Kind regards, Tony." 11:10

So, that email illustrates the clinical impact and potential patient risk from the absence of quoracy. 11:10

I think your reply is just above that. You reply to everyone saying:

"Tony, yes, I understand that there has been, and are, ongoing challenges with quoracy at the Urology MDM. This has been escalated at HSCB level, particularly from an oncology perspective as the lung and GU Service is currently facing staffing issues. The Northwest Cancer Centre opened recently and recruitment of 11:10

oncologists there has depleted the service within Belfast Cancer Centre, and there currently is not the same in number of oncology registrars available to provide cover within clinics. Rory and I attended a meeting last week with colleagues within Belfast Trust and commissioners to explore options to address the current difficulties. I have highlighted that there is a risk that the Urology MDM here in Southern Health Trust is at a point where full quoracy is making it extremely difficult to function. We are due to meet again next Friday and hope to have potential solutions agreed by then. I am happy to meet with you in the meantime to discuss further." 11:11 11:11

You've mentioned in that email that the Northwest Cancer Service is now opened; you'd referred to it earlier in your evidence. At this point in January 2017, it had opened? 11:11

A. Yes, that's right.

101 Q. When had that opened, can you recall? Was it just before this? 11:12

A. Yes. It was just in or around - sorry, I don't have the specific date, but I know that it opened and in tandem with that there was an agreement to roll out an acute oncology consultant led service across Trusts, which further depleted oncology resource. I do recall at a meeting, the late Stephen Hall, who was my Associate Medical Director in Cancer Services in the Trust, and also a radiologist, he raised his concerns 11:12

back in 2015, you know, the difficulty that that would bring, trying to roll out an acute oncology consultant-led service in tandem with another cancer centre opening in the northwest, because there simply wasn't enough oncologists to deal with all aspects of the service.

102 Q. Within the context of a significant evidence base from 2015 of quoracy --

A. Yes.

103 Q. -- at MDTs. By your email, it seems clear that those expansions of services had a negative impact on the existing ones? 11:13

A. Yes.

104 Q. I wonder if we could take a break just at the moment, if that's okay? 11:13

CHAIR: Yes. We'll come back again then at 11:30.

THE INQUIRY THEN ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

11:14

CHAIR: Thank you, everyone.

MS. McMAHON: Ms. Reddick, just before we move onto the last two sections I want to ask you about, I had asked you about the funding secured through Macmillan that was going to be match-funded by the Board. I asked you were they paid for by the -- were they the posts that were advertised for Urology in 2016 and you said: "I would believe that would be the case at that point." 11:31

I just want, for the Panel's note and for everyone else, to identify three documents. We do not need to bring them up but I need to put them on record, and I'll speak to Mrs. Corrigan about them. I just want to note them at this point. For the Panel's note, it's WIT-94649, which is the HSCB and PHA funding document dated April 2016. Then WIT-94653, where it indicates that the additional Urology CNS will be in Phase 3. Then WIT-94651, where it's referenced that Phase 3 is 2018-2019. That's really just for our exploration, we've got your answer to the question. 11:31 11:32

You were initially involved in the SAI process, in the nine SAIs?

A. That's correct, yes. 11:32

105 Q. How did you come to be involved in that?

A. Well, it was during the Covid pandemic, and I literally got an invite into a virtual meeting from governance, the governance team in the Trust. And I wasn't -- it was put in my calendar and I wasn't aware of what actually the context of what the meeting was about. So, I linked in and then I discovered that I was being invited in as Head of Cancer Services to look at -- initially it was a few and then the numbers were growing as the meetings went on. 11:33 11:33

The context of me being there was, from a Cancer Services point of view, to look at MDTs and tracking and things like that. So, that was my understanding

but I wasn't given a clear explanation as to what the meeting was about or anything, so I went along with the process. It was quite difficult because at that time it was a big commitment and I already was working over my hours, trying to run Cancer Services and keep things flowing in the midst of a pandemic. Our chemotherapy service outpatient setting was very, very busy; it was busier than pre-pandemic because we were trying to give patients additional chemotherapy because of delays in access to theatre and surgery. There was an on-call commitment as well as part of my remit, which was very busy. So, it was an added pressure to my already busy workload. 11:33 11:34

106 Q. So, there was no preamble for you as to what the context was, you were copied into an email and you attended the meeting and that's when you found out? 11:34

A. Yes.

107 Q. Was that the meeting of 4th January 2021, or were you involved earlier than that?

A. No, it was earlier. I think it was late summer of 2020 whenever the process started. 11:34

108 Q. Had you had a few meetings by the time it came round to January 2021?

A. Yes. Yes.

109 Q. When you've described your role in that process, was there an expectation that with your experience, you would go and speak to individuals to find out the evidence base or get facts from them about what the situation was on the ground? 11:34

A. No. The only time I was asked to find out information was in regard to where the patients - those patients in the SAI process - were on their pathway at that moment of time. That was really the only time that I was asked to go away and discover additional information. 11:35

110 Q. So, was it the understanding from the outset of your involvement that Dr. Hughes would be the only person who spoke to others; had meetings with interested parties?

A. No, I wasn't -- that wasn't made clear to me but I discovered it then subsequently in the report. I felt that I didn't have the opportunity to -- as part of that SAI Panel, I was denied that opportunity to speak to others in tandem with Dr. Hughes. 11:35

111 Q. Do you know why that was? 11:36

A. I've no idea.

112 Q. Did you ever raise it with Dr. Hughes?

A. No.

113 Q. Did you know who he was going to speak to at any given time? Did he share that information with you? 11:36

A. It wasn't very clear who the individuals were that he was. It wasn't made clear.

114 Q. You have seen the findings of the SAI, the recommendations?

A. Yes. 11:36

115 Q. Do you think that your particular role may have contributed more to the investigation if you'd have been allowed to speak to people and undertake some of the investigatory work?

A. Yes. I think it would have been good to be involved in that discussion with others across, you know, specialties across the MDT. I think it would have been good to be part of that. If I was involved in the SAI Panel, it would have been good to actually fulfil that role.

116 Q. Had you ever attended MDTs with Mr. O'Brien being present at them?

A. Yes, I would have went to various MDTs. Indeed, Mr. O'Brien held the position as Chair for a period of time. As part of the peer review process, at times I would have went, you know, ad hoc. It wasn't, you know, planned, I just would have went if my diary allowed me to go.

117 Q. Did you have a particular experience of Mr. O'Brien at those MDTs, the way in which he interacted? Did you form a view or share that view?

A. I always found Mr. O'Brien to be very professional towards me and very courteous. When he held the position as Chair of the MDT, we worked together on peer review documents, along with Mary Haughey, my Service Improvement Lead, and he was always found to be very willing to work to get those documents ready and in preparation for peer review.

118 Q. I wonder if we could go to WIT-84769? I just want to get the introduction page so that the Panel knows the context. This is a note of a meeting held on Monday, 4th January 2021 to discuss the complaint regarding Mr. O'Brien. Present are Patricia Kingsnorth, you,

Patricia Thompson, Hugh Gilbert and Dermot Hughes. Then in attendance, Peter Rogers. Do you recall this meeting, first of all?

A. Yes.

119 Q. This was a meeting in which the individuals, their context was set out and there was sharing of information gathered or gleaned to date about each individual scenario. I do want to go to WIT-84769 again, please. Just at the bottom of the screen, you can see FR, just on the left, the sentence beginning "FR". Can you see that? 11:39 11:40

A. Yes.

120 Q. "FR voices how it is imperative to have good communication amongst MDT, which Mr. O'Brien neglected." 11:40

Now, FR, I presume, is the initials for you. Have you seen these notes at all before?

A. I've just seen them as part of this process in my evidence bundle. 11:40

121 Q. Just in the context of what you've said about Mr. O'Brien, is that a view you formed about Mr. O'Brien or do you agree that that note reflects your contribution?

A. I totally refute the word "neglected". I would not have used that. I know that's not part of my language, and particularly in health care that's quite a strong word. So, I would totally refute that I used the word "neglected". I probably made that comment, how it's 11:40

imperative to have good communication amongst MDT, but definitely I do not recall using the word "neglected".

122 Q. Is your recollection then that, in your mind, there's a full stop after the word "MDT", or do you recall going on to say anything at all after that? 11:41

A. I don't honestly recall what would have been said after that. It's probably -- I couldn't, you know, say that... I couldn't, you know -- I just don't recall what was said after that. But "neglected" wouldn't be a word that I would use in regard to a peer colleague. 11:41

123 Q. Is it your recollection that it was Mrs. Kingsnorth who took the notes to the meeting; do you recall that?

A. Sorry?

124 Q. Patricia Kingsnorth took the notes to the meeting. Do you recall she was the note-taker at this meeting? 11:41

A. Yes. Generally Patricia Kingsnorth took the notes at those meetings, yeah.

125 Q. And I think her process was she wrote everything down and then and typed it up subsequently. But you didn't get a copy to confirm that you were content with these notes at all at any point? 11:42

A. No.

126 Q. Now, in his evidence Dr. Hughes has commented on your involvement in the SAI process, because you ultimately moved away from that role. Do you recall when you stopped being involved? 11:42

A. I actually went off ill on, I think it was mid February, 14th or 15th February. I unfortunately went off for a period of time ill. So, at that point this

process wasn't completed.

127 Q. And did anyone take over your role from Cancer Services in this process?

A. I'm not sure of that.

128 Q. When you came back, things had moved on and the report was ultimately completed -- 11:42

A. Yes.

129 Q. -- not long after? I just want to --

A. Sorry, just coming back to your point. Did you ask did someone cover generally my role or in this process? 11:43

130 Q. Sorry, in this process.

A. I'm not aware how in the SAI if that was replaced or not.

131 Q. Sorry. I should have made that question clearer, sorry. 11:43

Dr. Hughes, in evidence, referenced your involvement. We do not need to go to this, just for the Panel's note, because I'll just read the relevant extracts. TRA-81786 from line 10. He said this: 11:43

"Fiona Reddick, I felt, had probably the biggest conflict of interest and I think she was placed in an invidious position and in retrospect perhaps it wasn't best. I think she was in a place where the service 11:43 that she was managing was being implicitly criticised. I think she probably found it stressful."

Do you agree with Dr. Hughes' view in that regard? Was

there a conflict of interest, and was your involvement stressful?

A. No, I don't think. In the context of the understanding of Cancer Services and how it works, I think it was useful to have me sit on the Panel. I don't believe there was a conflict. You know, I managed the MDT processes; peer review was there, the reports were there; you know, the issues have been highlighted and escalated on the back of that. So, I felt contextually that was useful for me to be on the Panel. 11:44

132 Q. Did Dr. Hughes ask you your experience of attending MDTs when Mr. O'Brien was present?

A. No.

133 Q. Did you ever offer your view on any of that?

A. No. 11:44

134 Q. Now, in relation to one potential issue of relevance for the Inquiry, there was some movement around jobs restructuring in March 2016. The Inquiry has heard evidence of individuals moving posts. There was some movement in Cancer Services. I want to just read the following paragraph in Barry Conway's Section 21. It's at WIT-23915. This is just to give a context of the way in which directorates moved under different, other headings. Whether that had any governance impact might be a matter of interest for the Panel. 11:45 11:45

At 70.3, Mr. Conway states:

"The integrated Maternity and Women's Health Division

was a standalone division from April 2007 up to March 2016, when the acute directorate was restructured by the Director of Acute Services at that time, Mrs. Esther Gishkori, and then Integrated Maternity and Women's Health was coupled with Cancer and Clinical Services in April 2016, creating the large division that I took over on 1st June 2018. Early in 2021, I escalated work pressures to the Director of Acute Services, Mrs. Melanie McClements, and she agreed with me that the division needed split in two. Mrs. McClements was supportive and she secured approval from the Chief Executive, Mr. Shane Devlin, to adjust the structure, and from 1st June 2021 Integrated Maternity and Women's Health reverted to being a standalone division, with Cancer and Clinical Services division becoming a smaller but still a busy division. In my view, the decision taken by Esther Gishkori in April 2016 to couple Cancer and Clinical Services with Integrated Maternity and Women's Health as a large acute division was a mistake." 11:46 11:46 11:46 11:47

Now, you were there at the time, you were obviously there from 2012 and, four years into your tenure, this restructuring occurred. Do you agree with Mr. Conway that that restructuring was a mistake? 11:47

A. Yes. I think that was a huge remit for an assistant director to carry. Integrated Maternity and Women's Health on its own is a very, very busy service, with lots of governance. You know, there's lots of --

there's enough there for probably two assistant directors, never mind one in its own right. So I think, yeah, I would agree with that statement.

135 Q. Mr. Conway took over that on 1st June 2018 but you were already in the midst of that change, did you see any change or impact, either positive or negative, in governance terms when that change took place -- 11:47

A. I think --

136 Q. -- in your role, from your perspective?

A. -- it was a very busy role and Barry Conway was doing his best to manage all aspects of that, but to take on those historic two divisions was quite a remit. 11:48

But from my point of view, our one-to-one meetings continued, our performance continued, Barry done his best and kept the momentum up that I was used to, and the meetings. So, I feel he done his best with very busy services. 11:48

137 Q. His increased role didn't have any impact on his accessibility to you? 11:48

A. No.

138 Q. We've heard of - this is the last section - on improvements and things that have changed, because obviously the Panel are interested, if they want to make recommendations on areas, in making ones that are helpful. You've talked about the quoracy issue and tracking, and the Panel have heard evidence on that. Mr. Conway, in his statement, updates us specifically in some of the developments. I just want to take you 11:48

through them because at the time of the statement it wasn't clear whether they had actually taken place, so you might be able to provide further information on that.

11:49

One of the things he does mention is that he now receives monthly reports showing how cancer MDTs are working. Is that something that you feed to him?

A. Yeah, so that's done. I suppose we always had really highlighted the need, and through the Cancer Peer Review Process we were highlighting to the Health and Social Care Board, the need for data managers within Trusts, and that's something that we've been highlighting for a number of years. Unfortunately, there was no funding to do that. I think obviously Cancer Services has grown, the demand has grown, the numbers are going rapidly upwards, there's now one in two people diagnosed with cancer. So, I don't believe the funding has went in tandem with that to bring in the additional resources to meet the needs of that.

11:49

11:49

11:50

We did highlight the need for data managers to monitor more of our MDTs and to pull the figures and to audit and to make that really meaningful information. On the back of the USI work, we have now recruited an audit person who runs reports randomly from each of the MDTs to look at how outcomes are taken forward and if they are. I think that's a very positive step forward.

11:50

We also have an MDT administrator, who helps -- works very closely with the trackers and coordinates those reports as well. Mary Haughey is our Service Improvement Lead, and she continues to work with all of the MDTs to standardise protocols and how patients are presented to them. So, that work is ongoing. So that's all beneficial.

139 Q. Well, just so I can tick off what Mr. Conway has said was going to happen and marry it with what you said has happened, the first thing he talks about in his statement - and for the Panel's note, WIT-23917, at 71.3. He says. 11:51

"The current Director, Mrs. Melanie McClements, appointed two additional Band 7 staff in August 2021 to support the assistant directors in matters relating to governance. More recently, Mrs. McClements has also approved the appointment of four Band 5 governance staff to provide additional governance support to the Acute divisions with an expected start date of October 2022." 11:51 11:51

Do you have familiarity if those posts have been filled?

A. Yes. 11:52

140 Q. They all have. Then he speaks about - and this is at the next paragraph, 71.4, for the Panel's note:

"Concerns about the lack of clinical audit and support

to the Cancer MDTs has been noted in the MDT annual reports, including for the Urology MDT. I raised this issue with the Director of Acute Services in May 2022 and approval was given to appoint a new post to provide clinical audit support to the Cancer MDTs. The recruitment process is under way and I hope the post holder will be in place by September 2022." 11:52

So it's a clinical audit support for cancer MDTs, that's what you -- 11:52

A. That's what I was referring to, yes.

141 Q. Just different names. Then he also says at paragraph 71.5:

"More generally, there continues to be a deficit in clinical audit capacity in the Trust. It is my understanding that work is ongoing to expand the Trust clinical audit team, which sits within the Medical Director's office. The Medical Director are best placed to provide more detail on this." 11:53 11:53

Would you be aware of those posts having been filled at all? They're more ancillary to Cancer Services, I think.

A. I'm not aware of those. 11:53

142 Q. Then at paragraph 71.7, he says:

"I believe the previous governance arrangements relating to the Cancer MDTs were not sufficiently

robust to identify the issues in Urology." "A cancer MDT administrator was appointed in January 2022. They are now leading on establishing robust governance arrangements around the cancer MDTs."

11:54

A. Yes.

143 Q. And that's in place. How effective are all of those posts, those additional posts, how effective are they in bolstering or reassuring you around governance?

A. Those are very effective, you know. They can run reports to give us an assurance that when decisions are made at MDT, that, you know, we can now monitor the outcomes and assure ourselves that those outcomes are actually happening. 11:54

144 Q. He does mention that the peer review process was stood down during Covid and, at the time of his statement, had not recommenced. Has that recommenced, do you know? 11:54

A. Not a formal commissioning of peer review or peer review visits; that isn't happening. However, in the absence of that, I think it's good practice to continue to monitor our MDTs against the measures that are there. So, you know, our service improvement will continue to monitor our quoracy, monitor key worker role. That work will continue to happen, even though it's not properly commissioned or we do not have formal site visits. 11:54 11:55

145 Q. Are there any other changes or improvements that I have not mentioned that you wish to tell the Panel about?

A. Well, obviously we've got additional tracking resource. We have highlighted the gaps in tracking for a number of years, again to the Health and Social Care Board. We put in bids for additional resource because our numbers had significantly increased from when cancer trackers were first appointed. So, we now have got recurrent funding, and the numbers have expanded of trackers, which is good, and tracking is more often up-to-date than not, which is positive. 11:55

146 Q. Is there anything else you'd like to add at this point to your evidence that perhaps I have not covered, I have not taken you to, or is there a point you'd like to make or any evidence you've heard that you do not agree with? 11:56

A. Well, I suppose we did do a lot of work across the region and developed a cancer strategy for the first time in many years, and the report came out in 2022. That does highlight a lot of the inefficiencies and things that we've talked about throughout this process, and obviously a lot of the improvements that we need to make across Cancer Services in the future, right from, you know, sending out health promotion messages right through when patients are diagnosed, their treatment and life after cancer. I think there's a lot of need for resources -- you know, for services to be properly resourced to fully meet the needs of cancer patients going forward. 11:56 11:56

147 Q. Just finally, does Urology still sit outside your remit?

A. It does.

148 Q. It still sits under the Surgical Directorate?

A. That's correct.

149 Q. The issues around communication that you report, and the evidence would suggest are substantiated, do they still exist, the problems with communication? 11:57

A. No. I feel this process has improved things significantly.

MS. McMAHON: Chair, I've no further questions.

CHAIR: Thank you, Ms. McMahon. I'm sorry, we can't release you just yet. There will be some more questions for you, Ms. Reddick. Mr. Hanbury. 11:57

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 11:57

MR. HANBURY: Thank you for your evidence so far. I just have a couple of other clinical things. The peer review was originally 2015, and then your main comments seem to sort of come in 2017/2018 when you added that to the risk register. Just a question: The red and the green categorisation, how did you categorise it red, and what information did you use to come to that? 11:57

A. So the red, you know, those would have been where I graded from the peer review team, that would have been their rag rating, and then we brought that into Trust. They would have, actually it was their -- you know, if it was immediate risk or serious concern, they were rag rated accordingly from the National Cancer Peer Review 11:58

team.

150 Q. So that was them, not you?

A. Yes, that's correct.

151 Q. In the same document, the compliance rate was 67%. Could you expand on that? What would it have been to get into the green category on the peer review? 11:58

A. So what was the percentage, sorry?

152 Q. 67%.

A. Of quoracy?

153 Q. No, it was the compliance from the peer review. 11:58

A. The overall compliance?

154 Q. Yes.

A. Generally, you know, that wouldn't be bad for an MDT. You know, a compliance report, that ideally wouldn't be a low report. I suppose we always aim to be over the 70 mark in compliance. 11:59

155 Q. So, the fact that it was in red was more the quoracy problems in your view, was it?

A. Yes.

156 Q. Okay. Sticking with that in a way, when you did escalate it to Professor O'Sullivan, the regional, and there seemed to be some movement in your recruitment with the lung and urology appointment, I remember that there was a problem with that person who was then busy on a Thursday afternoon with lung responsibilities? 11:59 11:59

A. Yes, that's correct.

157 Q. What happened next? There was a person in but a Thursday afternoons is only one of ten sessions in a week. Did someone go and say is there a different

session we could do?

A. From an oncology perspective, you know, they would be job planned in Belfast Trust. So, you know, that person would have moved things around to make the MDT attendance more doable. 12:00

158 Q. Then you've gone to all this trouble, a new person came and they were doing lung, not urology. That must have been --

A. Yeah.

159 Q. -- a huge frustration to you? 12:00

A. Yes.

160 Q. Did anything happen? Did anyone go and say can we move the MDT, can we move the clinic to make this happen in any circumstance?

A. Yes, we tried to resolve that. It's quite difficult because we then have another MDT; you know, we had the MDT on a Thursday afternoon. So that was difficult to jig things around because we have an earlier MDT on a Thursday. So, we did try options to make it work. 12:00

161 Q. But it never really happened? 12:00

A. No.

162 Q. Okay. Thank you.

There was Mr. Glackin's email saying that, in his opinion, holding an MDT really wasn't always very difficult, to quote him. Was there any guidance from the National Peer Review Team at a point to say actually, this is not working, we should stop? Did they come back to you with a -- 12:01

A. No, there was no guidance. To be honest, a lot of clinicians, not just in urology, felt sometimes that peer review was a tick box exercise because there were things out with our control that required commissioning that just wasn't forthcoming. So, there wasn't really any control from peer review to say no, don't do this any longer or, you know, stop it, it's not viable. There was no direction. 12:01

163 Q. Do you think, looking back, that might have been something that they should have done? 12:01

A. Yes, I think that would have been helpful. You know, we did explore working with the Cancer Centre to see, you know, if they could have taken on more of our urology. But all MDTs are, you know, they're just -- the numbers are so large and there's so many discussions. I think over recent years there's a lot more complex discussions, you know. What would have been a five-minute conversation before can now be 15/20 minutes. That hasn't really been taken into consideration as time has went on and as the years went on. There are a lot of patients with other comorbidities and other quite complex cases. 12:02

We did try to explore, you know, the Cancer Centre taking some of our MDT discussions, but it wasn't -- they were already fully filled to capacity with discussions in the centre as well. 12:02

164 Q. Okay. Just one last thing. You said on the CaPPS system, there was a field there that you can say a key

worker allocated yes or no. Is that a recent thing or was that in existence back in 2016?

A. It was in early existence but I think it's been utilised more now. The key workers would click that, and if they have had involvement, they have the -- you know, they have access to do that. I think that's useful.

165 Q. But that's not something you necessarily looked at --

A. No.

166 Q. -- at that time? 12:03

A. I suppose we were, you know -- in 2016 we were really just on a journey to expand our nursing workforce. Some tumour sites didn't have a cancer nurse specialist. It's been a work in progress and development as more cancer nurse specialists come on board. 12:03

167 Q. I share your frustration, having gone through all the effort of raising the money through Macmillan, and a lot of departments did this. Did you feel fit to sort of go around and shout a bit? You say you were frustrated. Did you... 12:03

A. You just keep chipping away and raising the message as much as you can at every forum.

168 Q. Again, looking back, do you think you could have been a bit more assertive in your view then, your actions? 12:04

A. Probably, yes.

MR. HANBURY: Okay. Thank you.

CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

DR. SWART: You mentioned the patient experience survey

back in 2015; has that been done on an annual basis since? I have not seen it in the documents. How do you get your information about patient experience from the cancer patients?

A. So, we do -- certainly within Cancer Services, that would be -- patient and public involvement is very much high on our agenda. However, you know, that can be limited when I don't manage specialties. 12:04

169 Q. But that national survey that was done?

A. So, the national survey was repeated in 2018 again. 12:04

170 Q. But it's not done every year?

A. No, it's not because it is a commissioned service and not --

171 Q. The barrier is money to that then, is it?

A. Yeah. There's a whole data protection process as well around that, you know, where lists have to be cleansed in case people have passed away. So, there is a lot of work behind that before it's sent out on a regional basis. And it is a commissioned service. 12:05

172 Q. So, you haven't been able to do that big one. Within specialties, are they doing their own cancer patient experience surveys? 12:05

A. Yes.

173 Q. Is that reported back to you or where does that go?

A. So, that would be reported back to the specialty, generally. The cancer nurse specialists would very much take a lead on that because they obviously know their patients well, and they would send out, you know -- from time to time they would, in tandem with 12:05

our cancer service improvement lead, they would send out 20, 30 random patient experience surveys, and then pull a report from that to see what the key issues or themes are.

174 Q. Is that one of the KPIs that you would follow for cancer nurse specialists? 12:05

A. Yes. Yes.

175 Q. You mentioned a range of KPIs. Do you ever see those KPIs for the cancer nurse specialists or does that go as well as? 12:06

A. For the nurses in my area of responsibility, yes.

176 Q. What are the recurring themes from that, if you had to summarise it for us? You know, they are doing a lot of very important work; are there some recurrent issues coming up from their KPIs that you have had to take on board in terms of making improvements, for example? 12:06

A. I think one of the KPIs is regularly doing a holistic needs assessment with patients. You know, yes, when patients have a diagnosis, they want to know what's happening to me, what's my treatment planned, how long can I expect this to last, and then obviously, you know, when patients get to the end of their treatment, we, at that point, try to do another holistic needs to see, do an end of treatment summary to see what the key issues are moving forward and how we can support those patients living with and beyond their cancer diagnosis. 12:06

177 Q. Does that go to a Trust committee on patient experience, or how do you --

A. Yes.

178 Q. -- report upwards on that?
A. So, that would go to our PPI Panel within the Trust.
179 Q. You've mentioned a lot about the Health and Social Care Board, you have not said much about the Trust Board. Do you feel for cancer it more or less goes directly to the Health and Social Care Board for action? How does that feel to you? 12:07
A. We had a NICaN Trust Board, of which our, you know, senior managers would have linked into. That, in recent times, has been changed. I felt that was a route as well for raising any issues. 12:07
180 Q. What about the Southern Health Care Trust Board itself; did you have any reporting structure through to that as far as you're aware?
A. That would have been higher than myself. I never would have been invited -- 12:07
181 Q. So, you had a direct relationship externally but not internally; would that be fair?
A. Well, my senior managers would have had that.
182 Q. But not for you? 12:08
A. Not for me personally.
183 Q. The peer review process. There was a formal peer review process in 2015, wasn't there?
A. Yes.
184 Q. Is it right that since then it's been largely self-assessment with some sort of external validation? I'm just trying to get an understanding of this. 12:08
A. That's correct, yeah.
185 Q. The external validation is done by who, exactly? Is it

a paper exercise by a central team or...

A. Yes, that's right, the National Peer Review Team. We would submit our papers and then they externally look at that and agree that our assessment is correct and that it marries up with what their assessment has been. 12:08

186 Q. Is there then a Trust-wide meeting to discuss how the peer review processes have gone for all the tumour sites? Is there an opportunity to bring that together with some senior Trust challenge of any sort?

A. Yes. So all our reports would go up right up to Chief Executive in the Trust. 12:09

187 Q. But is there a meeting where you can all sit around and discuss the challenges from peer review for this year?

A. Not as -- no, that generally would have been discussed at our cancer performance meetings. It would have tied into the agenda with that. 12:09

188 Q. Okay. In the cancer performance meetings, do you specifically focus on all the peer review problems?

A. Yes. Yes.

189 Q. And discuss how to solve those, or just escalate them? 12:09

A. We try to, you know, solve what we can.

190 Q. Hmm-mm.

A. However, if it's commissioning and resource, that can be difficult.

191 Q. Yes. You've talked a lot about escalation but I get a sense that most of the actions you feel are outside your own control. Would that be fair? 12:09

A. Yes. Some of them, yes.

192 Q. Can you think of any examples where you've had to

escalate something and you've been able to fix the problem yourself through your escalation and through finding the source of the problem?

A. I can't just think offhand, you know, now, of... but yes, yes. That, I suppose in my role, is very rewarding when you actually see something that you have escalated, that you get to an end point and you get --

193 Q. Because it must be very hard to always be pointing out the problems and not be able to fix them?

A. Yes. I suppose, to be fair, the cancer nurse specialist workforce expansion was beneficial. I did see, you know, the outcome of that was really good for patients. 12:10

194 Q. Now, you've got a background as a cancer nurse yourself in chemotherapy and all sorts of specialism. It must be quite difficult to be producing all of these breach reports with large numbers of patients waiting a long time and not understand the impact on patients. You must be aware of that. Have the Health and Social Care Board asked you to assess the harm to patients at any stage of these long waits? Has there been any emphasis on that? 12:10

A. No.

DR. SWART: Thank you.

CHAIR: Can I just be clear because it's perhaps my misunderstanding of the language used here, but it seemed to me that you talked a lot about escalation. To my mind, escalation is where you move something up to somebody more senior so that they can do something 12:11

about it. Sending it back to the head of service, to my mind, is really not escalation. Is that not just sort of, well, you know, this is your problem, you need to deal with it?

A. Do you mean the head of service within the specialty? 12:11

195 Q. Within Urology, yes.

A. Generally, whenever I was escalating any issue, that would have gone through to the operational support lead, to the head of service and the assistant director within that area. 12:11

196 Q. Of Surgery and Elective Care?

A. Yeah.

197 Q. So, when you say escalation, it wasn't just the head of service who was expected to sort it out; by escalation you mean, in this case it would have been Martina 12:12 Corrigan and her line managers?

A. Yes.

CHAIR: Okay. Thank you. I was obviously not clear in understanding what you meant by escalation.

A. Sorry. They have been schooled to be courteous as well 12:12 and to give people their place, you know, if they are head of service and go up the chain of service as such.

198 Q. You don't go over their heads, you include them in it?

A. Absolutely.

199 Q. I understand. 12:12

A. That has always been ingrained into me, to give people their place and where they are in the chain of command.

CHAIR: Okay. Thank you very much, Ms. Reddick. I don't think we have any other questions.

Then I think our next witness is due at two o'clock.
MS. McMAHON: Mr. Wolfe has suggested 1:45, if that's possible, because the witness is available.
CHAIR: Yes. I have no difficulty with that. I take it, gentlemen, ladies? No? Thank you. 12:12

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone. Mr. Wolfe. 13:48
MR. WOLFE KC: Good afternoon, Chair, good afternoon, Panel. Your witness this afternoon is Dr. Marc Williams. Are you taking the oath or are you affirming?
THE WITNESS: Affirming. 13:48
MR. WOLFE KC: Our secretary will administer the affirmation.

DR. MARC WILLIAMS, HAVING AFFIRMED, WAS EXAMINED AS FOLLOWS BY MR. WOLFE: 13:48

MR. WOLFE KC: The first thing we're going to do, Dr. Williams, is bring your witness statement up onto the screen in front of you. The first page of that is WIT-60278. You'll recognise that as the first page of 13:49 your statement. It runs to approximately 20 pages. If we go up to WIT-60298, that's your signature?
A. Yes.
200 Q. You recognise that, dated 6th October 2022. Would you

wish to adopt that statement as part of your evidence to the Inquiry?

A. Yes.

201 Q. So far as I understand it, you've no corrections or amendments -- 13:50

A. No.

202 Q. -- to make to your statement. Thank you.

You are currently employed with the Southern Trust as a consultant radiologist? 13:50

A. Yes.

203 Q. You commenced work with the Trust in 2009; is that correct?

A. Yeah, yes.

204 Q. That's the only post you have held in the Trust? 13:50

A. Yes.

205 Q. You have a particular interest or specialism in uroradiology?

A. Yes.

206 Q. Briefly, could you help us with that? What does that 13:50 mean, that you have a special interest or an expertise in that area?

A. Well, as it says, it's a small, I suppose you'd call it a district general; it's a smaller hospital than a tertiary referral centre. So, we all do general 13:50 radiology with a specialist interest. So. Mine is uroradiology. So I would do the majority of the specialist urology examinations, such as prostate MR would be the biggest group of those, but also a variety

of other examinations; it's usually MRI.

I go to the Urology MDT. I am the lead radiologist for the Urology MDT. I'm often the first point of call for questions from the urologists about cases. I have done other meetings in the past, which we don't do at the moment. I would deal with any sort of urological imaging issues or queries about the service that need to be worked out. 13:51

I think that's the crux of it. In addition to other, you know, a lot of general radiology, a variety of other things, and general (inaudible). I provide opinions to my colleagues on urology, urology imaging. I think that's most of it. 13:51

207 Q. That's helpful. I wonder is there a sound issue, a slight sound issue this afternoon? I'm struggling a little bit.

CHAIR: I think we're...

MR. WOLFE KC: You're okay? 13:52

CHAIR: We're okay, yes.

MR. WOLFE KC: We'll persevere.

THE WITNESS: I can come in a little bit closer.

208 Q. MR. WOLFE KC: You are also the lead radiologist to the Urology MDT. Does that remain the case; yes? 13:52

A. Yes.

209 Q. Until relatively recently, you were the only radiologist with an interest, special interest, in urology; is that right?

A. Yes.
210 Q. You've recently been joined by an additional radiologist with a specialism in that field?
A. Yes. I think he has interests in other things as well but he does do some urological imaging. 13:52
211 Q. Yes. I suppose hidden within that question is part of the reason for having you along to give evidence this afternoon. As the Inquiry has heard, for a long period of time, you were what's described in the papers as the single-handed radiologist with this specialism? 13:53
A. Yes.
212 Q. That created issues around the quoracy of the Urology MDT.
A. Yes.
213 Q. That will be the main stay of some of my questions this afternoon. But before we get to that, the Department of Radiology, it sits within the Cancer Services Directorate; is that right? 13:53
A. Cancer and Clinical Services, yeah.
214 Q. Within that, you are responsible or report to the clinical Director of Radiology; is that correct? 13:53
A. Yes.
215 Q. And that's currently Dr. Yousaf?
A. Yes.
216 Q. Before that it was Dr. Gracey? 13:54
A. Yes.
217 Q. I think within your statement - we don't need to bring it up -- for example at WIT-60286, you make it clear that while you report and provide reports to urologists

for the purposes of the MDT, you're not employed in urology departments, self-evidently?

A. Yes, that's correct. Yeah.

218 Q. And you have no input into the operation governance or clinical aspects of urology as such? 13:54

A. That's correct.

219 Q. For the purposes of the Urology MDT, however, you do report to the Chair of that body?

A. Yes.

220 Q. Currently it's Mr... 13:55

A. Glackin.

221 Q. Glackin, thank you. Now, let's just put some figures around the MDT quoracy issue. If we could have up on the screen, please, TRU-84685. This is an extract from the report of the peer review visit to the Trust which 13:55 took place on 16th June 2015. If we just scroll down, please, to that fifth paragraph. This is reporting in respect of the visit in June 2015. It says:

"Radiology attendance is problematic and more so due to 13:56 long-term absence, which now leaves a single-handed radiologist to provide the clinical services, as well as MDT cover. The MDT recognises this is a problem and is in discussions with the senior management team on how to resolve this problem." 13:56

So that was you, you were the single-handed radiologist?

A. Yes.

222 Q. Can you help us with when approximately your colleague, the new radiologist who can attend the MDT, when was he appointed?

A. I can't give you the exact date but I think it's within the last year. 13:57

223 Q. Yes. Can you remember for how long the problem presented in this narrative; for how long that was an issue? How long had you been the single-handed?

A. Again, I would find it very difficult to give you exact dates but it's going to be for a few years, I think. 13:57

224 Q. And so for five, six, seven years perhaps?

A. It doesn't seem as long as that; maybe going on the shorter side. But to be clear, I really would have to check the dates.

225 Q. Yes. No doubt the Trust's representatives are hearing the questions and they can take it that the Inquiry would like to know the precise dates. 13:57

A. Yeah.

226 Q. The question being how long were you the single-handed uroradiologist. 13:58

A. Yes.

227 Q. If we scroll down this page to the penultimate paragraph. It says:

"Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period, only 25% of meetings were quorate." 13:58

That probably comes as no surprise to you, does it?

A. No, not really. Obviously, you know, it says there we had issues with both radiology and oncology attendance. Sometimes we had no oncologist for prolonged periods of time, which obviously still made us non-quorate despite me attending the meeting. Then there was my attendance as well; it was variable.

228 Q. Yes. We'll come on just to look at some of the reasons for that and what was done about it and the implications of it in a short period of time. 13:58 13:59

There's an external verification report from the next year, if we can just bring that up on the screen, please. TRU-98213. This is an external verification report and the reply at NICaN in 2016. If we just scroll down, please, onto the next page. It describes only 42 MDT meetings were held in 2015, 43% of those meetings had no radiologist presence and 19% no oncologist. So, just short of 50% of those meetings did not have you in attendance. Plainly at that time, if you couldn't attend, there was no alternative, apart from perhaps on some occasions a general radiologist; is that fair? 13:59 14:00

A. Yes. I don't think any of my colleagues really felt they wanted to take it on. You know, they didn't feel they had the experience to do it. So there really wasn't anybody. 14:00

229 Q. Yes. So, let's look at some of the reasons why the issue of quoracy wasn't resolved. In circumstances where you were the only uroradiologist, you, of course,

had to take leave on occasions, and if you were on leave and leave happened to be on a Thursday, it's fair to say that there was no substitute for you?

A. That's correct.

230 Q. Preparation time for attendance at MDTs is obviously important, isn't it? 14:01

A. It's vital, yeah.

231 Q. Is it your position that you can't attend an MDT unless you've done the preparation because without the preparation, you cannot safely and effectively participate? 14:02

A. That's true. I mean, obviously you can attend but you can have no input into the cases, unless the questions are just very generic.

232 Q. Were there situations, and how regular were these situations, where, instead of prepping for an MDT, you had to instead carry out acute work, clinical work? 14:02

A. I don't think those -- it wasn't a frequent thing, but it did happen. You know, that, in combination with the other things you've mentioned, plus study leave, you know, obviously were the reasons why my attendance was as it is. They usually kept me available for the meeting but I don't think those who made the rota really understood the prep aspect. So what would happen is they would usually take my prep session for acute work and then I would have no role at the meeting. 14:03 14:03

233 Q. Hmm-mm. Can you give us an example of that? What could crop up that would require somebody, your manager, to

prioritise the acute work and your attendance on the acute work rather than attendance at an MDT?

A. Well, it would usually be one of two things. It would usually be an acute CT list, so inpatients who needed a scan, needed a radiologist for that list. The other was we have a thing called general inquiries, which is a radiologist available basically for inquiries, so doctors to come and speak to a radiologist. Also, just to come and mop up any emergency work that is falling outside of the CT work, so urgent cases that needed to be done. So we always have an acute CT radiologist for every session, and some sessions usually -- I think in the afternoons now we have a radiologist for the inquiries session. 14:04 14:04

234 Q. The fact that on occasions you had to fill in on the clinical side rather than be granted time to get on with prep for MDT, is that a reflection of the fact that the Trust had been unable to recruit sufficient radiologists or a uroradiologist to divide the labour? 14:04

A. I think it's a combination of things. As the MDT was kind of in its infancy in the first few years, I think the Trust was probably still prioritising the acute work. It probably didn't, as I said, didn't really appreciate the need to keep both my Wednesday afternoon and the Thursday afternoon sessions free so as not to take my prep time. They maybe didn't appreciate that. In addition, I was the sole person available. I will just summarise the other things so I can tell you there. So, if I took leave on a Wednesday afternoon or 14:05 14:05

a Thursday afternoon or study leave on either of those days. So, all of those things were the reason why I wouldn't be at an MDT.

235 Q. Yes. Could I seek your views on something Dr. Hughes has told the Inquiry? Dr. Hughes, you may know, was the senior reviewer on a series of serious adverse incidents which were reviewed in 2020 in the Trust and into 2021. He addressed the issue of quoracy in his evidence. If we go to TRA-02027. Just halfway down the page, the Chair asks a question in relation to quoracy. I think upon reading Dr. Hughes' answer, the question incorrectly refers to radiology as opposed to oncology. So, oncologists were expected to attend the MDT; isn't that right? 14:06 14:06

A. Yes. 14:07

236 Q. The answer that Dr. Hughes gives in relation to this issue was that the urology service is a very large service. And, again, I think that should be oncology. It's a bit confused.

14:07

"The oncology service is a very large service and they did the lung cancer service in the afternoon, which is very large and complex as well and they simply didn't have the 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." 14:07

I think the sense of that is made clear by the last sentence, despite a number of false starts. The answer is in relation to oncology attendance at the MDT.

Were you aware that oncologists found it difficult to attend on occasions because there was a competing lung cancer service MDT arranged for the same time?

A. No, I wasn't aware of that. 14:08

237 Q. Were you aware of the fact that when oncologists did attend, they were locums, and there wasn't, as Dr. Hughes describes here, the presence of an embedded oncology within the team on a stable basis?

A. I mean, I never had any knowledge of anyone being a locum. I think there were periods of time where we did have an oncologist and it seemed to be the same person. Then my recollection is there were periods of time where we had no oncologist at all. That's how I remember it. 14:09

238 Q. I assume you did have appreciation that both oncology difficulties as well as radiology difficulties were contributing to the quorum issue?

A. I think oncology was -- I'm not sure of the reasons why the oncologists obviously didn't attend but I would think they probably had staffing issues of their own. I assume so. 14:09

239 Q. Yes. Now, in terms of the efforts that were made to try to resolve the issues affecting radiology, you've

said in your statement -- if I can pull it up, WIT-60287. 20.3 towards the bottom, please. You're describing the situation when, if you were on leave - the single radiologist - then there would not be a radiologist present. The issue with a lack of attendance by a radiologist was an issue for a prolonged period, as you've described, and this was mentioned at the MDT on a number of occasions but you don't know by whom, or you're unsure by whom, but most likely Mr. O'Brien and Mr. Glackin. 14:10

"But this was not solvable in the absence of an appointment of an additional radiologist, which was the Trust's responsibility, and I cannot comment as to how much effort the Trust made to achieve this. But I am of the opinion that the Trust did not do all it could do to appoint an additional radiologist by making an attractive job, particularly when in competition with other Trusts both within Northern Ireland and the UK. I think, but I cannot be sure, that the MDT Chair may have raised the issue of radiology cover with the relevant clinical radiological clinical director, but I have no detailed knowledge of this, nor the response which was received." 14:10 14:11

The impression is that the Trust had been making efforts to recruit but your evidence is that they needed to do something more to make the post, to make the offering, more appealing; is that fair? 14:11

A. Yes, and I think that's true. The problem is that radiology is -- there's a shortage, a big shortage of radiologists and a lot of places don't even advertise any more because they just can't fill their posts. So, newly qualified radiologists can almost pick and choose 14:12
where they want to work. The departments have to make themselves as attractive as possible to those people who are coming, which, it's difficult, you know, in Northern Ireland, because they're relying, you know, mostly to the extent on northern Irish trainees coming 14:12
through the programme who generally don't have much of an interest in uroradiology as opposed to the UK -- to England, sorry, where there are a lot of uroradiologists. But here there seem to be quite few, you know, if any really. So they're perhaps not 14:12
exposed to that specialty and, therefore, not really enthused to do it. I think, you know, there is a sort of combination of factors.

So, to be in competition with other Trusts within 14:12
Northern Ireland and the rest of the UK, you have to do something extra to make your job appealing, whether it be an attractive job plan, the on-call is good. Because the on-call is always a problem and it's something, you know, applicants will look at, whether 14:13
there's ability to work at home; any financial remuneration, things like that. You know, a good job advert, for example.

240 Q. We can see from some of the materials that have been

provided that you took this issue up with Sam Porter, I think, or mentioned it to Simon Porter. If you just look at WIT-89846. If we just scroll down, please. Just scroll down a little further. Thank you. You're writing to Simon Porter and you're saying you hear on the grapevine that you might be interested in reporting across the MRI, and you've explained to him the various requirements that go with that, including, as per the standards set by the European Society of Uroradiology, a requirement or at least a strong suggestion that such a person should attend the Urology MDT regularly. 14:14 14:14

You go on to explain the obligations that go with that. Just if we scroll down. Urology MDT, within that paragraph, you explain how arduous that is. Then you say: 14:14

"What we really need in the Trust is the recruitment of a radiologist with an interest in general urology, someone that can partake in the GU Service and attend and take the MDT. The only way to achieve this is to make a real attempt to recruit by putting out interesting job plans that offer more than the bare minimum, mentions of flexibility, offsite SPA, more than 1.5 SPAs, recruitment and retention premia. I remain unclear why the Trust does exactly the opposite and how it expects to recruit in the circumstances, which leaves me, as a sole practitioner, which is not safe and not recommended by the College." 14:15 14:15

So you're explaining yourself in fairly strident terms to -- who is Mr. Porter?

A. He is a colleague, another radiologist.

241 Q. Yes. If we just scroll up to the top of that email, please. You're copying in the Assistant Director for Cancer Clinical Services, Mrs. Trouton, and Barry James. Who is he? 14:16

A. Another colleague.

242 Q. Yes. 14:16

A. Not working now, but...

243 Q. Did you ever get direct feedback yourself on this point that you're making, that we need to, as an organisation, make the role more attractive, to be more proactive in our recruiting strategy? 14:16

A. No, I don't think so. I think this was something that I suggested a number of times over the years and I didn't get any feedback.

244 Q. Another theme that emerges from the materials that we've assembled is your job plan, and how, in terms of your ability to contribute as regularly and as comprehensively as you would have liked to have done to the MDT, you believed or you felt that you were being, if I can use the expression, shortchanged in terms of the amount of time extended to you within the job plan to enable you to complete the work. Wasn't that an issue? 14:17 14:17

A. I don't think there's any doubt about that. I think initially - and I am trying to remember - I think I had

two hours of prep time for two meetings. One was the Urology MDT, which lasted a variable amount of time, but towards the start it often ran until after five o'clock, so for three to four hours, with basically unlimited number of cases; they were not capped. The other was a benign sort of Urology MDT, sort of for stones and cysts and things like that, which was wholly inadequate, two hours' preparation for those two meetings. 14:18

245 Q. Yes. We can see how this is raised in the correspondence, if we just briefly work through some of that. If we go to WIT-89943. Scroll down the page, please. This is 2nd May 2016. This comes, I think, close to the end of a number of pieces of correspondence and, as we'll see, Mr. O'Brien becomes engaged in the debate on your behalf as well. 14:18

The essence of the point you're making is in the second paragraph. You're saying to David - that's David Gracey, your line manager - 14:19

"I will, from now on, be working to my job plan. I have two hours of prep time to wait in the job plan. The first hour is supposed to be for the Urology Thursday morning meeting. This leaves approximately one hour prepare for the MDT for a meeting that lasts up to three hours. Once this hour ends, I won't be spending any more time preparing nor providing radiology input into cases that I have not prepared 14:19

for. I will ensure that the MDT Chair knows which cases won't have any input that week."

You say: "I have been asking for extra preparation for Urology MDT but there is no indication whatsoever that this will be provided, and I have been asking for perhaps nine months. An email I sent last week was unanswered, which is most unfortunate. A new general urologist job has been advertised which has two hours of prep time for the MDT in it and I don't get this." 14:19 14:20

You say: "I remain unclear and confused as to why I should have to fight to get the time to do the job I am asked to do. I have been trying, by giving up my free time, to provide radiology input to the whole of the MDT but, as I have said, this will not continue indefinitely. I have also started looking for alternative employment and am considering taking locum work to bridge the gap." 14:20 14:20

We can sense your frustration in that communication. Did you, in essence, feel that you were being undervalued by the Trust, or is it more than that? Is there a suggestion there that they weren't taking -- in your view, were they not taking the preparation requirements for MDT as seriously as they should have been? 14:21

A. I mean, again my memory on this sort of thing is a little bit sketchy because it's quite some years back,

but I think I'd been asking for a long time to have extra time for the meetings, which were getting more and more arduous, and I wasn't being engaged with whatsoever. So this was probably one of the last emails that I sent, trying to get more time for the meeting. And, you know, it was very frustrating. As you've said, I'm only asking for time to do the job they're asking me to do, nothing more, and I couldn't get that.

246 Q. We can see that a couple of weeks before you sent that email, Mr. O'Brien wrote, sharing elements of the concern that you've articulated. If we can bring up AOB-77295. If we just scroll up slightly - sorry, the other way - so we can see the top of the email. Further up. Okay. It's Mr. O'Brien writing on 20th March, directing his correspondence to David Gracey again and copying in a range of both clinicians, such as Mr. Glackin, Mr. O'Donoghue, Mr. Suresh, Mr. Haynes, as well as relevant managers, including Ronan Carroll and Fiona Reddick, who the Inquiry heard from this morning.

To take up what he's saying substantively, he is writing to make the point that we have had a properly constituted Urology MDM since April 2010. During the earlier years, the greater problem had been to have the input of an oncologist. This has been resolved, he suggests, in that we have had clinical oncologists videoing in from Belfast and a medical oncologist

present onsite these past two years. However, the issue of radiological input remains unresolved.

"Having considered this issue at length and having experience and participated in repeated attempts over the years to have the issue resolved, I believe that the core issue is that the Department of Radiology has never acknowledged or accepted that radiological membership from MDT and presence at MDM are both compulsory." 14:23 14:24

He draws a contrast to the Department of Pathology, which has ensured that the pathologist is present at almost all MDMs.

14:24

"We urologists have to suspend all other elective activities to accommodate MDM."

Just before I conclude this email, do you recognise that criticism which Mr. O'Brien makes to the effect that within the Department of Radiology, there is a failure to acknowledge the compulsory nature of attendance by radiologists at the MDM, or do you think that overstates it? 14:24

A. I think it's difficult. I don't know, and I have no knowledge of what the manager's attitudes to the urology MDM were and whether they felt it was important for radiologists to be there. I think the problem is likely due to the fact that we were just very 14:25

short-staffed many times and they were just having this battle between getting everything staffed. If we had enough staff, then having a radiologist at MDT would never have been a problem.

247 Q. He goes on to say that he greatly - that is, on behalf of the MDT - 14:25

"Greatly appreciates the expertise and experience of the only radiologist who does attend. However, we find the lack of commitment to ensure attendance at the majority of meetings unacceptable. If not resolved with immediacy, this issue poses an existential threat to our MDM, which we may be forced to terminate." 14:25

He goes on to say that he would like to have this discussed, and he attaches the quoracy timesheet. 14:26

We know that, shortly thereafter, there was some improvement to the time allocated to you for preparation. Mr. O'Brien, in an email from June 2016, suggests that you were granted an increased preparation time allocation of three hours; is that fair? 14:26

A. Yes.

248 Q. So it took some time and there was a degree of frustration, but you got fair. Did the allocation of three hours make life easier for you professionally in terms of your preparation? 14:26

A. Yes, because it meant that I wasn't having to spend my free time preparing. It meant it could be done in work

hours.

249 Q. But was it sufficient?

A. It's often not sufficient but I kind of put up with it at the moment.

250 Q. You touched, in an email in 2017, on a particular case which had not, judging by the emails, been reported on terribly satisfactorily from your perspective. Let me bring this up and see if you can help us with a little bit of context to this. It's AOB-79923. At the top of the page we have obliterated the name of the patient, perhaps a little unhelpfully for you, but we can go back over some of the emails if you need it for context. But what you're saying here is that: 14:27 14:28

"In this particular case, I think we could have done better in radiology and I am in part to blame as my review of the case for MDT was not complete enough, and I think this is unusual for me. At least the relatives were accepting of things after your conversation. As a slight aside, despite having three hours of prep time for the MDT, I find I am having to rush and work at a speed I am not comfortable with just to get through the cases in this time. I will be taking this under review." 14:28 14:28

14:29

The fine detail of the case that was in discussion between various clinicians and yourself was, is it fair to call it an inaccurate diagnosis or inaccurate description of the precise location of the malignancy?

A. I think actually, as far as -- I remember the case now, having looked at it. As far as the MDT summary, it was absolutely correct and there was actually no error in the MDT summary, because I think it said something like we do not think this patient has metastases from prostate or bladder cancer, which was factually right. The error was that it wasn't clear on my part, or I didn't make it clear as to where the primary actually was, which was lung. The reason for that was because I had not looked at the chest part of his CT scan, which is a single event in twelve years, I think. It happens occasionally. 14:29 14:29

251 Q. Hmm.

A. And I don't know the reason for that, I don't know whether it was because I was rushing. I mean, I rush now, I have to rush to get through my MDT prep in three hours. I work at huge speeds. And I am also keeping it under review. I don't know whether rushing was the cause - it probably did play a part of the reason for it - or just something I forgot. 14:30 14:30

252 Q. Yes. And essentially that's what perhaps the Inquiry, in terms of your evidence, wishes perhaps to know something more about. Is it very much a radiology department, even today with an extra radiologist coming in to work alongside you in recent years, is it a department that has, for a long time, been under a high degree of strain? 14:30

A. I think you could say that as an understatement.

253 Q. Yes. Now, Dr. Gracey, in his statement, has put a

number of factors together to try to explain the pressures on the MDT and its quoracy, and I would invite your comments in relation to them. If we can bring up on the screen, please, WIT-89464. Just towards the bottom of the page, please, at 17.9. I think we've covered some aspects of this in what you've said already in your evidence this afternoon but let me read it and then invite your comments. 14:32

"Urology MDM radiology cover was problematic throughout my tenure. Dr. Williams was the sole consultant radiologist appointed to the MDM, as he was the only one with uroradiology expertise. He found a number of cases at the meeting and the length of the MDM notes arduous. His MDM preparation time was increased to facilitate the meeting in May 2016", and we've seen that. 14:32

"Initial clashes with other acute clinical duties conflicting either with preparation time or the actual meeting were addressed to optimise attendance in September 2017. Dr. Williams' leave also frequently coincided with the MDM. It was not possible to move the MDM or to discuss individual cases at another day or time to accommodate Dr. Williams and facilitate patient flow, and Dr. Williams was similarly not able to move his preparation time." 14:33

Is that a commentary with which you can agree?

A. Some of it I agree with. I agree that my leave tended to occur towards the end of the week, because my job plan is such that I don't have any formal commitments on a Friday, although when I'm not on leave, I usually work anyway. But if I'm away, I usually would take the Thursday then. So, Thursday for the MDT was never really a great time and it was always my preference to have it at another time of the week, but it was on Thursday anyway. So I did try to work around that as much as I could, but that's potentially why my attendance may have been not as good as I might have hoped for, though actually it is not far below what the recommended or the acceptable attendances should be. But I find now it's actually higher than it was before. 14:33 14:34

In terms of -- I'm just looking at the other things it says on there. Moving the prep time wouldn't have made a difference because often the prep time wasn't the issue. It wasn't possible to discuss a case at another time? Well, that's not true because we would regularly -- I would regularly take emails about cases. We had a sort of recognised, I won't say pathway, but urologists knew they could e-mail if there was something urgent that needed to be discussed in the absence of a radiologist being at the MDT. 14:34 14:34

254 Q. Yes.

A. And that would happen.

255 Q. Yes. I think we can show you an example just a little later in relation to that. But there was a workaround

whereby you could be contacted beyond or outside of the MDT to look at particular aspects of a case, if it was necessary?

A. Oh, yes. Yeah.

256 Q. We'll look at that. Now, was there also a situation where, on occasions, non-uroradiological colleagues would, perhaps with some reluctance, attend the MDT to try to progress cases if you weren't available? 14:35

A. That happened but not very often. It's probably on less than five occasions, I would estimate. 14:35

257 Q. So, again it comes back to the need to recruit a person with interest in the area was the big answer to this question, or the most complete answer to this question of addressing quoracy?

A. I think that was probably the answer to solving the problem. 14:36

258 Q. Yes. We have observed from your statement and some of the papers provided that the department made use of an independent sector supplier for the purposes of providing additional reporting capacity in some subspecialty urology studies. Was that of any assistance to you in freeing up time within your practice and perhaps within the practices of others within the radiological team? 14:36

A. No, that was the reverse. 14:37

259 Q. It was the reverse. In what sense?

A. Well, the cases that were reported by the independent sector or outsourcing companies, they would come up, they would still come to the Urology MDT but,

unfortunately, they are associated with a higher discrepancy rate. It would take me longer to review those cases rather than me having reported them in the first -- I mean, I had to review the whole case. There could be anything on them, right, wrong or miss, false positive, false negative, anything. So, it took me a lot longer when that was happening. 14:37

I don't think the urologists trusted the reports either. So, I think there were issues with the reports that were done outside of the hospital. 14:37

260 Q. Yes. The question, if I can go back to the question I asked, which was do you think it was the intention of the Trust in asking the independent sector to become involved, was that with a view to trying to free up your time, and the time of others perhaps, to address this demand issue, even if the consequence was, as you've described, leaving you to deal with poor quality reporting and costing you more time in the long run? The question is focused on what was the intention in going to the independent sector. 14:38 14:38

A. I'm not sure why they did that. I think it certainly wouldn't have any impact on the Urology MDT. The two are completely independent. Obviously, if you send work out, then it gets rid of your backlog. That's the only reason really you would send it out. 14:38

I think the problem was that whilst work was being sent out, what the Trust did at that time was they stopped

the waiting lists in combination with the outsourcing of the urology work. There was actually no problem really in us reporting it, because we did it as sort of extra work. So, when I couldn't do -- when the (inaudible) became too much, we took it on as the extra work and reported it to the same high standard that I would have done however or, you know, on whatever basis I reported it at. When it was outsourced, I think the additional work we were able to do was then stopped, so it was kind of an alternative to that. 14:39

I don't think there's any doubt that, you know, the outsourcing of work helps clear the backlog of work. There's no doubt about that. It just depends on what quality of work you want. 14:39

261 Q. We can see WIT-89905. This is 22nd November 2017 and you're writing to David Gracey again. You're referring to an email below with your comments contained in red. I don't think we need to go down to the detail of that for present purpose. But what you're saying, in a nutshell, is that: 14:40

"We should be in no doubt that the outsourcing of these examinations has caused significant quality issues and prevents the further improvement of our service to the best it can be. We are already ahead of any Trust in Northern Ireland and we could have done better. I have worked hard to get us to this position and I can do nothing more now. Ask any urologist if they are happy 14:40

with the service. Managers need to rethink what is happening here. The Trust could always try and recruit."

So, a number of issues are brought together there. You're unhappy with the quality of the reporting on the part of the independent sector provider, it's something that could be done better in-house, and things would be much assisted with the recruitment of an additional urologist. Is that the thrust of your response? 14:41

A. I think the way I recall is that since I came to the Southern Trust, you know, we have spent a lot of time trying to get the prostate MR service the best it could be, you know, with the assistance of the urologists; to try and make the service the best it could be for patients. Which, you know, the way that things were a changing from kind of Trust first, then MRIs later, to pre-biopsy MRI is what we'd achieved, and we were trying to move further ahead of that by progressing with fusion techniques to try and locate tumours and doing reduced numbers of biopsies in targeting tumours, and all of that fell apart as a result of the outsource, basically. That's the way I kind of saw it. 14:41 14:42

262 Q. Yes.

A. You know, I felt quite frustrated that all the work had been put in, to sort of lose that quality. 14:42

263 Q. If we go to WIT-89464. If we just scroll down to 17.4, please. Or 17.8. Thank you. Dr. Gracey, addressing this, says:

"The independent sector provider withdrew their services following criticism of some of the reports by Dr. Williams with the subsequent impact on report turnaround times."

14:43

First of all, did the independent sector withdraw as a result of criticism directed by you or suggested by you?

A. You see, I wasn't aware of that actually until I read the bundle. 14:43

264 Q. Yes.

A. I've no doubt that I was, you know, critical of their reporting because there were errors, and we feed back, and, you know, I've fed back the errors. Some of the errors I regarded as, you know, fairly basic. You 14:43 know, they're not just a matter of because radiology is an opinion. It's not just a matter of opinion, it's basic fundamental mistakes. I think they obviously weren't -- they didn't want to be criticised.

265 Q. You've reflected in your statement - I needn't bring it 14:44 up on the screen but it's WIT-60286 - that you received support from urologists in relation to your expressions of concern around the standard of the independent sector work.

A. Yes, I think that's true. My memory is not very clear 14:44 on that but I do remember some of the urologists not being too happy about the reports, yes.

266 Q. Now, if we go back to your statement, please, at WIT-60286, at 17.1. Scroll up a little so that I can

get the full question.

"Do you feel you are able to provide the requisite services to support Urology Service which your role required? If not, why not? Did you ever bring this to the attention of management?"

You've said:

"I felt and do feel able to support urological service in my role as a radiologist. I did not raise any issues in this regard." 14:45

The expression of satisfaction in terms of your ability to provide radiological services to urology, does that not rather fly in the face of what we have just worked through in terms of -- 14:45

A. Yeah.

267 Q. -- your ability to contribute, for example, to MDT?

A. In some ways, but I still think I'm able to do my job. 14:45

268 Q. Yes.

A. And I think that statement is correct.

269 Q. Yes.

A. Yeah, I stick with it.

270 Q. Yes. Let me ask why you stick with it. Have you interpreted that question as a question directed to you personally, in the sense of to the extent that you had control over matters, you felt able to support Urology Service, but you're not seeking to deny, with that 14:46

answer, that there were a raft of pressures and problems out with your control?

A. Yes, I think that's exactly right. I interpret that as it was asking me if I felt to support the service? I do feel fully able to do my job. If other things are happening around me that I have no control over, that's something entirely different.

271 Q. Now, just briefly on the consequences of these radiology pressures and inability on what were regular occasions to attend the MDT. If we scroll just four pages down to 26.1, please. Thank you. Here, you're asked did you have any concerns arising from any of the issues set out, and some of the issues you've set out were around quoracy. You say: 14:46 14:47 14:47

"I didn't have any concerns in regard to any of the issues set out and I have not raised any. To clarify, the issue in regards radiological attendance at the Urology MDT was not a concern I personally held, but one I simply had noted. This was an issue for the MDT Chairman and the Trust. The lack of radiology cover by a radiologist with the subspecialist interest in uroradiology at the MDT was an issue in some individual cases, as radiology reports made by non-specialist radiologists were not reviewed by the radiologist at the MDT with an interest in uroradiology, and in some instances resulted in inappropriate outcomes. For example, the follow-up of abnormalities that did not require any" - and here you refer to an incidental 14:48 14:48

testicular lesion for which follow-up was suggested and none was required, and a patient given a nephrectomy for a benign lesion.

"In regard to the latter, the case was rediscussed at the Urology MDT with histology, where I reviewed the kidney lesion for which the nephrectomy was performed and I considered it unlikely to be malignant." 14:49

To pick up with issues arising from that paragraph. Where you say you didn't have a personal concern about the quoracy issue, can you explain what you meant by that? 14:49

A. Yeah, I think I probably haven't phrased that in the right way necessarily, it appears rather blunt. What I mean is it kind of -- I mean it wasn't sort of my responsibility to solve the problem. Obviously it was a concern that, you know, I was the sole person and the Trust could do better than it was doing. I mean that I had raised the issue and it wasn't my issue, it wasn't my problem to sort, it was someone else's problem. 14:49

272 Q. Yes.

A. In fact, there was nothing I could actually do to solve it anyway.

273 Q. We can see that you brought issues to the table and raised concerns. From your perspective, you weren't able to achieve change around that? 14:50

A. It wasn't within -- I had no ability to make any change. You know, I actually didn't really need to do

anything anyway. The lack of another radiologist was well known without me having to comment on it.

274 Q. Your answer there suggests that, I think you said in an earlier answer, maybe four or five occasions when general radiologists would have attended if you weren't available. You point there to a number of examples, two examples, of misdiagnosis or inappropriate outcomes arising from their consideration of cases when, is it fair to say, they weren't sufficiently expert to give the opinion? 14:50 14:51

A. Yes, I think that's true. I mean, I do recall both of those cases actually. You know, these are infrequent but they're just an example of why, if you have a specialist MDT, you need a specialist radiologist at that MDT. I fully appreciate, you know, my colleagues' attempts to cover the MDT and why they would do it for the service but it's not always helpful. I think just having the knowledge and the expertise and breadth of the cases, you know, helps you make decision-making. 14:51 14:51

In regard to the nephrectomy, I think it was again probably because there was a review of imaging without a radiologist present, and I think maybe the report was maybe sort of taken as fact. But, you know, again opinions vary. 14:52

275 Q. Well, is it your firm view upon consideration of this in the presence of pathology that a nephrectomy was unnecessary?

A. Well, I mean, that would be a very easy assumption to

make if you had the pathology. But no, I saw the imaging first and thought I don't think this is going to be malignant.

276 Q. Yes.

A. But, you know, again I'm not the definitive opinion. Other radiologists may hold a different view. 14:52

277 Q. But I suppose in an appropriately resourced MDT, you would have two radiologists present, hopefully both with some expertise in uroradiology or some interest in uroradiology, and that would be talked through and the right answer arrived at, whereas what you're pointing to here was a situation where a general radiologist was present, no doubt doing their best to assist to progress the case in these resource-challenged circumstances, but the right answer not being arrived at? 14:52 14:53

A. Well, I mean, I don't think there was any radiologist there for the nephrectomy case. I think, you know, the answer is, I mean, the gold standard would be having two to three radiologists at every MDT, with each one having prepped all the cases and come to an opinion on each one and then those cases discussed. But I'm not aware of anywhere that that happens. 14:53

278 Q. Hmm.

A. I don't know if any radiology department could manage that. 14:53

279 Q. If you could help the Inquiry with this: Is that situation, or both those situations but maybe focusing on the major surgical intervention that a nephrectomy

involves, is that kind of thing very uncommon where a uroradiologist is present at the MDT, that kind of mistake?

A. I don't think these cases would be common. They wouldn't be a common occurrence. I mean, we review a lot of cystic lesions in MDTs and we suggest whether we should continue with follow-up or whether something more needs to be thought about. I think we hardly ever would see patients with nephrectomy for a benign lesion; it does happen. The most common example would be on a cytoma, for example. I think that would be acceptable. But I don't think I ever see cysts that are benign; hardly ever see that. 14:54 14:54

280 Q. Yes. A case or cases like this - and you can only think of two examples where a general radiologist may have expressed a view on it - would they have gone, the latter, into the governance system to be queried and questioned whether an incident report or leading to an SAI, or how would issues like that have been handled? Because they are reflective, are they not, of an MDT and of a process that's not well-resourced leading to harm to patients? 14:55 14:55

A. Yes. I mean, I think if there was -- yeah, if there was a radiological discrepancy that resulted in harm, then there would be an incident report. We do fill in Datix for the odd occasions that something happens like that. 14:56

For a surgical one, I would never do that one myself,

I'd leave that to the urologist if they wanted to complete an incident form, an incident report for that.

281 Q. Can you remember, in relation to this specific case, whether there was any response or challenge to what had happened? 14:56

A. No, I'm not sure. I don't know.

282 Q. Another consequence, I suppose, of an underresourced radiological input into MDT is delay, a delay in considering cases. I think we've seen in the peer review -- if we can bring up TRU-84685. If we just 14:57 scroll down. The penultimate paragraph, please. It records that:

"The quorate issues mean that a large proportion of patients are not benefiting from the knowledge and 14:57 expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result, this could lead to delays in the decision-making process and treatment."

14:58

The operational policy of the MDT was that if a case on the agenda for the meeting definitively does not require the input of the absence member, then every effort should be made to discuss the case; isn't that right? 14:58

A. Yes, I think that's right.

283 Q. Otherwise, the discussion will be deferred. If we look at the case I mentioned in passing earlier, WIT-89947. Just scroll down a little, please. Sharon Glenny,

writing to David Gracey in respect of a patient we call 113. The name isn't important, it's the fact that her discussion, or the discussion of her case at MDM has been deferred on three occasions due to requirement for radiology opinion, and Sharon Glenny, who is the Cancer Services Manager, is asking for any suggestions. 14:59

First of all, would that be, in your experience, not untypical of a number of cases, that they have to be deferred over several meetings before radiological input is available? 15:00

A. I'm not sure that there were many occasions where someone would have to be deferred three times. That's probably unusual. It would usually be a week at most, maybe two at most. You know, three would be quite unusual. 15:00

284 Q. Yes. If we just scroll up to see David Gracey's response. He is saying: "Discuss with radiology outside of the meeting."

15:01

I was asking you earlier about a workaround if you weren't available for the MDM. Is that what he's hinting at here, that you could be contacted outside of the meeting to give an opinion?

A. It's difficult to know whether he's suggesting me specifically or any radiologist; I can't really tell. But the urologists knew that they could ask me any time for... 15:01

(LOSS OF AUDIO AND VISUAL FEED)

CHAIR: Hopefully we'll not have any more technological problems. Today is Tuesday, so I suppose we shouldn't be surprised.

285 Q. MR. WOLFE KC: Just before we come to what the reviewers in the context of the SAI said about what was needed around quorum issues, could you bring together what you've said in evidence so far, doctor, and give us your observations overall on the impact of the quoracy issue within radiology and the MDT on yourself, for the service you worked in, and for patients? What were the real impacts of that over several years?

A. I suppose it's probably mainly the issues were just patient delays. But I mean, they're probably, you know, in a week, or the days of a week in discussion, because there won't have been that many instances where I was absence, for example, or there was no radiologist for multiple consecutive weeks, although it did happen on occasion. You know, whether those cases did have any particular impact, I can't imagine they really had much of an impact on the patient with a delay of a week more than a psychological, the anxiety of having to wait, which is never a -- you know, that's quite unpleasant, I suppose.

The impact on the outcome is probably okay for, you know, a week or so. It's not going to make any difference in the outcome.

286 Q. Yes.
A. The other things - we've kind of hinted at them already - are decision-making. If decisions are made about cases which are primarily based on imaging, then there's a potential for error if there's no radiologist to provide a second opinion on those cases. I think they're the main issues.
287 Q. Yes. The SAI reviewers picked up on this issue of imaging and whether there were implications for the quality of the process, given the absence of a second uroradiologist. If we could have up on the screen, please, TRU-163316. Just if we go to the second bullet, please. After setting out the quorate rates for the years 2017/'18/'19 and '20, they say of radiology that:

"Radiology had only one urology cancer specialist radiologist, impacting on attendance, but critically meaning there was no independent quality assurance of images by a second radiologist prior to MDM."

Have you noted that observation prior to today?
A. I have. I mean, I think I probably touched on that earlier. It's an interesting thing that because, I mean, that would suggest that a second radiologist reviews the images prior to the MDT as well, because I don't really think you can give a proper opinion based on what's presented at an MDT by one radiologist who has reviewed the images, because they're just going to

show you selected images. It hasn't enabled you to review the whole case, as you would need to if you wanted to give a proper opinion on a case. That would mean that two radiologists would need to be present at every MDT and need to have prepared -- each radiologist would have to prepare the whole meeting, and I don't know whether any hospital does that. 15:28

My impression is that usually if there's more than one radiologist attending an MDT, which is mostly the case, then they're usually on a sort of rota system where one radiologist could prepare the meeting and do the meeting and another may just attend to give. Usually they don't say a lot, that's my experience, you know, of someone who hasn't prepared the meeting attending. You often say nothing at all for the whole meeting, sometimes a little bit; depending on their seniority versus the presenter. 15:28

288 Q. Yes.

A. If the second radiologist is more junior than the presenting radiologist, who's more senior, the junior may not say anything at all. So, I do think that, as I said, the gold standard would be for both radiologists to prepare the whole meeting and, if there is any disagreement, to discuss. There should be, you know, two people agreeing that the images show this and, you know, maybe this is what should happen. But as I said, I'm not sure that any hospital actually does this. 15:28 15:29

289 Q. Yes. Let me go to the more specific recommendation and

perhaps the more general recommendation. It's to be found at TRU-163322. We'll look at this and then I'll ask you about the current situation as it applies on the ground in the Southern Trust now that you have a second radiologist with an interest in uro. 15:29

Recommendation 3. It says:

"The Trust must promote and encourage a culture" -- sorry, recommendation 4, I beg your pardon. Yes. 15:29

"The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals. This will be achieved by all MDMs being quorate with professionals having appropriate time in 15:30
job plans. This is not solely related to first diagnosis and treatment targets. Real discussion of patients as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral." 15:30

The assurance that is sought is that you have quorate meetings, sufficient radiology input to facilitate free MDM, quality assurance of images, answer patient pathway audit, and audit of recurrent MDM discussion 15:30
and of onward referral.

Now, can we try to unpack some of that in the context of what currently happens in the Southern Trust? You

can't remember the date of appointment but you now have a colleague who has an interest or specialised interest in, amongst other things, urology?

A. Yes.

290 Q. You, however, are the lead to the MDT and he is your substitute, is that right, if you can't attend, or does he attend with you? 15:31

A. No, if we both -- we both would attend. I think what happens from week to week is very variable. So, usually I tend to find that my two sessions - the prep time and the Urology MDT time - is kind of safeguarded so that I always get it, so that I can prepare and do the meeting. If he's there, then he's always scheduled to attend but he may not have any prep time, in which case I do the whole prep, I do the whole meeting. 15:31 15:32

Sometimes he's given prep time, in which case we usually would split some variation of the meeting, equally or either I do a bit more and he does a bit less; something like that. We're never really in a position where we can both prepare the whole meeting. I tend to find that when I'm preparing the whole meeting myself, I go well over my allocated time, or it's a big rush to try to get it done within the time that I'm given. You know, I think that's kind of what tends to happen. 15:32 15:32

291 Q. Yes. In terms of quoracy, are the meetings of the Urology MDT, from a radiological perspective or from a radiological input, are they now more often quorate

than not?

A. Yes. Yes, they're usually quorate now. It's quite unusual for us both to be away, for example.

292 Q. Yes. Stepping back into the prep time, we have heard in your evidence this afternoon that you sometimes lost prep time because of a requirement for you to come and do clinical work where there was nobody else available. Is that prep time now much more regularly protected, if not sacrosanct? 15:33

A. Yes, I think it is, yeah. I very rarely would ever lose that time now. 15:33

293 Q. Yes.

A. Although I have made changes to my job plan so that if, for example, it usually would be the case I'm on leave on a Wednesday afternoon, I would prepare the meeting on a Thursday instead. So, there are some other sort of safeguards that I can use if need be. 15:34

294 Q. If you just glance at the screen, under the heading of "Assurance" just before recommendation 5, it's back to that what you described as perhaps a gold standard, where it says here that there should be sufficient radiology input to facilitate pre-MDM quality assurance of images. 15:34

Is that available or is it potentially available through your colleague to you if it was required? For example, a particularly tricky case, imaging maybe not entirely clear, or whatever the problem might be; does that quality assurance option become available to you 15:34

because there's now two, even if you don't need to use it in every case?

A. Oh, yes. There would be no issue with that. If we wanted to ask a colleague a question or, in terms of the urology, the two of us wanted to go through a case together, that would be, fine, you know, that's easily done.

295 Q. The other issue raised here is in terms of you being available or your colleague being available for radiological input beyond first diagnosis, so if there's a need for re-discussion of a patient as disease progresses, for example. Again, is that something that you are available to contribute to?

A. Oh, yes. These patients just are put back onto the MDT so they're dealt with just in the same way.

296 Q. By contrast with how things were for howsoever many years - and we're going to have that checked - but let's say for the five or six years when you were single-handed, how would you characterise the improvements in terms of the capacity for radiological input to the MDT at Southern Trust?

A. I think things have significantly improved. I'm sure there is, you know, always more improvement possible.

297 Q. Where do you think there are some difficulties that are yet to be resolved?

A. Well, I think -- I actually think that the MDT's probably a three-person, three-radiologist job, I think, to ensure 100% quoracy. I still am a bit quizzical about even the recommendation there, does it

mean that you should have two radiologists prepping the whole meeting? I still think that's the way to provide a really good service.

298 Q. But it's not currently available to you with existing resources? 15:37

A. No, and I don't know whether it would be. I mean, it would need more time in job plans, particularly for my colleague more than me, because I have time to -- well, roughly time to prepare the meeting.

299 Q. Now, I prefaced your evidence this afternoon by reflecting the fact that you work within a different and a wholly separate division to urology. Urology sits within Acute, you sit within? 15:37

A. Cancer and Clinical Services, yes.

300 Q. Yes. You've made it clear, in answer to a long list of questions, for example at 27, question 27.1, that you do not and nor have you had any concerns with regard to the practice of any practitioner in urology. Is that still your position? 15:38

A. Yes. 15:38

301 Q. We can see from some of the emails that you would have had particular dealings with Mr. O'Brien. For example, he intervened on the issue of your prep time for MDT. He was obviously the Chair of the MDT for a number of years and then it became a rotational post or task. 15:39 Had you close dealings with Mr. O'Brien?

A. I'm not sure I would say close but we certainly would talk about, you know, have normal conversations in addition to the work conversations. Friendly, you

know, relationship as work colleagues, you know, in different specialties.

302 Q. In terms of his input into the MDT, how would you describe it?

A. I mean, I think he seemed to be doing a good job and trying to improve the MDT. From what I've read - because I wouldn't probably, sort of in normal work, go through the MDT annual reports, I probably wouldn't have time. Having a look here, there seems to have been a lot of work he's done to help improve the MDT. I think my impression of him as Chairman was that he was trying to make improvements, make things better. 15:39 15:40

303 Q. It's a different question to whether or not you had any concerns about any practitioner in urology; that's the question we've asked you in your Section 21. Apart from the quorum issue, did you have any concerns about the quality and standards of the operation of the MDT during your time on it from its inception until now? 15:40

A. I think it was more -- my issues really were more sort of organisational things rather than the quality of the service provided. More to do with questions about whether, for example, radiologists needed to attend the whole meeting. The detail of information provided in clinical summaries was often immense. More those sort of things rather than the actual quality of care that was being given, which I thought was excellent. 15:40 15:41

304 Q. For example, the two examples you've given, having to stay the entirety of the meeting and the denseness of the clinical information provided to you, that, staying

the whole meeting, reading all that material, obviously impacted on time required from you when perhaps you had other competing duties to perform?

A. Well, maybe I also didn't mention the fact that it's not always clear for each patient what's to be discussed, so I prepare every patient and sometimes it can take 20 minutes to look through a case, sometimes longer, and then the radiology is not needed. I think that's still the case, it's not always clear what needs to be -- who needs to do what for each case. 15:42

In terms of, you know, if a radiological opinion is not needed for a case that needs just clinical discussion, and as the Trust is under pressure, why have a radiologist sit doing nothing? Why not give them something else to do and try to cluster the cases that need radiological opinion elsewhere? I mean, I admit there is always a chance that a case could need a radiology opinion even though it may not be a reason for discussion, so there is that chance. 15:42

305 Q. The Serious Adverse Incident Review across the nine cases that you have looked at raised a number of concerns, and some of the criticisms were that there was no mechanism to check whether the actions recommended by the meeting were implemented; the MDM was underresourced for full pathway tracking; there was a focus on delivery of the access targets such as the 31/62-day targets, and limited capacity to benchmark quality to cite just some of the concerns that were 15:43

expressed. Those kinds of matters, did they ever come across your desk? Did you appreciate those were issues in realtime or did those issues only emerge for you when you read the report?

A. Yeah, just from reading the report. I think those are clinical. I would have no knowledge of that at all. 15:44

306 Q. Is that because of your particular role, which was distinct and limited to radiological input?

A. I mean, my input at MDT is quite limited. It's really about the radiology and suggestions about imaging, and sometimes a little suggestion on management but that's primarily the urologists. All of that follow-up of outcomes is really well out of, you know, my area. It's nothing I would have really had anything to do with. 15:44

307 Q. Yes. The SAI made some recommendations about how things could be done better. I suppose if you didn't appreciate that things weren't entirely optimal, then you perhaps didn't appreciate the need for improvements but I'll ask the question anyway. Have you noticed any change in the MDM environment since these issues emerged in 2020/'21? Have you noticed things being done differently? For example, is the team -- is the membership of the meeting better supported in any way, is it better organised, is the discussion any different? 15:45

A. A lot of it's similar but there seems to be more emphasis on particularly making sure the patient has a key worker. That's one thing, or a nurse who's kind of

looking after that patient. That's something that I have noticed, there's been more emphasis on that. Maybe some other things but I can't really put my finger on them particularly. But there just seems to be maybe more structure and...

308 Q. Yes. The Trust have carved out a new role for the person on the management side, if you like, who attends. So it's now an Angela Muldrew who is the MDT coordinator. It is said of her that her time, she's now better enabled to give more focus and more support to the needs of the MDT. Is that something you've observed from your role or do you think that's more recognisable in the hands of a urologist?

A. Yes. I think the urologists would know more.

309 Q. One of the cases that the SAI review looked at was the case of Service User C. I want to just have your views on this issue generally. The issue which emerges from the case of Service User C is the question of how clinicians respond to the reports that emerge from your department. In other words, the clinician, the urologist, refers a case to you or one of your colleagues for CT scan and you report and send it back. So, I want to explore that with you briefly.

If we look at TRU-163308 and at the bottom of the page, please, which is the case of Service User C. You can observe his history. The case comes in in December 2018 via the Emergency Department, seen by Mr. O'Brien, investigations arranged, and ultimately he's managed

through.

Just going over the page to where we really want to be. In late 2019, Mr. O'Brien arranged for a repeat CT scan to be performed, and this took place on 17th December 15:49
and there was a plan to review the patient in January 2020. The review didn't happen. The CT scan report was available on 11th January 2020 and it showed a possible sclerotic metastases in a vertebral body which had not been present on the previous scan, but the 15:49
report was not actioned until July 2020. Mr. O'Brien, when asked about this, has said at AOB-82733 that while he doesn't have a record of the date, he believes that it was either in late February 2020 or early March 2020 when he reviewed the report of the CT scan and its 15:50
recommendation that there should be a radioisotope bone scan.

To summarise, report from the CT scan coming out of your department available as of 11th January but, on 15:50
Mr. O'Brien's best recollection, not looking at the report until either late February or March.

Now, I don't wish to have your views on the specific case but, having that background in mind, could you 15:51
talk us through the procedure that happens when a CT scan report is prepared by yourself or one of your colleagues and it reveals a concern about the possibility of a drug or disease?

A. Yes. I think there's been sort of -- there's quite a lot of flux about this at the moment, so what we may do now may not necessarily have been what would have happened in 2020. So, like, I'll try and outline that for you. 15:51

If we report a scan and then once we've reported it and are happy with the report, we verify the report. Once that's done, it's finalised and it's available on the electronic care record, and the referrer will get a 15:52 notification that they have reports to look at.

310 Q. Is that an electronic notification?

A. Yes. I mean, I don't think -- there's not an alert or anything that comes up. I think it just shows in a bar maybe that there's, you know, a number will show or 15:52 something appears in red. There's not a box that comes up when you log in, I don't think. You have to check, you know, that there are reports there. It notifies you of the reports and you check them.

15:52

I think what you're maybe getting at is informing refers back unexpected findings. I mean, it's always been an option through PACS, to make an alert on PACS with an urgent -- you basically highlight an urgent finding, and then the secretaries or admin staff will 15:53 pick that up and I think they e-mail the referrer. There's a protocol that they should probably refer to but they e-mail the referrer to tell them that there's an urgent finding. So, that kind of works for things

that are not critical. So, you know, things that are not going to make the patient deteriorate immediately; that would require a telephone call. So, that's done for the urgent ones.

Then I suppose it's up to the radiologist what they feel is a significant unexpected finding. We all, I suppose, have different thresholds for using the system. I suppose we do make some assumption that the reports are going to be read. Ultimately in 2020, I think the opinion would be that it is the referrer's responsibility to read their reports. So, actually, you shouldn't really have to flag urgent or, you know, significant or urgent findings other than those which were life and death sort of critical ones. 15:53 15:53 15:54

311 Q. Is there a standard or an assumption, even if it's not written done, that clinicians who have referred the patient in for a CT scan will read the product of that scan in the form of a report within a period of time, or is it really at the discretion of the clinician, having regard perhaps to factors such as his own availability, risk to the patient, comorbidities or what have you? 15:54

A. Obviously I can't speak for other colleges but the Royal College of Radiologists has had certain recommendations, but it really, I think, would only comment - this is in and around 2020 - that it would be the referrer's responsibility to check their reports. It doesn't specify under what timeframe. I think we 15:54

would kind of hope, kind of give a discretion to the consultants that they would do that and not need to be told when and how to do that work.

312 Q. These reports that come from CT scans, are they difficult to read in terms of finding the key message? 15:55

A. So they're going to be very variable because obviously we all work in a slightly different way. However difficult they are, usually -- I mean, okay, sorry, I'll start again. Some people have very concise reports, some people's are like an encyclopedia, so 15:55 it's very variable. But there always should be some conclusion to look at which will give you the main salient findings. Even if you don't read the whole report, you should be able to pick out whether there's anything important. Most scan reports are somewhere in 15:56 between those two, from very short to very long. It shouldn't take more than a minute or two to read a CT report, in full actually.

313 Q. Have you heard of a practice whereby clinicians won't read the report until they have a review of the patient 15:56 set up or established, an appointment fixed, and at that point now's the time to read the report, but until that review appointment happens, I'm not going to read the report or there's less need to read the report?

A. Yes. I mean, that's what we used to do when I was a 15:56 houseman. We would have the patient back in clinic and the report would be in the notes. We didn't make any effort to read the report before then. I think things have moved on. You know, you have electronic reports

now that you can check, and you should do that before you see a patient in clinic because you don't know when you are going to see that patient.

314 Q. Yes.

A. In the past I think if we asked to see a patient with a CT report, that often did happen. You know, you would see them almost within a few days, it was quite organised. But now I don't think you can; you can't rely on really anything happening. 15:57

315 Q. You were outlining some of the steps that are now available to you that mightn't have been available in 2020. I think you were probably drawing from a particular protocol which came in effect from April 2021. If I could just bring that up on the screen, please. You could maybe help us with some of the keys aspects of how things are now done, if this protocol remains the appropriate base for that. WIT-60281. Sorry, let's not go there, that's where you mention it in your statement. If we go to the protocol itself, it's at TRU-103348. Is this what you had in mind when you were... 15:57 15:58 15:58

A. Well, yeah, sort of. I mean, this is a protocol, but it was kind of similar to what we may have been doing before that. I was more referring to more recent changes which are going to be more dramatic. 15:58

316 Q. Okay.

A. But they're more in process; it's only very recent.

317 Q. Yes. Well, this protocol speaks about categorisations of cases that emerge after radiological investigation.

If we just go down to the next page, please - 49 in the series - it discusses critical findings, urgent findings and significant unexpected findings. Are you working to that kind of categorisation?

A. Yes. I mean, we don't -- even though there is a sort of split, there's only one option for us to use within PACS, which is to kind of put an urgent report, communicate an urgent report. Whatever is the urgency, it's just one category. The critical findings, you would have to deal with those yourself. 15:59 16:00

318 Q. Yes. I suppose what I'm focusing on here is is there now a way of specifically drawing a clinician's attention or a cancer tracker's attention to an unexpected finding that wasn't in place in 2020?

A. No, I don't think so. I think this sort of pathway protocol, it's just going to outline things that were already in place in 2020. So, in 2020 you could still flag reports for urgent communication and you could flag reports for the cancer tracker. I think they've become a bit more robust. Sometimes the secretaries maybe didn't check the lists as often as they should do, and now it's much more, as I say, much more robust than it used to be. But the sort of process is still much the same. 16:00 16:00

319 Q. If the imaging showed the possibility of a sclerotic metastatic disease or some finding that wasn't available on a previous scan, is that something that would or should be highlighted over and above the description of the finding? 16:01

A. Yes. I mean, I think most of us now would probably highlight it. Being honest, I think most of us now would probably highlight it. In the past, I think there'd be a mixture, probably. Because I think, you know, in the past, as I said, there's more of an assumption that the referrer's going to read the report. But I think now we're beginning to change our practices a bit and assume that they are not necessarily going to do that, so we need to kind of do our bit to identify things that maybe do need action, as a safety. 16:01 16:02

320 Q. You said that there's a recognition of the need for radiologists to do your bit, to do more than simply provide a description. Does that suggest that within the Trust, or perhaps more generally, within health care provision more generally, there is a problem with clinicians failing to read the output from such investigations in a timely fashion? 16:02

A. I think that may be the case, but I think also you have to consider that clinicians can be on leave as well. They can be off for a fortnight and there can be things that need to be dealt with. Having mechanisms to deal with that is, you know, it's important. I mean, I certainly don't think the system that we have in place is adequate in any way at the moment; e-mailing someone who could potentially not check their emails every week or who may be on week is not going to be adequate. 16:02 16:03

321 Q. Is there anything within the current system that allows you, the radiologist, or the tracker or any other

responsible person to know that the clinician hasn't yet actioned the report?

A. Yes. So, this is what I mean by more recent changes. These are things that are being worked on. As we currently are, there is no way of knowing what's happened. 16:03

322 Q. So, there is a mechanism by which you can check to see administratively whether your report has gone out, you do the dictation and it's checked. Then does an administrator, a clerical person, issue that for you? 16:04

A. No. So, if the report goes automatically electronically, it just goes out, straight onto automatic, straight onto the electronic care record. There is a paper report sent as well at some point. It will be a little bit slower, obviously. That's done by 16:04 the administration staff. If there's a flag put on, then that's when the administration staff would be involved as well. They would send the email to the referrer.

323 Q. So, as we stand in 2023, where do you think the gaps 16:04 and the improvements are necessary?

A. Well, there's lots of improvements that -- I mean, there really is a lot of improvements that are possible, from using, you know, mobile devices to be able to alert consultants; you have to be sure who's 16:05 covering and you have to make sure that the report goes back to someone who's actually available, not someone who's on leave; or there is a safe mechanism for someone else to check if someone else is away. There

he has to be an acknowledgment of reports; when you receive them that you have to acknowledge that you've received them. If there's recommendations, then someone has to check that those recommendations have been followed, or if they have not been followed, why they have not been followed. Lots of back-up, admin staff to do all these tasks of reporting and checking. So there's quite a lot of change.

324 Q. Is there a need for a standard read time by the referrer? 16:06

A. Well, there probably -- I mean, there probably should be. I suppose it's the only way of picking up things which you may want to know about. Although, I mean, we are using this flagging a lot more than we're used to, which will identify anything that may need action. I think referrers should check their reports, ideally daily but at least every few days, I suppose. I'm not sure, there's no agreed recommendation. 16:06

325 Q. The document that I have up on the screen also refers -- if we go down to page 53 in the series, TRU-13353. I know that you say that this protocol, to some extent, is almost being bypassed by the pace of change, but it refers to communicating with the referrer or the cancer tracker. My questions so far have focussed on the referrer by and large. The Inquiry has heard evidence about the work of the cancer tracker. I'm not sure that this particular aspect of a communication from radiology to a cancer tracker has emerged in the evidence so far. Is this a tool or a 16:06 16:07

mode of communication that is used in the Southern Trust, in other words, telling the cancer tracker if a particular problem is identifiable on investigation, or is the tendency still to focus on sending the information to the referrer? 16:08

A. No. I think when we use the alert system, if you alert the cancer tracker, which we can do, then you would automatically alert the referrer as well. So, you either do that or you just alert the referrer. I think if we have an unexpected cancer maybe on the scan, then 16:08 we would alert both to the cancer tracker and the referrer in those instances, yes.

326 Q. So it's a severity issue? If it's...

A. I mean, the vast majority of -- I mean, we do a lot of scanning and a lot of them for very concerning symptoms 16:09 but the vast majority of those scans are going to be normal. It's trying to pick up the ones that aren't to try and give the clinician, to sort of focus their mind on those cases. So, if you have a patient referred with red flag symptoms and the scan's abnormal, it 16:09 shows a cancer, then you would flag those to the cancer tracker and also to the unexpected findings. That's what we would -- it's not really necessary. Well, I suppose it is severity, you know, you've found something important so you would flag that. 16:09

327 Q. Yes. Is there a particular reason or particular thinking behind bringing the tracker into the equation?

A. I suppose it's just another, it's another safety. You know, as we've said, the flagging to the referrer, you

know, in my view, is not really optimal; the referrer could be away; they may not check their emails as often as they might, for whatever reason, could be busy. Whereas the cancer trackers are normally there all the time and they're quite good at the admin. So, you know, they're checking lots of things and can make sure that someone takes that patient on. 16:10

328 Q. Yes. Thank you. Moving to a different issue now, if we go to AOB-77753. This is an email that you sent to Mr. O'Brien in August 2016 when he was, I understand, Chair of the MDM. You're raising a question about the discussion of private patients at the Urology MDT. You say: 16:10

"I understand that the Trust does not indemnify us for discussing these cases so if an error is made, we are personally liable. This is notwithstanding the fact that private patients should be paying for the services of all staff at the MDT. I have asked for clarification from the Medical Director and am awaiting discussion. I will not be providing any radiology input into these cases until I receive clarification and I suggest that this is discussed at the MDT AGM or such like." 16:11 16:11

An email sent, obviously, seven years ago. Can you recall what the issue was beyond what's plain on the email there? Was there a traffic jam of private patients coming through the MDT or what was the context

for this?

A. No, I don't think there was. There weren't many of these patients coming through. I think I just felt maybe a bit disgruntled by it, because you would find patients crop up in the MDT who clearly have not been seen in the NHS, and I didn't know whether these patients would have had their care transferred to the NHS or whether they were private patients who were sort of dipping into the MDT and then out again. I just felt a bit uneasy about that. I wasn't sure if we were supposed to be providing opinion, whether the Trust allowed us to provide an opinion, because my understanding was that the Trust didn't allow that to happen. I didn't know if we were indemnified by the Trust for providing an opinion, if anything happened. Just I felt uneasy and I wanted clarification as to what we should be doing, what the Trust expected of us. I never really, I never really got anywhere with that. I still remain unclear as to the situation. 16:12 16:12 16:12

329 Q. Hmm-mm. 16:13

A. So I think that was it, really.

330 Q. Was that a new issue at that time for you or was it something that had been annoying you for some time and you decided to raise it?

A. I think there were a few cases that had come into the MDT, but also, you know, there was the odd other patient who used to sometimes come for a radiological investigation and then, you know, were clearly not NHS patients. 16:13

331 Q. What was the reason for writing to Mr. O'Brien? Was it his patients? Was it other clinicians' patients? Or can you not be sure?

A. I cannot remember whose patients they were. I think it was just because he was the Chairman, so that's why I wrote to him. 16:13

332 Q. Does the Chairman have any controlling role in terms of what patients can be discussed at the MDT?

A. Well, I think they would maybe be more knowledgeable of the policies that the Trust would have for MDT discussion, or if they weren't, they should write a policy so that we're all clear. Because as far as I was aware, you know, what was happening was not what the Trust wanted. It didn't want patients coming into the Trust and going out of the Trust for either being MDT discussion or a radiological procedure or investigation. 16:14 16:14

333 Q. We can't locate any response from Mr. O'Brien to your email. Do you recall getting a response from him?

A. It is a long time ago. I do not recall getting a response. I don't think I received a response from Mr. O'Brien or the Medical Director. 16:14

334 Q. Yes. You say you are awaiting clarification from the Medical Director, and you also suggest discussing it at the AGM for the MDT. Again, did the issue receive any further consideration? 16:15

A. I don't recall but, you know, I'm not going to be able to remember whether I was at an AGM. It may have been discussed in my absence, for example. So I can't

remember.

335 Q. Is it an issue that continued to trouble you? In other words, were you seeing cases after that where you were suspicious that they may have had a private sector origin? 16:15

A. I think there have been some other cases. They're not very many. It's often -- you know, you still see patients, I still see patients, you know, even now where they do have a private sector origin but it's often not always clear to me where their destination 16:16 is. I'm still really sort of a bit unsure about this sort of thing.

336 Q. Is it an issue you've subsequently raised with anybody beyond this email?

A. No. I don't think I've -- I don't think I've ever 16:16 mentioned it again.

337 Q. Just finally, doctor, just in terms of some of your reflections that we could pick out from your statement to us. One thing perhaps arises in this context that we've just been looking at is that you say that 16:16 management, in certain circumstances, have been unresponsive to issues that you raised. This is perhaps one example; you've raised this with Mr. O'Brien and with the Medical Director. Let's just pull up your statement to see the context in which you 16:17 make this point. WIT-60293. At paragraph 35 you're asked:

"What could improve the ways in which concerns are

dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?"

And you say: "I do not think that management take concerns seriously within the Trust and often fail to act or do not communicate that they have done so. I have previously raised, for example, in regard to the duplicity" - is that duplication --

A. Yeah.

338 Q. - "of investigations and that hasn't been acted upon. When one raises an issue, usually a response is not received.

"35.2. Many issues I raised in regard to radiological practice through the Radiology Clinical Director and the Radiology Service Manager which are not specifically neurological are not addressed by managers and opportunities for the improvement of patient care and efficiency are lost."

You give examples of SPA entitlement for service improvements, and teaching.

"Such issues are raised infrequently as I do not think time raising them is not well spent."

Then at 35.3 you say:

"There is scope for improvement in radiological

practice. Managers need to acknowledge each and every issue raised with them and state how best the issue could be dealt with, rather than appearing not to engage at all."

16:19

You finish by saying, "Areas of improvement should be discussed with clinical and nonclinical managers and a plan made to make improvements to the service."

Does that reflect your experience over 15 or so years, doctor, that you are articulate in raising concerns from time to time about issues affecting your own practice, your service and its impact potentially on patients, but you seem a little despondent that the culture generally doesn't seem to direct responses by to you? 16:19 16:20

A. I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to. 16:20 16:20

I tend to find that, in the Southern Trust, I think there are so many big issues, major issues, that managers are probably dealing with many of these in their limited time, particular clinical managers, the limited time for managers are dealing with these things. So, things that I raise that are comparatively minor are probably just ignored, because there's no time to deal with them. I think that's probably what happens.

339 Q. Apart from giving you responses, can you think of any ways, any vehicles, any structures that aren't currently in place that might, with little effort and little resources, be put in place to improve things? 16:21

A. I think the problem is that we have -- the supporting professional activities, which as you probably know, is part of the job plan or things other than clinical work, of which it's kind of recognised that 1.5 is the minimum, and that's really for personal revalidation and, more recently, is supposed to include some teaching, but it doesn't include service improvement. I think the Trust is very unwilling to give individual consultants additional SPA time for managing a service. So, any improvements that you wanted to do a service you would do in our own time. I don't think there's been -- there hasn't been much encouragement to give consultants additional time, certainly in radiology anyway. 16:21 16:22 16:22

MR. WOLFE KC: Okay. Thank you for your attendance this afternoon and the answers to my questions. The

Panel may have some further questions for you.

THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:

CHAIR: Thank you, Mr. Wolfe. Thank you, doctor I'm going to hand over to my colleague, Mr. Hanbury, first. 16:22

MR. HANBURY: Thank you very much for your evidence. I think I speak for most urologists to say we depend very heavily on our uroradiological colleagues, so it is from that context that I am going to run through a few clinical things. 16:22

You mentioned about recruitment and we've heard about this certainly from a northern Irish perspective. What brought you to the Southern Trust? Was it the ability to perhaps develop uroradiology as a subspecialist interest, or other reasons? 16:23

A. Other reasons. They're usually the same reason, which is a wife from Northern Ireland.

340 Q. Okay. Thank you. If that hadn't have been the case... Perhaps I'll move on. 16:23

A. I know what you're going to ask now but maybe don't ask it.

341 Q. Okay. Thank you. We've heard a lot about MDM quorums and radiological attendance, and I would say that radiological attendance at these are even more important than perhaps your evidence would support. Just specifically, when you were there and specialist, you moved onto the specialist MDT with Belfast 16:23

colleagues, discussing, for example, things like small kidney masses --

A. Yeah.

342 Q. -- advanced pelvic cancer, there was presumably a Belfast radiologist who linked in, was there, or how did you interact with the other radiologists in the centre, shall we say? 16:24

A. That's been quite difficult because since Covid came, we're able to do the meeting virtually, which I have been doing quite a lot. I've never been able to -- there's always been a technical problem trying to log into the Belfast Trust really from anywhere unless you're actually in the Urology MDT room. So what's happened we're not really -- we're not actually doing that. So what tends to happen is we provide an opinion on the imaging first and then that case would then be -- once we've reviewed it locally, the case then would go to, say, the small renal mass, for them to look at. I think, you know, their radiologists would kind of present the case to the local, to the Belfast surgeons for a decision on the management. 16:24 16:24 16:25

Prior to that, so when I more physically attended the meeting, then what we tended to do is because I was in the room, it was possible to present the cases and we would present the cases to the meeting at Belfast. And their radiologists didn't usually, they didn't do anything and didn't say very much because I think most of the time it was okay, what we presented. 16:25

343 Q. But was there not an opinion coming back to say biopsy ablation for small --

A. Yes, the management. So, the management is decided by the urologists in Belfast.

344 Q. It was primarily the urologists? 16:25

A. Yes.

345 Q. Okay. Thank you. Moving on. Certainly Mr. Glackin, I think we heard, felt quite strongly that when you weren't there, then that put a big query over the quality of the MDM/MDT. Do you think they should have 16:26 dug their heels in and cancelled it?

A. I don't think it necessarily needs to be cancelled because I think there are quite a number of cases where there probably isn't -- they're not asking for a radiological opinion. There are a lot of cases where 16:26 they're just, you know, superficial bladders cancers, for example, or some questions about prostate cancer management in a patient whose PSA is... You know, those cases could be discussed.

16:26

Yes, the ones that need radiology to help determine the management, whether there's anything at all, even if it's just a renal cancer staging, anything like that, yes, those cases would have to be deferred.

346 Q. Okay. Thank you. Just moving away from cancer, which 16:26 you'll probably be quite relieved about, I was interested to hear that in the past there was a uroradiology meeting, I think on a Thursday morning?

A. Yes.

347 Q. That seemed to have stopped?
A. Yes.
348 Q. I mean, there's lots of urology that's nothing to do with cancer.
A. Yes. 16:27
349 Q. Stones, upper tracts --
A. Yes.
350 Q. -- hydrology; lots of stuff.
A. Yeah.
351 Q. Why did that happen? 16:27
A. That meeting, as you say, it was mostly stones, the odd other thing, and a lot of cysts, a lot of complex cysts. Those cysts have actually, a lot of them have now moved over to the MDT because I suppose they are potential cancers, although very rarely the case. So 16:27 we deal with those there. It's really just left to stones and the odd other thing. I get emails about those other cases and sometimes about the stone ones. There is a stone meeting, but it's not an MDT. There is no radiologist, which is an oversight, I think. 16:27

But in answer to your question why did it stop, it stopped because I used to find that I was there at half past eight or whatever to start the meeting and no one came. Or Mr. Glackin would come and that was it. Or 16:27 when Mr. Glackin wasn't there, no one else was there. I looked at the cases and I just got a bit -- I'd sort of had enough of it, really. So, I just didn't continue.

352 Q. A lack of interest from the clinicians?
A. I think so. I don't think -- Mr. Glackin certainly wasn't surprised about that because I think he said we've got a meeting, why is no one turning up?
353 Q. On that, you've made a comment about substandard imaging of patients with stone. Is that something you still -- 16:28
A. Yes. I mean, what I mentioned was that more recently, within the last maybe year or two, we're doing a lot of CTs now for patients with stone disease. I think in the past there was probably sort of an over-utilisation of ultrasound for inpatients with stone disease, and then no one was really sure what was happening with the ultrasounded patients. So they're using, I think - because I think CT obviously is the standard for knowing, you know, whether a patient has a stone or not. I think they're using CT a lot more than they used to do, for sure. I think there's more of an overall reliance on ultrasound. 16:28 16:28
354 Q. Okay. Thank you. Moving on to sort of interventions. Nephrostomy, that's putting a needle into, say, an abstracted kidney? 16:29
A. Yeah.
355 Q. Were you the only uroradiologist who would do that, or would your other colleagues do -- 16:29
A. No.
356 Q. -- needle abscesses and do other interventions?
A. It's a bit complicated to answer that because when I first started, I was kind of able to do, you know, a

fair bit of interventional things, basic interventional. I could do a nephrostomy; I could do sometimes do ureteric stents. But I think we have an interventional uroradiologist in our department who is keen to do that work, so I kind of let it fall by the wayside and he took most of it up. I think our department is quite unusual, in that there's a lot of -- what I found was quite unusual, because there are a lot of radiologists who are happy to do a lot of interventional work, albeit basic drainages, so the work is quite spread basically, so sometimes it's difficult to get any cases. So I do less and less than I actually probably had hoped for. 16:29 16:30

357 Q. That's a good service to the patients who need it?

A. Yes, because there's a lot of people. We are never struggling to find someone who is happy to drain something. 16:30

358 Q. Okay. Thank you. You mentioned the outsourcing. I don't want too talk about the governance issue, but was part of the push for that this sort of surgeon demand for prostate MRI pre-biopsy? 16:30

A. I'm not really sure why that happened because we were covering -- I think we were covering that work, albeit on, you know, waiting lists if need be. So, it was additional work. Then it seemed to switch to additional work for the outsourcing companies and the waiting lists were stopped. There was a sort of an alternative. I never understood the rationale of why that happened. 16:30

359 Q. But it's come back again now?
A. Yeah. Yeah because, I mean, the outsourcing companies stopped providing the service, I think, as we mentioned, because I was critical of what they were doing and there was no choice but to bring back the waiting lists for that. I think again we're in quite a good position now where they're getting reported quite quickly and everything's happening as it should. 16:31
360 Q. Okay. Thank you. Just a couple of other quick ones. Discrepancy meetings, just describe what that is. 16:31
A. So it's meant to be -- it was meant to be -- they changed the name to something called REALM, which I think is more of a learning meeting rather than an errors meeting. You are meant to be learning from cases rather than pointing fingers. So it's called REALM. It's a monthly meeting which happens every month. Whoever is there will attend. We do it virtually now because it kind of continued on from Covid, where the cases of discrepancies are presented by the consultant who basically chairs the discrepancy meeting. He shows examples of errors and we kind of talk about those and try to learn from them and feed back to the original report. 16:31
361 Q. An internal audit type?
A. Yeah, and educational as well. Sometimes we present cases where there is a discrepancy but it's not meant to be critical, but maybe something to learn from. 16:32
362 Q. Okay. Thank you. You mentioned a nephrectomy for a benign lesion on one case that popped up. I mean, I

would never imagine doing a nephrectomy in a case that I had not discussed with a radiologist. Are you aware of any other cases in your time there that --

A. No, I think that would be very rare. I mean, there may well have been other cases where - I'm sure there were other cases - the management was progressed without a radiologist being at MDT. In the most part, most reports are going to be correct, so, by luck, all will have been well. I suppose there's always going to be that chance that either the report's wrong or you just get unlucky, and that was that instance. 16:32 16:33

That certainly doesn't happen any more. Any case where it hinges on the imaging needs a radiologist to give the second opinion on it. 16:33

363 Q. So, just pushing a bit more. If you had had someone with a symptomatic but simple kidney cyst, would you...

A. Sorry, what's...

364 Q. Someone with flank pain, a simple watery cyst in the kidney -- 16:33

A. Yes.

365 Q. -- seemingly needing intervention, would you expect that would be discussed?

A. I don't think that would get to MDT. Probably not.

366 Q. But it would come to perhaps a benign meeting if you did have? 16:33

A. Yes. I mean, I think it's going to be very variable as to who looks at that case. If it's reported by a radiologist that the urologists are happy with, they

would probably just take that, I mean as a benign case, simple cyst. A lot of the urologists are happy to look at the images and sort of double-check them. I know they're not radiologists but they're good at it. So, they do that. If there's any queries, they'll come back, often to me. They might e-mail me and say could you have a look at this? Sorry, is that what you are asking? 16:34

367 Q. I think so. Particularly going towards intervention, I guess that's what I was hinting at. 16:34

A. Yeah. Often they ask us to drain these cysts to see it if it gives symptomatic relief, so we're often involved any way. Yeah, because they're very rare. I mean, obviously you know better than I but I'm not sure they would do the surgery immediately. They often like for us to drain it first to see if there's symptomatic relief, and then they have got a radiology opinion basically. 16:34

368 Q. That's what I was getting at, its a two-way conversation? 16:34

A. Yes. Yes.

369 Q. One final one, if I'm allowed. You mentioned your frustration about developing new things as a department. Did you have departmental meetings, say once a month and present a collegiate view to your management or your clinical director? Was that the sort of culture, or you say you e-mailed the lot? 16:34

A. I used to e-mail a lot but I don't tend to do that now. I think in my initial frustrations which you've seen in

those e-mails, I don't have those so much now, I just don't think it's too important.

We do have a management meeting. It goes hand in hand with the discrepancy meeting that's every month, so we could discuss really any aspect of radiology. Some things are taken on as a group; other things the clinical director might impress himself even without general agreement. It's variable. 16:35

370 Q. So, at least you have an opportunity? 16:35

A. Yeah, you can. You can always go and speak to someone if you want to about something. I find that's more useful now than writing an email, which generally doesn't achieve a lot.

MR. HANBURY: Thank you very much. 16:35

CHAIR: Dr. Swart.

DR. SWART: Another opinion, not writing emails and having discussions with management, there is clearly a problem from your perspective in terms of the culture of management. I just wanted to ask you a bit about that. Is that, do you think, a general feature because of the busyness and pressures at the Southern Health Care Trust? Is it specific in your department? Was it particularly your clinical director that you'd had some sort of conflict with, or was it a more just a general disillusionment of not being involved? 16:36 16:36

A. Yeah, I don't think I've had really anything I would say is a confrontation. I think I just generally get the impression sometimes that -- well, quite a lot of

the time, that if you raise an issue, particularly by email, it often doesn't get -- nothing really happens with it, or that's the impression. I think you can raise it with non-clinical managers and clinical managers to the same sort of general outcome. 16:36

I think our clinical director, he is more responsive certainly than maybe the nonclinical managers, and he will reply.

371 Q. Do you have an opportunity not to have necessarily regular management meetings but, say, once a year sit down and say this is how we're taking our radiology department, this is how we think things should go forward, these are the things we want to make better this year, and have some sort of a sense of where you're going? Is that atmosphere there or is it getting to be there, or what's your view on that? 16:37 16:37

A. We tend to discuss more of that at the monthly meetings. There is usually a section about equipment or recruitment. So, it's kind of discussed more on a monthly basis. 16:37

372 Q. If I said to you do you know what the plans are for five years for radiology in the Southern Health Care Trust, would you know?

A. No, I don't. 16:37

373 Q. I'm really thinking of, you know, you're a uroradiologist, have you had thoughts about how that service should go forward, and has anybody asked you to develop those thoughts?

A. No, I don't get asked to do anything like that. It would be -- we've just done things over the years ourselves really rather than anyone kind of asking us to develop a service. The only thing, I suppose, as I alluded to, is the SPA time. We are not really given any service development time. We know things about what may happen in radiology, where they're trying to get another MRI scanner and... 16:38

374 Q. I'm trying to get at do you feel there is a role for you in designing your own destiny? You know, if you want change to happen, do you see that as part of your role or do you see it as not part of your role? 16:38

A. I don't see it much as part of my role now. I used to see it much more. But I've found - a bit candid here - I've found, coming from England then to Northern Ireland, there was a big discrepancy in what we did and the services that were well kind of entrained in England were not even being used at all. I found that changing some of this was a really -- very, very difficult, and I used to get a lot of resistance, you know, things which were clearly things that shouldn't be done. Just often I kind of gave up really. 16:38

375 Q. You gave up. If you take the issue of the independent service provider, for example, did somebody sit there, sit the radiologist down and say we've got too much work to do and we think we should outsource some of it, what should we outsource, what do you think? Did you have that chance to input before it started? I know you've fed back afterwards, but were they saying we 16:39

don't want to pay you waiting list initiatives any more or anything of that nature?

A. I don't think it was really discussed. I think I have made -- you know, I have said to them, please don't outsource any urology. 16:39

376 Q. But they didn't ask you?

A. I don't think they did. I don't think I was asked whether it should be done or not.

377 Q. Was there a tension around the waiting list initiative payments; was that causing trouble? 16:39

A. It did cause some trouble for me, not necessarily because of financial things, but more, as I say, because I used to get two things from those: I used to be able to report them and it saved me time for the MDT, because I relied on, you know, I looked at my 16:39 report and I was happy with it, obviously. Whereas if it was someone else's and someone I didn't know, that I knew the service was associated with a discrepancy, it cost me time.

378 Q. I meant before the independent service provider. I 16:40 mean, was it an issue that there were lots of waiting list initiatives that were regarded as a bad thing from the point of view of job planning, for example?

A. No, I don't think so.

379 Q. That wasn't part of the tension around how you did your 16:40 job plan or anything like that?

A. No, because the waiting lists were always separate, completely separate from the job plan. I mean, I would never put the two together. Waiting lists are

completely -- they're something you do in your own time. They're not really...

380 Q. But the Trust have done that. The reason I ask, they've said we're paying too many of that, we're going to send it to Australia overnight? 16:40

A. Yeah. It's very difficult to work out what -- because we've had issues with waiting lists in the Trusts that you probably know about. Why they wanted to stop waiting lists at that time, I really don't know. I'm not sure whether it actually saves them any money to 16:40 send them anywhere else.

381 Q. The job planning, was that a source of confrontation with you personally and the whole job planning and leave and all of that? I'm thinking now of the MDT quoracy and the fact that you were missing for a quite 16:41 a few Thursdays.

A. Yeah, I mean, I take some of the blame for that anyway in terms of my own priorities and leave and study leave. You know, I'm not blaming the Trust for that. I would... 16:41

382 Q. But did you try and change it to another day. If you were kind of tagging it on to your Friday, I can kind of see how that would happen?

A. Yeah. Well, I think I did mention the Urology MDT changing to another day. I suggested a Tuesday or a 16:41 Wednesday and my quoracy rates were probably high for those days, but I don't think it was something that was --

383 Q. So you didn't have a conflict about people telling you

couldn't take your leave those days or anything like that?

A. I don't think so. Well, leave is always a request and it was signed off.

384 Q. Yeah. 16:41

A. I don't think anyone ever came and said you can't have this leave. No, they never did that.

385 Q. So that wasn't a source of it, you just didn't know why the decision was made about the waiting list initiative versus independent sector? 16:41

A. Yes. I still don't know why.

386 Q. Another issue is, you mentioned the issue of MDT and sitting there all afternoon and radiology input, which is something that I certainly recognise. Have you had any discussions with people about streamlining the 16:42 radiology input into MDTs to make that better, either within the Trust or within Northern Ireland?

A. No. I think from what I've -- the emails I've kind of read in the past - I think maybe some were contained in the bundle - the expectation is they want all core 16:42 members there, they made it very clear, for the whole meeting.

387 Q. But there are the various initiatives about how radiology input can be made a bit easier because it's a general problem, I think? 16:42

A. Yeah.

388 Q. It's not unique to the Southern Health Care Trust. You're not aware of anything that's coming on that?

A. I think Mr. Glackin has expressed interest in trying to

make it clear which cases need radiological input. He does keep mentioning that. Certainly, even if I had to stay for the whole meeting, it would at least substantially help the prep time, which is very valuable, because I find I'm at the limit of it a lot of the time.

389 Q. You mentioned the Belfast Trust and some of the working during Covid. Have there been any discussions about sharing imaging formally through networked PACS images?

A. Yes. 16:43

390 Q. Because that's a way of getting a bit more expertise together, isn't there, over a wider geographical area? Where have you been able to take that, or is that --

A. I can't give you have much information, unfortunately. I know it has been discussed before. 16:43

391 Q. Is that the sort of thing that you feel you could take forward as a consultant if you were given a bit of support for development?

A. I think people have tried to take that forward already and I don't think it's worked. So, probably wouldn't be something I would -- 16:43

392 Q. Similarly on the recruitment, have there been any discussions with the whole consultant body as to what are we going to do to make this more attractive? Have the senior management team in the Trust, HR and Medical Director got you all together to talk about that? 16:43

A. No. No. I think they tend to discuss along the traditional lines with, you know, with the clinical director. I do --

393 Q. Would you welcome that? Do you think people would feel engaged and listened to?

A. I think -- yes, I think I have provided opinions before on what could be done to improve.

394 Q. That is different from people actually asking you. 16:44

A. Yes, yes. I mean, I've never been asked. I rarely would get asked anything really, unfortunately.

DR. SWART: Okay. Thank you. That's all from me

CHAIR: You'll be glad to know I have no further questions -- 16:44

THE WITNESS: Great.

CHAIR: -- for you, Dr. Williams. Thank you very much for coming along.

THE WITNESS: Thank you

CHAIR: It's now a quarter to five and we'll see everyone again in the morning. 16:44

THE INQUIRY WAS THEN ADJOURNED UNTIL WEDNESDAY, 24TH MAY 2023 AT 10:00 A.M.