Urology Services Inquiry

Oral Hearing

Day 47 – Thursday, 25th 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.

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1 THE HEARING COMMENCED ON AT 10:00 AM. ON THURSDAY,
2 25TH DAY OF MAY, 2023 AS FOLLOWS:
3
4 CHAIR: Good morning everyone. Ms. McMahon?
5 MS. McMAHON: The witness this morning is Aldrina 09:59
6 Magwood, who was the Director of Performance and Reform
7 in the Trust until 2022, and she is going to affirm.
8
9
10 MS. ALDRINA MAGWOOD, HAVING BEEN AFFIRMED, WAS EXAMINED 10:00
11 BY MS. McMAHON AS FOLLOWS:
12
13 1 Q. Good morning. Thank you for coming in to give evidence
14 the Inquiry. You have already provided evidence in
15 written form in a Section 21 response, and I will just 10:00
16 take you to those. The first one can be found at
17 WIT-35918, and that's Section 21 Notice No. 54 of 2022.
18 Your signature can be found at WIT-35974, and it is
19 dated 15th July 2022. Do you recognise that as your
20 signature? 10:01
21 A. I do, yes.
22 2 Q. Do you wish to adopt that as your evidence to the
23 Panel?
24 A. I do.
25 3 Q. We have received an addendum notice dated 22nd May 10:01
26 2023. It can be found at WIT-96706. Again, your
27 signature is at 96713. WIT-96713. Do you recognise
28 that as your signature?
29 A. I do.

1 4 Q. And you wish to adopt that as your evidence to the
2 Panel?
3 A. I do, indeed.
4 5 Q. Thank you. The second addendum notice made some
5 additions and corrected some typos and, where 10:01
6 necessary, I'll take the Panel to those, but thank you
7 for that evidence.
8 A. Okay.
9 6 Q. You have provided a lot of detail of your work in your
10 role as Director of Performance and Reform, and today 10:01
11 I just want to ask you about some key aspects of your
12 evidence. First of all, we'll start with looking at
13 some of the governance structures and the information
14 processes, and the way in which information would have
15 either reached you as Director of Performance, or you 10:02
16 would have passed that information on to others such as
17 the Trust Board, fellow members of the SMT, or to HSCB
18 and the Commissioner.
19 A. Mm hmm.
20 7 Q. We'll look also at how your role interacted with others 10:02
21 in governance terms, so the Panel can look at how
22 information sharing took place among the various
23 layers. Then, we'll look at what you knew about the
24 issues around urology and about Mr. O'Brien; what you
25 should have known or could have known, and what you 10:02
26 might have done had you have known?
27 A. Okay.
28 8 Q. Then you have provided us with some reflections which
29 I just want to ask you about also.

1
2 Before we get into all of that, just in relation to
3 your background and role, you have a nursing background
4 and a variety of Health Service roles throughout
5 the years. Over a 14-year period you have held a 10:03
6 number of posts in the Southern Trust?
7 A. That's right.
8 9 Q. You held the post of Director of Performance and Reform
9 in an acting capacity between 2015 and 2017?
10 A. That's right. 10:03
11 10 Q. And then you became the substantive post-holder in that
12 role from 2017 until February 2022?
13 A. Correct.
14 11 Q. And you have since moved on from that role?
15 A. I have, yes. Yes. 10:03
16 12 Q. Your job description while Director of Performance is
17 described as.
18
19 "Including leadership of the performance management
20 framework, strategic and operational planning, capital 10:03
21 planning and strategic reform, and modernisation of
22 services".
23
24 You were also the key link with the HSCB on
25 commissioning and delivery services? 10:03
26 A. That's right.
27 13 Q. So, you would have had to have a fairly broad
28 understanding of most aspects of Health Service
29 provision within your role?

1 A. Yes. Yes.
2 14 Q. Your role is described in your statement as the
3 coordination, supporting, planning and enabling
4 performance improvements, but you weren't involved in
5 clinical governance or operational delivery? 10:04
6 A. No, I wasn't.
7 15 Q. To some degree, your role did overlap with the Director
8 of, for example, Acute Services when you had to look at
9 performance issues --
10 A. Yes. 10:04
11 16 Q. -- or any matter, in fact, that may have impacted on
12 targets that were agreed through the Commissioner?
13 A. Correct.
14 17 Q. Or any issues that, in fact, impacted on the agreement
15 with the Board and the service delivery expectations. 10:04
16
17 Now, I just want to turn, first of all, to some of the
18 examples of ways in which the information reached you.
19 A. Okay.
20 18 Q. If we start off with the quarterly cancer performance 10:04
21 meetings. Now, these were meetings I think you
22 actually didn't attend?
23 A. That's right.
24 19 Q. But there was an expectation from those meetings that
25 issues would escalate to you, especially in relation to 10:05
26 performance targets. Would that be fair?
27 A. Yes, that's fair. There would have been the cancer --
28 the quarterly meeting would have been one of a number
29 of network meetings. I think you have had evidence

1 from Fiona Reddick, for example, as Head of Cancer
2 Services, and you'll hear from others. But those sorts
3 of groups, all that would have met and networked, all
4 would have fed into any issues to be escalated to go
5 into a wider Trust level across all directorates 10:05
6 meeting with the Health and Social Care Board, and that
7 was the level at which I pulled those together.
8 20 Q. Specifically in relation to cancer data, if we could
9 use that broad term --
10 A. Sure. 10:05
11 21 Q. -- this is the way that information percolated up so
12 that you could either assure or inform or warn either
13 the Trust Board or the Health and Social Care Board of
14 concerns around meeting targets?
15 A. Yes. 10:06
16 22 Q. Was that data purely based on numbers rather than the
17 narrative behind the numbers?
18 A. Yes, I think that's a fair question to ask. I suppose
19 it was twofold. If you look at access to care as a
20 quality measure, which I certainly would, it was 10:06
21 numbers in terms of who was accessing care within the
22 timely parameters of 31 days, 62 days et cetera in
23 relation to the cancer pathway. So, it was numbers in
24 that regard. But when you're not meeting them, it is a
25 quality indicator. 10:06
26 23 Q. Well, we'll come to look at the ways in which perhaps
27 the story beneath the figures was not explored shortly.
28 A. Sure.
29 24 Q. Just for those particular meetings, would it be fair to

1 say that particular issues of concern around
2 performance, individual performance or indeed
3 directorate performance, and the reason for that were
4 not brought to those meetings and were not brought to
5 you? 10:07
6 A. When you say "those meetings", do you mean in relation
7 to the quarterly meeting?
8 25 Q. The cancer service?
9 A. I wouldn't have been present at that but my member --
10 I would have had Lynn Lamb, as the Head of Performance, 10:07
11 would have attended that, alongside the Assistant
12 Director, Barry Conway, for Cancer Services. So, if
13 there was issues coming from that, generally the way
14 that would have made its way to me from the quarterly
15 meetings would have been Lynn maybe would have taken 10:07
16 issues from it that would have then fed into the
17 performance report that would have went the Trust
18 Board. So, whilst the Trust Board got numbers, there
19 was also a narrative. There would have been, for
20 example, we would have highlighted examples of 10:07
21 particular specialities that were under pressure. So,
22 it was all at a speciality level, it certainly wouldn't
23 have been at individual level.
24 CHAIR: Can I ask you to slow down a little bit because
25 we're trying to get notes of your evidence. I know 10:07
26 it's very tempting to want to get it all over with but
27 if you could just slow down a little bit.
28 A. I'm a fast speaker at the best of times so I'll try to
29 slow down.

1 26 Q. Ms. McMAHON: (Off microphone) because we'll come to
2 the performance report in a moment - -
3 A. Okay.
4 27 Q. So that will give the Panel a better indication of an
5 example of where your narrative accompanies data, and 10:08
6 the Panel can look at the adequacy of that.
7 A. Yes, okay.
8 28 Q. For the purpose of the quarterly cancer performance
9 meetings, these were attended by the HSCB
10 representatives also? 10:08
11 A. Yes, correct.
12 29 Q. And the Acute Directorate senior staff?
13 A. Correct.
14 30 Q. And the Head of Performance, which would have been
15 someone you line managed? 10:08
16 A. Yes.
17 31 Q. And the Assistant Director of Performance Improvement.
18 So, it would be fair to describe those meetings as
19 quite high level?
20 A. Yes, but they would have gone into detail at particular 10:08
21 specialities around challenges. You know, things like,
22 oh, Mr X is taking a sabbatical or whatever. Things
23 like that might have been the sort of things we had a
24 chance to get ahead of the game, if you know what
25 I mean, in terms of saying, look, there's some 10:08
26 challenges that are coming over the hill here in
27 relation to that particular speciality because of this,
28 or other wider system challenges. So, from the Board's
29 perspective, perhaps talking about cancer delivery in

1 that speciality from other Trusts or across the system.
2 So, it would have been still sitting at that level;
3 I don't think you would have much individual clinician
4 type discussions at that level.
5 32 Q. Just based on what you have said then, it sounds like 10:09
6 it was both formalised but ad hoc, where people raised
7 issues that were potentially coming down the road so
8 that there could be some preparation made for them. If
9 there were identifiable localised concerns, for example
10 around cancer targets that had been identified to 10:09
11 particular areas, would the narrative behind that be
12 spoken about at those meetings? We are just trying to
13 get a feel of how useful those meetings are from a
14 governance perspective.
15 A. Okay. So, I suppose, just to clarify in terms of your 10:09
16 response there, I would say it was a formal meeting.
17 It was a formal meeting in that it was held by the
18 Board, the Board took the notes, the minutes et cetera,
19 so that was our interface meeting in relation to cancer
20 with the Commissioner. So, it was a formal meeting in 10:10
21 that regard.
22
23 In terms of other discussions around things that,
24 I mean, again that would have been based on
25 relationships. There would have been issues brought in 10:10
26 if it was relevant to the performance in a formal way
27 at that meeting. But, I mean, there would have been
28 other meetings within the Trust, perhaps. Maybe that's
29 where you are nudging into, were there other

1 discussions that were happening within the service.
2 That would have been happening within the service under
3 the management team in terms of the operational team.
4 33 Q. Well, just I'll ask you a specific question, because
5 that is one of the few meetings that has cancer in its 10:10
6 title --
7 A. Yes.
8 34 Q. -- that directly feeds up to you. If there was an
9 issue like triage, for example, that was impacting on
10 the 31/62 day pathway and that was coming from one 10:10
11 source or one area, would you expect that information
12 to percolate up from this meeting to you?
13 A. What would have come to me really would have been, as
14 I say, it was more to do with the overall corporate
15 position. So, you really would have just got things 10:11
16 that were threatening the -- where there was trend
17 changes in particular, for example. For a long period
18 of time, we would have looked at our cancer performance
19 relative to the rest of the Northern Ireland system,
20 for example, and would have looked at... 10:11
21
22 Our discussions with the Board at the meetings I would
23 have been at would have been, okay, here is where you
24 are as a Trust in relative terms. Particularly for the
25 62-day pathway, for example, we would have been in a 10:11
26 better position than other Trusts. At a point in which
27 it became evident that the volumes and the demand were
28 actually compromising us, we would have been given a
29 heads-up, for example, to say this is now going to

1 start impacting on our 31-day. So, it was all very
2 much at system level in terms of the information that
3 would have been coming to me from those.
4 35 Q. Just going back to my question, would you have expected
5 that information, individualised or directorate level 10:12
6 information, that was impacting on cancer targets to
7 percolate up through these meetings; your answer would
8 be no?
9 A. No, not from those meetings.
10 36 Q. And the Panel will know or can be told that it didn't 10:12
11 percolate up?
12 A. It didn't, no.
13 37 Q. Another way in which information reached you was
14 through performance metrics. Now, if you could just
15 briefly explain what performance metrics are and how 10:12
16 they assist you in your governance role.
17 A. Oh. So, in terms of we would have -- a couple of -- a
18 range of ways that would have come. If I start with
19 the performance meetings; I don't know if you are going
20 to go specifically into those. We would have looked at 10:12
21 -- my team would have met with each of the
22 directorates, so Acute would have been one of a number
23 of meetings with the director and with their senior
24 teams, and they would have looked at all our
25 performance metrics that were part of our commissioning 10:12
26 plan, direction and goals for achievement that were
27 agreed with the Commissioner. That would have been
28 volumes of activity, waiting times, length of waiting
29 times, longest waits, all at speciality level across

1 diagnostics and individual specialties, et cetera. It
2 wouldn't have been -- also, would not have been at
3 individual clinician level.
4 38 Q. So they loosely can be described as performance
5 management arrangements? 10:13
6 A. Yes, that would have been the performance management
7 arrangements.
8 39 Q. They would have then fed the information into the
9 metrics, the data would then have informed you how
10 everything was operating? 10:13
11 A. Yes.
12 40 Q. And presumably you would have had your own markers for
13 being alerted to areas of concern through those
14 metrics?
15 A. Yes, absolutely. I mean, it's no surprise that the 10:13
16 performance metrics that are sitting in the current
17 commissioning planned direction, which has been rolling
18 forward for a number of years, is no longer being met.
19 So we had moved into, for example, a position of
20 agreeing trajectories, performance improvement 10:13
21 trajectories. That gave us a range of what we were
22 expecting to see delivered. So, anything that fell
23 outside of that would have been alerted.
24 41 Q. One of the other aspects of your job -- I'm not sure if
25 you were the drafter or overseer of the annual quality 10:14
26 reports?
27 A. Yes. It would have been coordinated through my
28 Assistant Director for Quality Improvement.
29 42 Q. Would that sign-off come from you? Would you be the

1 one who -- that fell on your directorate, I presume?
2 A. It did. It did. I would have sort of managed the
3 pulling it together. But it was very much a corporate
4 document, because if you look at the content of it, it
5 certainly would have been indicators. Even the likes 10:14
6 of some of the mortality figures and re-admission rates
7 et cetera, that would have been other metrics that
8 would have been coming from, for example, say the
9 Medical Directorate. So, what we were responsible for
10 doing was pulling it together to deliver what was 10:14
11 commissioned, which was to ensure we delivered an
12 annual quality report based on the content and metrics
13 as determined by the Department of Health. So, I would
14 have coordinated that.
15 43 Q. You have described it as a corporate document? 10:14
16 A. Yes.
17 44 Q. It's also the way in which the public and staff are
18 assured of both the quality, the standard and the
19 safety of patients the Trust. Would that be a fair
20 comment? 10:15
21 A. Yes, I think it is. I mean, I think there are some
22 limitations to the document. How it is constructed is
23 determined as what they call a minimum data set by the
24 Department of Health, and so we would have included
25 that. But we did find that as a Trust, it didn't 10:15
26 necessarily meet all our needs in terms of some of the
27 items that we would have wished to have presented in
28 it. So it started a grow a little, if you will, in
29 terms of some of the content that was included in it.

1 45 Q. I just want to look at the one for 2017/2018 --
2 A. Sure.
3 46 Q. -- just for the Panel's information. They'll see what
4 this looks like and what's reported. WIT-36606 is the
5 first page. 10:15
6 A. Yes, early one.
7 47 Q. This is the cover of it. Then if we go two pages in to
8 WIT-36608. The third paragraph down:
9
10 "The purpose of the annual quality report is to detail 10:16
11 what we do, how we are performing, and provide
12 assurance that our systems assess the quality of our
13 services and drive continuous improvement."
14 A. Mm hmm.
15 48 Q. It says later in the report: 10:16
16
17 "The purpose is to allow the Trust Board to scrutinise
18 and seek assurance regarding the quality and safety of
19 services provided. The report is for the benefit of
20 patients, carers, families and staff." 10:16
21
22 A. Mm hmm.
23 49 Q. The report has a user-friendly feel about it when you
24 look at it?
25 A. Mm hmm. 10:16
26 50 Q. As a matter of comment to see if you would agree with
27 me, there doesn't seem to be a lot of bad news in the
28 report, it does seem to be very public relations
29 positive, if I can use that term?

1 A. Yeah, I think it's a fair comment. I think I included
2 in my witness statement it does read a bit more as an
3 annual report. It did actually -- a bit feature of it
4 is that piece that you have just mentioned, which was
5 as an organisation in our 2017/2018 corporate plan, one 10:17
6 of the key strands within that was about encouraging
7 and empowering our staff. So, what we did, one of the
8 things we added to this was to try and ensure that we
9 did feature and demonstrate where staff were taking
10 positive efforts for improvement of our services. So, 10:17
11 it did have quite a lot of content in that regard.
12 51 Q. It may not be the place then for anyone to find
13 concerns around patient safety and patients' concern,
14 concerns around service delivery?
15 A. I would say it was light in terms of again -- but it 10:17
16 was in line with the data set as required by the
17 Department of Health. But for the likes of things like
18 re-admission rates and mortality rates and things like
19 that, that was also included in there, so some of that
20 data was in there certainly. But I do accept that it 10:18
21 is a fair comment that it reads as probably a positive
22 story.
23 52 Q. I ask these questions in the context of that particular
24 report, 2017/2018.
25 A. Sure. 10:18
26 53 Q. The Inquiry has heard evidence of incremental knowledge
27 gathering from 2016 around concerns that subsequently
28 escalated into findings of, for example, notes at home
29 and issues with triage and referral and patient safety,

1 and ultimately the SAIs, which I am sure you know about
2 because you were acting up at the time when the alert
3 was handed in. But we'll come to that.
4 A. Can I just say on that, if you don't mind. They did
5 also -- that report also includes, as you know in the 10:18
6 pack there, the scope and scale of the SAIs, the trends
7 in the SAIs et cetera, and complaints. That would have
8 also been included in the content.
9 54 Q. That's a data reflection rather than a quantitative
10 reflection? 10:19
11 A. Well, it reflects the types of complaints that the
12 organisation is receiving, et cetera. It gives a
13 flavour but it certainly doesn't go into detail as a
14 report.
15 55 Q. Would you agree with me if I said that as a quality 10:19
16 assurance document for the Trust Board, it falls short?
17 A. Yes, I would.
18 56 Q. Now, in your role as director, your governance
19 responsibility overlapped with others. You were a
20 member of the senior manager team? 10:19
21 A. Yes.
22 57 Q. You attended Trust Board meetings, I think seven times
23 a year is what Shane Devlin says the requirement is.
24 You also had a significant relationship with the HSCB
25 and the Commissioner? 10:19
26 A. Yes.
27 58 Q. We'll just look at how you might have become aware of
28 issues. The starting point of your evidence in your
29 statement is that you were acting up for Mr. Devlin

1 when you were approached by Maria O'Kane at the time to
2 alert you to the fact that the department had -- an
3 alert notice had been placed with the department in
4 light of issues arising and concerns around
5 Mr. O'Brien. I think you were temporary in that post 10:20
6 for a couple of weeks, were you, when it --
7 A. No, actually it was days.
8 59 Q. Days?
9 A. That's the way it worked.
10 60 Q. And that was the first time that you were aware that 10:20
11 anything had happened?
12 A. Aware of a clinical concern.
13 61 Q. Clinical concerns. As I understand it, you didn't take
14 any action or any decision-making around that because
15 of the short-term nature of your acting up? 10:20
16 A. Yes, yes.
17 62 Q. Were you assured by Mrs. O'Kane at that time around
18 patient safety and harm when she reported that to you,
19 or was that something that came up subsequently?
20 A. Yes. No, I would describe that discussion as very much 10:21
21 in-hand, if you will, expression was the way it was
22 sort of presented. What I understood at that point in
23 time was that there had been work underway led by
24 Mr. Haynes. Maria had advised me, because I was
25 covering at that time, because they were going to be 10:21
26 making an alert. So I was assuring around the process
27 of the alert being made, et cetera. But it was very
28 much a work in progress, if you will, is what
29 I understood it to be at that time.

1 63 Q. Your view at that time was there was still information
2 gathering, there was enough information to alert?
3 A. Yes.
4 64 Q. But the full picture hadn't yet been obtained?
5 A. Yes. 10:21
6 65 Q. And subsequently Mr. Devlin came back; this is July
7 2020?
8 A. That's right.
9 66 Q. He came back and took the reins from there?
10 A. Correct. 10:21
11 67 Q. Before I move on to the area of ways in which you might
12 have been informed by others, what was your
13 recollection when you heard that at that time in July
14 2020?
15 A. I think I immediately felt... I said clinical concerns 10:22
16 because I have to say the differentiation for me there
17 was -- and I mean the Panel will have heard plenty in
18 relation to an awareness of a triage and a workaround
19 situation that was going on with respect to
20 Mr. O'Brien, but I wasn't aware of any direct clinical 10:22
21 issue, and I'm not going to mention the fact that
22 I know you have discussed very much whether triage and
23 issues with triage do, in fact, become clinical issues,
24 so I don't dispute that.
25 68 Q. And we'll come on to discuss that issue shortly. 10:22
26 A. Sure. But I suppose my immediate reaction was just
27 I was surprised, to be honest.
28 69 Q. So --
29 A. And concerned, of course.

1 70 Q. The ways in which you may have been informed of the
2 issues at operational level, your starting point is
3 that you had no operational responsibilities for
4 urology?
5 A. Correct. 10:23
6 71 Q. Or any of the other directorates?
7 A. Yes.
8 72 Q. The assurance regarding governance oversight you
9 consider in your statement to be a matter of
10 responsibility for the Director of Acute Services? 10:23
11 A. Yes. For the services, yes.
12 73 Q. Now you have referred in your statement to directorate
13 performance meetings at operational level. Were those
14 meetings in which you received assurance of performance
15 issues at service level? Was that the purpose of those 10:23
16 meetings for you?
17 A. Yes. For me it was, because that was essentially how
18 we built the picture around where there was
19 intelligence to tell us there was challenges with
20 performance, or where we maybe importantly needed to 10:23
21 challenge in or provide support to for that matter. I
22 mean, my directorate was entirely constructed around
23 providing support to directorates as they asked for it,
24 or as the Board -- where we could bring in additional
25 resources, et cetera, and working with the Board to 10:24
26 secure support for the directorate. So, that was my
27 direct line for finding out when there were issues
28 coming forward or concerns that we would need to
29 preplan for.

1
2 So again, I have mentioned it was on more than one
3 occasion. So, for example, where we did know like even
4 somebody was going to retire or leave, for example,
5 then that would have been fed up through the 10:24
6 performance and then the question would be 'and what
7 does that mean for us then in terms of us as a system'.
8 I would have been looking at that from a performance
9 perspective, of course. Obviously the Operational
10 Director would have been thinking about that in a 10:24
11 broader perspective.
12 74 Q. Was it all members of the SMT or was it a variety of
13 levels of staff who attended the directorate
14 performance meetings?
15 A. The directorate performance meeting was generally the 10:24
16 director over the service area, so in this case the
17 Director of Acute Services with their senior team,
18 their Assistant Directors. Then, my Assistant Director
19 Performance Improvement or my head of performance would
20 have attended those. The most directorates were 10:25
21 structured in that they had -- so they would have had
22 different types of what they called SMTs in their own
23 area, so there was an SMT governance in most of which
24 none of my team attended.
25 75 Q. Why was that? 10:25
26 A. I guess just, you know -- it's something I've reflected
27 on actually in looking at this. We would have had --
28 the other supports that I would have provided to
29 directorates was in corporate planning, so our planners

1 would have been doing projects or working to support
2 directorates or whatever, and they would have also
3 attended senior team meetings. But nobody attended the
4 governance meeting which was very much around
5 individual governance issues. I am not sure -- 10:25
6 76 Q. Was that always the position during your tenure as
7 director?
8 A. Yes.
9 77 Q. Did you ever think, hold on, maybe we should be in on
10 those meetings? 10:25
11 A. Yeah. Well, I did but probably not from the
12 perspective of -- some of the issues would have tipped
13 from the governance meetings into the performance
14 meetings. If that was the case, things came to me
15 where it was relative to the performance portfolio, if 10:26
16 you will.
17 78 Q. Can I just confirm, were you at these directorate
18 performance meetings at operational level?
19 A. No.
20 79 Q. You didn't attend those? 10:26
21 A. No, no. My assistant director would have attended
22 those.
23 80 Q. So, the only way in which you had interaction with
24 others with responsibility around governance and
25 performance was at the SMT? 10:26
26 A. Or directly with the individual directors. So, I mean,
27 I would have had one-to-one meetings with the
28 individual directors.
29 81 Q. As and when needed?

1 A. As and when needed. They were scheduled, they weren't
2 always used. There was an informal -- probably a more
3 informal relationship. But, I mean, it didn't need to
4 wait for meetings. If I take any example of -- and
5 I actually picked up, it was one from very early days 10:26
6 there that Dr. Rankin had included within her witness
7 bundle, for example, in relation to cancer urology
8 pathway. There was -- I think it's from 2010 and I was
9 assistant director at the time. So, where a director
10 would have thought, right, I've got a problem here 10:27
11 coming out of their governance meeting, we would have a
12 port of call through the Director of Performance and
13 Reform to provide support for them. So, that
14 particular email as I read it, I didn't recall it but
15 when I have seen it, that there sort of typifies the 10:27
16 type of where Dr. Rankin clearly had asked for us to go
17 in and work with her assistant director to provide some
18 support. So it would have been that kind of direct
19 relationship with individual directors. That happened
20 with the directors across all services. 10:27
21 82 Q. We'll come on to look at another example in which you
22 were asked to provide support and an improvement
23 initiative in the day care --
24 A. Elective day care centre.
25 83 Q. We'll look at that in a moment. I just want to be 10:27
26 clear for the Panel the structure by which you were
27 personally present and could have been informed of
28 things. SMT governance you weren't part of, your
29 directorate wasn't part of that?

1 A. SMT governance in the directorates. Certainly some of
2 the stuff in my bundle and references I have heard of
3 others talking about SMT governance might be a
4 different thing. So, historically the senior
5 management team used to meet weekly on -- I think it 10:28
6 was every Thursday -- or once a month anyway. The SMT
7 meeting was called SMT governance, so I definitely
8 would have been present as that as a member of the
9 senior management team. I think I have included this
10 in my witness statement as well. 10:28
11
12 In the main, that was around taking the full suite of
13 governance papers that would have been gong to
14 Governance Committee, going through -- so there was
15 certainly an opportunity for me. 10:28
16 CHAIR: You're speeding up again.
17 A. I'll slow myself again. There would have been an
18 opportunity at that time, certainly when SMT governance
19 was there and you were reviewing the papers, for me as
20 a member of the senior management team to question 10:28
21 that, to have conversations about that. That's
22 different from the SMT governance at directorate level,
23 which was also present under the leadership of the
24 Directorate of Operational Services.
25 84 Q. MS. McMAHON: Despite all of these, the availability of 10:28
26 all of this information and people together, none of
27 the issues that are before the Inquiry ever came before
28 you?
29 A. Correct.

1 85 Q. You also reference a document called the Trust
2 Performance Management Framework, and that comes from
3 your directorate?
4 A. Yes.
5 86 Q. That is a way in which the Board again and HSCB are 10:29
6 assured of performance and outcomes?
7 A. Yes. Well, it's defining the mechanism.
8 87 Q. Defining the mechanisms in order to satisfy the service
9 agreement?
10 A. Yes. 10:29
11 88 Q. I don't want to go over old ground again, but again
12 that's information before the Inquiry that wasn't
13 reflected in any of those documents because you didn't
14 know about it?
15 A. Yeah. I suppose that document in particular - yes is 10:29
16 the answer to your question - but that document in
17 particular was to try to set out the full scale of how
18 we worked within the Trust. So, it wasn't just the
19 Board. That would have been very much for the Trust
20 Board in understanding how areas and issues were to 10:30
21 come to the fore and through that mechanism. But yes,
22 you are absolutely right. Even with that, this
23 particular issue hadn't come through.
24 89 Q. The Inquiry has heard and will hear evidence that the
25 information and the detail and the extent of concerns 10:30
26 didn't ever reach the Trust Board. Is that something
27 that surprises you?
28 A. Well, I mean, I know in looking at my bundle, there was
29 obviously some items that did come to Trust Board. The

1 Trust Board confidential in January 2017, for example,
2 which was following the exclusion of Mr. O'Brien, that
3 issue had come.
4 90 Q. That was a staffing issue?
5 A. Yes. 10:30
6 91 Q. But the clinical concerns and the patient risk,
7 potential for harm and the safety issues generally
8 arising from the concerns before the Inquiry don't seem
9 to have found their way to the Trust Board?
10 A. Correct. 10:30
11 92 Q. Does that surprise you?
12 A. In light of while I'm sitting here today, yes.
13 93 Q. Even in your job at the time when you were in post --
14 A. Well, it does. Yes, absolutely.
15 94 Q. -- would you have expected those sort of details to 10:31
16 rise up through?
17 A. Absolutely.
18 95 Q. There is a lot of detail in your statement and, to be
19 fair to you, a lot of information provided by the Trust
20 around the core activity being delivered against the 10:31
21 service and budget agreement, the impact of service
22 agreement -- the impact of service delivery against
23 ministerial targets and objectives; there seems to be a
24 lot of data. Was there more focus on the data and not
25 focus on the detail? 10:31
26 A. Sadly, I would say yes in terms of what we were being
27 held to account from our commissioning perspective. It
28 was always -- I mean, if I give an example of that how
29 it sometimes became a challenge to get some of those

1 issues. I do recall a time at which the targets in
2 particular that look for Outpatients, for example,
3 focus on new Outpatient appointments. I recall a time,
4 which working through my network, which was the
5 Directors of Planning Network within the other Trusts, 10:32
6 you know, concerns were raised through our organisation
7 appropriately of clinical concerns from clinicians
8 around the backlog review position, which wasn't
9 sitting within anybody's targets. We called it as, you
10 know, reviews beyond clinically indicated timelines. 10:32
11 96 Q. What year was this? What sort of timeframe are you
12 talking about?
13 A. Michael Bloomfield still would have been as director
14 with responsibility for performance. So, Michael would
15 have worked very well with us and recognised that that 10:32
16 was something that we wished to then report on, because
17 we felt that we had concerns there about the growing
18 lists. With, you know, changing our clinic templates,
19 for example, to reduce the numbers of new appointments
20 which was going to have an impact on the target, we 10:33
21 agreed with Michael so that we can increase our review
22 appointments because of the clinical concerns around
23 having those run out.
24 97 Q. I think that was around 2015/2016. Would that be about
25 the same timeframe? 10:33
26 A. Yeah, that's about right.
27 98 Q. I will deal with, now you have mentioned
28 Mr. Bloomfield's name, I'll perhaps go to that point.
29 A. Okay.

1 99 Q. You have said already that you had no knowledge of the
2 specific clinical concerns around Mr. O'Brien prior to
3 or after the matters pertaining to this Inquiry emerged
4 until the time you left the Trust?
5 A. With the exception of the triage issue. I was aware 10:33
6 of.
7 100 Q. That's the issue I am just going to mention, just to
8 square that off. Now, when you talk about your
9 knowledge of triage, I think this goes back to a report
10 or a review of Outpatients booking by the HSCB under 10:34
11 Mr. Bloomfield, who was the Director of Performance and
12 Corporate Services at the time. Maria Wright from
13 HSCB, she led the piece of work with the Southern Trust
14 looking at the way Outpatient booking was handled and
15 the way in which it was carried out? 10:34
16 A. Yes.
17 101 Q. Now, the report was sent to you --
18 A. It was.
19 102 Q. -- ultimately. Is that first time you were involved in
20 the report, or had you been -- was it an independent 10:34
21 report carried out by the HSCB and then sent to the
22 Trust.
23 A. Yeah. No. No.
24 103 Q. Or were you involved in the initiation of it?
25 A. The development of it. I wasn't involved in it; I was 10:34
26 aware. So that happened just -- it would have happened
27 just before I came into the director role, so I was
28 aware that the Board would have been present in doing
29 the review. I knew Maria because Maria had worked

1 previously in my team. I had worked her with her;
2 she'd been very much one of the architects of writing
3 the Integrated Elective Access Protocol back in the
4 early 2000s. I was aware they were in and I was aware
5 that they were doing the review. They did it across -- 10:35
6 it wasn't just the Southern Trust, it was across the
7 piece. Michael had commissioned that across just to
8 get a stock-take, I suppose.
9
10 And then with that -- so from our own perspective, 10:35
11 Anita and the team, the Acute team, would have been
12 aware. When that document would have come to me, it
13 wouldn't have been the first time we'd seen it. It
14 certainly would have come from a perspective of having
15 been QA'ed et cetera with the team that was involved 10:35
16 during the Outpatient review, et cetera. Then it was
17 formally issued -- I think the actual review itself was
18 probably -- I think it was like December or January.
19 104 Q. January.
20 A. Yeah, January. Then the formal report wasn't then 10:35
21 issued until June, at which point I had moved into post
22 in March.
23 105 Q. And you were in full-time post then?
24 A. Yeah. I was in the full-time director role.
25 106 Q. We don't need to go to this reference, members of the 10:36
26 Panel, but Anita Carroll refers to this in her Section
27 21 at WIT-21284, paragraph 12.7. She says:
28
29 "The report made specific reference to triage as

1 follows: For the majority of urology referrals, daily
2 triage is now achieved but there is a longstanding
3 issue with turnaround time from one consultant, and
4 referrals not returned from triage continues to be a
5 key issue for booking staff." 10:36
6
7 Now, did you read the report before you sent it on to
8 all of the other directors and assistant directors?
9 A. I will have read that report.
10 107 Q. Do you remember, it's a small extract; it jumps out -- 10:36
11 A. It's a small extract.
12 108 Q. -- to us for obvious reasons, but do you remember this?
13 A. I do. I think it actually jumped out at that point in
14 time. There was a discussion about because it had been
15 individualised in that way, which we felt was unusual. 10:37
16 But, that said, because, for example, there were, if
17 you looked at -- the review was across a number of
18 specialties. When I think about the actual
19 recommendations that came in with that report, whilst
20 that was one comment, I mean I recall at that time that 10:37
21 knotty issues, if you will, to deal with in terms of
22 the management across paediatrics, for example. So,
23 quite a lot of attention once that report was had was
24 actually not even in Acute Services initially. There
25 was an acknowledgment around these ongoing challenges 10:37
26 that was documented in the report, right, wrong or
27 otherwise.
28
29 Certainly, I would have sent that out to the relevant

1 directors, of which there was three because I believe
2 it covered geriatric medicine, which was a different
3 directorate, Paediatrics and Acute. So I wouldn't have
4 expected that document to be any surprise. As I said,
5 it had been circulating before it was formally issued. 10:37
6 I would have asked the usual question if there is any
7 concerns around anything within the recommendations in
8 terms of deliverability, to have been alerted to that
9 so that I could at least have a follow-up conversation
10 with Michael. I don't recall at any stage there being 10:38
11 any particular issue coming up. I did try to find
12 through evidence if there has been any formal responses
13 to me on that but I don't recall there being so.
14
15 I know certainly the way that would have worked back in 10:38
16 the day when Directors of Planning met every month, and
17 Michael would have joined our meetings, so we would
18 have had a follow-up discussion. My impression of that
19 was that a patient review was done across the piece.
20 I didn't feel that the Southern Trust was sitting in 10:38
21 any more challenging position than any others in terms
22 of implementing and adhering and complying with the
23 IEAP than anybody else at that point in time.
24 109 Q. Perhaps if I suggest to you that they were in a
25 slightly different position because they had a very, 10:38
26 very focussed and specific spotlight on an issue that
27 was causing lack of triage and referrals?
28 A. Mm hmm.
29 110 Q. Do you know where the HSBC got that information from

1 that informed their report? Where did they find out
2 this bit about "a longstanding issue with turnaround
3 time from one consultant and referrals not returned
4 from triage continues to be a key issue for booking
5 staff"? 10:39
6 A. I think that would have been from Maria, who would have
7 done the report. And I'm assuming, and even having
8 heard and read Katherine Robinson's evidence here to
9 the Panel, I don't think the team would have been
10 holding back with an honest issue if they had a 10:39
11 challenge. They would have been reporting that.
12 111 Q. So you think Maria Wright from the HSCB went out and
13 spoke to members of staff and took evidence
14 effectively?
15 A. I think that was part of the review. She was working 10:39
16 in amongst the team. That would have been my
17 understanding of how it was conducted.
18 112 Q. In your role as Director of Performance, and given the
19 very significant impact triage has for targets and
20 turnaround, what did you do when you saw that 10:39
21 specifically to assure yourself of any concerns around
22 patient safety or risk?
23 A. I suppose the assurance that would have been received
24 then, and throughout I have to say, was - right, wrong
25 or otherwise - that there was a workaround in terms of 10:40
26 what was being managed within the service to work in
27 the way with Mr. O'Brien to adhere, to sort of chase
28 up, if you will, to follow up another systems. That
29 said, I didn't understand the detail of it. I did hear

1 Katherine Robinson's evidence and learned much about
2 that was going on that I have to say I wasn't aware in
3 terms of the amount of effort and time and systems that
4 went in to trying to manage that process. But I was
5 assured that that process was under way. 10:40
6 113 Q. Was the workaround referenced in the Review Report or
7 was that something you learned from someone else?
8 A. No, it would have been just an understanding because we
9 knew that there was a way that Mr. O'Brien worked, that
10 the triage in particular, this -- and I think 10:41
11 I included also in my witness statement, again twigging
12 memories from even before, that there had been issues
13 around records going to his office and then taking
14 longer; some of them having to be obtained basically by
15 the team. 10:41
16 114 Q. I just want to make sure my chronology is correct in
17 your evidence so that I didn't misrepresent when I go
18 on further. By the time you got this Review Report,
19 you were already aware that there was a workaround in
20 place? 10:41
21 A. No, I wasn't. When I seen that again, I suppose, like
22 I say, what I became aware of was it triggered that
23 there had been something previous - which I have
24 included in my witness statement - at a time at which
25 I was commissioning integrated clinical assessment 10:41
26 treatment services, just around a sort of a closed
27 door, bring the records into the office type thing, and
28 difficulty for the staff getting manual records back
29 out. It wasn't that they couldn't do it, it just took

1 more effort, shall we say.
2 115 Q. The Panel have heard all that information from the
3 witnesses who were involved in that. I am just keen to
4 pin you down slightly because I just want the Panel to
5 be clear. 10:42
6 A. Sure.
7 116 Q. You didn't know. The review was carried out by the
8 HSCB. It was published on 26th June 2015. It was sent
9 to you, you then disseminated it across the board to
10 all of the directors and assistant and associate 10:42
11 directors, I presume; all of the people who were
12 relevant to the review --
13 A. Yes.
14 117 Q. -- because it was about outpatients, and it made
15 reference to triage. Is it your evidence to the Panel 10:42
16 that you already knew at this time that there was a
17 workaround in place, or is it your understanding that
18 there was a workaround as a result of this review in
19 order to try and get things back on track?
20 A. No. I think I understood that there was a workaround 10:42
21 in place.
22 118 Q. And how did you know that?
23 A. Yeah, I think it was just because it was known. Like
24 I said, I knew it from before, from years before,
25 before I worked the Trust. And I guess I hadn't -- 10:42
26 because I wouldn't be working operationally, I wouldn't
27 have been aware until such time as I seen that
28 reference. Did I know that that was Mr. O'Brien when
29 I seen that report? No, I don't think so. But what

1 I did do is when I sent it out, I knew there was a
2 number of clinicians. When I looked at the issues that
3 were in that particular report, as I said, I recall my
4 attention being on paediatrics because I was concerned
5 more about the issues that were there. The other 10:43
6 things I felt assured were in hand by Anita and her
7 team within the booking centre, and the operational
8 team managing outpatients.
9 119 Q. So, you have mentioned a longstanding understanding of
10 that. What I am trying to find out -- and I'll just 10:43
11 ask you in simple terms --
12 A. Sure.
13 120 Q. -- it's perhaps easier for both of us.
14 A. I think so.
15 121 Q. If you were aware that there was part of the triage 10:43
16 process that was being arguably systematically delayed
17 through the actions of one person, maybe others --
18 A. I think there was others.
19 122 Q. -- did that not alert you to consider, as Director of
20 Performance, that you needed to get involved in some 10:44
21 way to unblock that?
22 A. I think it's a fair question. I think when I think
23 about that, I think of 72 hours and I think the volumes
24 of referral come into the system. I didn't believe,
25 and still I would understand that I didn't believe 10:44
26 Mr. O'Brien was the only issue in relation to achieving
27 that at that time. I knew it was a challenging
28 targets, one amongst many challenging targets that we
29 were trying to meet. Again, if there had been a

1 particular concern around a particular clinician,
2 I would have expected that to have come up again, as
3 evidenced, for example, in Dr. Rankin's letter, of a
4 request for some support or whatever to go in and do
5 something if there was a view that there would be 10:45
6 something that could change that.
7 123 Q. You have mentioned that you were surprised that the
8 HSCB, in their own report, their own review, mentioned
9 one consultant?
10 A. Yes. 10:45
11 124 Q. You have said that it wasn't just Mr. O'Brien. Do you
12 think that that was an unfair representation in that
13 report?
14 A. I do in the sense of I think -- like I said - I mean,
15 again I have to go back, it's some years - but I do 10:45
16 recall that it uncovered quite a lot of issues we had
17 in paediatrics, for example, and attention going into
18 the work with the Director of Children's Services at
19 that time to sort of address some of the challenges
20 there. So, those to me were the bigger system issues 10:45
21 that needed addressed.
22
23 Naming one individual. I mean, it's like anything from
24 an information perspective. If you say one individual,
25 you know, it is clearly naming an individual. For a 10:45
26 report that was to do a review of an entire system, I
27 thought it was unusual. It's an unusual comment.
28 125 Q. But it does give a timeframe for the knowledge for HSCB
29 of this issue?

1 A. It absolutely does. It wouldn't have been -- there's
2 no way that would have been written and issued by
3 Michael Bloomfield and him not asking the same
4 question.
5 126 Q. You have mentioned -- I don't think you ever met 10:46
6 Mr. O'Brien, did you?
7 A. I'd met him but not in a -- I wouldn't have -- I'd met
8 him in the corridor sort of thing and I would have met
9 him at the time at which I was working in the
10 commissioning role back in 2006 for ICATS because I had 10:46
11 actually hosted a urology session and I had led it, so
12 I met him at that particular event. So, I would have
13 met him loosely but I wouldn't have known him
14 personally very well.
15 127 Q. You mention some knowledge of him with your role in 10:46
16 implementation of IEAP?
17 A. My role was in -- no, my role was in ICATS.
18 128 Q. ICATS?
19 A. Integrated Clinical Assessment Treatment Services. I
20 actually noticed in my -- I think I called it 10:46
21 integrated care in my statement.
22 129 Q. You've changed that in your addendum. I think you
23 corrected that. What year was that? When were you
24 involved in that?
25 A. That was the 2006. 10:47
26 130 Q. In 2006. In your witness statement you refer to your
27 knowledge of Mr. O'Brien at this time. We can go to it
28 actually. It's WIT-35972. You can read it while
29 I read it. At paragraph 67.6, the sentence begins

1 "I can recall..."
2
3 So, you are referring at the start of the sentence to
4 the review exercise in ICATS.
5 A. Yes. 10:47
6 131 Q. "At the time of conducting the review exercise, the
7 intention was to take a dip sample of referrals from a
8 number of consultants. I recall a delay in accessing
9 the referral letters from Mr. O'Brien and his secretary
10 at that time that was reported by Sharon Glenny, the 10:47
11 Urology ICATS Implementation Lead in Craigavon Area
12 Hospital Group Trust".
13
14 Then you go on to say: "As I remember it, Sharon
15 reported having to seek support from her line 10:48
16 management to gain access to the letters. I expect
17 I remember this as I recall that Mr. O'Brien had
18 expressed resistance to the changes to the referral
19 process from named consultant to speciality referrals.
20 I also recall he was not the only clinician opposed to 10:48
21 this particular change at that time."
22
23 A. Mm hmm.
24 132 Q. Then you say :
25 10:48
26 "However, I do not recall any other difficulties
27 reported by hospital speciality leads in accessing the
28 referral letter samples from clinicians for the trial
29 pilots."

1

2 Now, the ICATS was at that time, 2006, a fairly
3 innovative way to try and look at the triaging issue?
4 A. Correct.
5 133 Q. What this paragraph explains is that a 10:48
6 multidisciplinary approach was anticipated across all
7 disciplines, healthcare disciplines, to both spread the
8 load and to utilise expertise, I would imagine. So,
9 referrals would come into one point of contact;
10 physios, nurse, consultants, GPS would all be involved 10:49
11 in the triage process. You were at this stage trying
12 to get a sample of referrals to compare against those
13 that had been triaged by this new set-up to see if you
14 were on the right track, I suppose; to see if people
15 still shared the same clinical assessment? 10:49
16 A. It was really mainly probably to build confidence in
17 the system. The main change was that we had brought in
18 a range -- and I was working across a range of
19 specialities and at regional level, so it wasn't just
20 with urology at Craigavon Trust, it was with others. 10:49
21 It was to bring in GPS with special interest, for
22 example, and physios into orthopaedics, for example, to
23 build the confidence that from a referral letter, you
24 could probably determine the next step on the journey,
25 and to essentially try to build in what that next step 10:50
26 on the journey meant. It didn't determine that others
27 would necessarily all be involved in the triaging of
28 the letter, but what we were doing was saying there's
29 some cases, for example, where you could determine from

1 the letter that the next step might be actually to do
2 some treatment, or something. So, for example, in
3 physio type musculoskeletal things, prior to actually
4 being seen by the consultant. What we were actually
5 trying to do was maintain the capacity of the 10:50
6 specialists for those who definitely were either likely
7 for surgery or needing a specialist input at that
8 stage. That was the intent behind it. So, it was a
9 system change.
10 10:50
11 The reference I make to Mr. O'Brien necessarily being
12 -- having some resistance to it, I recall it because at
13 a session that we had - and I mentioned it, at a
14 confidence - that he had outwardly said he wasn't
15 supportive of the notion of moving from the named 10:51
16 consultant. To be fair to him, the concern that was
17 expressed at that time - and he wasn't the only one -
18 was that there was a particular relationship between
19 primary care and speciality secondary care consultants;
20 they liked that relationship of where the GP could pick 10:51
21 up the phone and say I'll send you to Mr. O'Brien, I'll
22 have a conversation with Mr. O'Brien at that time. But
23 the problem with that was obviously what that meant was
24 that then predicated on the relationships with those
25 GPS and individual practitioners, which created what we 10:51
26 had at that time in 2006, extreme differentials in the
27 waiting times for individual clinicians.
28 134 Q. As you say, your recollection is triggered because
29 there was some difficulty giving one of the letters

1 back. There was - you even expressed it - Mr. O'Brien
2 had a resistance to changes in the referral process,
3 and I am sure he would have a reason for that. But he
4 also was not the only consultant?
5 A. No, he wasn't. He wasn't, no. 10:51
6 135 Q. Would it also to be fair to all of the consultants and
7 the GPS perhaps to say that was a significant mindset
8 shift in the way in which access from primary to
9 secondary care was going to be managed?
10 A. Absolutely. I mean it's not something that is fully 10:52
11 embedded today.
12 136 Q. Mr. O'Brien has raised issues in his witness statement,
13 and when he gives evidence - and has done and I am sure
14 will do - identifying the lack of resources, the
15 staffing problems, the general concerns around capacity 10:52
16 and demand that he, and others, would say infected
17 Urology Services from its inception. When it was
18 created, there was an already identified shortfalls
19 that perhaps were never really recovered from in one
20 way of looking at it. Are you surprised, given the 10:52
21 extent of Mr. O'Brien's concerns and what you have
22 heard in evidence in the Inquiry, that no one ever came
23 to you for assistance around either capacity building
24 or trying to find ways of delivering a safe service
25 with what was available? Would you have expected to be 10:53
26 involved in those more systemic problems and
27 conversations around those?
28 A. I think I was in the sense of -- I mean you have
29 touched on maybe coming to the day elective care

1 centres. I think the capacity demand, you only have to
2 listen to the news today, this is not unique to the
3 Southern Trust, not unique to Northern Ireland. The
4 capacity and demand is a misfit. The demand for
5 services is well outstripping the capacity, not just in 10:53
6 urology but within other services. Within Northern
7 Ireland we've had 20 years of service reforms telling
8 us what we need to do in relation to some of the
9 transformation that needs to happen with regard to the
10 servicing of a population of 1.8 million, as we 10:53
11 currently do. So you don't need me to tell you
12 potentially what I think in terms of what some of those
13 solutions might be, but there would have been a lot of
14 work done around trying to look at that.
15 10:54
16 With specific relation to urology, the movement into a
17 day elective care, separating essentially unscheduled
18 care and planned care, was the direction of travel to
19 try to make changes. But I don't necessarily believe
20 that we had -- we had, actually - actually before 10:54
21 I finish this sentence - we had at one point considered
22 looking at the hospital system within the Southern
23 Trust about how we might have looked at the splitting
24 of our services at that point in time. But none of
25 those types of changes would have been doable without 10:54
26 system support from the Commissioner and wider, and I
27 think now very much sit in a system-wide change
28 programme.
29

1 I think, to be fair to Mr. O'Brien, to be fair to
2 everybody in the system, I think we've got to the stage
3 now where the system is just so completely overwhelmed,
4 and I don't believe it to be just clinicians. It is
5 admin staff. I have heard Tracey Boyce yesterday 10:55
6 talking about ADs, assistant directors in Acute and
7 others, and Heads of Service, people working well above
8 and beyond the call of duty. You only need to read
9 staff surveys around the amount of hours. I think in
10 the Southern Trust, the last survey we did we had 77% 10:55
11 of staff reporting that they worked unpaid hours. It
12 is just a system that is overwhelmed and I don't know
13 what other way to put it than that.
14
15 Certainly, the day elective care centre in respect of 10:55
16 urology was an attempt to manage capacity and demand.
17 Back to your question. Sorry for going on.
18 137 Q. That's helpful. Some of what you say might extend
19 beyond our terms of reference but I would ask the Panel
20 take your comments under note. 10:55
21
22 When I asked had you been approached about helping
23 increase capacity in urology, one of the examples you
24 do give, and perhaps the only example, if I might be so
25 bold as to say that, is when you were asked in December 10:56
26 2018 by the Chief Medical Officer to assume a
27 managerial co-chairing role at regional level, also
28 with Mr. Haynes?
29 A. Yes.

1 138 Q. To explore opportunities for improved capacity to
2 urology through future planning for day elective care
3 model. Did that day elective care model come to pass?
4 A. Some of it is passing to coming to pass now. I mean,
5 from I've left the Trust, I understand we had worked 10:56
6 out sort of a phased programme of some of the
7 particular types of presentations that could go to
8 different Trusts, for example. In the Southern Trust,
9 because they had the lithotripter and were able to do
10 stone treatment but didn't have capacity commissioned 10:56
11 to use it, I know that that business case, since
12 I left, has been in line with the programme that we'd
13 set out in the day elective care centre. It has been
14 commissioned now and I believe the sessions for stones
15 will be increased in Craigavon. It was about three 10:57
16 sessions when I was there; I think it's going up to
17 about ten. That would mean anybody in Northern Ireland
18 would go to Craigavon for that particular treatment.
19 That's sort of the starting to work as a networking
20 system and change how some of the procedures and 10:57
21 practices are done on each of the sites to help
22 alleviate some of that capacity/demand mismatch.
23 139 Q. Would that be a normal timeframe? It was five years
24 ago when that process was commenced and you are saying
25 now that it's coming to fruition; not fully but you are 10:57
26 suggesting that there is some movement towards that.
27 In your experience, is that sort of timeframe normal?
28 A. My experience is that the timeframe is very protracted
29 for most changes. I actually am pleased to hear that

1 that's moving on. I mean, there's been much talk in
2 the press around the elective care reform and the need
3 to move on with some of that. Some very vocal people
4 in our medical professions locally making regular
5 presentations, and I would agree with their positions 10:58
6 on that.
7
8 So it's five years, it's probably not bad, if I'm
9 honest, relative to what's taking some of the other
10 changes to happen. 10:58
11 140 Q. I suppose it's difficult to understand from this remove
12 when there are concerns around capacity and demands,
13 and some of the references you have made to staffing
14 concerns, that something that takes five years to come
15 to fruition can really have any impact on improving the 10:58
16 service that people are complaining is broken,
17 including Mr. O'Brien.
18
19 In your experience, working with the HSCB and with the
20 Commissioner, how important are those relationships in 10:58
21 order to move things on, get things done?
22 A. Very important. I would say -- I mean, I know I have
23 included in my statement some reflections and whether
24 there is a space for that. At the time at which the
25 announcement to cease the Health and Social Care Board 10:59
26 in 2015, I would say what we haven't done is moved
27 quickly and rapidly enough with what was to replace
28 that. As we sit today, you know, we're now moving into
29 the space of an integrated care systems type

1 arrangement. I think the fundamental challenge that
2 the system will face, including right through to Trust
3 and into urology and other specialties, is workforce
4 planning has not kept pace with this. I think -- I am
5 slightly going on a tangent here I so will bring myself 10:59
6 back. I am conscious I am probably just -- I don't
7 mean to be on a soapbox; that's not what I am intending
8 to. I suppose what...
9
10 I'll ask you to ask me the question again actually and 11:00
11 I'll just stay focussed.
12 141 Q. What I am asking you about is one of the threads that
13 runs through your statement is the constant shifting
14 plates within the Health Service?
15 A. Yes. 11:00
16 142 Q. We had RPA, and then we had the HSCB, no more; moving,
17 not goalposts but certainly the landscape seems to
18 evolve consistently?
19 A. It does.
20 143 Q. There have been many reports, you have mentioned some 11:00
21 of them. The (inaudible) Report and Expectations For
22 Change. I suppose my question globally around all of
23 this is twofold. Firstly, does all this change make
24 governance easier or more difficult?
25 A. More difficult. 11:00
26 144 Q. I'll have to ask you why then as you've answered that
27 one that way. I ask you why you say that.
28 A. Okay. I think it's more difficult. My experience, and
29 this is my experience, is certainly during the period

1 of change, I mean, not least losing expertise in the
2 commissioning board through the likes of Michael, Dean
3 Sullivan who went before as Director of Commissioning,
4 people who had been involved in the services for some
5 time; and the very closely knitted-in relationship, 11:01
6 I will say, with the Public Health Agency around having
7 your consultants in public health working very close.
8 I am long enough, I suppose, in the tooth, if I will,
9 in the local area of knowing how that worked, where we
10 had local commissioning with local public health 11:01
11 practitioners working in with our medics, commissioning
12 services locally, understanding the challenges locally,
13 that that relationship was very important to impacting
14 change and making things happen, probably more
15 expediently than we experience currently. 11:01
16
17 That said, I'm not looking back with rose-coloured
18 glasses; there was challenges to that. I think the
19 relationship -- what's important is there's good
20 relationships across the network. For example, and I 11:02
21 use in my witness statement some examples of where our
22 services would have struggled. I think the breast
23 example is the one I included in my witness statement.
24 It wouldn't have been difficult for me to have
25 commandeered support from Directors of Planning, for 11:02
26 example, to support my operational colleagues to get
27 clinical support from across the other Trusts, and we
28 would have worked in a networked way. That
29 relationship became more important.

1
2 Prior to that, I suppose the commissioning very much
3 would have led enabling that, making that happening,
4 supporting it, funding it sometimes, just even to make
5 things -- to grease the wheels, if you will, to help us 11:02
6 to develop that. I suppose what my experience was, as
7 I was left that, is very much nearly left within the
8 provider Trust to work amongst themselves to create
9 solutions. In the long run, that might be more
10 expedient than what we have experienced previously. 11:03
11 But I believe the Commissioner holding the strings can
12 help and influence workforce planning and supporting
13 investment in services as you need them is an important
14 relationship. But I definitely would say in the period
15 that I was in the director role that that became more 11:03
16 challenging, mainly because, as I said, the experience
17 shift. What also was different was -- and this
18 probably was slightly unique to the southern area. At
19 the same time while I was the director, obviously
20 having lost the Chief Executive and we had a number of 11:03
21 changes in post there, which you will be aware of, we
22 had the standing down of the local commissioning group,
23 which would have been our direct link. Through the
24 through the entire period that I was a director,
25 nothing that I can recall through me was commissioned 11:03
26 by the local commissioning group directly into the
27 Trust, which would have been a real shift from what we
28 would have experienced before in terms of working with
29 us locally. It just became more difficult. But I do

1 believe that to be an important relationship.
2 145 Q. You have answered my second point as part of that, so
3 that's helpful, which was the issue about the loss of
4 corporate memory when staff move around. The Panel
5 have heard some -- as you say, the Chief Executive post 11:04
6 was a position held by numerous people over the years.
7 Did you think that was a particular cause of concern
8 for you as a director?
9 A. Oh, it definitely was. I mean, of course it is. The
10 senior team needs -- for me, it was about trying to 11:04
11 redefine. You know, I changed what I did. I think
12 I mentioned in my witness statement as well in terms of
13 trying -- as each Chief Executive comes in or is trying
14 to navigate their paths, their vision and how they wish
15 to have things done, a director with the responsibility 11:04
16 for planning and performance et cetera, I would have
17 been working differently and trying to drive forward
18 the vision of the Chief Executive and work closely with
19 the Chief Executive. So, that was a challenge.
20 11:05
21 It was a challenge also because it wasn't just Chief
22 Executive changes. You'll have heard from some of the
23 other evidence, I am sure, but we did have changes to
24 our senior team in terms of creating a new role in the
25 Director of Nursing, and different things that were 11:05
26 shifting. For the matters pertaining to this Inquiry,
27 the assistant director team and the Acute Director was
28 a very stable team as in it hadn't changed over that
29 period of time, but there was a lot of change and

1 movement within it. I mention also that within the
2 Governance team, and I think Tracey Boyce's evidence
3 yesterday alluded to that in terms of quite a lot of
4 changes in that as well. So, all of those changes do
5 make it more difficult. There has been a lot of 11:05
6 expertise lost and experience lost.
7 146 Q. It is also the case that some of the changes brought
8 about by new Chief Executives can also be beneficial?
9 A. Oh, absolutely.
10 147 Q. One of the examples I want to discuss with you is the 11:06
11 establishment of the Performance Committee, which was
12 something established by Mr. Devlin with the Board in
13 2019?
14 A. Mm hmm.
15 148 Q. This was done in preparation for changes to the health 11:06
16 and social care performance management arrangements
17 that you have discussed already?
18 A. Yes.
19 149 Q. But also, and this is the issue I just want to tease
20 out a little bit to see if you know anything about it, 11:06
21 but also in response to Board members request to have
22 further time allocated -- are you okay?
23 A. Sorry, yes.
24 150 Q. If you need to take a break or anything. Do you need
25 to take a break now? 11:06
26 A. It's okay. I'm okay, I'm fine.
27 151 Q. Are you sure?
28 A. Yes. I'm okay.
29 152 Q. It was also created in response to Board members'

1 request to have further time allocated to discuss
2 performance?
3 A. Yes.
4 153 Q. Now, obviously you were the Director of Performance in
5 2019. Was that something that Mr. Devlin discussed 11:07
6 with you; did you bring the idea to him; were you
7 involved in that at all?
8 A. Yes, absolutely was. It probably actually predated
9 Shane in terms of some of the challenges that would
10 have came from Board members. For example, the 11:07
11 performance report changed quite a lot during my tenure
12 and prior to me, but it did get -- at the time that
13 I started - and I think I mention this and it has been
14 in others' evidence around - the report became quite
15 large, but when the performance of the organisation had 11:07
16 started to shift and deteriorate, as it did and as has
17 the rest of the system, that became more and more
18 naturally a concern for the Trust Board. So, a lot
19 more of the time on the main Trust Board agenda ended
20 up being the discussion of the performance report. We 11:07
21 would have went in to that in great detail, and it
22 really was sort of squeezing out all other areas on the
23 agenda, if you will. A number of Trust Board members
24 had expressed concern on two sides of that. One, that
25 the other items were being squeezed out and, (b), that 11:08
26 we were looking at performance but we really needed a
27 meeting on its own for it.
28
29 I had done some work with directors of planning

1 initially to look to see what the arrangements were in
2 other Trusts. As it stood at that stage, not at all
3 but a number of them had performance and finance
4 committee, where they took those items as a
5 subcommittee to the Trust Board separately. I had 11:08
6 mooted that notion with previous chief executives and
7 we didn't just get it over the line. At that point, it
8 wasn't just at a state of readiness to say -- it was
9 the finance bit in particular, for example, that we
10 just thought, well, are we going to create another 11:08
11 structure, it's another set of meetings, et cetera. So
12 it had been a discussion that had been underway for
13 some time.
14
15 When Mr. Devlin came in, he was certainly very 11:08
16 supportive and had come from a Trust that had had a
17 separate committee. Also then, the draft framework
18 from the Department, which was the essentially
19 signalling to our Trust Board that whilst the
20 Department will retain responsibility and lead on 11:09
21 performance and finance matters, that the
22 accountability and the amount of flexibility that we
23 will give you as an organisation will be down to the
24 Trust Board. So, that essentially set the context, if
25 you will, to make it the right time to create a 11:09
26 committee that would look specifically at performance.
27
28 The other key driver on that for our Trust Board
29 members was, again, the extant targets of the

1 commissioning planning direction, even though we
2 weren't meeting them, just continued to be the required
3 targets to report on, but they became less meaningful.
4 You know, the further away you are from meeting the
5 targets, the less meaningful. 11:09
6 154 Q. So there is an acceptance perhaps that those targets,
7 although they were set, there was no longer any --
8 A. Correct.
9 155 Q. -- belief, really. The reality was they weren't going
10 to be achieved? 11:10
11 A. Absolutely. That was accepted also by the Commissioner
12 when they introduced performance improvement
13 directories.
14 156 Q. Just perhaps that's a bit of a spotlight on the
15 culture. I wonder if I could ask you a little bit 11:10
16 about that.
17 A. Sure.
18 157 Q. When the performance committee and the HSCB and the
19 Commissioner all accepted that what had been agreed was
20 impossible, it doesn't sound like that that led to 11:10
21 anyone moving up a gear to really understand what was
22 happening. Do you feel that the mood was an acceptance
23 of that as a reality and how you managed going forward
24 based on that?
25 A. I wouldn't say there wasn't any activity. By any 11:10
26 means, I wouldn't say that. There was quite a lot of
27 work that went on, for example, in trying to actually,
28 for example, validate the types of things that were on
29 our lists, and understanding our demand better, and

1 whether or not there were other responses that we could
2 make to the demand in terms of creating alternatives,
3 et cetera. I mean some of that will be part of the
4 reform agenda that will be happening now, including the
5 likes of virtual consultations and things like that 11:11
6 that maybe weren't, pre-pandemic, at the fore of
7 people's mind as a potential answer to some of the
8 demand. So, I wouldn't say they weren't.
9
10 I think what the new performance management framework 11:11
11 were very clearly signals, not an acceptance but a
12 recognition that the targets as they are set, right,
13 wrong or otherwise, weren't being met. But that one of
14 the objectives in that framework document was to reset
15 essentially clinically indicated outcomes that the 11:11
16 service would -- and, I mean, I'm not sure where
17 exactly that work is but that would have been a
18 resetting of the target regime.
19
20 I also mention in my witness statement a point at which 11:11
21 when there was a department lead who was doing a sense
22 check of it -- it was on the schedule care emergency
23 targets now, but did a check with the system to say is
24 four hours still a doable target. I remember that
25 approach was very welcomed at the time, albeit we stuck 11:12
26 with it.
27 158 Q. Just when you mention the four-hour target, just take
28 that as an example. Was there any discussion around
29 balance, around risk, target meeting and patient risk

1 or patient safety? Was that something that was
2 discussed at these Performance Committee meetings?
3 A. Yes, it was. In particular, for our ED department the
4 Southern Trust was very constrained with regard to
5 infrastructure, and our main issue was around 11:12
6 overcrowding because of the volumes not only the target
7 meeting but the risks associated with overcrowding.
8 That was a major focus for our Trust Board, and
9 particularly obviously during Covid where social
10 distancing et cetera was a compounding factor. So, it 11:12
11 was very much a live issue.
12 159 Q. Mr. Devlin refers to reports that are sent up to the
13 Board from the committees in his witness statement. He
14 says that it is a fair reflection -- sorry, in evidence
15 he said that it was a fair reflection that reports from 11:12
16 committees aren't generally the subject of great debate
17 or input at Board level?
18 A. Yes.
19 160 Q. Would that have been your experiences also?
20 A. It would. I think what the non-executive director 11:13
21 members and the Chair of those committees would have
22 brought for noting, you know, there would have been an
23 update, maybe a verbal update on just what the last
24 meeting had been about, et cetera. But I suppose the
25 assumption was that's why you had the committee, the 11:13
26 committee to do the work and to do the challenge, the
27 discussion on behalf of the wider Trust Board. So,
28 I would have said there wouldn't have been a lot of
29 time spent on those at Trust Board.

1 161 Q. It seems that there was a slight shift, you have said,
2 about the assumption in that assumption. Mr. Devlin
3 states in his evidence:
4
5 "It was not a regular occurrence for information that 11:13
6 was discussed at committees to have any detailed
7 conversation at the Trust Board."
8
9 Then he goes on to say:
10 11:13
11 "We did in probably October and November 2021 then
12 begin to have a conversation about risk appetite and
13 about what the process should be for escalating from
14 committees to the Board."
15 11:14
16 A. We did.
17 162 Q. Given that was only in 2021 and given the historic
18 nature of the issues before the Inquiry, do you think
19 that conversation should have been happening sooner?
20 A. I think that's a fair comment. 11:14
21 163 Q. I just want to cover just one more area before the
22 Chair may want to take a break, and it is just to look
23 at the performance dashboard that was provided to the
24 Trust for the Trust Board meetings.
25 A. Okay. 11:14
26 164 Q. We have an example of that at WIT-35976. For others'
27 note, the reference from Mr. Devlin in his evidence can
28 be found at TRA-01619 to TRA-01620.
29

1 This document is obviously something you are very
2 familiar with?
3 A. Mm hmm.
4 165 Q. You are the lead director, it's your document,
5 effectively? 11:15
6 A. Yes.
7 166 Q. This was a report summary of performance for the Trust
8 Board for the meeting on 25th January 2018. This was a
9 performance dashboard ministerial targets as at
10 December '17, and also performance update over 11:15
11 Christmas and the New Year period when Trusts are
12 historically under a lot of pressure?
13 A. Yes.
14 167 Q. So, the Panel will be aware of the context of 2017 and
15 the lead-up to December 2017. I just want to go to 11:15
16 WIT-35982. This is the way in which you give
17 information - just down at the bottom, please - the way
18 in which you provide information to the Board. This is
19 the performance?
20 A. Mm-hmm. 11:16
21 168 Q. It's called a dashboard for a reason; it gives an
22 oversight of everything really of relevance. On the
23 waits on the cancer pathway, we can see the 62-day
24 pathway:
25 11:16
26 "I suspect that cancer patients continue to wait in
27 excess of the 62 days for their first definitive
28 treatment associated with demands in excess of
29 capacity. At the end of November, 23 patients waited

1 in excess of 62 days. Whilst urology continues to have
2 the largest volume of patients waiting over 62 days
3 from the pathway, there has been no increase in this
4 trend over the past three months."
5 11:16
6 I wouldn't suggest that there was an acceptance of a
7 larger volume in urology, but would you agree with me
8 that that indicates that there's something going on in
9 urology if it has to be specifically mentioned in the
10 report? 11:16
11 A. Yes. Urology would have got -- urology, but not only
12 urology, certainly other specialities over the period
13 of time, trauma and orthopaedics, dermatology. We
14 would have always pulled out by exception just
15 highlighting on each report where something was worthy 11:17
16 of noting.
17 169 Q. But urology is the only one mentioned in this,
18 Ms. Magwood?
19 A. In that particular one, yes.
20 170 Q. Yes, and I'm using this as an example. When we look at 11:17
21 the performance dashboard as at December 2017, there's
22 specific reference to urology --
23 A. Breaching.
24 171 Q. If we look at WIT-35993, this is a bit more challenging
25 to read? 11:17
26 A. Sorry.
27 172 Q. So at the top of the page, again under the "Cancer
28 pathway 62-day"?
29 A. Mm hmm.

1 173 Q. At the point in time Mrs. Gishkori was the director?
2 A. Correct.
3 174 Q. I'll just read half way down that paragraph where it
4 starts:
5 11:18
6 "The percentage of confirmed cancers has not
7 demonstrated a disproportionate increase. 23 patients,
8 8 external ITT, and 15 internal, were waiting in excess
9 of 62 days at the end of November 2017. The two
10 predominant breaching specialities were urology, 7 11:18
11 patients, and surgery 7 patients. The breaches within
12 breast surgery are reflective of the pressures that the
13 breast service has faced throughout 2017/2018."
14
15 Would it be unusual to just explain why one of the 11:18
16 particular specialities is in breach and not say
17 anything about why urology is?
18 A. Only because -- it wouldn't be unusual, it was just
19 whatever got escalated up as a discussion. I can only
20 but do my best to think back to that time. Urology -- 11:19
21 breast had not breached for quite a long period of
22 time, so I can only but think that was at the point at
23 which...
24 175 Q. It was unusual?
25 A. Yes, it was unusual for breast. But we were still 11:19
26 keeping an eye on the urology and clearly those seven
27 patients, there would have been an action happening at
28 operational level from performance, because that would
29 have come out of the operational and performance

1 meeting that those seven patients had breached. So
2 there would have been work underway there, so probably
3 that's why breast was pulled up because that was more
4 unusual.
5 176 Q. I know I asked you earlier, given the evidence base the 11:19
6 Panel have seen and will continue to see and the
7 evidence of numerous witnesses, it does appear to be
8 the case that urology was under significant pressure?
9 A. Yes.
10 177 Q. The performance dashboard provides the facts of that 11:19
11 and the fact that urology was specifically
12 identified --
13 A. Correct.
14 178 Q. -- as being in breach?
15 A. Yes, that's correct. 11:20
16 179 Q. Given those facts and given that context, does it not
17 surprise you -- sorry, I'll just finish up this last
18 point?
19 A. I'm there.
20 180 Q. Does it not surprise you that you were never 11:20
21 approached? I know you talk about the day elective
22 care model. I know you have mentioned that.
23 A. Mm hmm.
24 181 Q. But really there isn't any other substantial evidence
25 of someone coming to you and saying, well, the 11:20
26 performance issue is a matter of concern, there are
27 underlying factors that we think we can provide a
28 remedy for, can you provide us with staff or a plan or
29 anything, any part of your expertise to improve this?

1 A. No. To be fair, I don't think that would be the case.
2 I do think there are other examples. I mean I recall,
3 for example, at a point at which we sought additional
4 funding for nurse cystoscopy, to train additional
5 nurses to do cystoscopy. That was something that would 11:21
6 have came. Maybe I didn't include that in my witness
7 statement. But there were other examples.
8 182 Q. Let me bring you back just to the cancer 62-day pathway
9 examples that I have brought you to.
10 A. Sure. 11:21
11 183 Q. Triage is obviously central to the issue of the targets
12 being met if cancer is suspected or confirmed. Did no
13 one ever come to you and ask for help around this if
14 this is an issue that is of longstanding knowledge of
15 yours, and many others I should say? Were you 11:21
16 surprised as Director of Performance that no one came
17 to you and asked you for help?
18 A. I suppose yes is the answer in that, whether or not --
19 I'm probably trying to lean in to think of why that
20 would have been the case. Again, I'm thinking of where 11:21
21 there was requests for help prior to. So, for example,
22 changing clinic templates and stuff. I mean, at one
23 point we got to the point where Outpatient clinics were
24 nothing more about red flag just about the time that
25 I was leaving. 11:22
26
27 In terms of what you can do, there was -- I wouldn't
28 want to say the team hadn't come and hadn't sought
29 support, because I think that was the case. I think

1 also the letter, for example, that in Dr. Rankin's
2 bundle, where they were seeking support; that was on
3 the cancer pathway.
4 184 Q. That was 2010?
5 A. 2010. It was 2010. What I am saying is there was 11:22
6 different points at which the services would have came.
7 Looking at that are you asking me, yes, am I surprised,
8 you know. At any stage we would have offered support
9 to do whatever we could. Whether we had anything that
10 we could do is maybe the question at that stage. 11:22
11 I don't know. But I guess I'm answering very
12 longwindedly.
13
14 Am I surprised? Yes. And no in the sense that --
15 that's not a very good answer, is it? Yes, I'm 11:22
16 surprised if there was a very specific concern, but the
17 fact that we have mentioned in that report there is
18 seven patients, it would be my understanding that those
19 seven patients down the cancer pathway and with if
20 cancer trackers and whatever was being done - an 11:23
21 additional clinic or whatever would have been put on
22 operationally - that may or may not have happened.
23 I don't recall specifically any reaction to that
24 particular report. My understanding is they did seek
25 support where they thought that could be provided. 11:23
26 185 Q. Just not from you?
27 A. Just not from me on this one.
28 186 Q. The Panel will have the context of the timeframe of
29 that particular report, as I've said, December 2017,

1 where it notes seven patients only.
2
3 Just to finally make the point around awareness around
4 the problems with urology, I just want to reference a
5 few points in your statement where you have 11:23
6 acknowledged. You say:
7
8 "I was aware of the deteriorating position in urology
9 along with the range of other specialties from around
10 2014/2015." 11:24
11
12 You refer in your statement to "a system level
13 recognition of the lack of capacity within urology".
14 That's the context in which perhaps I should have put
15 that first when asking you about others seeking your 11:24
16 particular department's or your directorate's
17 expertise. We don't need to go but you say that at
18 WIT-35921, paragraph 1.11. You also make reference to
19 the Acute Hospital Review in 2001, Transforming Your
20 Care in 2011, the Donaldson Review in 2014, and, most 11:24
21 recently, the 2016 Systems Not Structures Report of the
22 Expert Panel. There are lots of reviews over a long
23 period of time.
24
25 In your role as Director of Performance, as a director 11:25
26 in one of our health Trusts, did you consider that
27 there was a lack of stability around bringing home the
28 changes that were recommended by these various reports?
29 A. Without a doubt. I mean, there was a couple of points

1 at which every time a report was produced. I remember
2 the Donaldson Report, for example, because whenever it
3 was done, we did a wide scale engagement with the
4 staff. Most of the recommendations of the reports, the
5 key tenets within it are much the same; something that 11:25
6 says that we're spreading ourselves too thin and that
7 we need to forward plan for reconfiguration of
8 services, amongst a number of other recommendations.
9
10 I mean, I think it's a source of great disappointment 11:25
11 to me that I have now left the Health Service and that
12 some of those hadn't landed in terms of the changes
13 that have been made. I think the changes needed to be
14 made faster. I think the biggest challenge at the time
15 that some of the reports were written, you know, in the 11:26
16 news today you'll hear we know about the fiscal
17 challenge certainly for Northern Ireland and wider.
18 I actually believe the fiscal challenge now to be less
19 the challenge than the workforce challenge; I think
20 that's the greater challenge for Northern Ireland. 11:26
21
22 I think the workforce planning -- I think it was last
23 week I heard on the news about the proposals to cut
24 nursing places, et cetera. I really just think it's a
25 source of great disappointment that we haven't managed 11:26
26 to make some of the big system changes faster, quicker.
27 Even if they were -- it's always easier to make a
28 decision than to take no decision, and I think we have
29 sat too long not making those changes. That's my

1 personal view.
2 MS. McMAHON: That might be a convenient time, Chair,
3 for a break.
4 CHAIR: To 12:00 then everyone.
5 11:27
6 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
7
8 187 Q. MS. McMAHON: ... go to this document but for the
9 Panel's note, it is at WIT-02146. It is the minutes of
10 the Trust Board meeting. You were in attendance at 11:41
11 that meeting; I don't think there is any dispute about
12 that. That was the meeting in which Vivienne Toal
13 advised the Board that a consultant urologist had
14 immediately been excluded from practice from 30th
15 December 2016 for a four-week period, and that 11:41
16 exclusion had at that point been lifted and he was to
17 return to work with controls in place. Dr. Wright, at
18 that meeting, explained the investigation process, the
19 personnel involved and confirmed that an early alert
20 had been forwarded to the Department from the GMC and 11:42
21 NICAS had been advised. Do you remember that meeting?
22 A. I didn't on my initial statement. As you know,
23 I amended it to refer to that. I don't remember the
24 detail, I don't recall. What I do recall, I have to
25 say, when I brought and look at the notes, I do recall 11:42
26 some of the other matters on that agenda. If
27 I described it, there was a number of burning platforms
28 in around January 2017, and I recall that. I recall
29 the closure of it but I don't recall any detail is the

1 truth.
2 188 Q. Was it an unusual thing for you to hear at a Board
3 meeting, a staffing issue like that, that a consultant
4 had been temporarily excluded?
5 A. Yes. 11:42
6 189 Q. That was an unusual event?
7 A. Yes.
8 190 Q. I know you don't recall a lot. Would you recall or do
9 you recall if anyone raised any questions around that
10 and asked anything about it? 11:42
11 A. I honestly don't recall the full detail. I can't
12 imagine that we wouldn't have. I can only work from
13 what's in the minute itself. It describes that
14 Dr. Wright had given an explanation of the
15 investigative process. I can only but assume that he 11:43
16 had given as fulsome a report as he could have at that
17 time. And there may well have been questions but
18 I don't honestly recall the detail of the questioning.
19 I recall the incident. I recall the fact, in
20 particular when I read it, that struck me around that 11:43
21 there was an additional controls in place. So, there
22 was some sort of assurance that the consultant had come
23 back into post with controls in place. I honestly
24 don't recall any further detail than that.
25 191 Q. Did you ever discuss it with anyone after the meeting? 11:43
26 A. No.
27 192 Q. Did you raise it with anyone?
28 A. No.
29 193 Q. You have mentioned in your statement that you are -- is

1 it SIRO?
2 A. SIRO.
3 194 Q. And that stands for?
4 A. Senior information risk owner.
5 195 Q. I think you said you listened to the evidence of 11:44
6 Katherine Robinson and Helen Forde?
7 A. Yes.
8 196 Q. Did you listen to both of their evidence?
9 A. Yes.
10 197 Q. Obviously there were multiple issues arising there from 11:44
11 data protection issues and just data management issues
12 at a basic level?
13 A. Yes.
14 198 Q. Was that the first time you were aware of those issues?
15 A. Particularly the records at home, yes. 11:44
16 199 Q. When you heard the evidence?
17 A. Yes.
18 200 Q. What was your view on that, that records had been kept
19 at home, offsite, maybe in cars or other places? What
20 was your view around that? 11:44
21 A. First of all my view was of the scale of it. I was
22 very surprised at the numbers. Helen Forde, also in
23 her evidence, you will be aware, talked about how she
24 leaned heavily into the information governance leads in
25 terms of her role, et cetera. She would have worked 11:45
26 with my head of information governance, who would have,
27 generally speaking, provided an advisory role.
28 I remember, for example, at a point in time at which
29 further advice was asked around what the appropriate

1 arrangements were for transport of records, for
2 example, from one site to another, and a policy et
3 cetera was developed and created in support. So,
4 information governance would have worked with records
5 but I was surprised and was not aware, nor had it been 11:45
6 escalated to me in terms of my SIRO role about any
7 concerns with regard to the scale of numbers and
8 records that were off-site.
9 201 Q. How would you have expected that to have escalated to
10 you? How would you have expected to have been informed 11:45
11 of that issue?
12 A. I suppose through governance --
13 202 Q. Well, just rather than in generic terms, who would you
14 have expected to escalate it and to whom?
15 A. I would have expected it to have been escalated again 11:46
16 from the operational service probably to Head of
17 Information Governance, and then it would have come
18 through. If it was a concern escalation through the
19 Assistant Director Information Governance or infomatics
20 to myself. 11:46
21
22 We produced, just for the Panel's awareness, in
23 relation to, you know, the Governance Committee,
24 I produced a report for each of our Trust Board
25 governance committees that mainly was in relation to 11:46
26 compliance around the Data Protection Act and subject
27 to access request timelines, et cetera. As a Trust
28 Board, we spent quite a lot of time going through the
29 detail of that report as well. There was mechanisms

1 for those through information governance to have
2 escalated that through from the services. If the
3 information Governance Team weren't aware of it, then
4 it wouldn't have come to me through my own routes.
5 203 Q. Why do you think they weren't aware? Why do you think 11:47
6 that particular governance oversight around data
7 protection, which is obviously in legislation as well
8 as a requirement under local guidelines for Trusts, why
9 do you think that information wasn't passed on?
10 A. I really couldn't say. I don't understand why it 11:47
11 wasn't.
12 204 Q. Do you see that as a failure of governance?
13 A. Yes, I do. I do. One of the things - sorry, just to
14 say is helpful - in some of the things that have been
15 put in place since. There would have been no direct 11:47
16 feed in the wider governance, you know, sort of a
17 week-by-week report to the senior management team, but
18 Dr. O'Kane had brought that in. I'm not quite sure
19 when or the exact time but certainly before I left in
20 '21/'22, and I think I refer to it in my witness 11:47
21 statement as well. That was a helpful weekly update
22 that just gave a sense of some of the -- as other
23 members of the senior management team, to get a sense
24 of in a live times sense of issues that were arising.
25 When she brought that in, I had asked at that stage 11:48
26 that there was governance that was outside of clinical
27 and social care governance, which was information
28 governance that I would have wished to have also had
29 that same sort of format.

1
2 Catherine Weaver, who would be the Head of Information
3 Governance, she joined that weekly Thursday morning
4 weekly meeting, so there was then a mechanism to make
5 that connect in more recent terms, just for the Panel's 11:48
6 awareness.
7 205 Q. When was that, when you say more recent?
8 A. I would say that was introduced -- I would have to
9 check back but I'd say it was in 2021, possibly early
10 2021. I would have to actually check that, just to be 11:48
11 specific. It was a weekly report.
12 206 Q. Did it cover things like charts not being able to be
13 tracked?
14 A. Well, it covered -- there was an information governance
15 section in that allowed the opportunity at that meeting 11:48
16 to say are there information governance issues to be --
17 mainly it was around -- it highlighted things, for
18 example, you know, extended time periods of people
19 responding to subject access requests, for example. It
20 brought a new light to it, bringing it into that weekly 11:49
21 forum that allowed a more live conversation rather than
22 waiting for quarterly committee meetings.
23 207 Q. I think the Panel have seen those documents, actually,
24 I remember now, through Mrs. Forde.
25 A. It was just trying to connect that information 11:49
26 governance. So, there was a mechanism for doing that
27 at that stage.
28 208 Q. In your view, the merging of the information governance
29 with clinical and care governance is beneficial

1 overall?
2 A. I do believe so, yes.
3 209 Q. Some of the other reflections you have put into your
4 statement, the Panel may find helpful. I just want to
5 mention a couple of them to you. You do say in your 11:49
6 statement:
7
8 "Having had the opportunity to reflect, I feel the
9 process and opportunity to engage fully with the
10 problems in urology came in 2016 with the MHPS 11:50
11 process".
12
13 Now, you obviously didn't know anything about that. We
14 can see that your first formal indication of the
15 specific problems was in the Board meeting of January 11:50
16 2017. Had you have known or been sighted of that
17 process and the issues that arose during it in your
18 particular role as Director of Performance, what may
19 you have been able to do?
20 A. Well, I suppose again I would start by saying I do 11:50
21 regret, even in the knowledge of thinking back to the
22 Trust Board discussion in 2017, of perhaps maybe not
23 having more inquisitive inquiry at that stage, to seek.
24 I don't know whether I did or didn't ask at the time
25 was there anything further, any further support 11:50
26 required. I think what I think I could have done or
27 offered as a team is much to what our team already did
28 for the organisation. It does come down to leadership
29 and people seeking help and choosing to receive it, if

1 you will. Whether it was about doing some process
2 mapping in terms of having the quality improvement
3 team, work with the team to do work around that so it
4 was an enabling kinds of support to urology certainly
5 would have been the sort of things I never would have 11:51
6 refused helping colleagues to help improve the service.
7 210 Q. You have mentioned that. I'll read the paragraph you
8 say this in. That's at WIT-35960. We don't need to go
9 to it but it's paragraph 49.1:
10 11:51
11 "In the understanding now from issues brought to light
12 as part of the matters pertaining to this Inquiry,
13 particularly concerns raised as part of the earlier
14 MHPS process in 2016 involving Mr. O'Brien, I would
15 have expected a risk assessment of service impact to 11:51
16 have been carried out by the operational team
17 responsible for the service."
18
19 A. Mm hmm.
20 211 Q. Does that suggest that you know there wasn't one done 11:51
21 or you don't know if there was one done?
22 A. No, I don't but I suppose what it reflects is taking on
23 board my understanding of even being aware that there
24 was sort of a, say a triage workaround, shall I say, it
25 is the scale of that that has come to light in terms of 11:52
26 the numbers of either charts or patients not triaged,
27 et cetera, that I would have assumed and hoped that
28 there would have been a risk assessment done on that.
29 I can't say whether there was or wasn't. I don't know.

1 I couldn't answer that.
2 212 Q. Was that be something you would have expected to be
3 involved in had it been done, if it was being done at
4 director level?
5 A. Not necessarily, but what I would have expected is that 11:52
6 perhaps what would have happened is, in exploring the
7 risks, potentially some of the mitigations I might have
8 been involved in; or if the risk was such that it made
9 its way to the Directorate Risk Register, that I might
10 well have seen - as other things had, for example the 11:53
11 evidence that I mentioned earlier about the review
12 backlog position, for example, that did through risk
13 assessment get on to the directorates, the Acute
14 Directorate's register and then subsequently through to
15 the Corporate Risk Register, and subsequently through 11:53
16 to discussions with the Commissioner around how we
17 change templates in reflect of that. So some things
18 did, there was evidence of how they did come through.
19 You know, I am just reflecting that essentially.
20 213 Q. Well, there are the formal risk registers and then 11:53
21 there are information indicators that would suggest
22 risk. For example, the cancer pathway could indicate
23 that there is something wrong or there is a risk. So
24 there are formal risk notifiers and then informal
25 knowledge about risk. Did you ever feel that you 11:53
26 should have been involved in assessing risk, given the
27 broad range of issues that arose through the MHPS
28 process that went on about in advance all of which
29 effectively touched upon your directorate and your

1 responsibilities. Did you ever feel that you should
2 carried out a risk assessment or some oversight --
3 A. Yes.
4 214 Q. -- of what was happening to make sure that you were
5 satisfied and you could assure the Commissioner? 11:54
6 A. I think that's a fair comment. When I look back now,
7 I do regret that that wasn't maybe something I had
8 initiated, as opposed to perhaps assuming that maybe
9 others had and would have engaged me appropriately. So
10 yes, I think I should have done that. 11:54
11 215 Q. I ask that because you have mentioned in your
12 statement that the potential for the patients not being
13 recorded on the Patient Administration System may have
14 had an impact on the accuracy of the Trust reporting
15 waiting list position in urology? 11:54
16 A. Yes, that's fine.
17 216 Q. The subtext of that is the information you are
18 receiving isn't actually accurate, it's not a true
19 reflection?
20 A. So, that's my concern. 11:54
21 217 Q. I know that you can't know what you don't know. If you
22 are going to rely robustly on the information and you
23 are providing an assurance to others on that --
24 A. That's right.
25 218 Q. -- then there is that expectation, I suppose, that you 11:55
26 command some oversight on the process?
27 A. Yeah. I mean, that certainly would have been even the
28 thinking behind, particularly as waiting lists got
29 longer, validating and the setting up validating.

1 I recall certainly in terms of supports, for example,
2 going to the Commissioner to seek funding support for a
3 validation team, so that there was some support given
4 to clinicians to actually go back through the lists and
5 to carve out some time for them to actually validate 11:55
6 their own lists, et cetera. There was those sorts of
7 activities and things that were not just about
8 supporting the service, but were also about, for me,
9 assuring myself of the validity of what we were
10 reporting as well. So, there was activity going on in 11:55
11 that space but could there have been more done? Yes,
12 I think there could have; in light of what I know now,
13 yes.
14 219 Q. Just so I understand the answer, when you talk about a
15 validation team, does that require you going back to 11:56
16 the Commissioner to get funding specifically for that
17 purpose?
18 A. I mean, you can do it -- you can choose to do that as
19 an organisation yourself, which absolutely you can do.
20 But one of the things that was done, it was one of the 11:56
21 things that we actually did work as when the waits at a
22 system level got very long, that the Commissioner was
23 very supportive around us looking into particular
24 specialties and doing some validation.
25 11:56
26 There was another piece of work also that was done.
27 Again, these are touching around the edges, they are
28 not addressing the core issue, which is obviously the
29 mismatch of capacity and demand. But there was another

1 piece of work done out of a report that had come out of
2 the Patient Client Council around the waiting lists in
3 Northern Ireland and the people on them. I recall a
4 time at which the Trust Board had asked about that,
5 about the experience of people on the waiting list. 11:56
6 So, there had been a patient experience piece done as
7 well. I remember it because we had said, well, is
8 there -- I remember actually Mark Haynes had done a
9 piece about do you contact people who have been
10 essentially languishing on the waiting list for a long 11:57
11 time, but it was quite morally distressing even for
12 clinicians to do so when you had no solution for how
13 you were going to be able to see them and when.
14
15 There was a lot of work done around that sort of 11:57
16 things; that people were recognising the difficulties
17 and the potential harm essentially to people on long
18 waiting lists.
19 220 Q. Is it ever the case that the Commissioner or the HSCB,
20 with an awareness of the issues that are causing 11:57
21 problems, offer help or seek to provide, for example,
22 funding for Peer Review or speciality review or an
23 external audi? Is it ever the case that they would
24 unilaterally approach the Trust, or is it a
25 wait-and-see for them? 11:57
26 A. I'm not aware of them having approached us to suggest
27 that. I suppose what I would say, to be fair to both
28 Commissioner and the services, is that if you
29 approached them to seek that sort of funding for

1 support for that, I wouldn't say that would have fallen
2 on deaf ears. They would have certainly -- my
3 experience, any time I sought support from the
4 Commissioner, I would have got a reasonable ear.
5 Certainly in the earlier days when the relationships 11:58
6 were well established. It's a little bit more
7 fragmented is the way I'll describe it now.
8 221 Q. That fragmentation, does that in your view impact
9 detrimentally on governance and oversight?
10 A. I mean, it shouldn't directly because there is still 11:58
11 mechanisms for escalating requests for supports, so no.
12 I am just saying in terms of how attuned essentially --
13 your question was would the Commissioner commission on
14 behalf perhaps to do a peer review, et cetera. They
15 need to be very close to and in tune with the service 11:58
16 and knowing the challenge that the service is facing
17 perhaps to know what to do that. Otherwise, they are
18 reliant on Trust providers seeking that support.
19 222 Q. So, it's never the case that, even taking away the
20 issue of funding for it, the Commissioner wouldn't say 11:59
21 we're commissioning you for services, targets aren't
22 being met, there is a problem in the system that when
23 one lens is identifiable, we are asking you to carry
24 out, for example, a review or have an external audit
25 carried out, would they ever proactively facilitate the 11:59
26 meeting of targets by nudging the Trusts to take
27 action?
28 A. Not in the way you've described. The only way I would
29 say is they would ask us at the Trust Performance

1 Meeting around is there anything more you can do type
2 thing. But no, I never experienced it as you described
3 it there.
4 223 Q. The other areas that you have mentioned in your
5 reflection about the loss of experienced staff, staff 11:59
6 movement and the periods of instability, I think we
7 have covered in a bit of detail.
8
9 You have heard other people's evidence. Obviously some
10 of their evidence touches on areas that you are 12:00
11 responsible for or have an interest in. Is there
12 anything that you have heard that you would like to
13 speak to now, or clarify or disagree with?
14 A. No, I don't think so.
15 224 Q. I know we have shortened your statement considerably 12:00
16 and tried to highlight the key issues that will allow
17 the Panel to explore them with you in oral evidence.
18 They obviously have the written evidence to supplement
19 that. Is there anything else you would like to say or
20 want to cover while you're here? 12:00
21 A. No. Other than, you know, I'm very sorry for the
22 position that we're in and it's a source of deep regret
23 for me for that. In terms of some of the work that's
24 going on now to address maybe improvements, and
25 particularly the governance link, I think some of that 12:01
26 is going in the right direction. We described the
27 governance report. One of the things I had started,
28 and it's maybe just because as I'm talking now -
29 I don't think it's in my witness statement - some

1 things that I think is important in terms of
2 relationships and stability within the Trust and the
3 leadership and bringing together information, is,
4 I had, as you know in my witness statement there, some
5 responsibility around the quality improvement sort of 12:01
6 agenda. In particular, in 2016 I had established a
7 quality improvement steering group, which was intended
8 at that time to do what the systems don't do yet, which
9 is a bit more triangulation of information and insights
10 from a number of sources. That group had been 12:01
11 established, but it never really got full traction
12 because of the changes in personnel, et cetera.
13
14 It continued to meet. But I think there is something
15 there in terms of learning around, aside from just data 12:01
16 driven - which is important - data driven indicators
17 and change and bringing information together. But the
18 relationships particularly across the professional
19 disciplines, that steering group we had established had
20 the Head of Social Work, Head of Nursing, Head of 12:02
21 Medicine, with a key indicator around enabling our
22 workforce.
23
24 One of the thing that was described, I suppose now that
25 you have asked the question, I did hear some evidence 12:02
26 from Marc Williams. One of the comments he made is
27 that the organisation didn't encourage people to
28 improve services. I would disagree with that quite
29 strongly. I think the point of establishing the

1 quality improvement function within the organisation
2 was to do just that. We had a model in the
3 organisation, No Improvement Too Small. There was
4 opportunities for people to be supported to bring
5 forward improvements, and I think that's a good thing. 12:02
6 It's not as connected at the moment in terms of
7 directing the improvement works to the areas that maybe
8 need to be targeted. In the first year of establishing
9 the improvement team, Dr. Wright and I had established
10 from the governance agendas, and in particular the 12:03
11 complaints data, around issues around communication
12 and, at that time, infection prevention control. We
13 did a campaign with staff on a broad spectrum of
14 encouraging people to do improvement projects, and we
15 committed in support of 15 projects in that year, 12:03
16 taking information that was coming from governance.
17 I think that's something that could still be done more,
18 that there could be a bit more done in that space.
19
20 12:03
21 I suppose I'm not in the organisation any more so when
22 you ask me is there anything more, I think that's
23 probably something that shouldn't be forgotten, that
24 there is maybe opportunities to do more in that space.
25 MS. MCMAHON: Thank you for that. I have no further 12:03
26 questions. The Panel may wish to ask you some
27 questions, but thank you.
28 CHAIR: Mr. Hanbury, do you have questions?
29

1 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
2 FOLLOWS:
3
4 MR. HANBURY: Thank you for your evidence so far.
5 Just a few clinical things, hopefully not too taxing. 12:04
6
7 Starting on the 62-day breaches, we saw the table
8 earlier on. Of those 23 patients, there were, I think,
9 eight listed for the inter-Trust transfers. Were those
10 patients that were at Craigavon waiting to go to 12:04
11 Belfast?
12 A. Probably.
13 225 Q. So that wasn't necessarily your responsibility to round
14 up that pathway on those patients?
15 A. Without going into the detail of it, I wouldn't be 12:04
16 sure. That would be the general sort of inter-Trust
17 transfer. It would have been a Belfast-Southern Trust
18 relationship in the main.
19 226 Q. Okay. That was about a third, so the other two thirds,
20 the other 15, what would you have done with that 12:04
21 information? Would you have gone to the Head of
22 Service, or would you be expecting answers to those
23 patients being dated if they were awaiting surgery, for
24 example?
25 A. It's probably not something I could answer because 12:04
26 operationally, that would have been done through the
27 network links for service to service. I suppose from
28 my perspective in reporting it, by the time it got to
29 me, really all my report would have been doing was

1 letting our Board be aware of what the types of waits
2 we had and why they were breaching, or some of the
3 issues around the types of profiles of those who were
4 waiting over the 62 days. I would have to go into the
5 detail. I honestly couldn't answer that. 12:05
6 227 Q. It wasn't your responsibility to make sure it was
7 fixed?
8 A. No, it wasn't. What would have been my responsibility,
9 when I say that there was times certainly when I would
10 have been involved directly, not so much on the 62 days 12:05
11 breaches, but a big area where I would have worked with
12 colleagues in the other Trusts in particular would have
13 been on delays, inter-Trust delays in discharge. So,
14 that sort of kind of would have come to me. It would
15 have been "Aldrina, can you facilitate" or whatever, 12:05
16 and I would have spoken to colleagues either as we know
17 director on-call, because that might have been an
18 issue. Or just in general from a planning perspective,
19 we would have brought it into our Director of Planning
20 meetings. Things that were system sticklers, if you 12:06
21 will, that were impacting patient flow.
22 228 Q. Thank you. Moving on to something with your
23 information governance hat on. We have heard that the
24 urologists were quite keen to partake in national
25 audits often from central organisations bowels but were 12:06
26 sort of discouraged from that. Did that come from your
27 level or was that more of a regional or political
28 thing?
29 A. Definitely not. I'm not aware of that and I don't know

1 about that. What I can say about audit, the clinical
2 audit function, and I think it was in maybe even
3 Tracey, Dr. Boyce's, evidence yesterday, she mentioned
4 about how the clinical audit function hadn't been what
5 it had been, and I think that was a fair comment. At 12:06
6 the time at which I left the Trust, certainly the
7 clinical audit function was mainly working on national
8 audits. It wasn't as much and wouldn't have been the
9 scale of local audits going on as there would have been
10 in the past. By that, I mean when within a service 12:07
11 directorate, a service manager actually wanting to
12 audit something, the team didn't seem to have the
13 capacity to do that.
14
15 They weren't under my remit, they were under the 12:07
16 Medical Director, and I wasn't really aware of that
17 until at a point at which actually the clinical audit
18 lead left the Trust, who had been in a well-established
19 post for a long period of time. But I wouldn't have
20 been aware of anybody being discouraged certainly to 12:07
21 audit anything.
22 229 Q. Okay, thank you. Just a couple of things on work
23 force. One of your attachments was a report from about
24 2017 about Northern Ireland urology. Who was the
25 author of that? Was it the Bengoa Report or was that 12:07
26 local?
27 A. It was the Department and the Board. But the actual,
28 Dr. Rankin, who had been our previous Director of Acute
29 Services, actually took a bit of a lead role at

1 regional level once she had retired, as I understand
2 it.
3 230 Q. Essentially that showed that Northern Ireland was about
4 sort of 10 to 13 urologists down?
5 A. Yes. 12:08
6 231 Q. Do you know if anything came of that?
7 A. I can comment for what happened within the Southern
8 Trust, certainly. We did secure additional funding.
9 In the Southern Trust, six consultants, we had secured
10 funding for a seventh consultant which we weren't able 12:08
11 to appoint. Again we're now in a situation that it's
12 not so much about money, it's about work force and the
13 ability to recruit.
14 232 Q. I totally agree with that. That's my second work force
15 point which is, I think you co-authored a letter to the 12:08
16 Western Trust about previous arrangements --
17 A. Arrangement.
18 233 Q. -- with the South Western, illustrating that, although
19 you funded for seven, you only actually had four?
20 A. That's right. 12:08
21 234 Q. What sort of led up to that? That was waiting list
22 pressures, what led up to that?
23 A. Yes. Well, actually it's funny because again that was
24 brought to my... So there had been an arrangement - and
25 I have to say I hadn't even been fully aware that that 12:09
26 was still going on - so there had been an arrangement
27 in as part of an earlier agreement around changes that
28 had happened in the Western Trust in terms of, that
29 patient flow, technically, geographically, easier

1 coming towards us rather than within the Western Trust.
2 The Western Trust had had work force challenges at a
3 point in time. That had come about, the Western Trust
4 had actually been able to recruit and had recruited an
5 additional capacity. So it was brought to me by the 12:09
6 Commissioner actually, we started to have a
7 conversation about that and the pressures that were on.
8 Mark sat on the urology group, regional group, so he
9 was aware that there was some changes afoot. We also,
10 of course, the timing of that letter I think you will 12:09
11 find coincides when we were doing the lookback for the
12 matters pertaining the Inquiry. So there was a need to
13 carve out specific capacity for that. So that's how
14 that all sort of come to be.
15 235 Q. And Mark, that's Mark Haynes? 12:10
16 A. Sorry, Mark Haynes, Dr. Haynes, yes.
17 236 Q. You have answered my second question. So the patients
18 that were coming to you are now being looked after
19 closer to home?
20 A. Yes, back to the Western Trust. The Western Trust 12:10
21 reconfigured their arrangement with their consultants
22 to accommodate that.
23 237 Q. Right, thank you. Last question: A little bit more
24 about the day elective care initiate that you are
25 involved with, and that's happening quite a lot around 12:10
26 England, so it was nice to hear about the lithotripsy?
27 A. Yes.
28 238 Q. So now you're taking patients around the region for
29 that. Also in your attachment, you look at

1 ureteroscopy for stones, bladder tumour surgery and
2 laser surgery for prostates. What's happening in your
3 local area, is that a new build or are you using an
4 older hospital with the new facility?
5 A. For the stone? 12:10
6 239 Q. For the day elective care centre, how is that, have you
7 made it happen?
8 A. No, it's reconfiguration of existing as far as I know.
9 I honestly don't know because some of that has happened
10 from when I left. But what I can say is, it had all 12:11
11 been scoped as part of our planning around what could
12 be accommodated. The day elective care group was very
13 much a regional discussion with clinicians around what
14 could flow where and what would be -- in particular the
15 first thing was to work out what could be in standalone 12:11
16 units and what needed to be still on an acute site, so
17 trying to get the right and then whether or not we had
18 the capacity for that. I'm not sure if there has been
19 any further investment or changes needed or what the
20 knock-on effect of that has been, because it hadn't 12:11
21 been agreed at the time that I had left. So I am not
22 just certain of the detail, but certainly somebody in
23 the Urology Service, any one of the other witnesses
24 would know a bit better about how that's looking now.
25 240 Q. Strategically you are expecting stone patients to come 12:11
26 to Southern Trust for lithotripsy in the same way where
27 Southern Trust patients are going to then move to other
28 trusts?
29 A. Correct.

1 241 Q. To have other procedures?
2 A. Other procedures, yes. So it was a different flow
3 basically.
4 MR. HANBURY: Thank you, that's all I have.
5 CHAIR: Dr. Swart? 12:12
6 242 Q. DR. SWART: One of your roles is in regard to strategic
7 planning, I think you have said?
8 A. Yes.
9 243 Q. How did you go about supporting strategic planning down
10 in the services? Did you set up a framework that 12:12
11 people should follow, have you got a set engagement
12 pattern? The reason I'm asking that is, I haven't had
13 the sense from the witnesses so far that they felt they
14 were involved in setting their strategic plans, so can
15 you just outline your approach and some of the 12:12
16 challenges that you faced with that?
17 A. Sure. I'll pick up and reflect maybe specifically on
18 radiology because I did hear those comments.
19 244 Q. But that isn't the only person I have asked?
20 A. I appreciate that. But just to give an example. 12:12
21 245 Q. So you see where I am coming from.
22 A. Yes, absolutely. So in terms of engaging with, I mean
23 we would have engaged across all the directorates in
24 terms of preparing a corporate plan. From service
25 specific, the planning team would have been -- each of 12:12
26 the planners, we had a planner identified to support
27 each Directorate. So they would have worked in and sat
28 in on the business very much of any service changes
29 that were happening in the directorates. They would

1 have supported the development of the business cases,
2 the development of future strategies. So things like
3 any number of services that were changed, the future
4 direction of our non-acute hospitals, our strategy for
5 stroke, for example, and stroke care, we would have 12:13
6 engaged with the teams and developed the papers and in
7 fact the public consultation documents where that was
8 necessary.
9 246 Q. Was there a process where it was routinely required
10 every year -- 12:13
11 A. Yes.
12 247 Q. -- that each service should have a plan and there was a
13 chance for people to be involved in it?
14 A. Yes, there was a corporate management plan in each
15 Directorate that then fed into the corporate plan. But 12:13
16 there would have been specific strategies as well
17 developed. So in radiology, to use that as an example,
18 in radiology we put forward, my planner worked
19 alongside the Assistant Director in radiology and there
20 is in place a five year strategy for radiology. 12:14
21 I drove that in the main, because one of the other
22 areas of my responsibilities was the capital allocation
23 for the organisation. And radiology being a big
24 capital asset piece, it was important to get a forward
25 sight of other assets, their future vision and what 12:14
26 they were planning to do and securing the funding for
27 those to support the services, whether it was an
28 additional CT or an MRI on another site or whatever.
29 So planning forward for that, so I did work with them.

1 248 Q. So if people don't feel involved what is your
2 reflection on the causes of that disconnect?
3 A. Yes. Well, cultural is going to be the main issue
4 there, I suppose. When I say culture, it's an easy
5 word to say and I have heard it mentioned in these. 12:14
6 I mean, in my experience there is a lot of subcultures
7 in any organisation the size of the Southern Trust. So
8 I don't think it's as easy as just saying it's the
9 culture in one. It's down to individual engagement and
10 how people feel about how engaged they are in their 12:15
11 work area. Could there be more done? Absolutely.
12 Some of the issues, even system issues, around,
13 I suppose the fundamental question is how much can the
14 Southern Trust navigate its own destiny --
15 249 Q. Yes, that's what I am getting at really. 12:15
16 A. -- is a little bit part and parcel of the conversation,
17 so people feel like...
18 250 Q. So do you think there is a need to re-energise that?
19 I mean, you have made your comments about quality
20 improvement which clearly is an opportunity in the same 12:15
21 vein really, would that be one of your reflections
22 maybe looking back?
23 A. Yes, I do. I think there is an opportunity to
24 re-energise it, but I think what we need really clearly
25 is a vision to where we're going. And I do believe 12:15
26 that to be system level, even taking Mr. Hanbury's
27 comments there around the change of urology etc.
28 I mean what that evidences is, is the solutions don't
29 lie within the Southern Trust, they lie at system

1 level.
2 251 Q. So, slightly different, you have got the role of SIRO,
3 how do you execute your responsibility in that role
4 and, in particular, is there an annual report to the
5 Board about issues? 12:16
6 A. There is.
7 252 Q. Are there any challenges with supporting the huge
8 amount of work that actually potentially lies with that
9 role?
10 A. Yeah, there is. I mean, there would have been over, 12:16
11 approximately 110/115 information asset owners across
12 the organisation. In terms of, from an assurance
13 perspective.
14 253 Q. That's what -- yes.
15 A. They would have completed an annual assurance sort of 12:16
16 statement and assessment. That would have all been
17 managed through the information governance department.
18 I would have completed an annual assessment and report
19 on behalf of the Board and the Chief Executive issuing
20 that. The regular reporting around position right 12:16
21 through to fairly granular detail, I would say, would
22 have been through the quarterly reports. We maintained
23 monthly reports, but training would have been provided
24 certainly from the information Governance Team,
25 particularly when there was changes of staff and hand 12:16
26 overs, quite a lot done around the records management
27 strategies et cetera. So that's more --
28 254 Q. So bearing in mind we had huge numbers of notes at home
29 which you didn't know about?

1 A. Yes, correct.
2 255 Q. For me that indicates there is a problem with
3 escalation and yet many people have said in their
4 evidence that they escalate issues, I mean one has to
5 ask what does escalation mean? 12:17
6 A. Mm hmm.
7 256 Q. And why is it that escalation is regarded as a
8 substitute for action. Now I don't expect you have to
9 have the total solution to that, but do you have any
10 reflections as to why that's the case, other than the 12:17
11 extreme work pressure, which we have heard about and
12 which is acknowledged and the complexity of the
13 organisation, is there anything else, do you think,
14 that's fundamentally responsible for the fact that a
15 number of things don't seem to have filtered up to the 12:17
16 right people?
17 A. Yes. There's probably something in the space and it's
18 very much in the governance space, I guess, people
19 being very clear on what their roles and
20 responsibilities are and it's not necessarily somebody 12:18
21 else's responsibility. So whether there is a
22 diminution of people's understanding of what each
23 person is responsible for and what you are certainly
24 responsible for as a leader, I don't really have the
25 answer to that. I do think, as you have articulated 12:18
26 quite well, I suppose probably my own assessment and my
27 own experience. Like I said, I would reiterate the
28 fact that I do think it's not just as simple as saying
29 culture, I think there is more to it than that. And

1 I do believe there to be subcultures, but clearly it's
2 a leadership challenge at all levels.
3 257 Q. So, in that vein, there is my impression, and I think
4 we have heard evidence that people have concentrated
5 very well in their areas -- 12:18
6 A. Silos.
7 258 Q. -- of the different committees and in their
8 professionals areas, so you can call it silos, you can
9 call it all sorts of things, but it doesn't seem to be
10 integrated governance in action as far as the evidence 12:19
11 we have heard. So what discussions have been had at
12 Board level about how to make a more integrated
13 approach to performance, et cetera, a reality, because
14 it's another thing that's easy to say and difficult to
15 do. My question is around does the Board regularly 12:19
16 discuss this, has it discussed it, did you have any
17 contribution to that discussion and, in that regard,
18 what did you regard your role as a Board member in
19 terms of facilitating the difficult discussions
20 underneath some of these issues? 12:19
21 A. Okay.
22 259 Q. So that's quite a broad area.
23 A. There's quite a lot there, yes.
24 260 Q. It's about integrated governance and how you as a Board
25 member can execute your responsibility for everything, 12:19
26 it's not just within your portfolio?
27 A. Sure.
28 261 Q. And whether the Board in a wider sense really grasps
29 the need for that given the breadth of the issues you

1 are facing?
2 A. So if I start with thinking about the intent of the
3 Performance Committee, for example.
4 262 Q. Yes.
5 A. The intent behind the Performance Committee was to 12:20
6 consider performance in a broader optic, and not just
7 about --
8 263 Q. The numbers?
9 A. -- the targets et cetera. So when we would have had a
10 session on cancer or whatever, I mean the Board 12:20
11 determined whatever area to drill down into in a deep
12 dive type thing, it was an opportunity then as Board
13 members to really get under the surface of some of
14 those things.
15 264 Q. Did you, do you think? 12:20
16 A. No, I think we made a start. I think we did make a
17 start. What I can say as a member of the senior --
18 here's how I measure that: As a member of the senior
19 management team those meetings started in October 2019
20 and at every meeting I learned something. I think that 12:20
21 is a measure of what I wasn't otherwise finding out
22 some way else. So there was an opportunity for people
23 to talk people into the other issues they were facing
24 within their services et cetera. So I think that could
25 be part of the solution certainly going forward. 12:21
26
27 The other area, and again under Mr. Devlin's Chief
28 Executive accountability meetings, I think, yes, you
29 will have had that in your witness statements as well.

1 There was, again albeit you could say it is siloed in
2 the sense that it is looking at specific directorates,
3 but it was certainly aimed at, we created those
4 dashboards to try to say well what the safety
5 indicators, what are the quality indicators. So my 12:21
6 team were very much around trying to enable that. As
7 I said it is a corporate role to try to enable the
8 optics on some of that and governance was a part of
9 that as well, as well as other indicators that come
10 from finance and HR. So it was to get a broader look 12:21
11 at the challenges in the organisation. But, given the
12 scale and size of it, I think there are certainly
13 opportunities. And why I mention, perhaps, in my last
14 comments there around the likes of, whatever it is
15 called, quality improvement, steering group. Certainly 12:21
16 I know when Dr. Khan was acting in the medical role, he
17 says we could build this to become some sort of safety
18 quality oversight group. And it didn't need to be
19 producing just reports, it needed to be relationships,
20 insights, putting things on the table and trying to 12:22
21 make connections. So I think there is something more
22 that could be done in that space. Whether that could
23 actually be replicated at other levels given the scope
24 and span of the organisation into particular service
25 areas, something like that I think would be useful. 12:22
26 265 Q. So a performance meeting clearly that attempts to get
27 underneath it, but it's work in progress you are
28 saying?
29 A. Work in progress.

1 266 Q. I think Mr. Devlin said the same?
2 A. Yes.
3 267 Q. There weren't really any serious delves into peer
4 review standard, gaps in cancer or anything of that
5 nature. But that wasn't lack of appetite, it was more 12:22
6 lack of time and maturity of the committee. And your
7 dashboards, again, work in progress. Similar to that,
8 does the senior management team have a sort of
9 performance review with each directorate a couple of
10 times a year bringing everything together, has that 12:23
11 ever happened? In terms of, do you sit down with the
12 whole senior management team, the Acute Directorate and
13 say, right, tell us about your governance, tell us
14 about your finance, tell us about your performance,
15 what do you need help with, what's your strategic plan, 12:23
16 that kind of thing?
17 A. Yes. Okay, so the whole senior management team know,
18 there's maybe something in that. The Chief Executive's
19 accountability meeting, as I described it, brought
20 whatever the directors say - it was the Director of 12:23
21 Cancer - and he brought the corporate directors in, so
22 you had finance, you had me and you had HR.
23 268 Q. Yes.
24 A. But you didn't have children's and you didn't have
25 older people's directorates so it wasn't done in that 12:23
26 way.
27 269 Q. Was it done by a directorate with medicine and nursing
28 there as well and all of that?
29 A. No, they were.

1 270 Q. Oh, they were?
2 A. Medicine and nursing were. So you had your
3 professional leads and you had your corporate leads
4 into that service area.
5 271 Q. How often did that happen? 12:24
6 A. They were three times a year.
7 272 Q. Yes. Was that effective?
8 A. They hadn't got to being overly effective in the sense
9 that we put the infrastructure down but then the
10 pandemic hit and during the pandemic everything 12:24
11 reverted to just one-to-ones.
12 273 Q. So it was the realisation?
13 A. Yeah, absolutely, we knew we were on that journey and
14 we were getting good traction out of it. Even in terms
15 of setting the next stage, essentially, which was, the 12:24
16 dashboard, as I said, was a bit cumbersome but we
17 didn't have the systems in place but we started to
18 recognise we could build. And before I left we were
19 trying to build a dashboard around that that would be a
20 bit more automated from other systems, not quite there 12:24
21 yet, but certainly that was the idea.
22 274 Q. This is a final question: The culture of the Board,
23 were Board members curious as to what was being done
24 about some of your really big issues or was there a
25 sort of acceptance that you are going to fail the 12:24
26 target and you are not going to meet the trajectory,
27 what was the level of enquiry and curiosity from Board
28 members?
29 A. I would say there was -- that changed based on

1 membership, I suppose, like anything. There definitely
2 was curiosity, there was certain concern. I mean, as I
3 said, just my tenure we went from, and again I'm
4 specifically speaking about from the performance report
5 perspective, but we went from a position of wanting 12:25
6 assurance that everything was all right, but when
7 things weren't all right, as in we got to -- definitely
8 the Board were very interested when we had even one or
9 two breaches of any particular target at that point in
10 time. We would have done a whole -- I'd have done a 12:25
11 report with that director about why. But then when it
12 just became --
13 275 Q. That's what I am asking about. This is almost you're
14 measuring consistent failure against targets?
15 A. That's it. That's it. 12:25
16 276 Q. It must be extremely demoralising for everyone
17 involved?
18 A. It was.
19 277 Q. Was there a supportive, critical friend challenge from
20 the Board or was there a sense of helplessness? 12:26
21 A. No, I think there was a reasonable critical friend.
22 I think it is actually, like I said, what I think was
23 the main instigator to why we needed a performance
24 committee, because we needed to actually understand.
25 Board member were keen to understand the service in a 12:26
26 greater detail beyond what maybe they were getting at a
27 Board level. By doing the deep dives in particular
28 areas, their level of understanding increased to be
29 able to ask more informative questions. To be fair to

1 members, I think it was very much driven by that.
2 278 Q. Particularly about all these patients who were waiting
3 so long, and some of whom definitely had suffered harm,
4 did that specific line of questioning come through from
5 Board member, because that's the most obvious 12:26
6 consequence of this, there are people out there?
7 A. Yes, I think.
8 279 Q. It did?
9 A. To be fair to members, I do think, and I recall
10 occasions of that very thing, about the scale of harm 12:26
11 and just concern, general concern about the waiting
12 lists and the length of them, particularly as we moved
13 into advising that we were now using nearly our full
14 capacity for red flag capacity. I mean I had to bring,
15 for example, to the Board -- and it was very 12:27
16 distressing for staff, operational staff and teams on
17 the ground. The first year I remember, when we were
18 over the winter period and we had a number of
19 cancellations of red flag surgeries, which was very
20 distressing for those individual patients, of course, 12:27
21 absolutely distressing; but also for the staff and the
22 ability to bring them. We would have done bespoke
23 reports. The Board did ask and wanted to know the
24 detail of that and I brought reports through to detail
25 that, you know. 12:27
26 280 Q. Did that include patient stories to actually bring it
27 to life?
28 A. Yeah, we did. We got better at patient stories, more
29 particularly in later years.

1 281 Q. It's difficult.
2 A. You will have heard in some of the evidence,
3 particularly around engaging in specific areas. We did
4 admit external support from on Patient Client Council,
5 in particular, would have got patient stories and 12:27
6 brought those in. We opened up a platform in the Trust
7 also called Staff as Service Users, so staff could put
8 in, because I mean a lot of people who worked within
9 the area are also users of the services. So, we were
10 trying to get stories in there. Then most recently, 12:28
11 the care opinion piece that the Director of Nursing
12 would have commissioned through to try and get those
13 real stories. But you got stories and complaints, you
14 got stories from many sources, and those are the most
15 important pieces. 12:28
16 DR. SWART: That's all from me. Thank you.
17 CHAIR: Thank you. I have no further questions. Thank
18 you very much for coming along and giving your
19 evidence, and we do have the statement.
20 THE WITNESS: Apologies for my speed of speak. 12:28
21 CHAIR: Don't worry. I think I have been guilty of it
22 too on occasions. Thank you.
23
24 Ms. McMahon, I think that then is us until the week
25 after next. 12:28
26 MS. MCMAHON: Yes, that's right.
27 CHAIR: I don't think we have any further witnesses
28 this week.
29 MS. MCMAHON: Yes.

1 CHAIR: So, ladies and gentlemen, I will see you again
2 on whatever date it is. It might actually be Monday
3 the 5th I think we're due back. Thank you.
4
5 THE INQUIRY ADJOURNED TO 10:00 A.M. ON MONDAY 5TH JUNE 12:29
6 2023
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