Urology Services Inquiry

Oral Hearing

Day 58 – Tuesday, 12th September 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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THE HEARING COMMENCED ON TUESDAY, 12TH DAY OF SEPTEMBER, 2023 AS FOLLOWS:

CHAIR: Good morning everyone. Welcome back. I hope everyone had a relaxing summer break and is ready for lots of hard work this term. I know we are.

MR. WOLFE KC: Good morning everybody. And good morning panel. It is, of course, great to be back. Your witness this morning is Mrs. Trudy Reid. You'll recall, members of the panel, that last term we were engaged in what we called Module 3 which was governance, governance processes in action and Mrs. Reid was due to come to speak to us in June, a bit of an emergency happened in a particular area of her work and we're glad to see her here today. And I understand she'll take the oath. 10:00 10:00 10:00

CHAIR: Okay. Thank you, Mr. Wolfe.

MRS. TRUDY REID, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MR. WOLFE KC AS FOLLOWS: 10:01

MR. WOLFE KC: Good morning, Mrs. Reid.

A. Good morning.

1 Q. We're going to start this morning by looking at the witness statements which you have provided to the inquiry and get you to adopt those. So starting with your response to - the initial response to the Section 21 notice. If we can bring up on the screen, please, WIT-95194. The notice was March of '23 and if we go to 10:01

WIT-95266, you'll see your signature?

A. Yes.

2 Q. Now, you put in an addendum statement to correct aspects of that but subject to that addendum statement, do you wish to accept that or adopt that statement as part of your evidence today? 10:02

A. Yes, thank you.

3 Q. And then the addendum which came to us on 8th September, WIT-100367. Okay. And this is, you will recognise the addendum witness statement which came in last week? 10:03

A. Yes.

4 Q. The signature page is WIT-100372. Again, would you wish to adopt that statement as part of your evidence?

A. Yes, thank you. 10:03

5 Q. Now, you're currently employed as the Director of Medicine and Unscheduled Care Services with the Southern Trust?

A. Yes.

6 Q. And you took up that position in January of 2022? 10:03

A. Yes.

7 Q. Now, we have you here today to speak about a different role, you were appointed as Acute Directorate Clinical and Social Care Governance Coordinator on 4th April 2016; isn't that right? 10:04

A. Yes. And apologies, it was January '23.

8 Q. January '23 you took up your most recent post?

A. Yes.

9 Q. So that's the post of Director of Medicine and

Unscheduled Care?

A. That's right.

10 Q. Self-evidently we'll call the post that you took up in 2016, Governance Coordinator for short, if that makes sense to you? 10:04

A. Yes.

11 Q. And your commencement in that post at that time, April 2016, is obviously of some significance in the Inquiry's timeline, because it was after about that time when the Trust began a process or we can see the beginnings of a process which examined some of the shortcomings which the Trust believe existed in association with Mr. O'Brien's practice and that led into, after the close of that year, into early 2017, into an MHPS process which continued almost to the end of your tenure as the Governance Coordinator. So it's an important period in the interest of the Inquiry. 10:04 10:05

So let's just ask you about that role. The job description that we have for the role appears to be that of your successor, Patricia Kingsnorth. We don't appear to have a job description -- 10:05

A. No.

12 Q. -- issued to you.

A. No. 10:06

13 Q. Is that right?

A. That's correct.

14 Q. Yes. I just want to look at your successor's job description briefly and you can maybe sketch in for us

the key components of the role that you took up in April '16. So that job description is to be found at WIT-92070. I should say, just before we look at this, to put the other temporal pillar in place, you continued in this role until January 2019; isn't that right? 10:06

A. Yes.

15 Q. And you were replaced by Patricia Kingsnorth?

A. Yes.

16 Q. If we scroll down to the job summary, your responsibility or at least the description of the post holder's responsibility was one of driving forward and coordinating all aspects of the Trust, clinical and social care governance agenda within the Acute Directorate. Is that, as a strapline, something you recognise about the role that you were engaged in? 10:06 10:07

A. Yes.

17 Q. It goes on to talk about providing internal and external directorate focus or prioritisation linking implementation, review and monitoring of operation and professional governance agenda for the directorate, again is that -- it's a bit, I suppose, buzzwordy, but is that what the job entailed? 10:07

A. That would be my understanding of what the job was to entail. 10:08

18 Q. Yes. In your own words, perhaps, sketch out how you envisaged the job as you applied for it and how it worked out in practice, in terms of the, if you like at a high level, the kinds of role you were fulfilling

within the Directorate?

A. The role was to ensure that clinical and social care governance was at the heart of what we were doing, it was part of the -- the main element of the role was to look at the governance within the Acute Directorate, identifying what needed to be done and make improvements as they -- you know, in any gaps that there were within the governance structures at the time. The post had been vacant for a number of years prior to me coming into the post and initially it was focussed on the small team that were there, were two lead nurses who focussed on the SAI process. When I took up post, I wanted to look at the entirety of clinical and social care governance from risk management, education and training, standards and guidelines, making sure they were appropriately implemented, complaints, making sure they were completed, looking at the SAI process, making sure that we had terms of reference for all of the groups that were sitting. So the entirety of the governance structure. So initially when I joined it was very focussed on the SAI process and responding to complaints.

10:08 10:09 10:09 10:10 10:10

19 Q. And you wanted, plainly, to broaden that out?

A. Yes.

20 Q. As we'll see as we go through your evidence in the course of today, incidents and the management of incidents, and some of those incidents would become SAIs, some of them could be dealt in other ways, some

of them were in the form of complaints, that was, as I would understand from your Section 21 response, really at the core of your team's workload and the most resource intensive aspect of the role?

A. It was. But to be proactive you need to look at all of the other elements of governance to make sure that standards and guidelines are implemented to ensure that we have robust processes to ensure that the quality and safety of the care is of the standard that we would want. The SAI process was a retrospective process looking at where an incident had happened and to identify the learning from that and then to make recommendations to mitigate it from happening again. 10:10 10:11

21 Q. Mm-hmm. So if you just scroll down, I want to take you to one -- if we just move to the next page, please. Under the key duties, the first key duty, perhaps, importantly, is, you were to "Take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and they are providing timely assurance and alerts to both the service director and the organisation." 10:11 10:12

We get a sense of how you found the ground, so to speak, within your Section 21 statement. I suspect you are going to tell us today that your ability to provide the kind of assurance that things were operating at a 10:12

sufficiently high standard of compliance was not, despite your best efforts, was not available to you because of resource issues?

A. Yes. I couldn't have provided an assurance in the organisation that all aspects of clinical and social care governance were robust within the Acute Directorate. There was a very small and limited team available, at times it was me and one other part-time person, so things in relation to audit for assurance wouldn't have been robust at the time. And there was an internal audit report that highlighted that the Audit Committee hadn't met for some time within the Acute Directorate and then that was one of the actions that I put in place to try and make the system more robust and try to provide a form of assurance to the Acute Director and, therefore, SLT. 10:13 10:13 10:13

22 Q. Yes. And we'll come to look at some of the challenges that you faced, particularly around resources, IT, that kind of thing, the initiatives that you did get up and running and how they fared. The Audit Committee, for example, you got that up and running again but it collapsed at a certain point and we'll look at that. 10:14

But just to, before we move on in terms of the job description, and I don't want to be a slave to the document, but in terms, did you see your job as, I suppose, one part ensuring that the systems and structures of governance were adequate, extracting data and lessons and learning and then on the other part 10:14

actively trying to ensure that governance had a visibility within the Directorate?

A. Yes.

23 Q. Is that a reasonable description of how you saw the job? 10:15

A. It is, when I went into the post that was what I envisaged that we would do. Although lots of it was very reactive in relation to reviewing incidents, the SAI process, but I did work to improve the structures within the system at that time. 10:15

24 Q. Yes. Let's just look briefly at where you were coming into this post. You've set out, I think helpfully for the panel, a summary of the roles that you held, if we can find that at WIT-95275. You're a nurse by profession? 10:15

A. Yes.

25 Q. You qualified back in September 1989. If we just briefly scroll down through this, we can see that, for example, you then moved into a number of management roles within the Southern Trust. We can see from 10:16 October 2009, for a two-and-a-half-year period you were head of service in general surgery. Then you temporarily, for about nine months or so, held the post of Assistant Director within the Surgery and Elective Care Service. In terms of your qualification for the 10:16 role of Governance Coordinator, how would you describe that? Did you feel comfortable coming into this post in 2016, that you were sufficiently well equipped for what was, I suppose, a middle management role

specifically focussed on governance?

A. As a nurse I've worked in multiple specialities. So I have worked in care of the elderly, medicine, I did my intensive care course, worked in theatres and had a broad experience, worked in infection control in the acute setting and in community. So I felt I had a good clinical background. I had good relationships with the clinicians within the Trust, with the team that I was going to be working with. But as with any post, when you move into a new post it's always a learning curve. So I attended courses on the SAI process, human factors, patient safety, read widely and tried to develop my skills and abilities within my knowledge of clinical and social care governance to equip me with the necessary elements that I needed to do the job. 10:17 10:17 10:18

26 Q. I should say, scrolling down, your next post in the list was as Head of Service within trauma and orthopaedics?

A. Yes.

27 Q. Did those Head of Service roles, I suppose, open your eyes to some extent to the kinds of governance issues that might be, I suppose, problems for you or a problem for you that you would need to solve in the coordinator post? 10:18

A. For example, as Head of Service in trauma and orthopaedics we would have had our various meetings with the clinicians and the multiple disciplinary team where we would have looked at incidents, looked at complaints, reviewed their audit information, looked at 10:18

the M&M process and learning out of that and put in place actions that would be required to mitigate risk within that service. So that equipped me with the knowledge of, you know, how the meetings that we ran within the Directorate should look like in relation to governance. And that would have been a full MDT meeting where we presented -- where the clinicians would have presented cases and had discussions in relation to the governance issues within that particular service. 10:19

28 Q. So is it fair to say that enabled you, when you came into the coordinator's role to be in a position to ask the pertinent questions I suppose?

A. It did. And I think that I sort of experienced a number of various services meant that you could ask, does that feel right? You know, there was that general, clinically does that feel right? Have we asked the right questions? Have we delved deeply enough? 10:20

29 Q. We know that when you took up this post in 2016 it had been vacant or it had been suppressed for budgetary reasons for a number of years. You say in your statement that you didn't receive a handover as such? 10:20

A. No.

30 Q. Is it right? 10:20

A. That's correct. Dr. Boyce would have been supporting the Director at the time but there was no formal handover from a previous sort of full-time coordinator.

31 Q. Just in terms of the importance of a handover, Patricia

Kingsnorth, when she gave evidence she said from a handover point of view, you handing over to her as you were exiting you were able to give her 45 minutes of a handover. First of all, are handovers important in your view? And the handover that you provided for Patricia Kingsnorth, was that adequate? 10:21

A. Handovers are important. And I think in retrospect 45 minutes probably wasn't enough. Although I was there on the end of the phone or if she needed any other guidance or support at the time. 10:21

32 Q. We'll come to your interaction with Dr. Boyce in a moment. I just want to go back to some of your experiences as Head of Service and as Assistant Director for Surgery, albeit on a temporary basis. You would have had some engagements with the problems of urology during those postings? 10:22

A. Yes. Not in probably a very in-depth way. But I would have been asked to support the team at different occasions. And again from the evidence file there are some examples of that. As a nurse I would have supported the Sister within 3 South. If Martina needed some assistance with that or if Martina was maybe on holidays, I would have been asked to, by the Assistant Director at that time to address any issues that might have come up. 10:22 10:23

33 Q. Yes. We can see, I don't need to touch on this in any great detail, but you would have appreciated, perhaps like other areas within the Trust, that urology had a particular issue with backlogs?

A. Yes.

34 Q. Whether out-patients or theatre; isn't that right?

A. Lots of the services over time have had large backlogs of patients on new and review waiting lists and theatre lists so at various times we would have put in plans to try to address those backlogs across all of the services. 10:23

35 Q. Yes. Now, one, I suppose, novel issue that you had some involvement with and maybe if I could just ask you about this and see if you can remember it, if we go to AOB-05918. I'm taking you back to 2011 here unfortunately. If we just go to the bottom of the page, please. Scroll down please. A Jane Scott is writing to you and Head of Service, Martina Corrigan. 10:24

10:25

"Trudy, Martina, can you speak to consultants on 3 South and highlight the backlog of results to be signed on 3 South? There are 1,000 unsigned results that need filed."

10:25

Can you remember what that issue was about beyond what it says on the written page here and how it was handled?

A. So, laboratory results come in in a number of ways there on the computer system, the laboratory computer system, and they also come in on a paper form at that time. Historically, the junior doctors on the ward would have signed the paper copy and it would have been filed in the notes. But at the same time there were 10:25

two processes ongoing. So the junior doctors would also have looked on the computer system, which was probably quicker and more alive at the time and potentially transcribe the result into the notes. So Jane has identified there that there were a number of unsigned forms and the request was for the clinicians to speak to the junior doctors to try to address and review those unsigned forms.

36 Q. Was there any concern that these reports or results -- presumably results from diagnostics? 10:26

A. Yes.

37 Q. Was there any concern that lying amongst the 1,000 unsigned results were results that hadn't been actioned?

A. There was that potential to be there. It was really difficult to know which results were reviewed online or which were -- you know, which hadn't been. 10:26

38 Q. I spoke a minute or two ago about, I suppose, the insights that were able to gain in these roles before you became Governance Coordinator and we'll look later today at the work that you did around results and diagnostics and your attempt to have a policy or an operating procedure adopted around that and how you fared with that. But is that an example, I suppose, of a governance issue that caused you some trouble at the coalface and you had to work up solutions? 10:27 10:27

A. Yes.

39 Q. Can you remember the outcome of this and whether it did lead to any cases where results had not been actioned?

A. From that particular incident I can't remember.

40 Q. Okay.

A. But it was one of those ongoing issues that we needed to continue to monitor.

41 Q. Yes. Another issue that came across your desk this time, just looking at the dates when you were Head of Service for Trauma and Orthopaedics, November 2015, you're copied into correspondence which spoke to the implementation of a process around triage, that is obviously of interest to the Inquiry. Let me just open that document and ask for your comments, please. It's AOB-00886. If we scroll down we can see that you're in the list of people who get the email below. And it is Anita Carroll writing and she's explaining that some areas of the service are particularly poor in triaging referral letters and she's asking if it could be agreed with clinicians that where referral letters are not returned within a week or thereabouts - the standard should be within 72 hours - that the regional booking centre -- is that a referral booking centre? 10:28 10:28 10:29 10:30

A. Referral and booking centre.

42 Q.

"...will add patients to the waiting list with the priority type dictated by the general practitioner. Given that waiting lists are now much longer than they were previously, this could cause problems so it is in everyone's interests to try and encourage quicker turn around of triage." 10:30

Is that an issue that caused you any pause to thought, to think at that time or was that just, I suppose, another straw in the wind coming across your desk that didn't cause you to intervene?

A. At that stage that wouldn't have been an issue within the trauma and orthopaedic service. But it was within others, as we now -- as we know. The IEAP did allow for urgent and red flag patients to be added to the waiting list as per the GP's instructions. But we now know that the patients who were added with the GP criteria that weren't upgraded then did come to harm. And when we look now approximately 8% of referrals are upgraded across the Trust and some services have a higher, such as breast and haematology, have a higher increase than that, but on average about 8% of routine referrals are upgraded. 10:30 10:31 10:31

43 Q. Yes. You appreciate, because you were the coordinator on the serious adverse incident reviews that looked at the case of the five patients who had not been upgraded? 10:32

A. Yes.

44 Q. Or hadn't been triaged and, therefore, hadn't been upgraded and were then to contact malignant disease, so you appreciate that the problem with what we have in front of us on the paper was that, in the absence of triage, the patients were added to the waiting list in accordance with the general practitioner's classification? 10:32

A. Yes.

45 Q. But there was no follow-up to, in this case, Mr. O'Brien, or with the urology service to ensure that the triage was actually performed?

A. Yes.

46 Q. And we'll look at your role in the SAI that followed a bit later today. But do you find that surprising, that the Trust and those charged with supervising the need for triage could have, some might say naively, failed to recognise the need to push to actually get the triage done? 10:32 10:33

A. I think, and with sort of the value of hindsight, you know, efforts were made to improve the triage. Patients who -- when the referral comes in you're not automatically added to a waiting list. So I think this was an attempt to have patients on a waiting list so they didn't get lost in the system and had at least an attempt to make sure they were assessed and treated. But with the value of hindsight and the knowledge of the amount of patients who are upgraded, it wouldn't be something we would do now. 10:33 10:34

47 Q. Mm-hmm. Now, coming into this role then as Coordinator of Governance within Acute, you, perhaps quite quickly, appreciated that there were conversations ongoing about the appropriate structure for Acute Directorate governance and the need to resource that structure. 10:35 I'll show you an example, I think it's from 4th April 2016, perhaps the very day you started in your role. If we could have up WIT-88277. As I say, I don't think you're -- you're not copied into this?

A. No.

48 Q. You probably haven't yet entered your office or you are just about to enter your office or maybe it's close to the end of your first long day. But we can see that Dr. Boyce is putting on paper a structure and we'll look at the structure briefly. She says: 10:35

"It incorporates a lead nurse role into the structure which I know that some of you are worried about." 10:36

She left the Band 7's role in as an option and she personally doesn't think lead nurses would be able to cope with the amount of governance work that needs to be done on top of their other roles. She refers to an "SAI investigation backlog that still needs to be addressed" and "we haven't started on the implementing lessons learned piece". So she's looking for discussion around that. If we just scroll down and we will see the structure that she is sending forward. On to the next page, please. So if we could have that on one page, thank you. 10:36 10:36

I suppose we don't need to look at this in slavish detail, I can bring you to another proposed structure from May 2018 and we'll maybe look at that in a moment to see what mischief that was seeking to address. But can you help us, I suppose, with this: You coming into the post after the coordinator role had been suppressed for a year-and-a-half for budgetary considerations, 10:37

what was Dr. Boyce looking to achieve in terms of putting a governance resource into the Directorate and what ultimately was achieved, if anything, during your tenure in terms of that governance resource?

A. So from this Dr. Boyce was trying to improve the resource within the governance team so that we could address the SAI backlog, start to identify lessons learned, start to implement them, make sure that recommendations were followed, that we had, you know, a good complaints process, learning from that audit, improve the standard and guideline function, make sure that there was education and training for the staff within the Acute Directorate in relation to governance, and that we had the appropriate information systems and processes in place to identify where there were risks and put plans in place to mitigate it. And to do that it needed more than me and the lead nurses that were there at the time. Some of it was to be embedded within the divisions and a report to me as well. 10:38 10:38 10:39 10:39

The lead nurses within the divisions had a significant workload and part of their role would have been clinical governance. But this was to be another layer on top of that to be able to provide that assurance that the Director would have needed. So the Band 7s then would have been there to help support the Sisters and work to the lead nurses and up to the Heads of Service and Assistant Director, in relation to reviewing their incidents and identifying learning and 10:39

appropriately close off the learning from any incident that there was.

49 Q. Yes. I suppose the last part of the question was, what was achieved during your tenure in terms of trying to meet, I suppose, the standard implied within this document, the ideal that Dr. Boyce was pursuing? 10:40

A. Throughout my tenure there were a number of people. So when I started first there was two lead nurses helping with the SAI processes, one of those returned to their original role quite quickly. The other, there was requests for them to go back in May of that year, of 2016. However, they were able to stay on until the end of 2017, with a period of unplanned leave in the middle. At various occasions we had a Sister from one of the wards came to assist with governance. Unfortunately, she had a period of unplanned leave and left quite quickly. We had two members of staff who would have worked to address complaints and issues at ward level or where patients phoned in to try to proactively address their concerns in relation to governance or the early processes of complaints. They were moved into the team in July, June/July 2017. And unfortunately one of them had a period of sick leave and retired. 10:40 10:41 10:41

So at various stages throughout my tenure there would probably be 103 weeks of unplanned leave within the team and on occasions there was myself and one part-time Band 7 to assist with the elements outside

the complaints process. The complaints team was a small team but remained largely unchanged throughout that tenure.

50 Q. Yes.

A. We did eventually, towards the end, get approval to appoint two permanent Band 7s into the process, into the team and they were recruited towards the end of my tenure into Patricia Kingsnorth's tenure. 10:42

51 Q. Yes. Just for your note, jumping slightly ahead on the speaking note that you have in front of you, I am sort of going between page 3 and page 8 for the moment, but you set out your staffing complement within your Section 21 statement at WIT-95197, and just as you have said just now, you had staff to cover complaints, you had staff to cover standards and guidelines, staff to cover equipment management, point of care testing and SAIs? 10:42 10:43

A. So from 2018 the point of care testing and equipment management person came into post.

52 Q. Yes. But what you have said just now, and as appears from your Section 21 response, your staffing resource was punctuated by difficulties. I think you are saying insufficient staff? 10:43

A. Yes.

53 Q. Excessive unplanned leave? 10:44

A. Yes.

54 Q. The use of seconded staff rather than dedicated staff?

A. Yes.

55 Q. A lack of continuity, in that staff were moved at short

notice or unhelpfully but unavoidably moved from one governance area to another?

A. Yes.

56 Q. I think it's the thrust of what you are saying, and we'll look at the scale of the work in a moment, but when measured against the scale of the work your staffing resource wasn't sufficient? 10:44

A. It wasn't sufficient and it was something I escalated on a number of occasions.

57 Q. Yes. You have said, if we go to your witness statement, WIT-95252, at 7.1. I think this is perhaps a helpful summary of your sense of it: 10:44

"The Acute Directorate is very busy, with significant resources required for day-to-day operational management of the service. There had been a focus on performance and finance in recent years, however good performance increases efficiency and flow of patients both electively and non-electively reduced waiting times and risk. There was a verbal commitment to governance but operational challenges and available funding limited time to proactively manage and respond to governance issues." 10:45 10:45

And then you highlight what is said in a Clinical and Social Care Governance Assurance Template which you completed in 2018. We'll go there now. So is it fair to say that, while you were receiving what you say there was a verbal commitment, the actual reality on 10:46

the ground was that that commitment wasn't translated into the number of bodies you needed to do the role and, I suppose, the kind of skill sets that you needed in order to achieve the kinds of proactive governance that you talk about? 10:47

A. That's correct.

58 Q. The Clinical and Social Care Assurance Template, governance assurance template, that was a document issued by Dr. Khan in 2018; is that right?

A. That's correct. 10:47

59 Q. In his role as Medical Director at that time?

A. Yes.

60 Q. We could have a look at that now if we go to WIT-96612. This is your email to Dr. Khan and Margaret Marshall and forwarding the completed template. If we go down 10:48 to the next page, please? Can you just help us orientate on where this has come from? We can see along the left-hand margin - and I'll scroll down in a moment after I say this - we can see that a number of governance activities such as SAIs, standard and 10:48 guidance compliance, complaints management, clinical audit are to be measured against your view of the strengths, weaknesses, opportunities and threats to that area, is that right?

A. Yes. 10:48

61 Q. We'll just observe that. So across the top, "strengths, weaknesses, opportunities and threats" against various questions. And strolling down we can see "SAI investigations". Next page, please.

"Standard and guidance compliance", "complaints management", "clinical audit". And that's that. So if we go back to the top of the page. And obviously we don't have the time this morning to go through it exhaustively and the panel will read it. But I think you refer elsewhere in your statement, it's at WIT-95263 at paragraph 8.6, that this document illustrates the weaknesses, challenges and gaps that you faced within your Directorate? 10:49

A. Yes. 10:50

62 Q. And within your role, I suppose, specifically of governance. It is notable as against SAI investigations you haven't felt able to say anything in terms of strengths?

A. The challenge at the time was significant. There was a large backlog of SAI reports. They weren't able to be progressed in a timely manner. And the patient and family engagement isn't what I would have wanted for those patients and families. 10:50

63 Q. Yes. You point out the core weaknesses: 10:50

"Staff do not have sufficient training to make them confident with the SAI process, particularly for chairs of SAI panels and it is difficult releasing staff to attend SAI meetings." 10:51

That's difficult to your staff or operational staff?

A. Operational clinical staff.

64 Q. Yes. Is that then pointing in the direction then of

particular problems with the SAI process? Was it almost facing a situation of near collapse because of these problems or is that too strong?

A. Collapse is maybe strong but there was a significant backlog of SAIs, I think at that stage probably about 33. The small team, myself and one other at the time, it was a challenge for us to be able to support all of the chairs, help draft the timelines, help with drafting the reports, supporting the chairs and supporting the members of the panel. And again to getting the teams released to have the meetings in a timely manner and support them in writing, you know, finalising the reports, it was a huge challenge at the time. 10:51 10:52

65 Q. You look at opportunities, particularly in the realm of training and you talk about threats in terms of resource, including clinician time. Maybe later today I want to look at it in a bit more detail, at what those problems actually mean, whether they were resolved. But could you give us, I suppose, a snapshot now? Were you able to get to grips with any of these problems? I understand, for example, that you did manage to develop a suite of training? 10:52 10:53

A. Yes. So when I started in the acute governance role there had been very limited training in relation to SAIs, so I sourced training from a company in England to provide training and then identified a company more locally to provide two-day and single day training. So it was more awareness and then a more in-depth training 10:53

for chairs on the management of the SAI process. But it was still a challenge to get chairs and other members for the SAI process. Some of that was time driven, they had busy clinical roles. And then there were other challenges where, if there were issues, they had to go to Coroner's Court, that again created a challenge. And one of the elements that made them less willing at times to become members of SAI panels.

66 Q. Let me just step out of this document a moment and bring you back to the structure. I talked about two structures that I'm aware of, maybe there are more, that were floated by Dr. Boyce during your tenure and I think this one from May 2018 endeavours to develop some resource around the SAI issue in particular. WIT-95323. Can you remember that? We can see along the -- I think if we scroll up. I'm guessing to some extent here. Scroll up first of all to see Dr. Boyce's commentary. Further up please. No. Just go back then to that. I think specifically -- back on to the structure, yes. 10:54 10:54 10:54 10:55

So in the red boxes -- if we can have that all on the screen, please? So the red boxes on the left-hand side, I think that was --

A. Yes. 10:56

67 Q. The idea there was to allow some protected time for the Chair of the SAI and that was directed at, I suppose, the problem that you have highlighted in that template to Dr. Khan, that the SAI process was struggling, at

least in part, because of an inability of chairs to commit the time needed to get SAIs through from start to finish in a better timeframe than was currently the case?

A. That's correct. What we wanted to do was have perhaps four hours of a clinician's time per week to focus on governance and SAIs and that would have meant that they had that very focussed time to review the evidence, organise, hold the meetings, and draft the reports and that, in my opinion, would have made a more robust process. 10:56 10:57

68 Q. If we just scroll down to 2.4, the next page down. I think that's where Dr. Boyce's commentary is hiding. As is, perhaps, captured in that third paragraph:

10:57

"Introduction of additional posts would allow the Acute Governance Team to introduce proactive governance activities, such as governance dashboards, incident trend analysis, additional governance training and learning events to trends/patterns identified from the Trust Incident Reports." 10:58

And then scrolling down specifically. I think just go on down. Over the page then. Yes. So on the SAI issue there was 0.5 of a governance PA was intended for 10 consultants to address the problems that you were currently experiencing with the availability of consultant medical staff for SAI chairs and other governance working groups. 10:58

During your tenure did you see any progress with these structures?

A. No. Within the structures, the only two posts that were progressed were the two Band 7 nurses for governance. The PAs for the consultants didn't materialise. 10:59

69 Q. If we go back to our template then at WIT-96613. If we move down the page then and we go to - yes, go to "Standard and Guideline Compliance", you comment that the Acute Directorate has robust processes in place in relation to standards and guidelines, and you talk about many proactive service improvement work streams being in place. But there were problems setting aside this as well and this template refers in particular to the issues around the database? 10:59 11:00

A. Yes.

70 Q. I think that is a familiar -- or it will be a recurring theme in the course of today, problems with the Datix -- 11:00

A. Yes.

71 Q. -- facility as well. Which we'll maybe look at later. And you also talk about the lack of a "dedicated cross divisional meeting to discuss S&G..." - and that's standards and guidelines - "...and that can lead at times to fragmentation." And you then are asking for a database which is fit for purpose and additional resource to support the standards and guidelines process. Again did any of these suggestions for 11:01

improvement come to fruition in your time?

A. No. We had one very dedicated person who managed the standards and guidelines process for us at the time, with some admin support, and the database remained until very recently and still is functioning. It was more of an Excel spreadsheet, I suppose, as opposed to a database and had significant problems. It was so large. So at the minute there is approximately 3,022 guidelines on that database of which 2,800, approximately, are linked to the Acute Directorate and many of those have very significant recommendations. Some of them have 70, some of them have 300 recommendations, none of which come with funding or limited within Northern Ireland. 11:01 11:02

72 Q. Yes. You alluded to, however, just now, reading between the lines of your statement, you're speaking in praise of the work performed by a Caroline Beattie -- 11:02

A. That's right.

73 Q. -- in the area of standards and guidelines. I suppose, notwithstanding the challenges that you reflect on this template, I think what you are telling us in your statement that, for example - and we don't need to bring this up, I can simply say it, WIT-95223 - you talk about the good work of establishing working groups -- 11:02 11:03

A. Yes.

74 Q. -- to implement actions around standards and guidelines. You talk, at paragraph 3.126 of your statement, about establishing a forum encompassing lead

nurses, midwives, allied health professionals, radiography to ensure that the actions needed to implement standards and guidelines was shared and embedded with frontline staff?

A. Yes. 11:03

75 Q. Were those initiatives that you took forward?

A. Yes. So whenever I went into the acute governance role the worry was that the recommendations stopped at a certain level and sometimes what you find within governance is it doesn't filter down to the wards and 11:04 departments. So this was our attempt to make sure that the lead nurses and midwives and AHPs were fully appraised and involved in developing the actions from the recommendations.

76 Q. One of the things I suppose you had a concern about, as 11:04 reflected in your statement at paragraph 3.96, was that it wasn't always possible to provide assurance audit that guidelines that I suppose had been adopted by the Trust were actually being adequately implemented by frontline staff? 11:05

A. So to provide assurance you need to try and develop an audit and make sure that the audits are completed to identify that all of the actions are taking place and within the Acute Directorate there wasn't the resource to be able to sufficiently do that. For some standards 11:05 and guidelines there were very robust audits but for others there weren't.

77 Q. And we can see, if we just scroll down on this template again to "Audit", this time I suppose in the context of

the clinical audit sphere, you say there were examples of good audit, but in terms of weaknesses you comment that:

"Engagement with the Senior Management Team and support from the Medical Director for audit work to support, for example, an audit conference which has recently not..." 11:06

I think you maybe didn't finish that sentence. But it doesn't appear to be in praise of the support or the lack of support from SMT and Medical Director's office? 11:06

A. When I went into the role and started to review what audit processes were in place I spoke to one of the previous audit leads and they highlighted that they didn't feel the support was there for audit. There had been an audit conference within the Acute Directorate previously, but they felt that the support wasn't there and, therefore, the engagement -- while audit continued, the engagement at that level they didn't feel was sufficient for them to continue to run the audit conference. 11:06 11:07

78 Q. Yes. You say that:

"There is a lack of administrative support or administration support for all forms of audit. More positively, clinical teams are still supportive of the audit with additional administrative resource and it is necessary to have an IT system to support audit." 11:07

I suppose this is written, I think I said early in November - October 2018 - just after the last meeting of the Audit Committee on 22nd September 2018, just after that last meeting had happened and then, as 11:08
I heralded in my earlier remarks, the Audit Committee collapsed, I just want to look at that briefly. You appear to recognise in your witness statement the importance of resources to support audit, you talk about audit being the cornerstone of assurance and 11:08
clinical audit is a way to find out if healthcare is being provided in line with standards, it's at paragraph 3.129. You go on to say that, when you started in your role, you recognised that there was limited audit support in acute, although there had 11:08
previously been a strong commitment to it. Did you get any understanding of why the support for audit had fallen away? Or what was it that had fallen away to leave audit in the poor state in which you found it?

A. I think at that time there seemed to be a move from 11:09
audit to quality improvement. I think that was sort of nationally, it wasn't just locally. The resource sort of followed the quality improvement lines as opposed to the audit at the time. So any resource that would have gone towards the teams in relation to developing and 11:09
recording, doing posters and presentations in relation to audit seemed to disappear and be focussed towards more a QI approach. And they are not mutually exclusive, one feeds the other and vice versa.

79 Q. I was just going to ask that. Was audit not viewed or how did things become so skewed that audit wasn't viewed as an integral part of quality improvement?

A. It should be. But the resource went to focus on quality improvement training, supporting the quality improvement as opposed to supporting the audit element of that.

11:10

80 Q. Now you go on to say, at paragraph 1.4 of your statement, that you facilitated the development of an acute Audit Committee. The first meeting got off the ground on 22nd September 2017, but you say due to a lack of administrative support and attendance the last meeting was held on 22nd September 2018. So it lasted but a short year. I suppose, first of all, what was your ambition for the Audit Committee, what were you seeking to achieve with its commencement?

11:10

11:11

A. I wanted to refocus audit, to have a process of oversight of audit and that audit would be linked to standards and guidelines and risk identified within SAIs or complaints or incidents that we identified. So in that way there would be an oversight, that the recommendations would be known and actioned and that the teams would have felt engaged, would have developed some administrative support for them, provided some form of spreadsheet or database to hold all of those recommendations to ensure they were actioned.

11:11

11:12

81 Q. Yes. During that year did you feel the Audit Committee was getting somewhere or, if we look at some of the reasons why it collapsed, and you set those out in your

statement at 3.63, you seem to point to a lack of leadership, Mrs. Gishkori was not always in attendance for all or part of the meetings. There was no additional admin support additional for clinicians to facilitate audit. This meant that meetings were often not even quorate, leading to its failure. So was it, despite your efforts, not to put too fine a point on it, almost born to fail? 11:13

A. Yes. I think if we go back to the meeting I had with the audit lead previously, the support at senior level was really what they wanted and the administrative resource to help with the audit function, because audit can be resource intensive. So without either of those elements it's my understanding that that's why the Audit Committee didn't continue. I think if I had been in the post for longer I would have had another attempt at trying to further bolster that. 11:13 11:13

82 Q. Mm hmm. Given its collapse and failure, what deficit do you think that left residually within the systems for assurance within acute governance? 11:14

A. Without proactive joined-up audit it could leave a large gap in assurance. So not everything that we would have needed to audit was audited and we wouldn't necessarily have had oversight of all of the local audits that were ongoing. 11:14

83 Q. You say, maybe bring it up on the screen, WIT-95257, you said, at 7.23, that:

"The lack of Audit Committee meant that there was no

local acute oversight of audit activity meaning that triangulation of data was challenging. This impacted on the ability to identify risk and manage."

Was that a message that you were able to, I suppose, formulate at the time, that you recognised this at the time and did you send that message, give that message to anyone in authority? 11:15

A. I would have highlighted to Tracey and Mrs. Gishkori that I felt the Audit Committee was an essential element of our governance. 11:15

84 Q. Yes.

CHAIR: Mr. Wolfe, can I just check whether you are planning to take a short break this morning?

MR. WOLFE KC: I was wondering whether to press on or 15 minutes. 11:16

CHAIR: Take the break now and come back at 25 to 12.

MR. WOLFE KC: Perfect.

SHORT BREAK 11:16

THE HEARING RESUMED AS FOLLOWS AFTER A SHORT BREAK:

CHAIR: Thank you everyone. Mr. Wolfe?

MR. WOLFE KC: Mrs. Reid, I have just spent the first part of your evidence taking a snapshot at some of the challenges that you faced and the issues that you faced when you commenced into the role. Can I draw your attention to the remarks of Dr. Charles or 11:35

Charlie McAllister who was appointed Associate Medical Director with responsibility for surgery and elective care in or about the same time that you took up your post. I think he sent an email on 9th May 2016, let's just look at that, it's WIT-14875. If we scroll down to No. 6 he highlights that: 11:36

"Within urology there are issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked regarding inappropriate prioritisation on to NHS of patients seen privately." 11:36

He also talks within this note of - I think if we just go to the bottom perhaps - of a "significant backlog of instant reports, SAIs, creating a governance risk." 11:37

And somewhere in there, sorry I can't see it, he talks about "no real functioning". No. 1. There you go. The top line: 11:37

"No real functioning structure for dealing with governance."

Just take a moment perhaps to digest that. But he's highlighting some specific issues in urology, if I can ask you about that first of all. Did you have any heads-up as you came into your post of particular issues of a governance nature or clinical issues that 11:38

required a governance response within urology?

A. There was nothing formally handed over to me when I took up post that there was anything specific that needed addressed immediately.

85 Q. Yes. And obviously we'll come on this afternoon to look at how you did become involved in some urology issues. The absence of a real function structure for dealing with governance, as he sets out there, and delays and a backlog of incident reports is a landscape that you would recognise. Would you accept the characterisation that he has placed on paper here? 11:38 11:39

A. Yes, there were a backlog of Datix reports and SAIs at the time. The meeting with Mr. Reddy, he wouldn't have been just as familiar with the internal workings of that. But the screening didn't routinely happen weekly within surgery and elective care at the time initially. 11:39

86 Q. Yes. So he's describing, I suppose, a difficult environment into which he is entering and it was a difficult environment for you?

A. Going into a post where there was already a backlog of SAIs and then a backlog of Datixes that needed addressed meant there was SAIs that developed out of that that had to be progressed as well. 11:39

87 Q. Yes. I want to ask you specifically about, I suppose, the reporting arrangements within governance, in terms of, I suppose, your relationship with Dr. Boyce and Mrs. Gishkori and how that worked or, alternatively, didn't work for the betterment of the governance issues. You have said in your witness statement that 11:40

Governance Coordinators in other Directorates reported directly to the Directorate Director and it was your anticipation that that would be the same but you reported to Dr. Tracey Boyce and you have described her as being your Line Manager on behalf of Esther Gishkori who was the Director of Acute. Did you have any understanding of why that was the structural reporting arrangement? 11:41

A. My understanding was that in the absence of a Clinical and Social Care Governance Coordinator that Tracey helped support Debbie Burns, the previous Director with governance at that time when the post was vacant and that continued on then, wherever Mrs. Gishkori came into the post, Tracey continued to support her with governance. And then when I came into post Mrs. Gishkori asked Tracey to continue on in that role and I would report to her. 11:41

88 Q. Yes. Tracey Boyce, in her evidence, has spoken about the difficulties that that arrangement placed on her, she had her job as Director of Pharmacy and she has told the Inquiry that this arrangement whereby you reported to her as opposed to directly to Mrs. Gishkori arose because Mrs. Gishkori was not prepared to take back direct responsibility for the acute governance lead for your role. Is that how you understood it? 11:42

A. Yes.

89 Q. Was there a tension around that that affected working relations?

A. Not that was very obvious on a day-to-day sort of

meetings and workings. Although I do know Tracey had a large remit and I know she would have liked to have been able to hand back that responsibility and focus on her pharmacy role.

90 Q. Mm-hmm. From Mrs. Gishkori's perspective, she said that she had Assistant Directors as such for other aspects or other tasks, I suppose, or business areas within the Acute Directorate and, I suppose, looking into the complexity and volume of governance related issues she made it clear from the beginning, I suppose, of her tenure, in the summer of 2015, that she believed that there should be an Assistant Director for Governance, in the same way that there was for other business activities. Do you understand or sympathise, I suppose, with the view that an Assistant Director, albeit informally as opposed to a formal appointment of Dr. Boyce to that role was a helpful means to ensure that, despite the challenges within governance, there was, I suppose, that resource there, at least at the early stages of your role, to help ameliorate the kinds of difficulties that were in place? 11:43 11:43 11:44 11:44

A. I can see with the volume of incident complaints and SAIs, audit requirement, all the elements of governance, why you may want an Assistant Director. But on top of an already heavy portfolio, an Assistant Director wouldn't -- with that added on would have been a challenge. So you could see that you may want a focussed post, but -- and again each Director will, within their other Directorate will have their own 11:45

structures. However, I felt that I could have supported Esther in that governance role. It was nice to have Tracey initially to help support that transition. But I could have continued to support her in that role.

91 Q. So what you appear to be saying is that the creation of this de facto Assistant Director's role in the shape of Tracey Boyce was not entirely necessary. From your perspective you needed resources elsewhere, it wasn't at that interface with Mrs. Gishkori? 11:45 11:46

A. No, I felt I could have provided that interface as a Governance Coordinator to Mrs. Gishkori. If she had wanted that as an Assistant Director role that would have been her prerogative within her Directorate. But the team, to make governance work it needed the people below that to help carry out the function of the governance team. 11:46

92 Q. You then, as I understand it, would have met with Tracey Boyce on a weekly basis. Was it on a Wednesday typically? Whatever the day it was. And was that to, I suppose, bring her up to speed with governance developments within your remit in the week that had just gone by and what lay ahead? 11:46

A. Yes. So it would have been to highlight any new incidents, complaints, issues, concerns, if there was any guidance that I needed she could have helped support that so we could have brought that to Mrs. Gishkori to make sure she was fully appraised of any issues within the Directorate. 11:47

93 Q. Then you met with Mrs. Gishkori the next day, is that right, to have a formal update with her so that she could bring any issues to the centre, to the Board or to the Senior Management Team or the Governance Committee as part of her Director responsibilities? 11:48

A. The plan was to meet with Mrs. Gishkori on a weekly basis to appraise her and update her on any issues within the Directorate or if there was something urgent I would have made it my place to contact her if something arose. 11:48

94 Q. In terms of that relationship between you and Mrs. Gishkori, was her insertion of Dr. Boyce between you, creating this further level, was that a difficulty for you in terms of how you practised your responsibilities? Or did that work seamlessly? 11:48

A. I think reporting directly to -- would probably have been more straightforward. But quite often Tracey and I would have gone together to meet Mrs. Gishkori so Tracey would have known what I would have known, if there was anything additional that Mrs. Gishkori needed 11:49 to know I would have been able to add it, add in at that stage. But in occasions where I couldn't have met or I wasn't able to, Tracey may not have had the level of detail that I would have had in relation to investigations and incidents and reviews. 11:49

95 Q. In terms of Mrs. Gishkori's interest in the governance agenda, in other words the issues that were churning up on a weekly basis, the kinds of developments on the ground, such as complaints, reports, incident reports,

that kind of thing, or the kind of longer term structural problems that you faced around resources, for example, were you able to capture Mrs. Gishkori's interest on those governance issues or does the insertion of an Assistant Director suggest that she was less than fully interested in the governance concerns? 11:50

A. When we met she showed interest. But there were papers, such as the one that you highlighted in relation to the structures, that I wouldn't have seen that Tracey would have worked on with Esther. So she appeared interested. She wasn't always able to meet. And that was a challenge at times. So having Tracey as another layer just made it another meeting that I had to facilitate on a weekly basis. Although Tracey was very, very supportive. 11:50 11:51

96 Q. Yes. In terms of Mrs. Gishkori's experience in governance, when asked by myself whether there was any deficit in Mrs. Gishkori's engagements with, for example, the problems within urology services, Dr. Boyce thought that there was a failure to adequately engage and she put that down to a lack of governance experience on the part of Mrs. Gishkori and she said - and this is at TRA-05849 - that she felt that Mrs. Gishkori was overwhelmed with the post of Director and that might have been due to a level of inexperience. Did you sense that her ability to work through governance issues with you was at all impacted by any noticeable lack of experience with the concerns that you were raising? 11:51 11:52

A. I think the depth of support and information that I would have got from Tracey would have been more than Esther. So whether it was a time element because our meetings were often short and sometimes didn't happen. So if I needed specific governance advice I would have gone to Dr. Boyce.

97 Q. Were there, over the period of time that you worked with Mrs. Gishkori, and she was in place when you started, she may have gone off on sick towards the end of your tenure? 11:53

A. Yes.

98 Q. But were there any key messages or key concerns that you were bringing to her attention, any consistent themes that you were bringing to her attention and if so, what were they? 11:54

A. The resource for governance was something that I frequently brought to Mrs. Gishkori. To be able to fully fulfil the requirements of clinical and social care governance there wasn't sufficient people in the team. There were issues in relation to the IT systems that we had, the ability to triangulate information, delays in progressing SAI reports. Initially we didn't have terms of reference for the Governance Committees. There was some guidance that we needed, internal guidance in relation to the management of the SAI process. The lack of audit within the Directorate was another issue that I would have brought to Mrs. Gishkori. 11:54 11:54

99 Q. Obviously she couldn't just draw down resources

automatically, but can I ask you do you feel that you got a sympathetic hearing in terms of the issues that you raised and do you know whether she set out to pursue them on your behalf and on behalf of, obviously, the Directorate? 11:55

A. I'm aware at the time that there was significant issues in relation to finance within the Trust and savings had to be made so getting the financial resource to bolster the team may have been a challenge. And I know there were some discussions with the Director of Nursing and 11:55 Older People at the time in relation to resource coming from that Directorate to help with the SAI process. That offer, the people that were offered weren't able to take up the posts for a number of reasons. So I know at that stage she had attempted to get some 11:56 resource then. The paper that you highlighted, that Dr. Boyce wrote, didn't go to -- well I'm not -- there is evidence that Mrs. Carroll subsequently brought that post, when Mrs. Gishkori was off, to the Chief Executive to see if we could bolster the governance 11:56 team.

100 Q. This is the 2018 paper I showed you?

A. Yes.

101 Q. Are you suggesting that that hadn't been brought to the Chief Executive during Mrs. Gishkori's time? 11:56

A. I can't be sure. But I do know that Mrs. Carroll then subsequently sent the paper to the Chief Executive.

102 Q. Yes. You have said in your witness statement, paragraph 1.23, that, just as you have said a moment

ago, that you highlighted that the resources available to the governance team did not allow for the development of robust governance systems and processes. You go on to say, at paragraph 1.23, that:

11:57

"Limited staffing resource prevented proactive work streams to support changes required to reduce risk or monitor implementation of actions from learning."

And this risk, you say, was "consistently escalated during my tenure". Now "escalated" in what way, from you to Mrs. Gishkori

11:57

A. Yes, so I would have highlighted to Mrs. Boyce and to Mrs. Gishkori and I would have provided numbers of SAIs outstanding and the workload of the team at the time as evidence of the challenges at that time.

11:58

103 Q. Yes. When you talk about risk in this context, I suppose the risk that follows from being unable to proactively pursue governance issues, spell that out for us, what does proactivity mean in this context? Can you give us an example or two and what risk flows from the inability to pursue it?

11:58

A. So if we take some of the elements of governance. If we are looking at SAI reports, having them be able to be addressed and identify learning at an early stage and the recommendations be implemented and audited just to ensure that they were appropriately implemented is one risk. So delay in learning; delay in implementing recommendations; the inability to audit to provide

11:59

assurance; to ability to provide frequent and robust training to teams in how to complete a Datix appropriately; how to identify risk; how to mitigate that risk again was another challenge and would have been a risk. 11:59

104 Q. Was it the case that, although you're talking the language of risk to Mrs. Gishkori, that while sympathetic, she didn't appear to be able to provide complete solutions, she talked about some initiatives that were tried, but did she appear to get it, that there was real risk here? 12:00

A. It would have been really challenging for her not to have got it because when you bring the number of outstanding SAIs, when you highlight the inability to audit to the level that we would have wanted to, it would have been really difficult for her not to have understood that risk. The challenge of providing the staff would have been a challenge from a financial perspective. But, again, how that was escalated outside and up to SLT I'm not fully aware of. 12:00

105 Q. Were there any solutions to the circumstances that you found yourself in as Coordinator that you thought were obvious and that could have been achieved with, perhaps, relative ease that were not pursued for any particular reason? 12:01

A. I think the main challenge was personnel and the ability to recruit and retain and train people. It was a significant risk and was something that -- so even if I think back to the lead nurse that we had in post to

start with, who was moved out of that post into another post, that person wanted to stay and could have stayed and had had significant time in the governance team. So that would have been one that could have easily been resolved. Although it would have put a challenge in another area. But I think with the backlog and the challenge within governance that was something that could have been maintained.

106 Q. I want to move now from that reporting structure to look briefly at the arrangements which were in place which enabled Mrs. Gishkori to connect with the various services that sat within direct -- sorry, within the Acute Directorate so that governance was, if you like, appropriately monitored and considered. Now, you said a moment or two ago that, when you came into post the terms of reference for the governance forums couldn't be found by you, perhaps they existed but they weren't readily available, is that right?

A. That's correct.

107 Q. Is that perhaps symptomatic of the lowly place to which governance arrangements within Acute had descended in the absence of a coordinator for 18 months or so?

A. I think not having a coordinator did impact on the ability to make sure that, you know, terms of reference and guidance and educational and all of the support that was required within the Directorate, not having that coordinator made a big impact, in my opinion.

108 Q. Yes. And there were two governance forums; isn't that right, within Acute

A. That's correct.
109 Q. There was the -- let me get this right. There was the Acute Governance Committee?
A. Yes.
110 Q. It met on a Tuesday? 12:04
A. Tuesday afternoon.
111 Q. And Mrs. Gishkori chaired that meeting?
A. Yes.
112 Q. You were in attendance?
A. Yes. 12:04
113 Q. And her Assistant Directors were in attendance; is that right?
A. That's correct.
114 Q. And then there was the similarly named but Acute Clinical Governance Committee which met monthly? 12:04
A. Yes.
115 Q. And the same attendees plus medical staff, that's the medical management?
A. Yes.
116 Q. You set out within your witness statement the terms of 12:05 reference for those committees which, I think it is the same wording, that they were to develop, integrate, promote and monitor all aspects of governance. So could you tell me how that worked, how those committees worked? Had they different functions and what was your 12:05 role in participating in those forums?
A. So in relation to my role, I would have helped develop the agenda and the reports for the committees and supported Dr. Boyce and Mrs. Gishkori and make sure

that the information that they needed was available for the committees. The committees potentially could have been one committee rather than two, with a collective leadership model. The Friday morning committee would be what I would view to be the most appropriate where you have the operational management teams and the medical management teams working together to ensure that we had robust governance processes in place.

117 Q. You say you provided reports to those committees, I think we have an example of a report. So that I understand this, you provided the report first of all to Mrs. Gishkori and then brought that into the meeting then later in the week? Is it the same report? 12:06

A. The reports -- so whenever the reports, the agenda -- I would develop the agenda. So Mrs. Gishkori wouldn't have specifically asked for an awful lot of information to go into the agendas. I would have looked through the month to see what the governance issues were at the time, briefly discussed with Mrs. Boyce what needed to go on to the Governance Committee and then circulated the papers in advance. 12:07

118 Q. Yes. We can briefly scroll through. You're providing the committees with a lot of information; isn't that right?

A. That's correct. 12:07

119 Q. WIT-95572. So this is 10th October 2018. If we scroll down then we can see -- just can we highlight that, the top of it. So across quite a number of pages, and maybe it's not terribly helpful to scroll down through

it, it's information gathered across complaints?

A. Yes.

120 Q. Ombudsman requests, major incidents?

A. (WITNESS NODS)

121 Q. Incidents awaiting review or in review per division? 12:08

A. Yes.

122 Q. An overview of the SAIs, including those in progress and those awaiting screening?

A. (WITNESS NODS).

123 Q. Rejected SAIs and closed SAIs. So a lot of 12:08 information, patients names included, obviously blanked out here, and descriptors of the issues arising. In each of those meetings was it simply an opportunity to take stock and say this is where we are across each of the Assistant Directors and the relevant Medical 12:09 Managers or what were the nature of the discussions in terms of active forward-looking work?

A. So some of the reports were to highlight where we were, the number and extent of the workload that we had. There would have been some specific discussions around 12:10 certain cases or how we could further progress the workload that we had. There would have been other reports in relation to patient safety audits that were carried out and actions taken. We would have discussed some of the standards and guidelines work that was 12:10 required, challenges in relation to chairs. In relation to SAI reports we would have gone, particularly in the Friday morning meeting with the medical teams, we would have reviewed the SAI reports

and there would have been a challenge in relation to areas that they felt maybe could have been strengthened within those reports.

124 Q. Was it an opportunity for you, in either forum, to get any key governance messages across? Because, as I view this and as I view your role, and I think you have told us this in your Section 21 response, it was very much a matter for each service to look after its own day-to-day governance activity and you see, I suppose, the results of that through the complaints coming through and how they are processed, the incident reports and how they are processed but you are not actually in the service itself, you are dependent upon what's coming out in terms of reports. So in governance terms what were the messages that you were getting across at these forums? 12:11 12:11 12:11

A. So, for example, if we identified a problem or a trend in, for example, incidents that would have been highlighted at this forum and the work of any of the QI groups in relation to trying to address those would have been identified and discussed. Another example would be the delays in sort of diagnosis work that we looked at, the action planning to try and help mitigate those. Results sign-off was another key element that we would have discussed at those meetings, the risks of not and how we were going to progress work to improve result sign-off to give us some evidence that action was being taken and to reduce risk. 12:12 12:12

125 Q. As a forum, take the Friday meeting you referred to,

you have people attending that from a range of different services and one person's concern or area of interest or challenge may be different from that of a person from a different service within Acute, was this an appropriate way to manage governance within Acute or do you think that stepping back from it with the benefit of your experience that there were, perhaps, more sensitive tools or more effective tools that might have been used to address governance within each service? 12:13 12:14

A. I think the purpose of that overarching governance meeting was to share the risks of something could happen in one area, it could potentially happen in all of the areas. So, therefore, it was important that we shared the learning from complaints, incidents, SAIs, standards and guidelines were sort of spread across a number of areas. So it was a meeting where all of the senior leaders could get together to look at the overarching risks within the Directorate and feed their expertise into that. 12:14 12:14

126 Q. We'll come back to that point about the work within each individual service in a moment. I want to ask you some questions about how the Acute Directorate fitted into, if you like, the corporate structure from a governance perspective. The Trust had a Governance Committee, as I understand it, Mrs. Gishkori would have attended that committee? 12:15

A. Yes.

127 Q. And at a point in time Mrs. Gishkori -- or Dr. Boyce

I should say attended as well. She might well have attended wearing her pharmaceutical hat but she also attended to assist with Acute. In terms of your role as Coordinator of governance within Acute, how did you fit into the governance arrangements corporately? 12:15

A. The Assistant Director for Corporate Governance would have had a forum with the governance coordinators that we would have met to discuss issues. In relation to the Governance Committee, the papers would have come down for comment, any reports that they were sending 12:16 out would have been sent down for factual accuracy checking, they would have asked for information that I would have supplied to them and then if Mrs. Gishkori had wanted anything escalated to the Governance Committee, that would have -- she would have let me 12:16 know. And if there were queries or anything I needed to get to her for the Governance Committee, I would have met with her beforehand with Tracey Boyce to highlight if there was anything on the papers that she needed to be familiar with. 12:16

128 Q. Did you get a sense that, if you like, the corporate took an interest in what was happening in the satellite areas such as Acute?

A. I think there could have been a more robust view of each of the Directorates and Acute in particular 12:17 because it is particularly large Directorate.

MR. WOLFE KC: Chair, do you need a break?

CHAIR: Yes, thank you. I think it might be the air conditioning, it is just caught in my throat.

SHORT BREAK

THE HEARING RESUMED, AS FOLLOWS, AFTER A SHORT BREAK:

12:18

CHAIR: Apologies everyone. Hopefully the sweet that I am now sucking will do the trick! If I suddenly start again I'll make a sharp exit. Thank you.

MR. WOLFE KC: Okay. I was asking you, Mrs. Reid, about the relationship between the Directorate, that is 12:26
the Acute Directorate and corporate governance, so the Governance Committee. You were saying that the relationship between that committee or that area of the Trust with the Acute Directorate could have been more robust when you think back on it. What do you mean by 12:26
that?

A. Reflecting, I think how the Acute Directorate escalated to the Governance Committee would have been a vital link. The systems within the Southern Trust, the IT systems and all of the reporting systems and the amount 12:26
of data analysts and all of those things that we had would have been a real challenge. So, therefore, the main element of escalation would have been from Mrs. Gishkori to the Governance Committee to highlight any issues or concerns that she had within her own 12:27
Directorate. I think that's how the Governance Committee would have learned of issues so, therefore, that element was the vital link, that escalation.

129 Q. Yes. Are you suggesting that's a vulnerable link or

it's a vulnerable way to do business or to communicate about it issues, that it is prone to, I suppose, people not seeing the point of reporting upwards or seeing it as important or valuable enough to report upwards, is that what you are alluding to? 12:27

A. I think that because of the systems that we have within the Southern Trust that was probably the key element of how we would have -- how the Governance Committee would have learned of issues that were within any of the Directorates. And the Acute Directorate as one of those. 12:28

130 Q. And when you - I am just trying to get a better sense of your point - describe that relationship as not being sufficiently robust in one of your earlier answers?

A. It would have been very person dependent, so it would have been dependent on the Director escalating those issues. The corporate governance team would have been able to review complaints. There was a process where we brought in a team to look at complaint themes and trends and so the governance team, the corporate governance team would have looked at some of that and provided those reports to the Governance Committee. But if there was key significant issues within a Directorate, those would have been escalated by the Director. 12:28 12:29

131 Q. Can you give us an example of something you think ought to have been reported in that wasn't perhaps? Or to put it another way, can you think of examples of things that were reported in but weren't given the urgency or

the stress or the emphasis that you would have liked, issues within the Acute that really should have been in the face of the Board's Governance Committee because of the lack of robustness in the communication structures didn't quite get there, the message didn't quite get delivered?

A. Even something as simple as the resource within the team, I'm not quite sure how robustly that was escalated within the Governance Committee because that's something that they should have been appraised of. If I'm thinking of some of the SAIs we had, I'm not sure if some of those would have been escalated and the importance of those highlighted at the time.

132 Q. Yes. Put it this way: Did anybody at that level come directly to you to say I hear that you're the person to speak to, you're on the coalface leading and coordinating the governance team, I hear you have a stack of problems in being proactive or doing governance in the way that you think is safest, can we help you, was there any conversation like that with you directly?

A. Not in that way, not in that -- I would have again highlighted at the coordinator's meeting with the AD some of the challenges that there were. The 2018 paper in relation to, that we discussed earlier, that was sent through to Dr. Khan as the Medical Director who would have been responsible for governance within the Trust at that time.

133 Q. Yes. That's a neat join to where I want to move to.

We can bring it up on the screen please so that we can see it, just to get the point you're making, WIT-92503, this is where you talk about relationships with the Medical Director's office. Let's see if I can, it might be WIT- -- yes, thank you. You say: 12:32

"During my tenure it is my experience that professional issues being addressed through professional lines were not always known to the Acute Clinical Governance Team and vice versa." 12:32

I know you have corrected the spelling of "versa" in your addendum statement. You go on to say:

"The Medical Director would have had governance 12:32
processes such as appraisal and latterly I became aware of what I now know to be maintaining high professional standards process."

So I want to just better understanding what you are 12:33
getting at there, particularly with the first sentence. It is the case that while you had some interaction with the medical directors, and, for example, we saw how Dr. Khan engaged you in relation to the governance
template earlier this morning, but it was very much a 12:33
limited interface is how you describe it elsewhere in your statement?

A. Yes, that's correct.

134 Q. Does that suggest that standing back on this with the

benefit of thinking about what you now know, for example, about how the Medical Director's office essentially ran the MHPS process in connection with Mr. O'Brien and how other matters on the professional side of the line were managed, are you pointing to something of an unhelpful disconnect between your governance role and the governance roles and agenda of the Medical Director's office?

A. I think they could have been more transparent. As a Clinical Governance Coordinator you're in a role where you see lots of confidential information, you're able to maintain that confidentiality and I think having a process where the issues in relation to clinicians was more -- if we'd have been more aware of it it would have been helpful because, therefore, when you are reviewing incidents et cetera you are maybe more aware to look for issues in relation to key practices or clinicians that might have helped both ways. 12:34 12:34 12:34

135 Q. Yes. So there wasn't a forum as such for you to meet the Medical Director on a regular basis? 12:35

A. No.

136 Q. And I think you pointed to some examples where you might have engaged with the Medical Director but they tended to be on very discrete and narrow issues as opposed to giving you both the opportunity to exchange more general concerns, perhaps, about governance themes or clinical themes that touched upon the governance arrangements? 12:35

A. At that time, yes, that's correct.

137 Q. Yes. You're now obviously working at Director level within the Trust and we have some heard evidence already about changes in terms of how governance is done?

A. Mh-mhh. 12:35

138 Q. Is that - and I call it something of a disconnect between the Medical Director's office and the Directorate governance arrangements - is that disconnect now a problem of the past or does it still exist do you think? 12:36

A. On a Thursday morning there is a new forum where the Medical Director's office and the Governance Coordinators, and it has now become a more extended group, meet to review the governance issues of the week. So that's a forum for the Medical Director and 12:36 his team to meet with the Governance Coordinators, the Standards and Guidelines Team to review the incidents, the complaints and issues of the week across all of the Directorates. It is also a forum where the Directors are able to share their experiences. So where there are 12:37 cross-Directorate issues that could impact on the other Directorates that's also highlighted at those meetings.

139 Q. Okay. That suggests a more integrated and joined-up way of sharing common issues?

A. It is. And it is a weekly meeting, it happens at 8:30 12:37 on a Thursday morning.

140 Q. Yes. I've touched on it briefly but I want to just go back on it in a little bit more detail, I want to ask you how much oversight did you have of governance

activity and the application of governance standards within each service within Acute?

A. Probably the service where I had most oversight would have been medicine and unscheduled care. We had an Assistant Director there who would have invited me to her governance meetings and we would have provided reports to those. So that was the area where probably we had the most oversight.

141 Q. And why were they -- was this a voluntary arrangement, inviting your input at that level? 12:38

A. Yes, yes. The other Directorates probably not as much. I think reflecting on one of your previous questions as to what would have made a difference more locally would have been an increase in the governance team where you would have had a governance person within the Directorate at their meetings helping support them and then feeding back out to the Acute clinical governance meetings. 12:38

142 Q. Yes. We'll go on to look at a number of the initiatives you took forward, for example around delays in diagnosis and patient care and the impact of that and how you filtered that down to the services. But what you're telling us through your statement, for example at paragraph 3.19, was that as Acute Governance Director you weren't involved in the day-to-day governance issues arising within, for example, urology. 12:39 12:39

"This would have been with the urology team at their operational meetings. If incidents or complaints were

escalated or identified, these were taken to the screening meetings for review."

So that was essentially the way you got to learn about what was happening in a service? 12:40

A. That's correct.

143 Q. Obviously there's other methods. You had access to Datix within your team?

A. Yes.

144 Q. And Mr. Cardwell would have had full visibility, complaints would have come through your team as well? 12:40

A. Complaints Mr. Cardwell would have had full view of. Incidents he probably wouldn't because he was more focussed on the complaints element of it. When I came into post, on a daily basis we tried to scroll through all of the incidents at a very high level to see if we could identify anything that immediately sort of looked as if it was an area of concern. But on a daily basis there were multiple Datixes came in so it was a very high level view of them. 12:40

145 Q. Yes. I think it's probably important to put in context, I suppose, the scale of the work that faced your team, if we can go to your statement, WIT-95238. You set out, just going down, the significant workload faced by your small team, that's across the three and a bit years of your tenure. I think adding it up, it comes to something in the region of - I think scroll down on to the next page - I think it is 15,591 incidents reported. That's incidents going through 12:41

Datix, is that how you have achieved that?

A. Yes.

146 Q. Of which 44 over the period, I think, is the figure you have given became serious adverse incident reviews; is that right? 12:42

A. There would have been -- so those would have been the SAIs submitted, not the SAIs in process.

147 Q. Yes.

A. And on one, in one governance report in 2018 there were 33 outstanding SAIs being drafted at that time. 12:42

148 Q. Yes. And a substantial number of complaints, enquiries and political representative queries?

A. Yes.

149 Q. So obviously that sets the work of your small team in some context. But I wonder when you look back at 12:43 matters and how you and your team were able to do your work somewhat divorced, as you have accepted, from the day-to-day governance activity within each service, is there a better way of doing governance, providing that superintendence, if you like, or overview from the 12:43 governance office within Directorate to the teams?

A. Having an adequate resource to be able to be embedded in those teams, work closely with the teams on a day-to-day basis and having appropriate IT systems and data analytic capacity would have made a difference and 12:44 maybe would have identified issues quicker and allowed us to address risk in a better way.

150 Q. Yes. Was there any alternative mechanism by which you would get to hear of problems within a service?

Obviously you have the complaints, incidents, SAIs, the screening meetings, you have the Friday meeting at which you get to see the whites of the eyes of those who are on the ground within each service, but was there a good level of, I suppose, informal communication, did you talk to each other or was that, I suppose, hampered by the stretch and pull of your commitments and the smallness of the team?

A. So at the time when I was in Governance we were based on the administrative floor which was where all of the Assistant Directors and Heads of Service were based, or the majority of them, so that made person-to-person conversations in the corridor possible. However, the small team did definitely impact on the ability to have more, you know, the level of informal and formal discussions that I would have liked.

151 Q. Obviously, where an issue of risk to patient safety arises, it arises out of an operational environment and you plainly are divorced from operations, but we know that, in the case of Mr. O'Brien, that issues were bubbling away in the background and as we saw from Dr. McAllister's report in, just as you were taking up your post, not sent to you, I'm not suggesting that, but we know that these issues are in the background; do you think in the culture of the Trust at that time that enough emphasis was placed on the need to share, disseminate, communicate concerns to, for example, those in the governance environment who could suggest perhaps, ways of dealing with these issues?

A. I don't think so. I think at the time it was felt that the issues could be addressed within the sort of division that they were happening in on many occasions. So things were escalated, you know, when a Datix went in or if there was a significant issue where there were poor outcomes.

152 Q. Some issues we will see and I'll take you to some of the incidents specifically in the course of this afternoon's evidence, some issues which on the face of it should have at least had the ceremony of a Datix, an incident report being completed, some incidents which on the face of it perhaps ought to have gone down the road of a serious adverse incident review, and I'll give you the opportunity to comment on the specific incidents this afternoon; do you, upon reflection, see any concern around the fact that each individual service had an element, perhaps a significant element of autonomy in terms of how it exercised its decision making, in, for example, how it handled issues that arose which, when you think about it now, the governance office might have taken a different view?

A. Yes, I think when you look at the structure that Tracey had suggested, having governance officers embedded in the Directorates that had reporting line responsibility to the Governance Coordinator might have highlighted issues earlier.

153 Q. We spent some time earlier this morning talking about what I think you have positioned on the centre of the stage as being the main challenge to proper governance,

proactive governance, and that was staffing and staffing resource and the problems that came with that. One of the other issues you have touched on and I'll deal with in a bit more detail now was technology and data management and that kind of thing. One of the issues that you point up in your statement at 1.7 was that the Datix system at the time was a number of versions behind the other Trusts in Northern Ireland. It has recently been upgraded from version 12.2 to 14.12/, obviously these things get improvements and add-ons over the period of time. I suppose the thrust of the point, ignoring the fine detail of that, is that the Datix facility available to you made for difficulties. The way in which, as you said earlier, standards and guidance was documented made it difficult for you. Could you tell us more about that, was that simply again resourcing issues that you, if you like, complained about but it remained unchanged? 12:50 12:50 12:51 12:51

A. Within the Trust the Datix system was, that we used for incidents, was behind. But within Datix there is a number of modules. So you have complaints, you have incidents, you have litigation, and they were all on slightly different systems so it made triangulating that information between all of those systems a challenge. The Datix system that we had at the time also made it challenging to report and set up dashboards for the wards, departments and the Assistant Directors a challenge, so that they could see trends and be able to triangulate the information between, for 12:51 12:52

example, the litigation, complaint and an incident.

The M&M process sat on another system. The standards and guidelines was an Excel spreadsheet. The cancer tracking system was another system. And the PAS system that we used for recording patient appointments et cetera is again an old system. So the systems didn't speak to each other to allow us to triangulate that information.

154 Q. Yes. Did you have any analytics, data analytics support? I suppose you're shaking your head. No? 12:53

A. No. Within the team we had -- Mr. Cardwell was probably our expert on the Datix system and we worked together to see if we could develop some dashboards for the wards and departments and ADs to see if they could at least see their information on a graphical fashion. Because lots of reports, as you will have seen, are lines and lines and lines of information, names and detail. And it's only when you get a really expert in data analysts that actually the information tells you the story. Because information can be presented in many ways to tell different stories. So the expertise of a data analyst is really important to get the actual facts to the people that need them in a timely manner and in a manner that actually tells a story that people can identify the risks. 12:53 12:53 12:54

155 Q. Yes. You say in your statement, at paragraph 1.7, leaving aside the Datix issues you talk about "audit data and reports were mostly manually recorded"?

A. Yes.

156 Q. Ultimately it seems to come to this, you use this word which we're hearing a lot about, triangulation, "triangulation of risks was therefore challenging". You seem to put a lot of store by the need for good data access and good data analysis; why was that? Why is that? 12:54

A. Very simply, it's really challenging to identify risk when you can't see it from the different systems all aligned. So you may have a large amount of information but to identify from one system to another to another and pull that all together is really, really challenging and without being able to pull the information together you don't get the overall picture and, therefore, you can't see the overall risk. So some of the issues that had been identified, you know, with good data systems may have been easier to identify. But again it's as good as the information we put in so, therefore, making sure that your staff have the appropriate training to make sure that they know how to identify risk, how to fill in an information form so that you have got a clinician name to identify if it's a clinician or identify if it's a specific issue in relation to a medication or the sort of recording of the deteriorating patient, all of that is really, really vital to be able to really identify the risks that we have. 12:55 12:55 12:55 12:56

157 Q. Do you know whether - obviously long out of the job you were doing in Acute Directorate - do you know whether

the picture has changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?

A. It is still a significant challenge. The systems haven't changed that much. If you look at the demonstrations of the new Datix system that's available, you can put everything from your incidents, complaints, litigation, safeguarding, audit, recommendations, everything can go on it and be potentially triangulated and have reports coming out of that. So we don't have the most modern version of that. In relation to audit, again we need to continue to develop a system to put our audit recommendations on. And data analysts are really challenging to employ and we have a very limited team of probably one person. And again even having IT specialists who can put applications across data to, such as one of the click applications that will pull information from one or two systems into a report that is pictorial, for example, again there is a challenge with being able to resource those people within the organisation. 12:56 12:57 12:57 12:58

158 Q. Yes. Just before lunch, if I could maybe take you to two initiatives that you pushed, I think I am right in saying. One was around delays in treatment and care. You say in your witness statement, by September 2016 you were only in the job, I suppose, four or five months. You were working with Dr. Boyce and Mrs. Trouton in relation to delays in treatment and 12:58

care, and you have attached a spreadsheet to your evidence to support or to illustrate, I suppose, what you were doing, if I could maybe bring that up briefly, WIT-95352. You touch briefly on this area in your witness statement at paragraph 1.24, and I think it's an area which the Inquiry is interested in.

Could you help me to better understand, I suppose, the motivation for this work and what your objective was in doing it? 12:59

A. So I would have looked at a number --

159 Q. Just maybe to start you. What I understand we have in front of us is a series of SAI reports that have been finalised or some not completely finished and you set out the outcome. And then, let's go to an example down 13:00 at the bottom of the page, if you scroll down please. Take the patient at the bottom of the page, and we shouldn't say her name. It concerns an issue to do with unexpected result or an unanticipated result from diagnostics. The recommendation on the right-hand side 13:00 of the document is that -- have we lost it? So the recommendation - just highlight the far right - so the recommendation, I'm not sure if this recommendation came from the SAI or is it something that you were working on. It's to send, it's for the radiology 13:01 department to send electronic notification on unexpected abnormal findings to the referring clinician etc. Can you help us to understand what your, the group that you assembled, was doing in addition to

these SAI outcomes?

A. So the report is a report from the Datix system to identify any potential delays in diagnosis or treatment. I can't remember exactly why I ran it at the time. But it was to illustrate that there was potentials there for delays in assessment, treatment and care.

160 Q. And that's just one example, isn't it?

A. So that's one example of one of the Datix incidents from that. Some of those were screened as SAIs, some were dealt with through the operational teams identifying an issue and coming up with their recommendation through the Datix review system within their own areas. 13:02

13:02

So when we identify that there had been a number of incidents where patients potentially had delayed assessment or treatment, decided to set up a group to look at how we could prevent that or mitigate that happening again. So we brought together administrative staff and operational staff to look at the potentials where this could happen. Having been a head of service before and understanding the patient journey, there were a number of areas where we could put reports in to help identify where there had been delays in identifying those. And the other element that came out was the sign-off of results, so to make sure that results were appropriately reviewed and signed off as per the GMC recommendations. 13:02 13:03 13:03

161 Q. Yes. And so was this a case of, if you like, identifying some of the more common traps which could lead to delays in treatment and care --

A. Yes.

162 Q. -- and highlighting those for each service to enable them to get on with the business of creating solutions on the ground with their clinicians? 13:04

A. Yes.

163 Q. Is that an example of, I suppose, the kind of proactive work that you had in mind for a properly functioning governance unit? 13:04

A. It is. It was reviewing trends within the incidents and, when you identify those, it is putting action, reviewing what had happened, putting actions in place to help mitigate the risks. So that was one. There was issues in relation to insulin. And again with QI projects set up to reduce the risks of issues in relation to insulin prescribing and administration, again looking at falls. Again we looked at all of the trends in relation to falls and put QI projects in in relation to that. So there is a number of things. Absconding patients was another report that we would have run, violence and aggression. So it was to look and see different elements of the patient journey, different elements of incidents within the Datix system to develop action plans. 13:04 13:05 13:05

164 Q. Sticking with this one - just the last couple of questions before lunch - were you able to take it further or would you have liked to have taken it

further to work with individual services to ensure that they were actually doing the work to deliver real change or real solutions around this problem of delays in treatment?

A. It would have been nice once we had developed the action plan to be able to work with the teams to ensure that all the actions were put in place. The resource within the team meant, when the action plan was developed, it was handed over to the teams to implement the actions and unfortunately the resource didn't allow us to continually go back and evaluate that that was happening. 13:06 13:06

165 Q. Yes. Because, to take this kind of example - and I think if we were to go back into the sheet there is a second example of Patient 128, I know that was an SAI, just back into the sheet and go down a page. The reference is WIT-95353. So at the very top entry, this is a case that goes by the name of Patient 128. You can see, going to the right-hand side, and again this was a delay in treatment because there wasn't a handover between a leaving clinician at a point in time when a diagnostic report had been sought and it was the subject of an SAI. But I suppose the question, the point I was going to make to you is that there were to be further instances of delays in care because diagnostic tests, while received by the clinician - a number of them relate to Mr. O'Brien in 2020 and the 2020 series of SAIs - those delays in care were still happening, is that something you recognised or were 13:06 13:07 13:08

able to do anything about?

A. So in relation to results and result sign-off, when I was in post we worked with the Medical Director's office to see if we could implement policy or guidance in relation to electronic sign-off -- 13:08

166 Q. Yes.

A. -- which would have given a level of assurance as to results that were or were not signed off, the paper copies, if they were received, if they got lost in the post, if they got lost on the desk, were they signed 13:09 off, were they reviewed is a really hard process to follow. So, therefore, electronic results sign-off is one of the ways that we could have audited our ability and escalated where results weren't signed off. The NIECR system in itself is challenging to get reports 13:09 from. And while the Southern Trust is probably one of the trusts, it is the trust that has signs of the most electronic results, there is still large gaps in that, some of it to do with the system itself and others to do with just clinicians physically going in and hitting 13:09 the sign-off button.

167 Q. Yes. Maybe after lunch, because I don't want to prolong, we'll go to the electronic sign-off work that you did. Can I summarise what I think you are saying is that you from a governance perspective and with the 13:10 limited team around you did a good deal of work around identifying the pitfalls that lead to delays in treatment and care, but at the end of the day it is for the service itself to go the next step of putting in

place the solutions?

A. Yes. It would be nice if the team had been able to go back and regularly review the recommendations and get assurance that the actions were in place but the resource didn't allow for that. 13:10

MR. WOLFE KC: Yes, okay. Sorry for overrunning.

CHAIR: Ten past two, Ladies and Gentlemen.

MR. WOLFE KC: Thank you.

LUNCHEON ADJOURNMENT 13:10

THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIR: Good afternoon everyone. 14:08

168 Q. MR. WOLFE KC: Good afternoon, Mrs. Reid. I want to bring you to a draft guidance document which I think you were responsible for developing around diagnostic test and electronic sign-off and some questions arising out of that. So it is WIT-95358. Just while we're 14:11 getting that up on the screen. There it is. What prompted this area of work and what was your role in taking it forward?

A. It was part of the delays in diagnosis work.

169 Q. So it came out of that work stream that we talked about 14:11 before lunch?

A. It did. And it was to try and implement guidance that the clinicians could follow to help evidence sign-off of results.

170 Q. Yes. We can see, if we just scroll down we'll touch on some of the headlines in it. If we can go to page 6.1 in this series. So it is three pages further on. There is the guidance document title page. And then, if we go to 6.1 we can see that the purpose of the 14:12 document is set out. And you say the intention of the document -- did you actually draft this or did you use the services of?

A. So I trawled various documents from various Trusts to see what was available and what other Trusts were 14:12 doing.

171 Q. Yes.

A. And, therefore, took another Trust document and modified it so that it would work for the, potentially work for the Southern Trust. 14:12

172 Q. Did I see in my readings was it Salisbury Trust?

A. Yes.

173 Q. Was that a precedent you picked up and worked from?

A. Yes.

174 Q. So you say: 14:12

"The intention of the document is to enable all Clinical Acute Directorate Trust staff in ensuring that all diagnostic tests undertaken within the organisation are appropriate and managed to minimise the risk to 14:13 patients and to improve patient outcome and quality of care."

Were you seeing within some of the incidents coming

through by way of report, some leading to SAIs no doubt, that failing to sign-off on diagnostic tests and to take the necessary next step, which might be a new care pathway or whatever it might be, you saw failures around that?

A. Yes. And obviously the potential for that to happen. If we look at the email from earlier with the results setting unsigned, it was the potential that this could have been a more robust process for evidencing sign-off.

175 Q. Yes.

A. It is not to say that it wasn't. People didn't look at results. But this would have given us an assurance.

176 Q. Yes. The Inquiry is aware of, for example, a never event took place in 2010 where the difficulty might have been spotted earlier if the results of a scan had been read and actioned, that was part of the conversation in 2011 and you're doing this work in December - or, sorry, you're doing this work in 2018 or thereabouts. Had there been progress around that issue of diagnostic tests and signing off on them and taking the necessary actions before you took up the mantle or had it, to the best of your knowledge, sat unworked with, sat without progress?

A. There was no guidance developed. But when you look at the reports sent through by BSO it did evidence that there was some sign-off but it still needed some improvement.

177 Q. Yes. So you were building into this document an

emphasis on the use of electronic sign-off as a way to audit and monitor compliance and to be able to, I suppose, identify the teams or perhaps the individuals that were not practising safely, is that...

A. That is possible within the reports you can get from BSO on sign-off on ECR. 14:15

178 Q. Yes. Just scrolling down the next page, you set out the duties resting with the Acute Directorate and you explain those. Over on to the next page, you set out the duties of the clinicians. Keep scrolling down. 14:16

Then, on page 67 in this sequence, you make the point at the bottom of the page that:

"It is the responsibility of the clinician or other individual accessing a result to act on that information in an appropriate and professional manner. If the individual who accesses the result cannot take appropriate action it is important that they bring this to the attention of someone who can." 14:16 14:17

So that's a key working principle, if you like, putting an onus on the clinician who has sought the investigation to action the results. And then, at 68, over the page, you provide for audit, I think. Just scrolling down. Yes. 14:17

So this paper, you've told us in your witness statement, wasn't approved?

A. No, not before I left. And still isn't approved.

179 Q. In doing this work did you consult with other interested personnel, whether on the clinical side or operational teams or other governance people?

A. We had a working group with an operational staff and clinicians. The document went to the Friday morning governance meeting as well for discussion. 14:18

180 Q. Mm-hmm.

A. There are challenges with ECR which impact on the ability to fully implement the guidance. But it was progressing the journey to try to improve the sign-off. 14:18

181 Q. Mm-hmm. Amongst your working group was there any discussion with the clinical side about the feasibility of complying with electronic sign-off?

A. There was. And again the challenge of the volume of results was an issue. How ECR was set up in relation to you getting your own results back and identifying them. Making sure that the appropriate clinics were aligned and results were aligned to correct clinicians. So those were the things that the team that worked with the BSO were highlighting to try and amend. 14:18 14:19

182 Q. Was any issue raised with you by anybody on the clinical side about the administrative time available to clinicians to work with this system?

A. That was part of the challenge at the time. The more clinicians that sign off, so if you start at junior doctor at ward level and they sign off the first lot of results, the ones that escalate to the consultants are those that the juniors are concerned about or can only be, you know, those that are left unsigned. So if you 14:19

implement the process early in the journey and everybody signs off the results as they go, it reduces the impact on the clinician.

183 Q. So you would contend that it is in many respects for the senior clinician possibly a labour saving or a time saving device if the results that come to them are restricted to the most complex? 14:20

A. If everybody signs off it should limit. It still is an administrative burden but one that, you know, the GMC requires the clinicians to address and sign off and action the results. Now whether that is electronic. There's no specific reference that it has to be electronic but it is a way that we can audit sign-off. 14:20

184 Q. Is it any more of an administrative burden than working with the paper? 14:21

A. Paper can be quick, if it is sitting on your desk and it is just a matter of scrolling down it can be quicker. Logging in to a system, uploading the results can take longer. Probably something the clinicians would maybe be able to answer better than me. 14:21

185 Q. Yes. So what, to the best of your understanding, was it that has prevented and during your time did prevent this policy from being adopted, what were the arguments that you were hearing against?

A. Some of them were technical difficulties with the NIECR process to make sure the results were appropriately aligned and others were time. And then I moved on and potentially the impetus for moving the guidance along potentially was lost. 14:21

186 Q. But you say it is still an area that is not the subject of policy or of a written policy?

A. Electronic sign-off isn't written into guidance at the moment. It's something that we are reviewing.

187 Q. Does that, therefore, remain an area of risk or vulnerability? 14:22

A. It means that we can't evidence that all of the results are signed off.

188 Q. Now, I want to bring you for a period of time this afternoon to the area of the serious adverse incidents, I want to engage you with a number of incidents and take your view on whether things could have been done better, whether in terms of how things were screened and sometimes not screened and whether you recognise the problems of delay, whether in screening or in bringing a SAI review to a conclusion. First of all, your statement suggests that you felt it necessary to put in place a number of, if you like, building blocks to provide a better foundation for the processing of adverse incidents than was in place when you commenced your role. I suppose by that I mean, for example, you developed internal guidance on the management of the reporting of serious adverse incidents, we'll look at that. And you also developed an action plan template and a quality improvement template, as well as engaged in training for the staff. So let's look at some of those building blocks. 14:22 14:23 14:23 14:24

Before we do, how would you describe the arena of SAIs

when you took up your role in 2016? We've heard about backlogs. Was it underdeveloped in terms of its, if you like, the expertise around it and the professionalism, perhaps, with which staff were unable to approach these issues? 14:24

A. There was a backlog and we had our lead nurses supporting the chairs and helping with drafting the SAIs. They were exceptionally hard working and made all of the efforts they could to progress the SAIs as efficiently and professionally as they could. There had been some training for the lead nurses but the level of training until the organisation in relation to SAIs I think at that stage had been limited so that was one of the things that we started to progress when I came in to the role, particularly in the Acute Directorate because it's a large Directorate with multiple incidents that needed reviewed and SAIs in progress. 14:25

189 Q. Mm-hmm. Lead nurses in that role, was that deliberate? Is it a particular accident of history? How did that come about? 14:25

A. Possibly more an accident of history. There was a reorganisation within Debbie Burns' time and two lead nurses in their roles were moved in to help the governance and the SAI process in particular. 14:26

190 Q. So these were Nurse Managers who --

A. Yes.

191 Q. -- were perhaps recognised as having, I suppose, the skill set and the experience, perhaps, that would lend

itself to contributing to an SAI process?

A. As lead nurses they would have reviewed incidents and helped the Ward Sisters and their teams to identify risks and develop action plans. So it would have been another step up from that to proactively support the chairs and SAI. 14:26

192 Q. As I say, you developed in turn guidance on the management and reporting of SAIs. If we could just take a look at that, WIT-95417. This is, I suppose, a definitional section to the guidance. You define an adverse incident there on the left-hand column and you say, in the last line: 14:27

"The following regional criteria will determine whether or not an incident constitutes an SAI." 14:27

And the list is not exhaustive. Just perhaps an obvious point to make from the definition that, in order for a case to fall within the SAI process, it's not necessary that the patient or the client should have come to harm 14:28

A. No.

193 Q. It's 4.2.2. A risk of harm to the client or a member of the public may be sufficient?

A. Yes. 14:28

194 Q. If we scroll down to the bottom of the page:

"Serious incidents of public interest or concern."

Again it doesn't have to be harm to a person. But to take an example, the process may be important

A. Yes.

195 Q. And if there are any particular case, gaps in the process or a failure to comply with the process or if the process has a shortcoming in some shape or form that might be sufficient to attract the public interest reason for a SAI review? 14:28

A. Or risk of potential harm.

196 Q. Going through the document, if we just -- I'm not sure if we need to go -- you create a number of pieces of guidance, so, for example, how reports are to be written is an aspect. Just to remind me, if you could just maybe move through it slowly. Obviously the early alert process and it is defined. The types of people who need to be informed, the roles and responsibilities of various staff. And then guidance on the support for staff who are caught up in an incident. Contact details. Then the role of the chairperson, who can be either an internal or external independent. 14:29 14:29 14:30

One area, correct me if I am wrong, it maybe doesn't seem to have been covered in any great detail within the guidance is the roles and responsibilities in the context of screening. I'm thinking in particular whether any work was done around the application of the test for an SAI, if you like, the - I hesitate to call it the legal test - but the test set out and we've just looked at the fact that it doesn't require actual harm; 14:31

do you think that those charged with screening responsibilities fully appreciated the niceties of the guidance around the applicable test?

A. They would have because most people involved in the screening would have attended the SAI training. Which would have included the definitions of what an SAI is. And again the guidance would have been shared to the Operational Assistant Directors and the AMDs and CDs. 14:31

197 Q. Yes. And, moreover, step back from the application of the screening test, do you think most of the staff, or certainly let's focus, perhaps, on clinicians, do you think they were well versed on the requirement to make reports, to use the IR 1 into the Datix system to file a report when it was appropriate to do so? 14:32

A. I think they would have. 14:32

198 Q. And where would their knowledge come from? Is that something that's part of the medical training or is it part of, if you like, the rollout of the expectations upon you as an employee of the Trust when you come into employment? 14:33

A. Like, in general at that level clinicians know they are to report incidents. The Datix system is widely available, it's on every laptop screen so anybody within the organisation can report an incident. As I came into the post we did more general rollout training for all disciplines in relation to reporting of incidents and risk. 14:33

199 Q. You have said in your statement that when you came into post there was no central repository, if you like, or

filing system, in plain terms, for SAIs and the recommendations that flowed from them. You saw a deficit, a problem with that, why was it a problem?

A. For me the history of what happens, so knowing what incidents we'd had in the past, knowing what the recommendations were and evidencing that they were implemented was important. Sometimes whenever we were asked for an update on an action plan for an SAI it may have been similar to an incident that had happened more recently and, therefore, that history wasn't readily available. So as I identified -- as we got new cases we put those on to an Excel spreadsheet and then added ones as we historically went back and found others. 14:34 14:34

200 Q. Mm-hmm. So it is about, I suppose, proper information management so that the cases were visible to you? 14:34

A. Yes.

201 Q. And your team. On the issue of action plans, you developed an action plan template. Why was that necessary?

A. On occasions whenever the HSCB had asked for an update on an SAI it was difficult to find the action plans and action plans varied, so it seemed a reasonable thing to develop a template. And then, as the recommendations came through, the governance team would have populated that template to make it easier for the operational teams to have it accessible. 14:35 14:35

202 Q. Yes. So - and I'll give the Panel the references, I don't think we need to look at the documents, I think they are fairly straightforward. For the spreadsheet,

I suppose, of SAIs, it can found at WIT-95628 and the action plan template at WIT-95783. So this was a process, I suppose, of professionalising and putting the house in order in terms of good administration around SAIs. I suppose a more substantive concern and what you describe in your witness statement as your particular concern, one of the, I suppose, main learnings you take out of your role was around the timelines and there was insufficient resources to allow you or your team to provide oversight of actions. So the timelines issue was one of getting the cases screened quickly enough but once that had been done and the SAI had come out the other end, your main concern was around the follow-up, the inability, because of your resources, to provide oversight of actions? 14:36 14:36 14:37

A. Yes.

203 Q. Was that something you were able to mould the process around during your tenure or were there any solutions to be found to enable a governance input to ensure that actions were indeed followed up and implemented? 14:37

A. At the time the resource didn't allow for us to do that. If there were specific actions that we were asked to follow up in relation to, you know, from either Dr. Boyce or if the HSCB had asked for particular cases then we would have reviewed, gone back to the teams, asked for the updates. But it was limited in what we could achieve. 14:38

204 Q. We'll hear from Mr. Cardwell tomorrow and I think he has particular evidence to give around, I suppose,

happily, a change around that?

A. Yes.

205 Q. That happened, perhaps, relatively recently with the appointment of three new staff into governance --

A. Yes. 14:38

206 Q. -- to take forward and support action planning?

A. That's correct. So we have appointed three new Band 5s recently and their role is to help work with the Operational Directorates to ensure that the recommendations are implemented, but equally that there 14:38 is evidence that they are implemented.

207 Q. I suppose the third building block that, and you have touched on this already in the course of your evidence, was the arrangement of training for key personnel in the SAI process or those who are likely to be brought 14:39 into the SAI process. Who did you direct that training to?

A. It was open to all the members of staff but particularly we were interested in making sure that the senior members of staff within the Directorate, the 14:39 ADs, the AMDs, the Associate Medical Directors and the Clinical Directors or anybody who wanted to Chair an SAI and on occasions if we knew that we had people coming up to be chairs we would have tried to facilitate them on to the next available training. 14:39

208 Q. Yes. In terms of your role around SAIs, so we see in a number of the incidents that we will look at in a moment you are the governance person who forms part of the four or five people who make up the SAI review

team?

A. Yes.

209 Q. And I think your role is given as Coordinator --

A. Yes.

210 Q. -- in the SAI review context. So what were the kinds of tasks that you had to conduct in that role? 14:40

A. So even from the very start it would have been developing timelines for the Chair so they had all the necessary information in a chronological order, as to sequence of events that led to a particular incident, reviewing the notes, having what was available, organising the meetings, addressing any queries the Chair had, drafting initial drafts on occasions of the SAI, making sure that it was shared with the people involved so that they could comment on factual accuracy. It would then have been making sure that it was presented to the Friday morning governance meetings so that this review of the SAI and any queries or challenges that the clinicians there felt maybe hadn't been addressed. And then back and then finally sharing the SAI with the families. 14:40 14:40 14:41

211 Q. So it was really end-to-end?

A. It would have been.

212 Q. Yes. Was it inevitably you from -- directly you who was the Coordinator on the SAIs during that three-year period or were you able to share the burden? 14:41

A. So at times whenever we had some of the teams in, so one of the lead nurses in particular would have been the coordinator at quite a number of the SAIs. More

latterly probably me for the Level 3s and 2s. And then when there was me and a part-time person, she would have done some.

213 Q. Okay, you've put the various building blocks in place to try and improve the setting in which SAIs can be conducted. But you say in your statement that there was a real challenge quite often to get the process off the ground, for example screening meetings would be regularly cancelled, your recollection is that surgery and elective care would tend to cancel meetings more often than others and they'd have to be re-arranged. You brought this issue to Mrs. Gishkori's attention perhaps on a number of occasions, we see it on the weekly governance committee meeting agenda for November 2018, no doubt there may be other examples. What was the problem there in terms of delays before you get to screening? Was it simply a case of the practicalities of bringing four or five diaries together to get an agreed date? 14:42 14:42 14:43 14:43

A. That would have been one of the issues. So medicine and unscheduled care would have had a routine time, date and times for theirs. Surgery and elective care initially wouldn't have been as sort of focussed on a particular day. And then the clinicians' diaries, sickness, absence, annual leave, clinical commitments, it was quite a challenge on occasions to get them all together to get a robust screening meeting. 14:43

214 Q. Another feature of some of the cases that we'll look at shortly is, I suppose, the delay from - let me not call

it a delay - the passage of time between incident and final report. Obviously you have a lot of steps in the middle, you have to assemble the material, get the timeline, get the screening done and then research, interviews, analysis, drafting, maybe multiple drafts, lots of steps till you get to the final report. Some cases have taken three years to produce an outcome, again can you, in the generality, not necessarily referring to any particular case, but what is the problem there in realising the prompt delivery of an SAI outcome? 14:44 14:45

A. I suppose that's one of my sort of greatest regrets, that many of the SAIs took such a long time. It was essentially resource, resource of the governance team, myself and a small team, the number of SAIs, the complexity of some of them, the timelines, then diary management, sometimes getting a Chair. So if you start from the initial, we screen, we have to decide there is an SAI, we have to decide who the panel is, who the Chair is. There were challenges in always getting chairs, particularly if there was an external Chair required. Then organising the meetings, getting the diaries aligned. If we had to interview individuals in relation to the SAI it was getting their diaries aligned as well. So steps, small steps all along the way all slipped over time and unfortunately and regrettably the SAIs took too long. 14:45 14:45 14:46

215 Q. Yes. I suppose more often than not you're looking to an experienced clinician to Chair an SAI?

A. That's correct.

216 Q. Perhaps a clinician with other clinical and governance commitments; was that part of the problem, getting clinicians, who are no doubt to be thanked for putting his or her hand up to do the SAI when it is undoubtedly something that they maybe wouldn't necessarily have wanted to do? Is there a solution to be found? Have you thought about whether there is a better way of doing it, rather than calling ad hoc on clinicians out of the blue, perhaps, to become involved? 14:46 14:47

A. So the clinicians all have very busy clinical schedules and they did the SAIs within that diary commitment that they had. So that is why one of the governance structures looked at having some time set aside for people to be -- for chairs to have that half PA a week to help facilitate governance and SAIs. The other element was to have professional chairs, for want of a better phrase. And the Trust now does have some people who Chair SAI meetings, that's their -- that's what they do, they have the time and the commitment to be able to do that. 14:47 14:48

217 Q. Because if we start with the principle that the SAI review is taking place in order to provide learning and an opportunity to do better in the future in respect of, for example, a clinical issue or a behavioural issue or a technical issue, whatever it might be, the learning obviously has to take place in a considered environment, you don't just rush out with the conclusions right away, it has to be considered and 14:48

thought about. But three years down the line or two years down the line is, would you agree, not much benefit if there is a real problem there that needs addressed?

A. They do need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So two years is too long. 14:49

218 Q. This question might come up again in some of the specific cases, but was there ever an opportunity or a method by which learning could be extracted relatively quickly or a change made relatively quickly and then let the SAI get on with the task of taking perhaps a more considered view, is that built into the Trust's thinking or approaches? 14:49 14:50

A. There could have been rapid debriefs following an incident to identify immediate learning and that did happen in some services, such as obstetrics. The Emergency Department would have sometimes had rapid debriefs as well. So that is something that could improve timeliness. Some of the more complex issues where you're delving into very complex systems, processes maybe take a bit longer. 14:50

219 Q. One thing you have done for us as part of your witness statement is to provide a table setting out, I suppose, the SAIs and sometime complaints that crossed your desk with respect to urology. No doubt there's many others in other services. But just to take a look at that table, it's at WIT-100377. This is the table from your 14:50

addendum statement, you took an opportunity to correct your earlier table. You set out the SAI number, the relevant consultant and what it led to, an SAI review in the majority of them. We can see that Mr. O'Brien wasn't alone in being relevant to an SAI review. 14:51
We see Mr. Glackin named, Mr. Suresh named. I want to ask you this: You see in that table I think a total of eight SAIs relating to Mr. O'Brien and aspects of his practice; did you see in realtime that this cluster of SAIs - I know that five related to the one issue, for 14:52
example - but did you see in realtime any concerns about the number of SAIs in such a short period of time particular to one consultant?

A. It would have been unusual to have that many for one consultant. The five at the top would have came out of 14:53
one SAI where we identified an issue in relation to non-triage of referrals and tracked back to a particular week to identify that there were a number of patients hadn't been triaged and those were five of those patients. 14:53

220 Q. Yes. Does the existence of such a number, albeit, as you say, five came out of, if you like, the one process, does that suggest to you that the Trust ought to have taken that information and asked questions about the practice of that clinician beyond the instant 14:54
SAIs and before 2020 when further concerns were investigated after they emerged in the summer of that year?

A. It's back to looking at trends and if you see a trend

where a particular incident or clinician is repeatedly coming, then it is something you need to investigate further.

221 Q. Yes. I mean, leaving aside the specifics of this Inquiry or the urology itself, is that problem of interrogating the data, marrying up concerns that are arising in different parts of the system, is that part and parcel of what you talked about earlier in terms of interrogating data and triangulation? 14:54

A. It is. It's everything from the quality of the input into the Datix system. So if you don't put a particular clinician's name, a particular nurse's name, if it is a medication, if that's not very clear, then when you go to run your reports that information is missing. If the information between the litigation system, the incident system and the complaints system isn't all talking to each other and you can't pull off one report from it, again that leads to a challenge in identifying risks within the system, whether it is process, piece of equipment, or a clinician. 14:55 14:55

222 Q. In Mr. O'Brien's case, I know you as the Governance Coordinator, it's important to say you don't just have these eight O'Brien SAIs and there is several others belonging to other clinicians or relating to other clinicians, you have all of the SAIs coming into your department from throughout the Acute Directorate; but it is fair to say that the operational teams, so within urology you will have the Head of Service, you will have the medical management, they should be sensitive, 14:56

should they not, to the fact that here is a clinician who has six SAIs relating to triage issues, another to do with the communication around and the management around a stent patient, another one to do with preoperative assessment and the problems that arose in that case. So the operational team would be better equipped to be alive to clusters of concern?

A. Within their own service, yes, they would be able to identify particular incidents, again whether it was a clinician or some other element of patient care. I think maybe what they might not be aware of is that something that's unusual within their area or, you know, are these numbers relevant in all specialties.

223 Q. Do you think the Trust continues to remain vulnerable to an inability to bring together different strands of information, some might call it intelligence, around the practitioners who may be putting patients at risk?

A. I think, because of the systems that we have in place at the minute, the Datix system, while it has improved, the ability to triangulate all the information is still a challenge. And again without good data analytics to help pull all the reports together, to evidence the trends, it could remain a challenge and does remain a challenge.

224 Q. I want to now ask you about some specific incident reporting and I apply the health warning that you may not have had direct involvement in all of these cases and I'll do my best to help you with the context.

A. Okay.

225 Q. And where you didn't have direct involvement, I suppose I'm asking you questions about the practice that emerges from it and whether you have comments to make. And you do have what we call a patient designation sheet in front of you and if I could remind you to try and use the number. I will say the number to you and if you try to repeat it. 14:59

So I'm talking now about a Patient 136. You refer to this patient in your addendum statement. You very helpfully looked at some documents in association with that because it's a case, as I understand it, that predated your appointment to the governance role. So if we could bring up the Datix in -- sorry, start with this screening sheet, it is WIT-95352. If we scroll down to the bottom of the page please? 15:00 15:00

A. It's up. Rather than down.

226 Q. There it is, sorry. Do you see the case I'm referring to?

A. Yes. 15:01

227 Q. So?

A. That's not a screening sheet, that's a report from Datix that highlighted potential delays in diagnosis or treatment in care.

228 Q. Okay. So that's the sheet we looked at this morning? 15:01

A. Yes.

229 Q. Yes. Okay. So it's a convenient starting point. So if I read from the top entry:

"The patient was waitlisted for removal of a ureteric stent on 17th November 2014. This request was registered in the book in the Stone Treatment Centre. A green booking form was also filled in at the same but this was overlooked. The patient had to have the stent in unnecessarily too long. He was reviewed in clinic on that day..."

Whatever the date was.

15:02

"...and realised that the stent was still in situ. Arranged to remove the stent only today."

So that was to form part of an incident report and we can see the Datix in association with that at WIT-50465. The description of the incident is as I have just read out. The person reporting it was Mr. Suresh and if we scroll down. You have had an opportunity to look at this. I think you have told us in your witness statement that having considered this Datix report, that that's what this document is?

15:02

15:03

A. Yes.

230 Q. It would appear to you that it wasn't screened?

A. Yes.

231 Q. We can see that if we -- scroll down please, I'll just see if I can find the reference. Keep going. Yes. So this was categorised as a "minor harm", it was described as being "medium risk" and that's defined as "expected to occur monthly". And then the "action

15:03

taken on review" is the next entry. If you just scroll down. It is described as not being an admin issue because the relevant forms had been completed. The wait is related to capacity. Then if we scroll down, it is said that the lesson learned is that: 15:05

"The issue having been discussed at a urological departmental and governance meeting, a new process was agreed that all patients that have a stent fitted need to be added to a waiting list with a planned date to come in." 15:05

So when we look at this one, it wasn't screened for SAI purposes. Do you believe it should have been screened, whether screened in or screened out, whether or not it became an SAI review it should have had a screening decision, is that fair? 15:05

A. If you're talking about the definitions of what you would screen an SAI for, yes.

232 Q. Is that the kind of case that you think ought to have had an SAI review or even an SEA? 15:06

A. It would have met the definition. But what the team appeared to have done here is looked for the early learning and implement it. They felt the early learning was and put an action in place to help prevent it happening again. 15:06

233 Q. Yes. So this was a patient who should have had his stent removed at a much earlier time. The presence of a stent, as we see from one of the next cases we're

going to look at, there is a significant risk of infection, of sepsis with delay in removing the stent. And there didn't appear to be a process in place to effectively manage patients on to the waiting list with a planned date. So all significant issues with a risk of harm. Are you suggesting it is appropriate on occasion to take the early learning, design a solution and, if you like, avoid an SAI review?

A. The SAI review could have gone on in the background but the important thing was that an early learning was identified. If it had progressed to an SAI, there may have been additional learning identified with an external team looking at it. 15:07

234 Q. To what extent - and we talked about this early perhaps - to what extent were you in a governance role or a member of your team - and I recognise this particular incident was before your time - to what extent were you able to, if you like, police the decision making, if a screening meeting had happened, to ensure that the, if you like, the appropriate standards were applied to decision making? 15:08

A. I would have challenged, you know if I thought something clearly met the definition of an SAI I would have challenged, and if I was particularly concerned I would have highlighted at a meeting with Dr. Boyce or Mrs. Gishkori if there was something that I particularly felt very strongly about. In relation to this one, looking at this in retrospect, the waiting lists at the time were long. And again it looks as if, 15:08

this looks as if it is a capacity issue which an SAI may not have been able to resolve because the willingness at the time, even with waiting list management, remained a huge challenge.

235 Q. Of course. But these patients with stents in place -- 15:09

A. Mm-hmm.

236 Q. - need to be managed --

A. They do.

237 Q. -- in an orderly fashion?

A. They do. 15:09

238 Q. It appears that this was recognised, at least in part, by the urology processes that looked at it suggesting the need for a planned date?

A. That's correct.

239 Q. The next case that I want to look at is that of Patient 15:09
16. Again that is another stent case. It comes with a background of, I suppose, greater complication than we are or were aware with the first case that we looked at. You were the coordinator on the SAI review that engaged with Patient 16's case? 15:10

A. Yes.

240 Q. That was an incident that came in initially as a complaint and it was directed -- you directed it to Dr. Boyce after Mr. Cardwell referred it to you and it was converted into a case for consideration for SAI. 15:10
Now, we think from the paperwork - if we bring up WIT-95488. Would you describe this as a screening form?

A. A screening form.

241 Q. Yes. It appears from the date at the bottom of the page that it may have been screened on 5th April 2017. Is that relatively quick or efficient for a screening decision, in your experience?

A. No, you would want your -- your incidents should be screened quickly so you can identify do they need an SAI, what the early learning is. Because sometimes even at the screening meeting you can identify some of the learning that the teams can start to put in place and then be able to progress to an SAI in a timely manner to identify the full learning. 15:11 15:12

242 Q. Obviously these early months of 2017 had another process relating to the work of Mr. O'Brien being undertaken and we'll ask you in a moment about your first knowledge of that. But you would have liked this matter screened earlier than April; can you remember any specific reasons why it wasn't screened earlier? One might make the argument that given that all that was going on around Mr. O'Brien's practice at that time and the scrutiny that it was subjected to and the commencement of MHPS and all of that, that there might have been a greater urgency in looking at this potential SAI? 15:12 15:13

A. I think, in general, from a governance team perspective it was very busy. We were looking at the other cases and from a screening perspective, I have to go back and check, but there may have been delays in actually the screening meetings happening as well. So the case would have been come in, we would have done a timeline 15:13

and brought it to the screening meetings. And if you scroll down, it might be on that, if there was multiple screening meetings, or it may not.

243 Q. I don't think there is any other dates on this.

A. Okay. 15:13

244 Q. There is some suggestion on the papers that there might have been a further meeting in July. But certainly the record here that we see in front of us is that:

"The review team considered there was sufficient failings in systems and processes, including communication, within Urology Department to require an SAI review." 15:14

And that was in the context that we see with the brief summary of the incident that this was a case of a cancer patient who had received radiotherapy and was ready by, I think, December 2015 to have his ureteric stents replaced, but weren't replaced then until June 2016. Obviously we have more material to understand the background to this case than the one I earlier drew your attention to. But are you reinforced in your view, perhaps, that the first case that I drew your attention to should also have been screened in for a SAI review, notwithstanding the suggestion of a solution which was talked about within the governance team? 15:14 15:14 15:15

A. It does, because the more you screen and the more in-depth view you have of your systems and processes

means you can identify earlier where you can put into place an action that might prevent a similar incident happening.

245 Q. Yes. We know that the final report for this incident then from, I suppose, a standing start following screening in April '17, the final report didn't issue until 27th January 2020. If we bring up PAT-000100. And date report signed off 27th January 2020. Was there anything about the subject matter of this case that justified in essence a three-year process? 15:16

A. No.

246 Q. Was it forgotten about or was there simply...

A. No, this case ran alongside the other cases with the five patients with the SAI chaired by the same external Chair. 15:17

247 Q. Dr. Johnston. And what do you put the -- what explanation do you put around the three-year delay?

A. Lots of small to medium delays in organising meetings, organising interviews, writing reports, getting the right people in the room together to finalise the report. 15:17

248 Q. The recommendations that came with this report we can see at PAT-000116. If we can just scroll down to No. 6. No. 6 refers to: 15:18

"The Trust, with the HSCB, must implement a waiting list management plan to reduce urology waiting lists."

We saw with the first case, Patient 136, that there was

something of that in the decision of the urology governance team, they talked about developing a specific return date or waiting list date for the patient to come back in and yet Patient 16's case happening a year or so after Patient 136's case, not -- well, I was going to ask you are you aware of whether anything had changed in the management of stent cases or is the answer it wouldn't appear that very much had changed? 15:18

A. I wouldn't have been sort of privy to the changes on the -- you know, the addition to the waiting list, had they a date on for this patient. There was multiple communications back and forward between various teams and missed opportunities in relation to administrative processes in this patient. And the waiting lists were still long at that time. 15:19

249 Q. Yes. But I suppose the point I'm making is that, Patient 136, urology had looked at that one in 2015?

A. Yes.

250 Q. Came up with a view as to how stent patients should be managed. Patient 16 is mismanaged in relation to his stent? 15:20

A. Yes.

251 Q. And then three years after that you and your colleagues are writing an SAI outcome which is still talking about essentially the same thing, managing stent patients so that they don't come to harm. Plainly the solutions for these kinds of things belong to the service and the ability of the service to escalate those issues up to, 15:20

perhaps, the top table, but do you recognise the difficulty here that actions were not being implemented or it would appear that actions are not being implemented to reduce the risk?

A. It would appear that similar things happened to these two patients and, therefore, the recommendations of the first may not have been implemented to prevent the second happening. 15:21

252 Q. Could I bring you to Patient 102. This would appear to be a case where again there was a failure to screen for SAI. If we go to WIT-100357. This is a Datix raised by or an incident report form raised by, I believe it was Mr. Haynes. If we scroll down. Yes. It says that the patient was discussed at a urology MDM on 20th November 2014. The recorded outcome was: 15:21 15:22

"A restaging MRI scan has shown organ confined prostate cancer. For direct referral to radical radiotherapy and then for out-patient review with Mr. O'Brien. Was reviewed by Mr. O'Brien in out-patients on 28th November 2014. No correspondence created from this appointment. A referral letter received from the GP nearly a year later stated that the patient had not received any appointments from oncology." 15:22 15:23

Now, I know that Mr. O'Brien's view is that the referral did go or should have gone via the CaPPS system, but leaving that to one side, we can see in this form an issue which -- it was being suggested the

issue was that the patient hadn't been referred for radiotherapy. If we scroll down to WIT-100364, just at the bottom of the -- sorry, the top of the page, I beg your pardon.

15:24

So, we will hear more specifically from Mr. Cardwell who has specific knowledge of this case, but I am seeking your input on it. I'm not sure you were directly involved with it. It appears that consideration was given to whether the investigation and the screening decision had to take place within the remit of functional services. You can see that Helen Forde has -- sorry, the entry for the 18th November, it records:

15:24

15:25

"The feedback is, Martina..."

That is the Head of Service in urology, Martina Corrigan.

15:25

"...I have taken this back to SEC..."

That's her service or part of where your her resides

A. Yes.

253 Q.

15:25

"...as it appears no dictation was done. Will need to review by yourself and governance will support if needed."

So the message in essence is this isn't anything -- this isn't a problem with typing, it's a problem with the clinician and so it's over to Martina Corrigan to deal with it with the urologist.

15:25

At the bottom of the next page then it says, this is a feedback message back from David Cardwell. He says:

"I think it should go to Martina Corrigan as it says there was no correspondence for the appointment, so it wasn't that the secretary didn't type it. I think it was that it wasn't dictated so that would need to go to the Head of Service Urology to discuss with the consultant."

15:26

15:26

And scrolling up the page I think there might be... I think there is a reminder on the 23rd March -- sorry, 22nd March. The plain position is that the Trust accept that this case wasn't screened. Martina Corrigan's evidence to the Inquiry has been that she knows that she never discussed it. And the reason she didn't discuss it was because there was another ongoing process at that time or the beginnings of an ongoing process and she was seeking advice. This Datix form doesn't contain any explanation as to whether screening took place or why it didn't. But we can see if we go to WIT-100360, at the top of the page, that essentially the incident was closed on 17th June 2016. And we'll obviously hear from Mr. Cardwell as to why he felt able

15:27

15:27

to close it.

Would you accept that an incident such as this - and I didn't bring you to the entry which suggests that the incident was categorised as "major" - that it should have been screened in for an SAI? 15:28

A. Yes, it should have been screened in for an SAI. It would have met the definition to be screened to identify learning.

254 Q. Would you agree that this Datix form should have been populated with some explanation as to why it wasn't screened or it should be documented elsewhere? 15:28

A. It should be -- if it wasn't screened it wouldn't be documented within the screening form. So there should have been something to indicate why it was closed. 15:28

255 Q. From a governance perspective was there anything in place that would have ensured that cases such as this were appropriately screened?

A. The cases like that should have been escalated from the operational teams up into the governance team or -- and I see some of the governance teams look as if they have been involved in it. So again we would have brought things to the screening meetings that, you know, looked unusual and had a discussion to see did it need to be progressed further. 15:29 15:29

256 Q. It's a little unfair to task you with these questions in the absence of direct knowledge, but can you see the problem, a major incident, not screened, and it would appear no mechanism by which the operational team were

challenged to explain why it wasn't screened? Was it possible in the environment in which you worked for incidents such as this to either be shuffled away by the operational team if it was, for example, too inconvenient or simply, to take a more benign view of it, forgotten about?

A. It would have been with the volume of Datixes that came through, sometimes with the quality of information on them, if they weren't escalated then there was a chance that they wouldn't have been screened, as in this case. 15:30 15:31

257 Q. Could we turn to the case of Patient 137. This was another case where the recommendation of the multidisciplinary meeting in urology had not been actioned, the practitioner concerned was Mr. Young, Mr. Michael Young and it was noted by you in the table that we looked at a few moments ago, indeed you were the facilitator, I think I called it coordinator earlier, but you were the facilitator for this matter. If we look at the Datix that was raised, WIT-100386, if we scroll down. It records that the patient was discussed at the multidisciplinary meeting 12th January 2017. 15:31 15:32

"The outcome was that the patient was to be referred to an endocrine MDM. Unfortunately this did not happen. A further GP referral came in five months later, 12th May 2017, and brought this to Mr. Haynes' attention, my attention, and a referral has now been done." 15:32

Now, if we go then to the incident checklist at WIT-100393, again the incident is summarised, the key point was that the referral wasn't made and the situation was only recovered by the GP's intervention. 15:33
Scroll down please. Plainly there were a number of discussions which you would have been party to, I assume. It said that, if we look at 21st September 2017, it records that:

15:34
"The patient has been reviewed by the endocrine team and is for discussion with radiology but likely outcome will be ongoing surveillance."

So although there was this five-month delay in the 15:34
referral, it would appear that the patient hadn't come to harm. So it says:

"Discussions concluded that while this is not an SAI there is learning regarding the processes in MDM. This 15:34
incident is to be shared with Mr. Glackin, Chair of the MDM for discussion regarding current processes."

Again, on 20th October 2017, outcome discussed at screening, not SAI. 9th January, not SEA. Could you 15:35
try to help us, Mrs. Reid, with the thinking there? An MDM decision hadn't been implemented, potentially catastrophic effects if it hadn't been picked up on by the GP. Happily, when he was ultimately referred he

was given a relatively clean bill of health, in other words no harm had been caused. Why, nevertheless, does that not enter the territory of an SAI review, having regard to the definition we looked at earlier?

A. Looking at the definition it should have been screened through as an SAI. I think in this case, and I think you can see from a number of, even after the decision that it wasn't, I have gone back on a number of occasions to see do we need to action anything, are they sure. And again, from memory, I would have escalated this through to meeting with Mrs. Gishkori as well. So, going by the letter of the definitions, it should have been screened through. 15:35 15:36

258 Q. The conclusion that appears to have brought an end to the process as such was that a letter would be given to Mr. Young, and we will look at that. But did you feel uncomfortable with how this was being talked through and the avoidance of an SAI or were you relatively content that in the absence of harm to the patient a letter to Mr. Young would address the mischief? 15:36 15:37

A. I probably, from memory, was uncomfortable. And I think, from what I can see here, I have gone back a number of times to ensure there was an action progressed in relation to the incident, even though it took quite a considerable time to get to that point. 15:37

259 Q. Hmm. Can you recall, because it's not clearly recorded here but it's maybe implied in the absence of harm to the patient, but can you recall the rationale for not pursuing an SAI?

A. From memory it would have been because there was no harm caused to the patient in this particular instance. The issue was being addressed through the operational lines in relation to discussions with the chair of the MDM and the specific correspondence with the clinician involved.

260 Q. Hmm. When you see these two cases taken together, Patient 102, which we have just looked at, and then this one, Patient 137, one could suggest that the service itself, the senior clinicians who sit on it maybe hold the whip hand, if you like, in determining where these things go and SAI processes can be avoided if they want to take that approach, is that an overly sinister suggestion or is that a fair analysis? 15:38

A. I think maybe overly sinister, but when you look back and you see the cases going, you can see why you would come to that conclusion. 15:39

261 Q. Yes. Whatever is the reason for it, I think you're accepting that it's not good governance?

A. No, some of those cases should have been screened and gone to SAI. 15:39

262 Q. The problem, I suppose, from the Trust perspective is that in 2020, several years later, you have this cluster of concerns about how the MDM was operating and whether good processes were in place and here you have two cases, different facts, obviously, but broadly similar theme about the implementation of MDM recommendations, the solution, as I say, was for a letter to be given to Mr. Young and that didn't reach 15:39

him until 15th August 2018, let's pull up the letter, it's WIT-100383, so 14th August. "The review team", just reading:

"The review team looking at this concluded the following MDM: Any actions must be progressed by the consultant nominated as responsible for the action required as per the outcome report from the MDM. Referrals for specialist care need to be sent from Consultant to Consultant." 15:41

And he is asked and Mr. Young is asked:

"Can you provide reassurance that you now have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner."

Now, you have said in your witness statement that you see no evidence of a reply from Mr. Young? 15:41

A. No.

263 Q. Is that still the case?

A. Yes.

264 Q. Yes. Who was the assurance to be provided to?

A. Well, it would have been to Mr. Haynes because the letter was sent by Mr. Haynes. 15:41

265 Q. Yes. Would you have expected to be informed if the assurance had been provided?

A. Yes, it would have been good for completion of the

process to have updated Datix and the screening form with a response.

266 Q. So you must be left wondering whether in fact Mr. Young or indeed the urologists had a process in place to ensure that patients are properly referred? 15:42

A. That the actions from the MDM were actioned, yes.

267 Q. Yes. There was no closure on this from a governance perspective if the assurance wasn't provided?

A. No, not in my time.

268 Q. Could I take you to Patient 138. 15:43

CHAIR: Mr. Wolfe, I am just looking at the time, it's quarter to four, would it be appropriate to take a short break at this point?

MR. WOLFE KC: Yes, it might help.

CHAIR: So we'll come back then at five to four, Ladies and Gentlemen. 15:43

SHORT BREAK

THE HEARING RESUMED AS FOLLOWS AFTER A SHORT BREAK: 15:56

CHAIR: Mr. Wolfe?

MR. WOLFE KC: Thank you.

269 Q. Mrs. Reid, could I then bring you to the case of Patient 138. This is another incident report. You were the facilitator. Ultimately there's no SAI review and the subject matter is again a problem with the processes around the multidisciplinary meeting in urology. So if we could have up on the screen, please, 15:56

the Datix report, it is TRU-178398. If we just go to the text please, thank you. So the position as summarised here is that:

"The GP phoned Mr. Glackin's secretary on 25th October 2018 to enquire about the patient's follow-up. The secretary looked into the patient's history and it was discovered that this patient had had their bladder surgery but that the patient's pathology had not been discussed at the urology MDM which takes place on a week's basis. The secretary then phoned the urology cancer tracker to advise of this and asked why and how this had happened. The tracker looked into the patient's details on CaPPS and could see that the patient was listed for a MDM discussion on 28th December 2017, but the outcome was to defer to the next week with pathology which was not available at the time of the MDM. Unfortunately, due to human error the tracker did not schedule the patient for discussion the following week and the patient was overlooked. The patient's episode was closed off on CaPPS as they had underwent the first definitive treatment, so that oversight was not picked up via tracking. As this patient was not discussed at the MDM, there was no post surgical review appointment arranged and no follow-up procedures arranged, if deemed necessary as per the consultant."

15:57 15:58 15:58 15:58 15:59

So what we know is that when Mr. Glackin became aware

of this difficulty in October 2018 he arranged for the patient to be assessed and further treatment or care provided.

If we then look at the outcome to this, if we go to WIT-100402. We can see, just scrolling down please, that Mr. Carroll, who is the Assistant Director, he is asking from this lesson what have we put in place to reduce the risk of reoccurrence. Now we'll explore how that develops. But before we get there, it's clear that this case was the subject of consideration by yourself and by the urology team but an SAI didn't result. Do you know why that was? 15:59 16:01

A. I genuinely can't remember the specifics. However, looking at the actions that were taken, it may have been because the issue was identified and an action was progressed in the development of a new guidance. But I can't specifically remember the exact details. 16:01

270 Q. Yes. I'm not sure I can put my hand on the rationale itself directly. But given that this was a patient whose pathology had not been considered by the MDM and was then lost to follow-up for ten months, and then had to come back into the system, albeit that he hadn't come to any harm, a significant risk had been created? 16:02

A. Yes. 16:02

271 Q. Again looking back on this, is this not an obvious case for a serious adverse incident review regardless of the happy ending?

A. It is.

272 Q. What we see, working through this, is that Mr. Carroll is asking the questions. If we go on up the page on to the next page -- sorry, just pause there. You're asking did we ever get an update. And then on to the next page, please. Sharon Glenny, was she the OSL? 16:03

A. Yes.

273 Q. In the cancer team. So she's telling Mr. Carroll who is asking what lessons have we learned from this and how are things going to be improved. He is told: 16:03

"To improve systems and processes should we explore the possibility of having a report set up on business objects which will pull out all of the patients which have been closed on CaPPS during a certain time period and reasons for closing which can be screened by MDM/consultants." 16:04

And then that is batted about. Let's just go up the page. He's happy to discuss it at next Thursday's performance. And that's the regional meeting, is it, with the HSCB? 16:04

A. That might have been the local performance, cancer performance meeting.

274 Q. Right. Then we can see, if we go to the next page, WIT -- scroll up please. So he is saying - just stop there: 16:04

"I don't recall we discussed this at the last performance meeting."

The issue is going on without satisfactory consideration, I am sure you would agree?

A. Yes.

275 Q. And he's asking, he won't let the issue go, he's asking what systems and reports are employed in the other four Trusts to prevent this happening. Then, Sharon suggests that: 16:05

"We will keep this on the agenda for the meeting in February." 16:05

And then, finally, if we go up the next page, please, just further on up. What Sharon Glenny reports is that: 16:05

"On the back of this event Vicky met with the trackers and discussed fail-safe measures and have agreed a standard operating procedure. This has been circulated among the tracking team and implemented." 16:06

I'm not sure what that looks like. But just from a governance management perspective, do you think this case was handled in a satisfactory manner?

A. No. Looking back, it should have been screened as an SAI and gone through the SAI process to identify the learning and make sure that the learning was identified, shared and processes put in place to prevent it happening again. 16:06

276 Q. Yes. I have just come across the note I wanted to refer to you, if we go to WIT-100404, and this is the screening form. It appears that you have discussed this with Mr. Haynes. Just go over the page, please. And 25th February, again discussing this with Mr. Haynes:

"Patient did not come to any harm, therefore close."

Is it your view that that is a, thinking about it now, an inappropriate analysis, that cannot be of itself a good reason for closing this down? 16:07

A. No.

277 Q. Would you agree that the analysis of whether an SAI review is indicated should also consider whether there was a risk of harm? 16:08

A. It is, within the definitions it is.

278 Q. Yes. While that may not always lead to an SAI review in every case, it is appropriate to look at the case through that lens and not simply whether the patient has come to harm? 16:08

A. It is.

279 Q. And when it comes to something as important as the tracking of cancer patients through a MDM process, where a patient can be lost to follow-up because of a human error such as this, something that can very easily happen, that's the kind of territory that needs to be visited by the SAI system, would you agree? 16:08

A. I agree.

280 Q. Could I bring you briefly to Patient 93. Again it's a case I'm quite sure that you have no direct knowledge of, but if I can orientate you by bringing up TRU-274730. Just at the bottom of the page, Mr. Haynes, on 31st August 2016, is reporting into the Head of Service, Mrs. Corrigan, a failure of triage. Now, at this time the case of Patient 10, with whom you have some familiarity, was, I suppose, midstream with an SAI review being conducted by Mr. Glackin, again in the context of a failure to triage on the part of Mr. O'Brien. Mr. Haynes is reporting in another failure to triage: 16:10 16:10

"GP referred in as a routine case but was not returned from triage so was placed on the waiting list as routine. If it had been triaged it would have been red flagged or upgraded to red flag given the PSA readings. The patient saw Mr. Weir for leg pain and the CT showed metastatic disease from the prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of three and a half months. It wouldn't have changed the outcome." 16:10 16:11

But Mr. Haynes is querying whether this should be an SAI. Now, the upshot of this, Mrs. Reid, is that there was no SAI, the case was batted around by email between Dr. McAllister, Mr. Young and the Head of Service, Mrs. Corrigan. Mr. Cardwell has searched and cannot find on the system that a Datix or an incident report 16:11

was even raised on this one. So I think you would agree with me that regardless of whether the outcome would have changed, this should first of all have been the subject of an incident report.

A. It should. 16:12

281 Q. It is really on all fours with the Patient 10 SAI and the subsequent SAI involving the five gentlemen who also come in as routine referrals and were upgraded. It brings me, I suppose, back to the point I raised with you earlier. Looking back on this now, do you 16:12 consider that the clinicians within urology were always applying the test for either reporting an incident or screening an incident into the SAI process in the way that you would have liked?

A. Looking back and looking at the evidence that we have 16:13 now it doesn't appear to.

282 Q. And what do you think it says about governance within urology if these incidents giving rise to risk of patient harm are not being adequately scrutinised by the system that you're charged with overseeing? 16:13

A. It left gaps that we could have potentially identified significant risks earlier.

283 Q. Does it suggest that you either weren't or weren't able to police the system that you were charged with overseeing? 16:14

A. If some incidents weren't escalated then I wouldn't have been able to identify. That particular one I wouldn't have been aware of at all because it wasn't on the Datix system. With challenge at the screening

process we would have got some. But there were others, as we can see today, that didn't get converted to SAI reviews. And that's a big regret.

284 Q. What do you put that down to?

A. In some ways it may have been an issue in relation to capacity, in others it may have been that the significance at the time wasn't considered. And with the value of hindsight and what we now know, if the incidents had been screened into the SAI process we may have identified the issue earlier. 16:15

285 Q. Have you any concern that clinicians would find it awkward or inconvenient to report, if you like, their colleagues into an SAI process or do you think the evidence doesn't support that?

A. I would like to think with their professional accountability that if they identified a risk that they would. From some of these it appears that on occasions that hasn't happened. 16:16

286 Q. Could I bring you to Patient 10's case. You may recall that, in terms of your involvement in this SAI, when you were relatively new in your post, you had to make contact with the Health and Social Care Board who were inviting the Trust to give consideration to appointing an external into the SAI review? 16:16

A. Mm-hmm. 16:17

287 Q. Do you recall that sequence?

A. I do, from having seen the evidence bundle.

288 Q. Yes. If he could pull up WIT-100378. Just scroll down. Róisín Farrell is within the Trust, is she

within corporate governance?

A. Acute governance.

289 Q. Acute governance. She points out to you that the DRO, that's the person in HSCB with oversight of the SAI, once you report an SAI in to the HSCB they appointed a designated -- 16:18

A. Responsible officer.

290 Q. Responsible officer. He or she has suggesting that the Trust give consideration to adding someone outside the Trust to sit on the Review Panel. You then report back on how you dealt with that. If you scroll up the page, you report that: 16:18

"Having discussed it with the DRO and discussed the case at length, he appeared content with the team membership we suggested." 16:18

And the team membership you suggested was all internal personnel?

A. Yes. 16:19

291 Q. Led by Mr. Glackin?

A. That's right.

292 Q. And:

"He did state that he may, during the review ,may want to take the opportunity to ask for an independent opinion if the team felt it useful, particularly in relation to x-ray. However, he did appear content that we start without an external representative." 16:19

Can you recall his or her thinking? Why was he or she proposing this to you? Did he see anything in the case that required a level of independence?

A. I just can't remember. I can't remember the exact discussion. When I trawled through to see if I could find any evidence of discussion, that was the only thing that I had that would provide some evidence to the panel. 16:19

293 Q. Yes. In terms of the interface more generally with the HSCB, in the context of SAI reviews, what was the nature of that relationship? 16:20

A. I felt I had a good relationship with the people that I was in communication with. The challenge that we had was the duration that it took to have the SAIs completed. 16:20

294 Q. Yes.

A. And that was a constant interface. But we kept the communication lines open. We would have met, had discussed on the telephone to see what we could have done to improve that. 16:20

295 Q. We needn't open up the fine detail, I can give the panel the reference at WIT-61947. We can see that in this SAI there is apparently frequent contact between the DRO at the Health and Social Care Board and the Trust as you walk through the various steps of this process. Did you find that the relationship was one of the HSCB challenging the Trust almost as a critical friend or perhaps stronger than that or was it not that kind of relationship? 16:21

A. It would have been that sort of relationship, there would have been that challenge in relation to could we improve the time frames of the SAIs, which was wholly appropriate.

296 Q. Could I take you then to the SAI concerning Patients 11 to 15. You know the background to this SAI, the five cases of missing triage. This case was moving off at the same point as the MHPS process began. You were the - I forget the term again - the coordinator? 16:21

A. The facilitator. 16:22

297 Q. Facilitator, I think is the word, on this one. Dr. Johnston, as with Patient 16's case, was the external reviewer. Why would you see fit to bring in an external into this case when you didn't see the need for it in Patient 10's case? 16:23

A. I'm trying to remember. I think the challenge was getting somebody internally to sit on the panel was exceptionally challenging. We tried a number of people to see if they would chair the SAI and they couldn't, so I contacted the Medical Director at that stage to see if we could get someone else to Chair the SAI. 16:23

298 Q. In November of that year I think Dr. Johnston was, presumably, trying to gather his thoughts and see where the review would take him, he was interested in obtaining further background on the whole triage issue and on his behalf you sent an email, if we pull that up on the screen please, TRU-257970. Just at the bottom of the page. You are writing to Mrs. Trouton, Mr. Carroll and Mrs. Gishkori. You explain that: 16:24

"As you are aware, we are doing an SAI on a number of patients where triage and waiting list management may have been a contributing factor. The Chair has asked for any previous correspondence/investigation/action in relation to the AOB triage and waiting list management."

And that was met by Mrs. Gishkori, if we scroll up that page, please, saying, she's asking for clarification and about which Chair is, is it the chair of the investigation or the chair of the board, presumably. Do you understand how she could have been confused around that? 16:25

A. Not particularly. Because the chair of the organisation probably wouldn't have been asking for that level of information, it would have been the chair of the SAI. I think the title is "confidential SAI" so she would have known it would be in relation to that. 16:25

299 Q. Yes. And she doesn't appear receptive to the requests, she is suggesting that a check is made with the legal team as to whether any background material would be shared. Do you know whether any advice was sought around this? 16:26

A. I can't remember. But because I don't remember, I don't think we did. And I don't think there would have been a requirement. As part of the SAI process we should have been sharing the information we had to identify the learning. 16:26

300 Q. Mm-hmm. Presumably Dr. Johnston was looking, for example, to know about the other SAI of Patient 10 and the systems around triage and that kind of thing?

A. Yes.

301 Q. Did you see anything unusual in his request? 16:27

A. No.

302 Q. If we go to TRU-256445 and just scrolling down. You're writing again pursuant to Dr. Johnston's request for further information and you are specific now in what is required. Then up the page Mr. Carroll writes to you: 16:27

"Can I ask that this SAI is "tight" on its remit? We have another Trust process which will pick up on several of the questions being asked."

16:28

I know there is a little bit of confusion around your date of knowledge, in terms of knowing that there was another process.

A. Yes.

303 Q. Does this help you to understand when you got a sense of the fact that there was another process in place? 16:28

A. It does. I think that is probably the first time that I would have been aware that there was another formal process in place in relation -- but as to what that exactly was, I now know it was MHPS, but I wouldn't have the time. 16:28

304 Q. Yes. Again, Mr. Carroll's response, do you find that surprising and do you understand the rationale now?

A. I understand the rationale now. The SAI was always

supposed to be around triage. Whenever it was first escalating the terms of reference it was agreed mostly to do with triage at the time.

305 Q. So this SAI, indeed the Patient 16 SAI, they were being managed, I suppose, entirely separately from the MHPS process? 16:29

A. Yes.

306 Q. Tracey Boyce has said in her evidence to the Inquiry that there was this disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team and she says from what I understood at the time they had to be kept totally separate. However, with the benefit of hindsight, she thinks that a joint approach would have been beneficial. So, for example, the SAI concerning patients, the five patients, might have been expedited rather than taking the guts of three years. A more of a joined-up approach would have led to a more efficient and perhaps a more universal learning. Do you have any view about that? 16:29 16:30 16:30

A. My understanding is that the two processes sit separately, one is in relation to the professional management of the doctor, the other is in relation to learning from a clinical incident. I think as a governance coordinator you are aware of lots of very confidential, very sort of information and it would be good to understand other processes that are going on within the Trust to help triangulate all that information and perhaps share between the two processes 16:31

so that you have got a very robust rounded learning from what was happening at the time.

307 Q. Now, the SAI review concerning the five patients had reached the point of a draft report by May 2019, TRU-264785. It's handed or sent to the then Medical Director, Dr. O'Kane, and she has concerns as to the quality of the report or some concerns as to the quality of the report. Were you ever offered an insight into what those quality concerns were? 16:31

A. I can't remember specifics. I do know from looking through emails that the format of the recommendations, so those that were relevant to HSCB were ones at the top, then the Trust ones and then the ones specific to the clinician. So I know that the layout of those changed but I'm not aware that anything else was significantly changed. 16:32

308 Q. Obviously, and perhaps for the reasons you have shared with us already, this SAI review took rather too long to reach a conclusion. I see you nodding your head. You would agree with that? 16:33

A. Yes.

309 Q. One can see from emails that you were engaging with at a relatively early stage with, for example, Katherine Robinson, that you were trying to get to grips with how the triage system had worked. Were you in the mind-set of we need to try and ensure that this doesn't happen again or trying to find solutions to ensure that the risk of it happening again was mitigated? 16:33

A. It was to -- in order to make recommendations and to

help with the processes it's really important to understand the entirety of the process, how the referral comes in, how it gets to the clinicians, how timely it is, how it is recorded afterwards. So that was the initial part of that. And then that in itself then helps lend to learning and putting into place recommendations.

310 Q. So obviously this took into 2020 before the review was completed; what assurance did you have that, leaving aside Mr. O'Brien, but in the generality, that this triage risk couldn't be repeated? 16:34

A. The only thing that we would have had in place would have been the process in relation to the delays where the missing triage would have been recorded and escalated through to the operational teams. But outside that. 16:35

311 Q. Yes. We know that Mr. O'Brien was the subject of a monitoring plan to ensure that at least his practice was supervised with regards to triage. But were you not concerned more broadly to ensure that the problems that gave rise to these SAIs couldn't be repeated by another practitioner? 16:35

A. Yes. Though the reports should have gone through to the Operational Directors and Assistant Directors so that they would have been aware of who was and wasn't returning triage to the teams. 16:35

312 Q. So was --

A. But I personally didn't ask for that assurance.

313 Q. Yes. We get a sense that, even during those days in

2016, and before that when the people you speak of were aware that triage wasn't being done, they knew that or had the ability to know that, but the problem as we explored, maybe, this morning was that they weren't following up to ensure that the triage was eventually done even though the patients were on, perhaps, a routine waiting list. Did you seek any assurance on that necessary follow-up?

A. No.

314 Q. Could I ask you just about a discrete point, TRU-257186. Just at the bottom of the page there. You're writing to Katherine Robinson and you are saying that Mark, that's Mark Haynes, has reviewed the, what I assume is the draft SAI report which you were writing up, it was your responsibility to take all of the opinions and write it up and before you forwarded it to Dr. Johnston you were seeking Katherine Robinson's input on a particular drafting point? 16:36 16:37

A. Yes.

315 Q. And the drafting point was essentially whether it was possible to understand relatively easily that triage had not been done. This is drafted to say that: 16:37

"Although there was a comment MTNL..."

16:38

Which means?

A. Missing triage, no letter.

316 Q. Yes. So there is missing triage and no letter. Although that was inserted into the system, you were

making the point that:

"In the drafting, however, there was a potential that this could be overwritten with a new comment and this meant that there was no simple way of picking up who had not been triaged and nor was there a safety net for incorrect GP referrals." 16:38

Just on that last sentence and the first part of it, "this meant that there was no simple way of picking up who had not been triaged", that was Mr. Haynes' point and you were seeking Katherine Robinson's view on that? 16:38

A. Yes.

317 Q. It's fair to say that Katherine Robinson rebutted that. She was making the point, well it would have been perfectly obvious to our system, using the MTNL designation, that cases had not been triaged? 16:39

A. Mm-hmm.

318 Q. If we can scroll up to the top of the next page. Yes. And she writes back to you? 16:39

"I would prefer my original comments to stay. We did escalate and we were advised to go by GP priority. It is also incorrect to say that the comment "MTNL could not be viewed", it could on a PTL. The odd comment would have been overwritten when the patient was selected for booking. Anyone viewing PLTs were fully aware that there were loads not triaged." 16:39

So to those using the PTL system it was perfectly visible that, as she says, loads of triage was not being done? Do you know why or how Mr. Haynes came to form the view that the reverse was true, that it was difficult to see when it hadn't been done? 16:40

A. If you have ever seen a PTL of lots of patient, they are huge, sheets and sheets and sheets of patients and because it's a free text box there is the potential that the odd patient one would have been overwritten with another comment that may have been more urgent. 16:40 So more latterly we got PTLs in an Excel spreadsheet so we could have filtered them by missing triage, no letter. But it wasn't a simple report that we could have -- would have been really accessible. The Heads of Service and OSLs would have reviewed the PTLs on a 16:41 regular basis and I would have done it for my service. But it would be something where you would have to look at those PTLs on a regular basis and understand the missing triage, no letter.

319 Q. Yes. But clearly Katherine Robinson and her team were 16:41 aware?

A. Yes. And probably more laterally the Heads of Service and OSLs would have been aware as well.

320 Q. Yes. The MHPS process was, I suppose, triggered at an Oversight Committee meeting on that 22nd December 2016. 16:42 You would have been, I suppose, blissfully unaware of that process, I think you are telling the Inquiry?

A. Yes.

321 Q. But at that meeting we can see - AOB-01281 - we can see

that - if you just scroll down please - that an action was handed to Dr. Boyce:

"It was agreed to consider any previous IR 1s and complaints to identify whether there were any historical concerns raised."

Now, Dr. Boyce, in her evidence, thought that she would have either asked you to conduct that piece of work or perhaps Mr. Cardwell, David Cardwell, who she described as being a real expert in the team. 16:42 16:43

Now could we go to AOB-01320, please? You are writing to Vivienne Kerr and copying Tracey Boyce in. Vivienne Kerr was within your governance team; is that correct? 16:43

A. Yes.

322 Q. And it's to her that you direct the query:

"Would you please check I have the correct patients? I have put in patient hospital numbers for those without, can you get me the hospital numbers?" 16:44

So if we scroll down just briefly, we will see the first page of what you are sending through. I suppose it's several pages, maybe more than several, of complaints, data arising out of the urology service. Does that email suggest that it was you who attempted to carry out the work pursuant to the direction issued at the Oversight Committee meeting to Dr. Boyce? 16:44

A. It does. And I would have asked, because my expertise in the actual Datix system wouldn't have been as good as David's or Vivienne's I would have asked them to run a report to make sure that we got robust data from the system. From memory, David was on leave then and it may have been bereavement leave, so Vivienne would be the next senior person that I could have asked to run the data.

323 Q. Yes. Can you recall how you searched for material? Because this appears to be limited to complaints data and it is not limited to Mr. O'Brien and it doesn't appear to include, for example, any Datix reports. We saw Patient 102's Datix, for example, earlier, it doesn't refer to any previous SAI that might have involved Mr. O'Brien's practice. And we know he had an involvement with the never event, which was Patient 95, he had involvement with another patient, Patient 128, which were each the subject of SAIs. Why was your work limited to bringing back a report on complaints?

A. I would have asked for the report to be run that I was asked to run. So I'm assuming that's what Tracey asked me for and, therefore, that's what I provided. And if I had asked for one report, if I had been asked for a second I would have asked for both of them to be run at the same time because Vivienne or David would have been able to run those.

324 Q. Yes. I mean, the wording from the, I don't have it up in front of me, but the wording from the oversight group appeared to be we need to understand whether

there are any historical concerns here and IR 1s were mentioned. Did you get a narrower message in bringing back the complaints, do you think? Or did you look to see whether there were incident reports or SAIs and simply didn't find them?

A. I genuinely cannot remember the conversation. However, if that's what I have run, that's what I would have been asked to run.

325 Q. And nobody came back to you to say is that the sum total? 16:47

A. They mustn't have if I haven't gone back and provided additional information.

326 Q. What was your query to Vivienne Kerr in relation to it? If you scroll back, you're asking her for clarity on whether you have the correct patients, can you remember what that was about? 16:48

A. There must have been some patients where there were hospital numbers not included.

327 Q. Okay.

A. I can't, sorry, I just can't remember. 16:48

328 Q. Can I take you to just one final issue. The MHPS report led to a determination reached by Dr. Khan on 17th September 2018, in advance of him finalising his report he asked you to provide him with the draft reports in the SAIs which were ongoing at that time, do you remember that? 16:49

A. Yes.

329 Q. And you acceded to his request?

A. Yes.

330 Q. You provided them?
A. I provided them with a caveat that Dr. Johnston hadn't finalised them and may want to make further changes to the report.
331 Q. Yes. Can you recall why Dr. Khan was interested in seeing these reports, albeit in draft form? 16:49
A. My assumption was the process that was ongoing was related to the SAIs and, therefore, he wanted to ensure that they had similar information available.
332 Q. Yes. He has explained -- or you have explained that Dr. Khan has requested them so they could cross reference with the issues that were emerging from the MHPS that's set out in an email from you, WIT-95704. Did you have any qualms about providing them or did you think it was appropriate to have this cross-fertilisation or exchange of information given that the issues were potentially similar across the processes? 16:50 16:50
A. I had been in discussions with Dr. Wright before Dr. Khan in relation to getting the external Chair so they would have been aware of the SAI and that would have been appropriate if there was learning to be had. It maybe wasn't evident in their process what I would have shared what I had. 16:51
333 Q. As regards his determination, we can see -- if I bring you to his conclusions at AOB-01923. Just go to the conclusion section. You can see there that: 16:51

"The investigation report highlights issues regarding

systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate."

It speaks about "missed opportunities to fully assess and address the deficiencies", "default processes in place". Then, at the last, at the bottom of the page he recommends that: 16:52

"...the Trust conduct an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Directorate and appropriate escalation processes." 16:52

Now, did you receive a copy of the determination during your time within the Coordinator role? This is September 2018 he's writing, you leave the post in the early weeks of 2019. 16:52

A. That's right. I don't remember getting a draft of the report. And I have looked to see and I can't find evidence of it. So I don't believe I did. 16:52

334 Q. Yes. Given the subject matter of his critique, he's politely pouring scorn on the administrative processes within Acute, directing criticisms at managers at all levels and talking about in essence systemic failures. This was the kind of material that a Coordinator in Governance within Acute ought to have been receiving and your views sought out with a view to conducting or assisting in the triggering of this independent review 16:53

that he asked about. You should have been briefed with this, would you agree?

A. Even if I hadn't seen the entirety of the report I would have thought I should have been briefed on the actions or the learning from the report so it could have been considered in other work that was ongoing within the Governance team at the time.

335 Q. But you can't recall ever being briefed with it during that role?

A. No. 16:54

336 Q. Now we can see, if we go to TRU-270460, by this stage you had moved to a corporate governance position; isn't that right?

A. Corporation governance, that's correct.

337 Q. You were Assistant Director for Clinical and Social Care Governance in the Corporate? 16:54

A. That's correct.

338 Q. If we can pull up -- so this is now February 2020. If we go to just the bottom of the page please, just scroll up a little. Sorry, I just need to -- what page are we on? Sorry, I need to find Mrs. Reid's. Scroll up a little. So maybe if I could -- we'll look for the email. I wanted to... 16:55

A. Yes.

339 Q. At this time you are involved in coordinating a response to the RQIA in relation to a number of matters? 16:56

A. That's correct.

340 Q. Including some aspects of the, if you like, the fallout

from MHPS; is that right?

A. That's correct.

341 Q. By this time both the RQIA and the GMC are looking to see whether the Trust has taken forward the review, the independent review of administrative processes and if not, why not. So at this stage you were plainly aware of the recommendations of Dr. Khan? 16:57

A. Yes.

342 Q. Did you receive any indication or explanation as to why the independent review had not been conducted by this time, February 2020, a year-and-a-half after the report of Dr. Khan had issued? 16:57

A. The only thing I was aware of was that an internal review had taken place but not an external review. I think that was, from memory, decided by the Director of Acute Services at the time. 16:57

343 Q. What you set out in this email is simply that, that there was an internal review but that did not comply with what Dr. Khan had intended. These emails tend to suggest that the Trust was perhaps caught on the hop, it had not done what it was supposed to do and was now coming under pressure from the GMC and the RQIA to take steps, is that fair? 16:58

A. I think the query from the RQIA at the time was what had we actually done. I think my query was, back to the Acute Services was, you know, would an independent review have identified other things that needed to be progressed, as opposed to an internal review. 16:59

344 Q. And presumably Dr. Khan asked for an independent

review?

A. He did.

345 Q. For good reason. This needed to be, I suppose the processes needed to be stripped down by somebody who was objective and external to the organisation or external at least to the Urology Service and Acute to get to the bottom of what went wrong. Again from a governance perspective you would have concerns that issues that had led to great difficulty identified 18 months earlier had not been visited by an independent process for reasons that are not well explained? 16:59 16:59

A. Yes, I think, you know, somebody coming in externally looking at your systems and processes is never a bad thing. It can identify weaknesses that you are not aware of and that's the importance of an external review, you may think your systems and processes are robust but somewhere else may have something that is more robust or that we could learn from. 17:00

346 Q. Now just finally reflecting back on your role within Acute Directorate as Coordinater. You said in your statement, WIT-95263 at paragraph 9.1 and 9.2, that thinking about the state of governance during your time, it would really have benefitted from a wholesale review of the governance structures with a recommendation to ensure that steps were taken to ensure that it was fit for purpose. Paragraph 9.1: 17:00 17:01

"Recommendations on improvement required to ensure

governance structures were fit for purpose."

You illustrate in 9.2 the kinds of things that we have talked about this morning that would have needed to be in place. It was Tracey Boyce's evidence that governance arrangements when scrutinised simply weren't fit for purpose. Is that what you are saying at 9.1, that's the view that you take, despite your efforts to improve things? 17:01

A. It is. The staffing and the IT systems and the ability to try and gain information and have data analysts available to help and support that weren't in place to make the system fit for purpose and identify the risks that we have subsequently identified. 17:02

347 Q. Yes. Plainly, as we have heard from your evidence, you took many initiatives to try and put things on a better footing. Maybe just to end on a more positive note, looking back on it, what would you say was your major achievement, was it changing the cultures in any way or was it a visibility of governance, was it any of the sort of hard processes that you put in place? 17:02 17:03

A. I think I have regrets from that time. I regret that the systems and processes didn't identify the risks early. When I came into post it was very reactive, it was looking at the SAIs and complaints. When I left we had terms of reference for our meetings, we had additional guidance and we had set up a number of additional groups such as the Standards and Guidelines Group to help implement guidance. We had a more robust 17:03

working arrangement with the M&M process where the M&M findings would have come back to the governance team to help identify information. We worked closely with the litigation team, developed some training for people attending the Coroner's Court and had a number of QI projects going in relation to diabetes. We looked at the delays, looked at the sign-off of results and there were other systems and processes that we put in place to help improve governance. 17:03

17:04

Being available on the floor and building those relationships with teams I hope helped improve the culture of governance within the Directorate at the time.

MR. WOLFE KC: You will be glad to know I have no further questions. Thank you for your evidence. 17:04

CHAIR: It has been a very long day but I am afraid we all have some questions for you, Mrs. Reid. I am going to ask Mr. Hanbury first of all.

17:04

MRS. REID WAS QUESTIONED BY THE PANEL, AS FOLLOWS:

348 Q. DR. HANBURY: Thank you, I have just got a couple of, hopefully, quick clinical questions for you. You obviously put -- thank you for your evidence today, it is extremely interesting. With clinical audit you obviously put a lot of effort into getting that up and running, you must have been disappointed that it wasn't taken on. Why do you think it didn't? Was it that the 17:04

clinicians didn't have time or they weren't given enough time or were there other problems?

A. I think it was multifaceted. The audit was ongoing so the clinicians were doing their audit, getting it into a robust process where oversight was the challenge. Time was one issue, clinical time. Administrative support for the audit processes was another. Having a robust data system in place to record was another. But I think, and reflecting on the feedback, they didn't feel that as a leadership team within Acute, and potentially wider, there was support for them for audit. And again the resource available was one of the issues. But people turning up to their meetings or to the conferences and things that they held in relation to audit on the annual basis beforehand was what they highlighted to me. 17:05 17:06 17:06

349 Q. Okay. Thank you. Moving on to SAIs. How did you disseminate the learning points from the SAIs that had been written up, what was the mechanism of that?

A. The SAIs would have been presented at the acute clinical governance meetings with the AMDs and the CDs and the reports went to the operational teams for cascade. And then we developed the spreadsheet with all the SAIs and all of the recommendations so that that was available at every governance meeting that we went to. And then it would have been for the operational teams to cascade that down further. 17:06 17:07

350 Q. Thank you. You mention the difficulty getting chairs for SAIs and having done one or two I appreciate that.

One of your initiatives was to put, I think, half a PA a week, which equates to about two hours a week, that's not very long to do all the interviews and things like that. I mean on reflection now do you think that -- how much time do you think a clinician, a Chair for an SAI would need to get it finished within a timely fashion? 17:07

A. So to be clear, the 0.5 of a PA never came into being. It was an attempt to try and carve out some specific time for the SAI process, for people to have time within their job plans to allow them to do that. 17:08

351 Q. Mm-hmm.

A. It depended on the SAI. Some of the Level 1s could have been quick learning and turn around. Some of the Level 3 SAIs would have taken multiple meetings, multiple interviews, some of the interviews took an hour, two hours. And then there was the review of the information, the writing up, checking. So it depended on the SAI. But at least if they had some protected time. And more latterly we're looking at roles for -- you know, Chair roles alone so that they have that dedicated time to give to the SAI process. 17:08 17:08

352 Q. Thank you. A couple more. We have noticed that you didn't speak terribly much about published audits for departments. National audits and regional audits, there appears to be, some of the clinicians have told us there has been a negative pressure on submission to national audits, were you aware of that? Certainly in urology. 17:09

A. No. I know that the national audits, the corporate governance team help support the clinicians in relation to the national audits. There have been some GDPR issues in getting the data across which has been a limiting factor regionally. And the resource in relation to notes and supporting some of the audits may have been an issue. But I'm not aware that there was a decision not to. Some of the audits maybe haven't progressed for the GDPR issues. And there may have been some resource issues in relation to some of the audits, particularly the repeat audits where you are auditing every year. Some of the services have administrative support for those, such as the National Fracture Database Audit, others don't. 17:09 17:10

353 Q. Okay. Thank you. One more question, if that's alright. You have obviously put a lot of energy into results sign-off and that is something a lot of urology departments grapple with and it seems as though it has not yet been taken on. I mean, many departments have felt okay, let's concentrate on radiology first. Because certainly looking at this Inquiry, if you had cracked that nut that would have been quite a progress. And as a clinician you need to see the radiology report and the last letter or the notes and records before you can make a decision and that all takes a bit of time. So had you thought of that, just concentrating on the to radiology particularly or was that not? 17:10 17:10 17:11

A. It is one element we had particularly looked at and worked with the CD for radiology to try and draft a

meaningful guidance for that. And that will hopefully as we progress be one of the things that we look at, trying to look at where the greatest risk sits and identify that.

DR. HANBURY: Okay. Thank you very much. 17:11

A. Thank you.

CHAIR: Thank you. Dr. Swart?

354 Q. DR. SWART: I just want to ask you briefly, I am sorry, about the screening meetings again because this keeps coming up. It's not entirely clear to me who actually 17:11 is responsible for making sure the right things come to the screening meeting, how did that work?

A. For me, the correct way of coming should have been from the operational teams up because they would have seen all of their incidents, all of their complaints and any 17:12 issues they had in relation to audits that would have been presented so, therefore, it should have come up as a fail-safe, myself and my small team would have scanned through the Datix to see if there is anything particularly obvious and maybe brought something to 17:12 them to say I wonder about this, or, for example, with one of the SAIs, David saw the complaint coming in, escalated up through me and then we sort of highlighted it through that process as well.

355 Q. And at the meeting who has the final decision as to 17:12 whether it is a serious incident or not? Because we have seen a few examples where this whole issue of potential harm has clearly not been interpreted in the way one might interpret it now. It can be quite a

difficult decision in my experience, it's not always that easy. Who has that responsibility at the meeting? Who casts the vote, if you like?

A. So the Assistant Director and the AMD or CD at the meeting following review of the evidence, if there was something I was concerned about then we would have gone back another time. And there were occasions where I would have escalated through to Mrs. Gishkori and Mrs. Boyce to say, you know, there has been an incident, I am a bit concerned and gone back. 17:13

356 Q. So you provide some challenge?

A. Yes.

357 Q. What about, is there challenge or was there challenge from other clinical specialties? Again, you know, I'm just drawing on the experience of a multidisciplinary challenge because if it gets too cosy within a specialty that can be a problem. So what efforts were there to bring a wider group of clinicians to that screening meeting? Perhaps also to cover the problem of clinical representation. Did you have those discussions? 17:13

A. We did discuss screening meetings from memory. We never got it that they were cross divisional. We would have had occasional meetings where, if an incident happened across two divisions, we would have brought the two divisions together. But on occasions it would have been two separate screening meetings and we would have then tried to amalgamate the... 17:14

358 Q. And who gave you the challenge? I mean these are very

important meetings. Where did you get your very senior medical challenge from? Who was saying have you really got this right? I mean, where did that come from? Or did it not come from anywhere?

A. I don't remember it coming particularly down. 17:14

359 Q. Okay.

A. We would have had discussions at the AD -- with the AD of Clinical and Social Care Governance but there wouldn't have been a huge challenge.

360 Q. Another theme relates to the actions and I think we have heard from quite a number of people that this was a bit of a recognised gap, lots of serious instance, you get action plans, they go into the action plan city in the sky which all Trusts have, you didn't have a way of bringing them back and checking on them. Did you do anything with regard to particularly high profile serious incidents in terms of saying to the service, well, it's your job to sort this out but I would like a report back in a year, was that culture there at all or were you just too busy to do that? 17:15 17:15

A. At the time there wasn't the resource to continually go back. What I would have done if there were particular SAIs where I felt there was something we could focus on. So conscious sedation, for example, we got the Conscious Sedation Committee up and going again and looked at developing new guidance. 17:16

361 Q. So you tried to give it a home?

A. Tried to give it somewhere to move the actions on.

362 Q. Just on that, in terms of getting things changed and

getting things done, I'm sure you are aware there are huge numbers of serious incidents across the UK and I am particularly familiar with England, where there are repetitive incidents and the National Patient Safety Agency produces guidelines, stents is one of them, radiology is another one and there's quite a lot there in terms of recommendations and things which can give more force, was there any Trust-wide forum for looking at that in terms of what's happening in the serious incident and error field? Did you have any support for that? 17:16 17:16

A. So when the HSCB would have sent down learning letters and alerts and the NICE guidance and those, initially there had been a corporate group looking at that and at a point in time that was stood down. So, then, within the Acute Directorate we stood up our Standards and Guidelines Group which would have addressed those. 17:17

363 Q. I am particularly thinking of things like stents. Was there a clinician who said 'well hey, this is a well known problem' or did you just not have that amount of time to spend on it? 17:17

A. Within the Standards and Guidelines Group we would have taken each of those or the learning letters and we would have had a change lead, which would have been a senior clinician, to look at that. We would have reviewed the recommendations out of that, mapped ourselves against where we stood, put action plans in place, and where we weren't able internally to resolve situations to do with either equipment or we would have 17:17

need an e-pro forma up to HSCB then

364 Q. So the stent one, for example, did any of that happen for the stents, because that's a well known big national issue?

A. I can't remember. But if it came in in my time we would have put it through that process. 17:18

365 Q. Okay. So when you were in that role what was your sense of the strategic importance of governance from the Trust Board point of view? Did you have any sense about how important this the governance was felt to be? 17:18 I know there was a lot of emphasis on performance and there was a lot of emphasis on timescales for SAIs from HSCB, but was there anything else coming down that made you feel that governance was a really important thing or were you entirely self-directed? 17:18

A. Within the Acute Directorate --

366 Q. I'm talking about Trust-wide?

A. It felt as if it was self-directed. So we took responsibility for the governance within our Directorate and would have fed up information. As to 17:18 whether there was a Governance Committee, I, on a number of occasions, for a short period of time, presented to the Governance Committee on particular topics. But there didn't feel as if there was an awful lot coming down at the time. 17:19

367 Q. And you describe a struggle with resource and a lot of ideas and some difficulty with that, since then you have moved on to different roles, what have you learned in those roles that if you came to your job, your

Governance Coordinator job today that would allow you to do things differently or be more successful in your bid for resources? What have you learned?

A. So when I moved to the Clinical and Social Care Governance Assistant Director I worked with Dr. O'Kane at that stage as a Medical Director. We identified risks within the corporate governance structure, asked for an external person to come in, review the governance processes, give us recommendations and then we tried to implement those. Resources is still an issue. In the current financial constraints Trusts have significant cost savings to make. That remains a significant challenge. But I would ask for the external review to help evidence the gap and then work with senior leadership colleagues to request funding for the service that I have. But it is still a particular ongoing challenge at the minute. 17:19 17:20 17:20

368 Q. Last one. I mean if a member of the Trust Board came to you when you are in your governance role and said 'How can you assure me that your consultants are following up to date standards and guidelines? What assurance can you give me?', what would you have said to them? 17:20

A. I would have highlighted the challenge of the resource that we had to do it. I can't remember the exact numbers back then, but now there are over 3,000 guidance. 2,800, all of them are applicable to the acute service. They don't come with funding. 17:21

369 Q. But will you be able to assure him is what I am really

saying?

A. No.

DR. SWART: Okay. Thank you.

370 Q. CHAIR: Just a couple of questions from me and they are sort of linked. Going back to the whole issue of screening, do you think that part of the reason why the cases that we were looking at this afternoon weren't screened as SAIs was a reluctance on the part of clinicians that they may be asked to chair the SAI in the knowledge that they didn't have the time to do it and if they could resolve it more informally, that that was the road to take? 17:21 17:21

A. I hadn't thought of it in that way. I think if lessons were identified or learning is identified and they thought they could implement change, that that might have -- that may have been one of the things that they thought, okay, we know what's happened, we know how to potentially resolve that, and, therefore, we've done that bit and maybe leave the learning to some of the bigger cases where it was identified. So resource and the timeframe to do an SAI could potentially have been one of the reasons that they -- 17:22 17:22

371 Q. It might have been something that they thought about?

A. -- took into consideration would have been screening.

372 Q. Or subconsciously even? 17:22

A. Potentially.

373 Q. Secondly, you said in answer to Mr. Hanbury about getting a bodies of chairs, if that's the right expression, but people who would Chair SAIs; are those

internal people that you are talking about within the Trust or are you looking at external chairs who you can call upon to come in and do SAIs?

A. So currently we have some retired clinicians who have come in and agreed to do that for us to help progress some of the SAIs. But there still is the requirement to have the teams continue to input into them because it is hugely resource intensive. 17:23

374 Q. So if you could wave a magic wand and resources weren't an issue what would you like to see happen in terms, first of all, generally in governance and more specifically what do you think is the one thing that would help prevent something like this inquiry happening again? 17:23

A. I think resourcing the teams appropriately, having sufficient resource to, both - at all levels, so making sure we had the right resource to make sure that the clinical workload was doable, having the resource within the operational teams to make sure that there was managerial time to make sure that actions were taken. From a clinical governance team it's making sure that the right number of people with the right skill set, the right training, the right time were available to review the incidents, take forward the proactive work, the education, the training, the audit, the triangulation of information, having data analysts that can actually really delve into information and show it in a meaningful way and having IT systems that mean that information isn't a challenge of going to 17:24 17:24

lots of different systems to try and pull it together.
CHAIR: Okay. Well, Mrs. Reid, you will be glad to know, it's been a very long day for everyone here but we are finished. So thank you very much for coming along and I am glad you don't have to come back, I am sure you are too. Okay. Ten o'clock tomorrow, Ladies and Gentlemen. 17:25

THE HEARING WAS CONCLUDED 17:25