Urology Services Inquiry

Oral Hearing

Day 80– Tuesday, 16th January 2024

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

INDEX

THE INQUIRY RESUMED AT 10:30 A.M. ON TUESDAY, 16TH JANUARY 2024 AS FOLLOWS:

CHAIR: Good morning, everyone. Many apologies for the late start. Some of us have taken just over two hours to get here this morning thanks to the weather conditions but thankfully all safe and sound. I hope the rest of you didn't have as difficult a journey getting in. I think we are ready to start. 10:43

MR. WOLFE: Good morning. Your witness this morning is Mr. Richard Pengelly, and I think he proposes to affirm. 10:43

RICHARD PENGELLY, HAVING BEEN AFFIRMED, WAS QUESTIONED BY MR. WOLFE KC AS FOLLOWS: 10:44

1 Q. MR. WOLFE KC: Good morning, Mr. Pengelly. I am going to bring up on the screen in front of you your Section 21 response to the Inquiry. It is to be found at WIT-105892. You will immediately recognise that. I'll bring you to the last page at 105901. You've signed that, I think it was 21st -- 20th December. It is customary to ask a witness would you wish to adopt that response -- 10:44

A. Yes, I would. 10:45

2 Q. -- as part of your evidence?

A. Yes.

3 Q. If we could go back to the first page at WIT-105892, it sets out something of your background. You are

currently Permanent Secretary for the Department of Justice in Northern Ireland?

A. That's right.

4 Q. And you are here primarily because of the role that you occupied from 1st July 2014 through to 4th April 2022 when you were Permanent Secretary for the Department of Health, as we now know it? 10:45

A. Yes.

5 Q. Your entry into public service and your professional background, could you help us a bit with that. I understand that you are a qualified accountant? 10:46

A. I am. I try not to admit that very often these days. I trained in private practice originally and then I started in the audit office. In about 1997 I was seconded to what was then the Department of Finance and Personnel, it is now the Department of Finance. Then after that secondment, I stayed in the Department of Finance in various roles until, as my statement indicates, I was promoted to Permanent Secretary in the Department For Regional Development in January 2013. 10:46 10:46

6 Q. And a relatively short stint there before moving to Health, where you occupied the Permanent Secretary's role for eight years?

A. 18 months in DRD and just under eight years in Health.

7 Q. I want to spend a little time, I suppose by way of introduction, by seeking through your evidence to understand how the health and social care system in Northern Ireland worked during your time, maybe something of the difficulties and the controversies, 10:47

something of the culture and where you entered into it. The starting point, I suppose, is to say that provision for health and social care in Northern Ireland is governed by statute. We'll not open it at any length but we have the Health and Social Care Reform Act 2009; it obligated the Department to published a framework document. Let's just bring up the framework document, DOH-35616. It is obviously beyond the scope of your evidence today to devote too much time to this document, but suffice to say that it seeks to define the roles and the responsibilities of those public bodies that make up the health and social care arrangements in Northern Ireland? 10:48 10:48

A. Yes.

8 Q. Can I start maybe just by looking at an organogram set within the documents. It is at DOH-35622. Just so that we can see that, yes. The Inquiry, because of its Terms of Reference, is primarily interested in how a Trust operated - in this case the Southern Trust - but it is also interested in the operations in a particular context of various other of the organisations set out in this document. The Department, of course the Health and Social Care Board as it then was, it's now the SPPG, the PHA and, to some extent, the RQIA. So the Trust, the Southern Trust and the other Health and Social Care Trusts in Northern Ireland, and indeed the Ambulance Trust, they are known as Arms Length Bodies; is that right? 10:49 10:49 10:50

A. That is, yes.

9 Q. Can I ask you, in terms of the Department, how would it have engaged at the top with the Trust or Trusts at the bottom of this pyramid?

A. I think in the context of my tenure over eight years, the relationship evolved a little but certainly if I go back to the start, it was a very intermittent relationship. One of the points that it is important to recognise in the context of Northern Ireland is when we look at that organogram, that's a coalition of a large number of individual legal entities and organisations. In England, as I understand it, there is a legal entity of the Health Service and there is a standalone and designated Chief Executive of the Health Service. 10:50 10:51

Uniquely in Northern Ireland - and I struggled with this in July 2014 when I took up post - when I took up post, I was told not only I was the Permanent Secretary of the Department, I was the Chief Executive of Health and Social Care in Northern Ireland. Now, Health and Social Care is our name for the Health Service in Northern Ireland, we have a different name because the social care dimension is included whereas in England that would be a local authority issue. So I was also chief executive of an organisation that didn't exist in legal terms. 10:51 10:51

When I mentioned it, I think the relationship evolved. One of the issues I tried to bring was more a sense --

I felt at the start there was a focus on the organisation as opposed to a focus on the system so I tried to evolve a more system-focus. When I took up post, there wouldn't have been routine meetings between myself and, for example, Trust chief executives or the Chief Executive of the Health and Social Care Board, or the PHA. One of the early things I established was what I then called an HSC Leadership Group, where I brought the chief executives together to try and take some collaborative ownership of the system. Out with those meetings - and we can talk how that evolved over time - the normal mechanism for engagement with the Trusts would have been six-monthly accountability meetings with the senior management of the Department and the Trusts. Other than that, if a specific issue arose that required a discussion but there was no routine engagement, the only other thing just to record is that as part of my own entry into the world of health and social care, which I had previously not been familiar with, I tried to get out on a regular basis to health care facilities across Northern Ireland. But that wasn't part of the governance structures, that was more just a part of my own learning process in trying to understand the nuances of the health and social care system. 10:52 10:52 10:53 10:53 10:53

10 Q. I'll come to some sort of specific issues touching upon the Southern Trust in a moment but I am just interested in sort of a slightly higher level in terms of your specific interaction with Trusts. Was it you and a

couple of members, perhaps, of your senior team meeting your counterparts in the Trust every six months?

A. The process that was in place prior to my taking up the post, as I understand it - now this was under the heading of accountability - as I understood it, that process every six months would have been virtually an all-day meeting, with the morning session to seat the whole Senior Management Team of the Department and the executive Senior Management Team from the relevant Trust, and then in the afternoon some of the Non-Executives of the Trust would have joined the meeting. 10:54 10:54

My own view was that those meetings, the preparation for them - and everyone arrived at the meeting with two or three lever arch files of paper and this was happening every six months - these were incredibly busy people that were trying to run an incredibly busy service in difficult times. My own view too is that accountability isn't really a spectator sport, and true accountability requires potentially some hard conversations between me and the Chief Executive or Chair. So, I moved very rapidly that accountability meetings were myself, the lead sponsor from the Department, who would have been one of my Grade 3 colleagues, and just the Chair and Chief Executive of the Trust. It was a meeting that we tried to time limit to no more than one or two hours at most. I put an emphasis on my colleagues at other levels in the 10:54 10:55 10:55

Department to do what we called a ground clearing meeting, where some of the routine issues -- so that the meeting didn't become a piece of theatre and running through lots of issues. In a one- or two-hour focused meeting with a small cast list, we could focus on critical issues that required myself, the Chair and the Chief Executive to engage on.

11 Q. Yes. Could you give us a sense of what kind of issues would have reached that agenda? Presumably higher level policy type issues, or was it more practical minutiae concerns?

A. It would have varied depending. Because the ground clearing meeting, if there was an issue, the colleagues -- and the ground clearing would have been departmental colleagues and maybe director level colleagues in the Trust rather than with the Chief Executive. So if there was an issue but either an explanation or an assurance was being sought by the Department, if that was provided, we didn't need to redo that.

My conversations. If there was a very specific issue that crystallised through the ground clearing, we would deal with it. Other than that it tended to be a general discussion about overall Trust performance; we didn't tend to get into very specific service areas unless there was an acute problem. There would have been issues like senior staffing. Just, you know, succession planning, a forward gaze about issues that were coming down the track from the Trust, where the

Trust might need some support or engagement from the Department. My aspiration was really to build much more of -- although it was called an accountability meeting, it was really about underpinning the fact that this was a collaborative endeavour as part of health and social care in Northern Ireland.

The purpose of the meeting wasn't in any way for me to catch them out or make them feel uncomfortable if that was necessary to drive forward, but it was really about how can we best work together to fulfil our shared purpose of providing high quality health and social care.

12 Q. Yes. Obviously there are these other bodies sitting below the Department. We've heard in terms of the Health and Social Care Board that it had a role, and a regular or routine role, to meet with the Trusts to understand where the issues, particularly around performance and delivery towards targets and that kind of thing, that that was very much its focus or one of its foci?

A. Yes.

13 Q. Is that a duplication of what you were doing through your meetings in the sense that you needed to hear it as well but perhaps in a different way?

A. I think there was a more granular dimension. The Health and Social Care Board primarily had three roles in terms of their dialogue with the Trusts. There was commissioning of services, performance management, and

then the overall financial position. If I look at the performance management dimension, the Health and Social Care Board would have very much got into the weeds in terms of let's look at each particular speciality, let's look at the issues there. The overview performance conversations I would have had would have been at the macro level, the totality of performance by the Trust. So it wasn't duplicating it, it was trying to supplement it by saying let's take the big picture view of what the issues are, and are there any common threads in terms of. 10:59 10:59

It tended to be that performance across all areas broadly moved in the same direction because all paths tended to lead to both money and people, the availability of resources. From time to time, you would get a particular -- because of the fragmented nature of health and social care, if a Trust, for example if a senior consultant took ill for a period of months, that could have a very, very destabilising effect on that speciality within that Trust because of the fairly small size of the team. That's where the Board got into those sorts of smaller issues. As I say, I talked more about the thematic approach to the higher level position. 10:59 10:59 11:00

14 Q. Yes. Just also looking along that line, the PHA, the Public Health Agency --

A. Yep.

15 Q. -- its focus was on improvement in health and

well-being, health protection, service development, according to the framework document?

A. Yep.

16 Q. Again, how did that work from your perspective and what were you seeing of the PHA's activities with the Trusts? 11:00

A. The PHA's activities with the Trusts, my sense always was PHA tended to work very much hand in glove with the Health and Social Care Board, but others will be more expert than I in this area. As I understand it, the 11:01 reform of the structures in health and social care in Northern Ireland in 2009, at that stage, you know, prior to the one Health and Social Care Board, there was four area boards for health. As I understand it, back in sort of 2008/2009 there was a very strong 11:01 debate about whether that should all be replaced by one organisation, so you would have had essentially HSCB and PHA combined. I am led to believe, and it predated my time, the then minister was uncomfortable that this would have been one unwieldy organisation that would 11:01 have been simply too large.

But for me, the best illustration of how closely they had to work together, PHA, which was a big organisation with a big budget, for example, it never had a finance 11:01 director so they shared the finance director with the Health and Social Care Board. I am not suggesting we get into the nuances of that but, for me, it indicates how closely the organisations were aligned. In terms

of the HSCB consideration of commissioning, PHA colleagues would have sat alongside them while they did that, so it was a very much a twin track approach by both organisations.

17 Q. Chair, I am receiving a lot of... I am trying to avoid the distraction; it is feeling like a distraction now. 11:02

CHAIR: There was a drilling going on with the development at Forestside and I don't know if that thumping is part of that or not.

MR. WOLFE: It is more a ringing. (Pause) I was curious as to whether it might be a phone in a nearby office but maybe not. Okay. 11:02

A. It's my staff outside trying to put you off!

CHAIR: I think we're just going to have to put up with it. We can't hear the ringing up here. 11:03

A. I can hear it.

CHAIR: I can hear the thumb more than anything, of the drill.

A. It is something vibrating after the bump.

MR. WOLFE: I am just concerned it might affect the witness but we are all in the same boat. 11:03

CHAIR: If we can continue on for a while. If it gets unbearable, please say, and we'll have a rethink.

18 Q. MR. WOLFE KC: The RQIA, it was responsible, according to the framework document, for keeping the Department informed about provision, availability and quality of services, promoting improvement, and for reviewing and reporting on clinical and social care governance with some registration and enforcement work. Again, did you 11:03

have direct or indirect engagement with the RQIA and get to see how they functioned?

A. As was the case for Trusts and as is the case for all Arms Length Bodies, of which RQIA was another one, I would have had the six-monthly accountability discussion on the same basis with the Chair and the Chief Executive. In terms of, I wouldn't have then -- the sponsorship for RQIA fell under the Chief Medical Officer's group and there would have been dialogue through there. 11:04

As I recall - and everything I say obviously will be to the absolute best of my memory but two years out of health, forgive me if I am on some of the details - RQIA's work programme from my perspective fell into two components. There was inspection activity, which was a rolling programme; most cases of unannounced inspections, which is an established way. They then had a review programme where there would have been some input from senior colleagues in the Chief Medical Officer's group to say here are particular areas where we would appreciate an RQIA perspective in terms of the quality and efficacy of service provision. I personally wouldn't have been routinely part of that dialogue but it was a dialogue that took place at senior level within the Department. 11:04 11:05 11:05

19 Q. Obviously you were there for eight years?

A. Mhm-mhm.

20 Q. You've suggested, I think, that your initial sense of

it was, particularly with the Trusts, maybe a lack of cohesiveness, thinking about themselves as organisations as opposed to the whole system. As things evolved, as you indicated, did that kind of cultural difficulty, as perhaps you perceived it, change? Were you able to secure any adjustment or variation in it?

A. I would say yes, very much so. But I would say that this was a personal agenda of mine, I would like to think we had some success. 11:05 11:06

With your indulgence, I could give you two short illustrations of this. This is as much a cultural point as a point where I could offer you a very, very clear set of metrics. A year or two into post, looking at a set of performance figures, there was a performance area for breast cancer where there was a 100% target for where a GP red-flagged a patient, that the patient would be seen in 28 days by the relevant Trust. If I looked at that time across the 5 Trusts, two Trusts were very, very close to 100% performance, in the high 90s; two Trusts were less than 50% performance. When I asked the question, the explanation was that within the two Trusts who had very poor performance, they had lost a couple of senior consultants on sick leave and they just weren't able to do it. 11:06 11:06 11:07

I asked the chief executives but how many of your

patients did you send to the other Trusts then you had a full compliment, or how many of the consultants from other Trusts took a session in your Trust, and the response was but you judge us on our organisational performance so why would other Trusts help us out to the cost of their performance. That in many ways underpinned my view, and the conversation I had with Trusts was this is very much about your contribution to regional performance, that is the benchmark that we will judge you, we need to look at your performance as a component of that. 11:07 11:07

If I turn the clock forward a couple of years, do I feel we made progress? I remember one time I was in my car driving to a meeting somewhere and it was on the radio about a crisis, I think it was at the Royal, with emergency department that patients queued out the door. In the duration of that phone call, two Trust chief executives phoned me to say we see there is a problem at the Royal, how can we help? For me, that was a real soft indicator of the cultural shift that we had achieved. 11:07 11:08

Just it's important that I pay tribute to Trusts for that. This wasn't the case that I had forced them to do something they didn't want to do, this was a case where they realised they had permission to do the thing that they always wanted to do. Trusts always wanted to focus on regional performance and do the right thing 11:08

but they felt there was a system constraint against it. I wasn't driving the improvement as much as facilitating and allowing it to happen naturally.

21 Q. Leaving the concerns of this Inquiry I suppose to one side, and just to reflect I suppose what might be a public perception that all isn't well with the health and social care system in Northern Ireland - and much of it I suppose is viewed as a difficulty caused by the structures, the organisation is not set up to be at its most efficient and that has in turn implications for budget and what can be spent and the efficiency of the spend - was that a difficulty through your time or what were, if you like, the three main challenges or difficulties that occupied your time during those eight years? 11:08 11:09 11:09

A. I mean if I could talk about my eight years, I think breaks down to a number of different issues. You know that period when I took up post in 2014 through to the end of 2016, at the end of 2016 we launched the transformation strategy Delivering Together, which was predicated on the Bengoa work. We then had a period from early 2017 until early 2020 where we had no ministers. In many ways it was care and maintenance in the absence of a new policy steer. Then early '20, we had Covid. 11:10 11:10

The point you make about is all well in the social health and social care system; the Transformation agenda recognises that up until 2014, waiting lists,

which tend to be the key marker certainly in the eyes of the public and the media about the health of the health and social care system, waiting lists were in a reasonable place but that was purely because there was sufficient buoyancy in the public expenditure system that money was available through the in-year monitoring process to allow the system here to run waiting list initiatives. So the capacity didn't exist within our system to meet the demand that was placed upon it but the availability of additional money meant that we could, through waiting list initiatives, secure additional capacity through the independent sector. When the public expenditure position changed in 2014 and waiting list initiatives ceased, all we were left with was the capacity within the system, and demand easily outstripped that. That was the start of the journey that brings us to today. The transformation journey is about trying to better align demand and capacity.

11:10 11:11 11:11

The points you make are absolutely right; there is structural inefficiency in our system. We have, in many cases, too many small, unstable units providing health care as opposed to fewer, larger, and more resilient. With that greater resilience comes greater efficiency and greater throughput.

11:11

I just emphasise finally, that is absolutely not to say this is a Belfast centric. The health and social care

system needs to be a regional service and needs to make services available across all parts of Northern Ireland. It is just that not every service needs to be available in every location; centres of excellence can be allocated throughout the province. But that would address that inefficiency point.

22 Q. I want to come to look at waiting lists specifically in the Southern Trust in Urology in a moment. Can I introduce that area by asking you, I suppose more generally, sitting in Castle Buildings, I know it's not an ivory tower, you do, as you have explained, have frequent interaction with the Trusts. There is the diary bound commitment to meet them on a regular basis. Any other interaction apart from the diary commitment with the Southern Trust in particular over the eight years or so you were in post? 11:12 11:12 11:13

A. The other interaction with them, there is the category I previously mentioned, that just as part of my own learning and development, I made a point of trying to get out to visit locations across the health and social care system to meet staff. Personally, I found it hugely important in my role to make sure that I heard what nurses and porters and occupational health staff and what colleagues on the ground were seeing as challenges, layered alongside what I was hearing from my very senior colleagues. Because quite often when I went out to visit a facility, I heard a story that was markedly different from what I could distill from what I was being told at a very senior level. So there was 11:13 11:14

routine engagement across all Trusts in terms of getting out and meeting and greeting.

Where a very specific issue bubbled up, there may have been need for a conversation, and that just happened sporadically. The other issue on top of the accountability meetings would have been just the financial agenda as part of the annual budget cycle meeting with Trusts to try and understand it. In terms of particularly with the Southern Trust, that dialogue, the big issue in that and what would have led to other conversations was the significant concerns at Trust level - that predated my arrival and continued throughout my time - was concerns just about Craigavon Area Hospital and the need for a new build. That was a clear priority for the Trust, and rightly so. There was money invested in the sort of care and maintenance basis, but there would have been an ongoing dialogue about the possibilities and likelihood of trying to secure the very significant funding needed for a rebuild of Craigavon Area Hospital. 11:14 11:14 11:15 11:15

23 Q. Mrs. Brownlee in her statement recalls introducing a Trust Board away day initiative; it tended to be November, I think was her recollection. She points out that Permanent Secretaries - she didn't name anyone in particular - regularly - sorry, "occasionally" was the word she used - occasionally attended those. Is that something you attended with the Southern Trust? 11:15

A. It is. I definitely can recall at least one and I

think possibly two occasions where, from memory it was in a local hotel in the Craigavon area. I would have went down, met with the Trust Board. I think the typical format is I would have given a short overview talk about the world from my perspective, a 10 or 15 minute talk, and then a Q&A session just in any areas of concern or a purely information basis. My sense was that they were very effective sessions in terms of building a cohesion among the Board, and it was a good opportunity to meet with the non-executives and have that conversation. 11:16 11:16

24 Q. Yes. You have referred to, I don't know if you meant specifically meeting, you know, occupational therapists and porters et cetera at the Southern Trust, and maybe you didn't mean the Southern Trust specifically, but equally you had met the boards specifically and there would have been interaction with Mrs. Brownlee and her NED team. 11:16

A. Mhm-mhm.

25 Q. Any noise emerging from those various interactions about life in the Southern Trust, quite apart from the fabric of the building issue at Craigavon? 11:17

A. The only other issue that I can recall being aired at that, and it was possibly as a consequence of the point in time, was senior executive leadership, because I think at that stage, certainly the first one, there would have been an Interim Chief Executive in post. There would have been a dialogue around the plans in process to run a recruitment competition to replace, to 11:17

get a substantial chief executive in. As good as the interim was, a substantive chief executive is always more desirable.

26 Q. Mrs. McAlinden was the Chief Executive for a number of years? 11:18

A. Yes.

27 Q. Then the Southern Trust fell into a situation where, as you pointed out, there was a series of Interim Chief Executives over a period of time --

A. Yes. 11:18

28 Q. -- before Mr. Devlin's appointment in the spring of 2018.

A. Mhm-mhm.

29 Q. That uncertainty around leadership, the absence of a permanent chief executive, was that coming back to you 11:18 as a difficulty in allowing, I suppose, the Trust to put down roots and move forward in a coherent way?

A. It was. I just want to make sure my language isn't clumsy; it was never raised with me in the form of a concern about the individual that was undertaking the 11:18 interim role, it was more the systemic point about a substantive post-holder would be better than an interim just in terms of the authority of the individual. So it was an issue that was raised.

11:19

I think, reflecting back on this in recent days, from memory one of the issues that we were trying to manage on a regional basis at that time was there was at least one, possibly two, other vacancies in other Trusts at

Chief Executive level, and it was about trying to sequence going to the market so that we didn't have three Trusts going to the market at the same time and competing with each other. Undoubtedly there was a longer period than was ideal where there were Interim Chief Executives in place, but again that was just as a consequence of trying to manage the regional perspective to that. 11:19

And, sorry, when we did go to the recruitment competition, there was a competition that was ultimately unsuccessful in appointing one, a chief executive, and so we had to rerun that and that caused a delay. 11:19

30 Q. I want to offer you the reflections of Eileen Mullan, who has given evidence about the instability which has been visited upon the Trust both because of the inability, some might call it the failure, to appoint a chief executive on a permanent basis in a timely fashion, and also the difficulties around NED appointments and the absences, as she perceives it, of adequate succession planning. 11:20 11:20

Let me just put that up for you and take your views on it. It's WIT-100468. If we start at 16.6 on this page. She refers to the Board's governance self assessment recognising the risk to the stability and effectiveness of Trust Board as a direct consequence of vacancies at senior executive and non-executive 11:20

director level. She set out the actions to address this. She says in her experience having instability in the Board and senior executive team impacts on the Board of the governance structures. She sets out something of the history of difficulties and goes on to say that the appointment of Dr. Maria O'Kane as Chief Executive in 2022 has seen the followthrough of completing the structure and recruitment of permanent and substantive posts across the senior leadership team. 11:21 11:22

So it's instability, it's impact on governance. Then, when invited to do so in her evidence to the Inquiry last week - I needn't bring this up on the screen but just to precis what she says - she emphasised that the need for succession planning hasn't been adequately recognised, she thought, on the part of the Department. She said that it's not up there with the top 10 things the Department of Health is keeping an eye on. She says succession needs to be thought about the moment you appoint somebody, and she has pointed to some work which your successor, Peter May, is taking forward in order to try to address that kind of difficulty. 11:22 11:23

Were you aware that things were suboptimal in terms of managing and planning for both Executive and Non-Executive appointments in Trusts? 11:23

A. I would -- I think we maybe separate these into three categories. I think the Chief Executive post, we have

covered; there were issues, there was a regional perspective to it. If we separate then Executive Directors other than Chief Executive as distinct from Non-Executive Directors. Succession planning, I mean I would be involved in recruitment process for a chief executive at Trust level but I wouldn't be involved in recruitment process for Executive Directors. 11:24

31 Q. Of course.

A. Issues about succession planning and running competitions, they are issues for the Trust as the employer in terms of Executive Directors. 11:24

Non-Executives, it is the role of the Department to run the competition and appoint. I think lumping the two of those together is potentially misleading. I would say it is very much for the Trust. 11:24

I would absolutely agree, succession planning is important at Executive Director level and that should be part of the regular management conversations within the Trust. 11:24

In terms of Non-Executives, there has been a difficulty. I cannot, and forgive me, recall the specific date but at a point in time if I go back, within the Department the process for running a competition and appointing non-executives for a Trust would have been done at different branches within the Department, because there was different areas dealt with different Arms Lengths Bodies and it would have 11:24

been the sponsor area. Recognising the holistic nature of this in the Department, we created a central public appointments unit to take this forward.

I wouldn't push back against Eileen's comments in terms of the importance of succession planning but we now have a central public appointments unit which are responsible for 160 appointments across, I think, across 19 Arms Lengths Bodies. From memory, the last public appointment competition for Trust Non-Executive Directors elicited in excess of 100 applications. If at a point of time there is a couple of vacancies in one Trust, with a central approach and given the regional perspective to this -- and I think personally it's a good thing that the Non-Executive cohort in the Southern Trust isn't exclusively drawn from the Southern Trust area; there is a different perspective. So sometimes the centralised public appointments unit will wait until they have a critical mass of vacancies to run a competition, particularly because running one competition with over 100 applicants that you can assess and interview, making appointments to a number of Trusts, is infinitely better than running three competitions where you may get close to 100 applicants for each competition. 11:25 11:25 11:26 11:26 11:26

Again, and sadly because people will tire of me saying this, all paths lead to resourcing. We have a resourcing crisis in health and social care. I can

recall in 2018 one of the local newspapers ran a story based on a statistical publication that came out that shows the make-up of the workforce. I can't remember the exact percentage figure but the headline was X percent of Health Service staff are penpushers. If you want to run a governance system and you want to run a central appointments position and if you want to recruit people, you need administrative colleagues to do that. There is a battle to get money to the front line; that's understandable. 11:27

Within the Department, as much as we would aspire to deal with every vacancy as it arises so that there is a seamless transition, we have to factor in the resource envelope and how we are equipped to do that. 11:27
Colleagues in the Public Appointments Unit in the Department I would argue do a heroic job in terms of the demands that are placed upon them. It means from time to time there may be some unfortunate gap, but we try to minimise that and manage it as best we can. 11:27

32 Q. One of the particular issues she raised in her oral evidence was there is something of a glut of appointments amongst the Non-Executive Directors in 2016 and 2017. In essence, she was explaining that in the next 12 months or so, she is going to lose all of 11:28 those experienced, skilled Non-Executive Directors and that's going to create a continuity issue. In essence, her concern was it is not well thought out, the appointment periods; it needs in some sense to be

staggered perhaps so that you don't bring a collection of new bodies into the room all at the same time?

A. As I say, I'm not familiar with the particular detail of that but it sounds it's not an unreasonable point about staggering the appointments. 11:28

There is another issue and I don't know if it's relevant. From memory, I think in legislation the maximum time for an appointment is 10 years. There is an initial appointment and that can be extended. There 11:29 has been a very, very strong push by the Commissioner for Public Appointments that there are no automatic renewals. It used to be the case that appointments - and this goes beyond health - if an individual was appointed as a Non-Executive director, they are subject 11:29 to annual performance appraisal. If performance across the first four-year appointment period was satisfactory, it would have been a fairly automatic reappointment. The latest push from the Commissioner of Public Appointments, and certainly in my current 11:29 department, my last minister was very, very clear that we wouldn't ever do any reappointments, there would have to be a competition. That in itself can cause an additional dimension to this issue where previously you would have assumed that when appointed, somebody would 11:29 be in post up to 10 years; that's maybe only four years and there is another dimension to it. The staggering point, I think, is well made.

33 Q. I want to move on to the specific issue of the

pressures faced within Urology, particularly at the Southern Trust. Can I introduce this area by just picking up on a particular document which poses some questions and hopefully you might be able to help us with aspects of it. DOH-12115. This is described as coming under the heading of DOH policies. It's explained that -- in fact, if we could just bring it back a page to start with.

11:30

I know that you've had an opportunity to look at this document. It appears to be a road map of some description or a definition of documents setting out where Urology sits in Northern Ireland, where the services are provided, and some, I suppose, current topics and trends. How would you describe the document and its purpose?

11:30

11:31

A. My sense that the purpose of this document -- if I take you back to the Bengoa report that was published, I think October 2016, October/November 2016, which was precursor of the Delivering Together transformation strategy, the Bengoa document highlighted a number of speciality areas that should be subject to a review and they grouped them into various priorities. I think Urology was what they termed a Priority 2 area. So, it was an area that was highlighted by an independent report where the service provision needed review, but it didn't kick off immediately. My sense is this document was fundamentally about trying to assemble an overview of the current position as regards Urology,

11:31

11:32

have that documented so that when the resources became available to take the review forward, there was a readily accessible starting point. It was an attempt. It wasn't in and of itself the start of a review but it was about capturing some baseline information so that when a review did start, that could be accelerated and that process didn't need to happen at that stage. That's my sense of what this is.

34 Q. Yes. Of course, there had been a review in 2009?

A. Yes. 11:32

35 Q. And a green light, as we'll see in a moment, to implement the recommendations of that review was only given in 2010. Is it your sense that although the review was just recently in the rear view mirror, there was a plan for a category 2 further review pursued? 11:33

A. Well, the 2009 review which I think, as you say, implementation commenced in 2010, there was all the architecture around there, I think there was 26 recommendations that flowed from that review. We then commissioned an independent external report which 11:33 identified Urology as an area that should be subject to a further review. So this was the ground clearing process for that.

36 Q. It's stated here rationale, there is no standalone departmental policy for Urology services. I suppose 11:33 the point might be made given the state of Urology Services in terms of the struggles in delivering against the demand for those services that we can observe in the Southern Trust, is this not the kind of

service that would benefit from a standalone departmental policy? What's the significance of that line?

A. I must confess that I don't understand that line. I would have thought if I have articulated to you my sense of why this document produced, I think a precis of what I've said - I'll spare you repeating - that should have been the rationale for this, something to prepare the ground for the Bengoa recommended review of Urology. 11:34

In terms of there should be a departmental policy, I think I would disagree with you on that point because I can't envisage what a departmental policy for Urology would look like. I think certainly we would need a set of clinical guidelines and clinical standards; that wouldn't be for the Department to produce. You know, I could argue that Departmental policy for Urology should be that we provide timely, high quality Urology Services. I'm not sure what a Departmental policy could add in this area. 11:34 11:35

37 Q. It might, in recognising the challenges faced by that service or that discipline, develop, and the policy could be used to give direction in terms of meeting that challenge? 11:35

A. But the Departmental policy... I mean, there's no standalone Departmental policy for Urology Services, Urology Services is but one discipline across the broad spectrum of health and social care. Departmental

policy enshrined in many other areas is that the policy is health and social care services will provide high quality services on a timely basis. Because if you do it for Urology, you do it for every -- I just genuinely would struggle to imagine what a Departmentally determined policy for a speciality area would actually contain or look like or what it would add.

38 Q. So would we be wrong to read that as for implying for some services, there is such a thing as a standalone Departmental policy? 11:36

A. That would be my position, yes.

39 Q. If we scroll down to page 17 in the series, a couple of pages down. At the top of that page, it refers to the regional review which I spoke about just a moment or two ago. It says that the main recommendations of the 11:36 review aim to improve capacity for the delivery of Urology Services, and summarises some of the main features of those recommendations: Including increasing the number of urologists in employment; the number of clinical nurse specialists; centralising some 11:37 surgeries in the City Hospital; increasing the proportion of elective surgeries undertaken as day cases, and deploying a three team-model, again bringing some element of centralisation to that service.

11:37

The document goes on. If we just scroll down to the top of the next page, it refers -- this is under the heading of "lines to take". Again I preface this question by recognising that you're out of Health

several years but if you can help us with this. Under "lines to take", that's generally a signpost for dealing with the media, or dealing with politicians perhaps asking questions in committee.

11:38

"A regional review of Urology services completed in 2009 resulted in a number of recommendations. The Department is awaiting an implementation report from the Health and Social Care Board".

11:38

Just alongside that, if I can just take you to a particular piece of correspondence which might be relevant in this context. It's at DOH-12120, and it's a letter from your Department to the Health and Social Care Board, again 2019. Scrolling down, please. It's 11:39
asking the Health and Social Care Board to deal with something called a post project evaluation. I don't know if that's talking about the same thing as an implementation report from the HSCB. Can you help us with any of those concepts? 11:39

A. Yeah. There is obviously a sense that I am trying to rationalise what I read before me as opposed to give you the version of events. My sense is a PPE, a post project evaluation, is a piece of work that should be completed after the conclusion of any project or 11:40
programme that's implemented. It is designed to articulate what were the planned benefits of implementation of this project or programme, and were those benefits achieved, are there any lessons to be

learned about how this was taken forward. So it's a neat summary of what did we intend to do, what did we actually do, was it successful. In the context of your very specific question, I suspect the reference to an implementation report in the "lines to take" may be about the same thing, that whoever drafted the "lines to take" was just referring to the PPE as the implementation report. 11:40

I would take the view that the review completed in 2009, implementation started in 2010. As I understand it, there was an Oversight Group put in place to monitor the implementation of the 26 recommendations. That would have continued, it would have finished. My view is that this is about preparing the way for a subsequent review. Whoever was doing this decided that the PPE would be a very neat summary because the PPE, by definition, would be completed after the conclusion of the previous implementation phase and it would neatly summarise what was the ambition of the previous recommendations and the extent to which they were achieved. 11:40 11:41 11:41

I am sorry if I'm being slightly opaque. I don't see this as being part of the systems to ensure the previous 26 recommendations were implemented - that was a separate piece of work that would have concluded - but rather this was somebody coming in later saying we are starting a new review, where is the neatest place I 11:41

can go to find an overview of how the last review finished. Is that helpful or clear?

40 Q. Yes. I suppose in a way it had been framed, both in the first document I showed you as well as this letter, there is perhaps a sense that the Department is waiting on something, perhaps with a degree of exasperation, waiting for something to be completed. I suppose I wondered whether it reflected any kind of disinterest in seeing where Urology was at? 11:42

A. I don't think so. As I say, I think this was a fresh piece of work at some remove from the previous review and implementation of those recommendations. This was about just establishing what the starting point is for a new piece of work. I personally don't get a sense of any implied frustration. I mean, I think there may be a bit of frustration that we asked for the PPE and we haven't got it yet, but that's distinct from the process of implementation of the previous recommendations from the review. 11:42

41 Q. We know, as you've have rehearsed 2009 review, recommendations go to the minister and, post consultation, he approves them, and this is obviously several years before you come into post. When you come into post in the Department, or at or about that time, there is a further, if you like, mini review. There is a stock take if you like; I think that's the phrase that was used. We can see, just bringing up WIT-52055, this is the Southern Trust's response to the 26 recommendations. It's kind of the stock-take outcome, 11:43

if you like, or update is set out on the right-hand margin in response to each of the recommendations. I'll take you to one or two examples just to illustrate the point, but there is a sense across these recommendations that one of the major obstacles to progress is recruitment, is staffing. 11:44

Let me give you an example or two. Recommendation 6, if we scroll down. It refers to the recommendation concerning the deployment of new consultant post and that they should take into account areas of special interest that are deemed to be required in the service configuration model. The Southern Trust is saying: 11:44

"Consultant turnover is only just settled with a consistent one person deficit to date". 11:45

That gives you a sense, four years or so down the track, they've been frequently battling to get the resources in place to deliver on the proposed model. 11:45

We can see recommendation 11, scrolling down just a little. The issue in terms of the recommendation is that Trusts will be required to evidence in their implementation plans delivery of the key elements of the elective reform programme. Part of that was, as we have seen, trying to get more day cases through the system. The Southern Trust respond: 11:45

"This remains an issue due to the deficit in staffing both at consultant and middle grade level",

although some positive noises around day of admission, preoperative assessment, et cetera. 11:46

Just a final example before I put the point, recommendation 26, just scrolling down. There we are. The recommendation is that:

11:46

"Each Trust must work in partnership with other Trusts within the new team structure to determine and agree the new arrangements for service delivery".

Again: "This is not complete due to the delay in recruitment of the full teams". 11:47

This issue concerning recruitment, which is hamstringing the efforts on the part of at least the Southern Trust to move forward with full implementation of the Urology Review, was that something that was 11:47 getting your attention specifically?

A. Not specifically in the context of Urology but the generality of the point. Just there were system level concerns about - arguably it was every thus - about the availability of experienced staff. I suspect every 11:47 Trust in every discipline will experience difficulties with recruitment and retention. The Departmental dimension to that is, and I would need to check for you the date that it was put in place, but there was a

debate within the Department and I think it was highlighted that there could be a conversation where necessary about recruitment and retention premium to the extent that salary was an inhibitor. Because the medical workforce is particularly mobile, unlike many, 11:48
many other workforces, and not just at a UK level but on a global scale. In most jobs you are competing with the opposition down the road; we are competing across the world. To the extent that terms and conditions and salary were an inhibitor, there was the possibility. 11:48
But that's the level of dialogue the Department would have on this issue about the Trust then, a relevant Trust in a specific area making a case about why a recruitment and retention premium might be needed, as opposed to fundamentally consultant recruitment is an 11:49
issue for individual employers and Trusts.

42 Q. Can I show you, just for illustrative purposes, something of the waiting lists that the Southern Trust was having to grapple with, particularly in Urology. I think it's interesting in this context. If we go to 11:49
TRU-98238. This table, if we just blow it up a little, is the Southern Trust, it's the number of patients waiting on a consultant-led first appointment for regional urology speciality by a consultant. We can just see at the top margin, the run date is 16th May 11:50
'16, so this is four years after the implementation has commenced of the review recommendations. If we scroll across to the right-hand side, we can see that the number waiting more than 52 weeks to see a consultant

for a first outpatient appointment is 420 patients, with 2,743 waiting overall.

If we go forward three years to April 2019 - let's bring up TRU-98241 - we can see that the numbers 11:50
waiting more than 52 weeks has increased from 420 three years earlier to now more than 2000, with more than 3,735 waiting overall. Then after the pandemic in 2021, the measurement for those waiting more than 52 weeks jumps to nearly 3,500; I needn't bring the table 11:51
up. These kinds of waiting lists, this one is for first Outpatients appointment, we see similar difficulties on other indices, in-patient day case waiting list; we also see problems around meeting the ministerial cancer targets. 11:51

You said the Department is challenged to develop policy around, for example, recruitment incentives by way of example. To what extent is the Department seeing the on-the-ground difficulties manifested in pressures on 11:52
staff and morbidity for patients? To what extent is that part of the conversation?

A. No, it would be a regular, I mean nearly a dominant factor in the conversation in Departmental level but it wouldn't be at the level of individual speciality, it 11:52
would be in the overview position.

If we go back, previously we touched on the responsibility of the Board. We would aggregate all

this information up. I said the financial pressures and the funding positioned changed. If I go back to July 2014 when I took up post. When I took up post, July 2014 was three months in to the 2014-2015 financial year; at that stage the Health and Social Care System in Northern Ireland, from memory, was forecasting an overspend of £160 million, so the big job of work for us was to try and bring us back into balance. The financial difficulties continued. I think the consequences of that are expressed best by Rafael Bengoa in his report because he talked about the importance of transformation and that transformation is about systematic change and improvement; the alternative to no transformation is fragmented and unplanned change. 11:53

That's the context we were in here. We were running out of money and so we had no ability to do external waiting list initiatives; we didn't have sufficient capacity within the system to keep pace with demand. At a Departmental level, it was dominating our thought process when we looked across the spectrum of all activity, it was the same trajectory everywhere. To the extent that we secured additional funding, any time we did, with the Board having responsibility for the granular detail of financial allocation and performance management, we would have passed that to the Board in the context of here is a sum of money we have secured to try and do something with waiting lists. The Health

and Social Care Board had the granular analysis of the speciality-by-speciality analysis of where the particular hotspots and problems where, and they would have in turn turned that into a specific allocation for specific areas at Trust level, whereas we would have dealt with the overall acquisition of additional funding. 11:54

43 Q. You talk about the difficulties financial post 2014. Was the effect of that -- let me ask it in a different way. When the times were good and money was available, it didn't provide for recurrent spending; in other words, foundations weren't put in place -- 11:55

A. No.

44 Q. -- for building capacity for the long-term, they were - forgive the cheap analogy - a sticking plaster dealing with waiting list initiatives as a one-off? 11:55

A. Yes. I would caveat this comment by saying hindsight is a wonderful thing, and I don't want to be the Smart Alec in the room. Looking back, for a sustained period of years additional funding was available and that funding was used year on year for external waiting lists initiatives. I would argue the better use of that money would have been to develop internal capacity within the system on a sustainable basis. Now, there would have been an element of doing that at risk because the funding was coming through - I will not take us down the wormhole of financial processes - that was coming through the in-year monitoring process as opposed to a budget baseline addition, so there would 11:55 11:56

have been an element of risk. But I think it would always be a risk to build capacity to deal with an accumulated backlog because you only need to deal with backlog once and if you build the capacity once, you are left with a capacity at cost. 11:56

But it was clear in 2010 through to 2014 that the annual year on year demand was outstripping capacity. So, increasing capacity was a low-risk appropriate response to that, and it wasn't done. As I said, I 11:56 suspect there were other issues at play by all my predecessors, and I don't want to be unfair to them but with the benefit of hindsight, I think that approach wouldn't have eliminated all the problems we face today but I think we would have had a slightly, at least a 11:57 slightly higher line baseline capacity going into these series of events.

45 Q. Indeed the 2009 review talked, as I mentioned earlier, of the objective being to improve capacity for the delivery of Urology Services. You look at those 11:57 waiting lists and you probably can't avoid concluding that in terms of the objective of the review, it hasn't succeeded; many good reasons for that perhaps. But do you consider it naïve to try and drive in the direction of that kind of objective without the kinds of reforms 11:58 suggested in Bengoa?

A. I don't think we'll make any material headway in terms of addressing this problem without material and fundamental reform of the way we provide health and

social care. I think just on your point about whether or not the review was a success or failure, I think always there is two stages to reviews. The first stage of the review is to determine what is it we should do to achieve the results we want to achieve. I think the review arguably was successful and it came up with a pathway to success, 26 recommendations. There is always a problem in the public sector in terms of implementation of any review because we now know what we need to do, the question is do we have either the money or the capacity to actually deliver that. The key constraint here was the money wasn't available for that capacity building, combined with some workforce issues, even where the money is available, about an inability to recruit experienced and skilled colleagues. 11:58 11:58 11:59

46 Q. Just one final area around this point. It's been a flavour of some of the evidence received by the Inquiry that for a certain number of years, and probably you've hit the nail on the head in the post-2014 period, there was this emphasis running through the Trusts, the Southern Trust in particular, on budgetary break-even, on, if you like, cutting corners or taking out of the provision any emphasis on quality, any emphasis on audit to ensure that risks were being well managed. These kinds of issues were viewed as almost as luxury items that the Trust could no longer afford. We heard this in particular through the evidence of Dr. Simpson, who was Medical Director for a number of years. Some 11:59 12:00

of the employees who had previously worked in governance type roles saw that really this pressure to break even and budget delivery was overwhelming them and taking emphasis away from where it should be.

12:00

If you accept that as the premise of their evidence, can I ask you this: Was that the kind of message that the Department felt compelled to, I suppose, deliver to the commissioning body the HSCB?

A. I want to be absolutely unequivocal on this, I absolutely and fundamental reject any assertion that we would ever compromise on quality. Quality is not a negotiable dimension to the provision of health and social care. By quality, I mean it has to be at the minimum acceptable level of quality. There may be an issue about whether you are into the territory of gold plating something, and that's particularly when money is tight. But let's adopt the definition by quality, we mean it is of a sufficient quality and it is safe. That is not negotiable. But you can't separate that from the provision of budget because, at the end of the day, you can only spend the money you have. If you run out of money, you stop providing any service.

12:01

12:01

12:01

I would also argue that waiting lists and growing awaiting lists are a manifestation of quality. Somebody who needs a surgical intervention sitting on a waiting list for two years, nobody can say that is quality. So, these are all dimensions to the same core

12:02

issue.

There has been a very public debate over the last 12 months in the absence of ministers about some of the decisions across all departments Permanent Secretaries are taking. That is all a manifestation of money. For the financial year just ended, '22/'23, we received a budget in November 2022. You can only spend the money you have. So, the awful decisions that were being taken by myself and my colleagues was a consequence of the fact that when the money starts to run out, you don't save money where you should save money, you save money where you physically can save money. So, a longer term perspective on things sometimes, you know, you could save money on some areas that would have a very low impact. I make that point because that's the territory we are in here. You can't ignore financial management and adherence to budgetary conditions and say somehow we will forget about that and focus on quality because when the money runs out, quality is swept off the chessboard completely. 12:02 12:02 12:03 12:03

It's not a choice; services must be provided to a level of quality. Certainly I know for a fact if I went to my medical colleagues in the Department of Health and said I want a conversation about slipping in quality, they would have thrown me out of the room in a heartbeat because all their instincts, their professional training, everything they stand for was 12:03

about driving forward the quality agenda. It was doing it in difficult and turbulent times but we would never compromise on that. Sorry for that lecture but I absolutely reject the notion that we compromise on quality.

47 Q. Nobody is suggesting that the clinicians and the nurses and all of the team that make up the delivery of care, nobody is suggesting that they are not aiming to do their best and not aiming to keep patients safe, but behind all of that is governance. 12:04

A. Mhm-mhm.

48 Q. And there are, in order to keep people safe and to ensure that safe processes are in place and that people are delivering in accordance with the recognised standards, you need that governance infrastructure? 12:04

A. Mhm-mhm.

49 Q. You need, for example, resources being devoted to audit so that checks can be maintained?

A. Yep.

50 Q. And certainty achieved in terms of what is being delivered. The sense of the evidence, and the Panel may speak to you on this, the sense of some of the evidence was that those features were being stripped out because the money wasn't there. They were the sacrifices that had to be made, so in that sense quality couldn't be guaranteed? 12:05

A. No. Sorry just to go back, I think there are two parallel issues here. The first issue, I absolutely acknowledge that no nurse or doctor is saying they put

patients at risk or jeopardise patient care, but there clearly is - and I read it in some of the documentation - there was an assertion that somehow, when it came to these conversations, the Board and the Department was only concerned about financial management and wasn't concerned about patient safety. That's my rant, sorry and apologies for it. I was very much saying we are absolutely concerned about patient safety. 12:05

The point on the audit. Firstly, I would say that audit and governance systems are hugely important. As a chartered accountant obviously I would say that; as an accounting officer in the department. But patient safety, fundamentally auditing risk tends to find out where things have gone wrong. You ensure high quality by getting it right first time, at the point of the patient transaction. The auditing risk is a mechanism, it's an important mechanism, and there is a loop round to it because sometimes knowing that the audit mechanism may subsequently follow, it encourages better care at the point of delivery. 12:06 12:06

If the question is resources were taken out of the governance system and the risk, I would contend that -- I would accept that there were efficiency savings made in all administrative areas, but I would play back my points about the narrative we must protect the front line. This is the consequence of if everybody screams at me as a civil servant every day you are just a pen 12:07

usher, you are an administrator, and I read it again earlier this week - there was a discussion on social media - the core problem with the health and social care problem in Northern Ireland there's too many bureaucrats and too many administrators, this point, I think, highlights that administrators and bureaucrats contribute to the continuing of patient care, whereas in a resource-constrained environment, we have had to make efficiency savings. Has that been less than ideal? Absolutely. Has it crossed the threshold of putting safety at peril? I don't believe it has done. It's a constant battle in terms of trying to manage the work that we need to do against the paucity of resources we have. 12:07 12:07

51 Q. Let me move from that sort of higher level discussion about governance into perhaps a specific example of the role of the Department and the role of the Health Service public bodies, HSC bodies, in overseeing policy change in a clinical setting. I want to seek your views (A) on how it worked or how you understood it to be working during your time, and whether you saw any gaps or any potential problems. 12:08 12:08

The vehicle I want to use to perhaps explore this issue, and we'll not worry too much about the detail, but it concerns the introduction of a policy on the surgical management of endoscopic tissue resection. The starting point was 2013. Just bring the letter up, it's a letter from the Coroner to the Chief Medical 12:09

Officer, WIT-99098. Mr. Leckey - obviously before you came into post, Mr. Pengelly - but he is writing October 2013, explaining that he has concluded an inquest into the death of a young woman who died in the Ulster Independent Clinic. He received evidence from various clinicians and he is making known his concern to the Chief Medical Officer - scrolling down - in this area. I think he goes on in the next page to explain, maybe attaching his verdict. That's the start of the problem. It's then the subject of policy documentation. 12:09 12:10

The next step is we go to WIT-54032. The next step is for your Department to send to the Trusts a policy on, as I said earlier, the surgical management of endoscopic tissue resection, and it highlights the action that's required. In essence, the Trusts are being asked to process this policy for endorsement within their organisation, and to work with commissioners to address resource issues. This is 2015, August 2015. We can then see that the Trust responded to the policy. If we just go to WIT-54023. This is now the autumn of 2015. There is an action plan in place. If we just scroll down, we can see the various steps are set out. The second one is perhaps important. The requirement is to introduce bipolar resection equipment and, during the switchover, to limit the use of particular irrigation fluid, Glycine, and provide for careful risk assessment. 12:11 12:11 12:12

If I can summarise, Mr. Pengelly, because I am anxious not to require you to descend into the fine detail, the Trust need to bring their resources together to purchase equipment so that the two main services that 12:12
are affected by this policy, Urology and Gynaecology, can move away from the use of Glycine and in to the use of saline and thereby reduce, if not wholly eliminate, the kind of risks that the Coroner was concerned about. It was the risk of patients acquiring something called 12:13
TUR Syndrome. That's the position by the autumn of 2015.

Could I put two other pieces into the jigsaw so that you can understand where my questions will come from. 12:13
TRU-395978. Just a moment in time, March 2016, Mr. O'Brien has been trialing an example of the new equipment, and he says he ran into difficulties and he has therefore pledged not to use the new equipment endorsed within the policy ever again. That's at the 12:14
level of an individual practitioner.

Come November 17, that's two years after the policy has been, if you like, adopted by the Trust, we can see that it has still not been implemented within Urology. 12:15
If I can bring up on the screen WIT-103698. This is Mr. Young, who is the clinical lead within Urology in the Southern Trust. Just scrolling down. I suppose the sense of this letter is that there is a recognition

among urologists that the Trust has endorsed this policy appropriately and the appropriate equipment has been trialed but the equipment has not been purchased. Just scrolling down, he says:

12:15

"It's come to my attention that the Trust is not able to or in a position to proceed with the purchase of this equipment. It is not clear why this is the case as we have been instructed to move over to the system by the Trust itself".

12:16

In essence he is threatening on behalf of his fellow urologists to down tools. They won't continue with this operation in Glycine because it's against policy.

12:16

The final piece in the jigsaw is early in the next year, the equipment is purchased. That's getting on for four years or so, five years perhaps, after the Coroner had first written, and three years after the Department had initiated the policy development.

12:16

Can I ask you this, after that long introduction: In terms of policy development on clinical issues such as this, where within your department or is it elsewhere that these initiatives emerge from?

12:17

A. I think there is nearly two separate answers to that. I think normally those sorts of -- and we're talking more about clinical standards and approaches, that wouldn't in normal circumstances be led by the

Department or even materially involve the Department, that would be led through the work of what was the Health and Social Care Board and Public Health Agency through the use of clinical networks. I think in this specific case, and again I'm not stating this as a fact, this is my interpretation of what's before us, the fact for the entry point fro this particular issue was the Coroner raising concerns with the minister and Chief Medical Officer, I think it is that trigger as to why the Department is involved in this. But normally the development and evolution of clinical standards would be an issue that would sit with the Board and PHA. 12:17 12:18

52 Q. In this case it was, with a bit of a nudge at the application of pressure by the Coroner, the Department through the Chief Medical Officer, it was its bright idea to develop this policy and require the Trusts to adopt it. In terms of ensuring that adoption and implementation, you know the on-the-ground application of the policy takes place, where does that sit? 12:18 12:19

A. That would sit firmly with the Trusts, and I think --

53 Q. Sorry. What I mean is the oversight of that, the ensuring that it is done?

A. Well again, as I say, normally this would be for the Board and the PHA and it would be part of their more granular dialogue. But fundamentally, it is just -- and again forgive me, because I'm very much in the role of interpreting a case study that's in front of me as opposed to talking with detailed knowledge about what 12:19

happened, but I would be beyond extremely confident that it wasn't medical colleagues in the Department of Health who set out the nuances and specifics of what the policy was in this area of clinical practice. What they would have done would have been worked with senior urologists and established a clinical network. What evolved here was a piece of what was determined by practising clinicians in the relevant discipline as the appropriate standard of good practice. 12:19

12:20

Now, where I have some difficulties with what I have seen, and these are questions I would pose, there was a statement that consultants could be exposed if they complied with the policy and harm came to patients; I would argue what if you didn't comply with the policy. 12:20

54 Q. I thought it was the other way round. I think Mr. Young was --

A. No, it says -- I thought...

55 Q. I think if we scroll up.

A. Sorry, it was just there. Yeah, the consequence of not moving. But in terms of a debate about quality, for an individual consultant to say I'm not complying with a piece of policy that has been determined by a senior peer group as representing best practice, the issue isn't whether an individual consultant takes issue with the Department and whether the Department should oversee his or her compliance with that, the issue is his first point of entry should be with the peer group because, being generous, his concern is that they have 12:20 12:21

developed a flawed policy and he has an alternative professional view. But at the point that policy is developed by that clinical network and is passed across to the Trust, that becomes the quality standard. The Trust needs to oversee that. The Trust is in direct -- 12:21
the Department, when you are talking about an individual clinician who doesn't want to comply with it, the Department or even the Health and Social Care Board has no levers over that individual, it would be the Trust as their employer. Fundamentally, all paths 12:21
lead back, and forgive me, I can't recall the exact legislative reference, the Trust has a statutory duty of quality, and this is the quality standard for this procedure.

56 Q. Let me come back to the individual. Just to be clear, 12:22
we have Mr. Young's email on the screen and Mr. Young was wholly compliant with the policy --

A. Yep.

57 Q. -- it was Mr. O'Brien whose email I showed you beforehand, who was determined, he would say for good 12:22
reasons, not to comply with this new standard. We'll come back to the individual in a moment. Let me start with at Trust level. The Trust has not purchased the equipment to enable the clinicians to implement the new policy. It takes two and a half years before the 12:22
equipment is purchased so during that time, patients are at risk. The Trust can't, or won't for financial reasons, implement the policy. Where does oversight of that sit?

A. That particular oversight, I would assume, would be in that dialogue and debate between the Board because they commission services from Trusts. Part of commissioning is you determine the standard at which the services should be provided, so that would be part of that dialogue.

58 Q. Yes. We heard clearly the flavour of it from the Trust is clearly we need to prioritise money to purchase this expensive equipment but we can't do it for a period of time. Equally we've heard evidence from Mrs. Mullan last week, she was talking in the context of the implementation of the IHRD, the Hyponatraemia Related Deaths Inquiry recommendations. She was making the point the Department wants us to implement all of these recommendations but it's requiring us to do so through our current budget, there is no extra money to deal with these kinds of recommendations. A bit of a parallel with this situation here?

A. Yep.

59 Q. There is a new quality standard requiring equipment in this instance, the Trust isn't complying with the policy because it says it can't because of resources. How is that to be resolved?

A. Well, I mean, if I start at the top level, the Hyponatraemia report, from memory, had 96 recommendations, some fairly short and easy to do, some requiring multi year action and legislative change. When John O'Hara delivered the judgment, he didn't give the Department any money. So I would just -- this

isn't the case that the Department got extra money and decided we'll not give the Southern Trust any, we will just ask them to do the recommendations. Sometimes standards move and evolve and you need to respond to that. That is the essence of leadership, and particularly leadership in a complex and contested environment. In terms of the specifics of this, I don't know the detail. I think I know --

60 Q. I suppose I am not asking you about the fine detail of this. 12:25

A. No, but in terms of orders of magnitude, I think I recall reading that the relevant equipment had a price tag of something like £27,000. That's a big sum of money. The Southern Health and Social Care Trust has a budget of £1 billion, so my crude arithmetic says that's 0.003% of their budget. I am not sure it is credible to say we can't do something for three years because it is to three decimal places of a one percentage budget impact. 12:26

As I say, this is fundamentally about leadership and choices and prioritisation. If this was a critical clinical issue about patient safety, if the Trust wanted, or if any organisation wanted to say we can't possibly do this for resource reasons, the first question I would put to them is is every single other thing you are doing in the Trust of lower clinical priority than this. 12:26

61 Q. I suppose the fact that they are not doing it is known.

It's known to the Health and Social Care Board, I suspect, and to other players in this environment. I suppose if this is -- maybe this is an outlier of an example but I suppose it comes to this for the Permanent Secretary: Were there gaps in oversight and the enforcement of standards? Was the culture not right in terms of getting these things done?

A. I think on that point I can only speak to the general rather than specific of this. You know, the culture is that compliance in a case as this is for the Health and Social Care Board to lead on. I suspect that there is a judgment call for the Board; for as long as they feel they are making the appropriate level of progress, they don't need to escalate it, but there are escalation approaches to the Board to come and engage the Department. Now, whether or not we have all the levers of control to force compliance, but at a minimum if this was escalated through to the Department, the Department could sit down at a very, very senior level with the Trust and say we need to properly understand why this isn't happening at the pace it needs to happen. I think there was some dialogue with the Department; certainly I don't recall any specifics of it.

Sorry, I think to try and precis all that, even if responsibility sits with the Board, there has to be an escalation mechanism available. I believe it does exist, it does exist. I think the real question is is

that methodology activated as often as it should be. I think that's maybe where lessons can be drawn.

62 Q. At the level of the individual which we've touched on, we have a clinician, again using this as a vehicle of general application perhaps, a clinician is handed, I suppose, the peer endorsed policy and he decides that he thinks there is a better way. We can see from the audit which the Trust has performed retrospectively that Mr. O'Brien, in this particular case or in this particular area, never did adopt the new way of working. I just wonder whether from your perspective, recognising I suppose the other governance problems that have affected the Northern Ireland health care system over the period of years when you were in the top seat - Mr. Watt's case stands out again as a series of incidents of governance failures - is there any sense from your experience that the Department and/or the HSC bodies failed to provide effective leadership so as to encourage Trusts to more robustly identify and challenge clinicians who were placing patients at risk? 12:28 12:29 12:29 12:30

A. I think, I mean in many ways it is the $64,000 question. It is difficult to answer categorically. I would make the point that, I mean firstly - and I used this issue as an example - notwithstanding the fact that there is a clinical standard that is developed on a peer basis and is acknowledged as the appropriate quality, let's not forget, I am speaking as a lay person, that the world of medicine is immensely 12:30

complex. There always has to be scope that even against a standard guideline, that an individual experienced consultant can legitimately depart from that if, in his or her view, the clinical circumstances in front of them justify that. There may be cases where this individual felt the clinical circumstances I'm dealing with... I think that's an issue that the Trust Clinical Director and Medical Director would need to take a view on. 12:31

I just want to be clear I'm not suggesting it's 100% compliance is the minimum. I don't think that's the territory we are in here, it was more a sense of I don't like that approach, I am doing something different. That should have been a different discussion. The core question about is -- I think your core question is is there sufficient emphasis on the oversight and governance mechanisms to try and catch, prevent and reverse these issues? I think those mechanisms need to exist fundamentally at Trust level because that's where the proximity to the issue is. If I take the neurology issue at Belfast, again there was a big dimension to that - an experienced consultant with a very, very heavy workload. As I understand it, the nuances of the neurology discipline meant that, more so than many other disciplines, there was a one-to-one relationship. It wasn't a ward-based discipline where others were observing the treatment that was offered. The reality there is it comes back 12:31 12:31 12:32 12:32

to resources. If we want to do more in terms of governance, the Department and the Health and Social Care Board can't ask more and more questions of the Trust and Trust clinicians without the Trust clinicians having to step away from patient care to be able to answer those questions. So, there is a fine balance to be struck and I don't have the absolute right answer to where the sweet spot is on that. 12:33

The point you're making that I would find very hard to resist is if we are dealing with a couple of critical cases where it's clearly gone wrong, it is very hard to stand up and say we are absolutely in the right place. I think if that's the point you are putting to me, it is a very fair point. 12:33

63 Q. I emphasise in case anybody is under any misapprehension in terms of how I put the question, I am not pre-judging --

A. No.

64 Q. -- the issues that this Inquiry has to assess. In terms of what you've seen from a high level, do you sense that there is more to be done in equipping Trusts to get these issues right? 12:33

A. It would be very hard to assert that we don't need to make process. We can improve what we do here. The bit that I struggle with is is the answer to that that we need a new and different system of governance and oversight, or do we fundamentally need to make good on the transformation agenda and take the pressure off in 12:34

terms of waiting lists and in terms of the sheer volume of work that sits in front of every practising clinician. I suspect the answer is probably a bit of both.

65 Q. Yes. One of the tools which Trusts and other health and social care employers have been handed in order to deal with things when they have gone wrong is the MHPS framework. That's developed notionally to investigate clinicians in difficulty, in other words poorly performing clinicians regardless of the reason for that poor performance, whether it's capability or conduct or whatever it might be. 12:34 12:35

We know that during your time in the Permanent Secretary's seat, the Belfast Health and Social Care Trust wrote to the Department. If I can just bring this up on the screen, WIT-42931. The letter goes from Mr. McNaney, I think to Mr. Dawson. He is saying that he wants the Department to consider a review of the MHPS arrangements. He makes the point that the clear intent of the guidance is being fulfilled but, in reality, its practical application in parts has become increasingly more difficult; cases are now taking an inordinate and unacceptable amount of time to progress. Plainly we're interested in this whole area because Paragraph E of the Inquiry's Terms of Reference ask whether the application of MHPS by the Southern Trust vis-à-vis Mr. O'Brien, was it effective and does the framework require strengthening. Your department 12:35 12:36 12:37

triggered a review back in 2018 but it didn't reach completion. The Department has more recently started a review process again. Are you able to assist us in terms of why the review in 2018 didn't reach completion? 12:38

A. I can't give you a categoric reason, again I can only offer some thoughts. The letter from Peter McNaney or from Damian McAlister there to Andrew Dawson; Andrew at that stage in 2008 was leading the Workforce Directorate, and I think MHPS in terms of Departmental 12:38 interest spanned the Workforce Directorate and Chief Medical Officer's group. I think some work was done on this, I don't recall ever having detailed conversations on it. I think the reality of what happened was Andrew's area in particular throughout the latter part 12:38 of 2018 and certainly into 2019 was overwhelmed with the prospect of industrial action. As we remember it was the industrial action that precipitated the return of the Executive. That was just a burgeoning workload. I think it was something as straightforward as a 12:39 workload pressure that regrettably meant that that review didn't go through to conclusion at that stage.

66 Q. The review in 2018 sought submissions from all of the Trusts. We know that the Southern Trust committed to that process. I'll just give the reference to the 12:39 Panel for their note, WIT-43011. The Southern Trust talked about MHPS setting time scales that Trusts can very rarely comply with. MHPS needs to be reviewed urgently, the Trust said, to ensure quick, effective

and appropriate action can be taken when there are serious concerns about doctors. So, it was clearly a message going in to the Department that this was something that was not wholly broken but was in need of some urgent intervention. Is that a message that was ever delivered to you at any point? 12:40

A. It wasn't delivered to me in the context of this exchange of correspondence. Where the message was put to me in very strong terms was in the dialogue I had with Brett Lockhart as part of the Neurology Inquiry because I remember speaking on that because there was a very strong sense - and I'm not offering an alibi on this point - I think it became very clear that this was going to be a focus of the neurology work, so I think subliminally within the Department, certainly in 2019 and 2020, there was a sense of nearly let's wait and see what the Inquiry says about it because we knew it was going to be a focus then. The report of the Inquiry was published after I left but I think I'm right in saying it does make strong reference to MHPS. 12:40 12:41 12:41

But the only other point I would offer, and again I'm somewhat reluctant because it's one of these points that it is very, very easy for people like me to make, this is guidance. This is not a cookbook that is to be four grammes of this and two ounces of that and stir it for 20; this is a guidance and it is a framework. It was initially developed at a UK level, so that sends a clear sense that there was acceptance that this is in 12:41

the right space. Now I don't know the extent to which things have moved on across the water, but it was always open to individual organisations when applying guidance to think is there a rational basis for an intelligent and informed departure from this guidance because the circumstances warrant a differential approach. That I would argue is a very reasonable and sensible approach in the short term, it is the way guidance should always be read. I wouldn't use that as a reason to say a fundamental review of the guidance should have taken place given that it was developed in 2005. But it is just to say there was a workaround available, I think, with some intelligent application of what was guidance. 12:42 12:42

67 Q. Can I move then to ask you about the appointment of Chairs to Trust Boards. 12:42

CHAIR: Sorry to interrupt, Mr. Wolfe. I am just conscious that we haven't had our break this morning. I know we did start late. It is a quarter to one; is there a neat issue that you can deal with in about 15 minutes before we take a break for lunch or would we be better leaving this until after lunch and dealing with it as a piece? 12:42

MR. WOLFE: It would be a convenient point in some respects. I suppose I am not at the halfway point in time but the halfway point in issues. So, if we could maybe take an early lunch and come back earlier. 12:43

CHAIR: This is what I was going to suggest. If we break now, ladies and gentlemen, and come back about

1.45.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

13:53

CHAIR: Thank you, everyone. Okay, Mr. Wolfe.

68 Q. MR. WOLFE KC: Thank you. Good afternoon, Mr. Pengelly. Can I start by having your reflections on the importance of the Chairperson's position in the context of Boards of health and social care Trusts. 13:53

A. Yeah. I think it's very important and I think it's not just the Chair, it is the whole cohort of Non-Executives. It is one of the appropriate checks and balances in terms of, you know, we use the language of sort of holding the Executive's feet to the fire at 13:53 times, just having that in-house challenge whilst, as we've touched on earlier, the Department has an overview perspective, having someone that is remote from the Executive day-to-day operations of an individual Trusts but knows the landscape and geography 13:53 and local population, having had that regular dialogue with executives, and providing leadership to the organisation. I think it is a very important role.

69 Q. And what are the kinds of attributes and qualities that you are looking for both in a Chair and in a 13:54 Non-Executive director?

A. If I deal with the Chair first, I think the leadership dimension, you know, someone that has some comfort and experience of having something of a spotlight on them

because there is a profile attached to it. You know, an open and inquiring mind. It certainly wouldn't be the case that the Chair would need a particular professional background. In many ways I think it's arguably better they don't have a particular professional background, it's more that generality.

It is a bit more interesting when you talk about other non-Executives. It could be a mindset change, particularly for colleagues in the Department when we're interviewing for non-executives because typically when you advertise for an executive director, you have a series of competencies that you want employees to have. The point I would emphasise with a Non-Executive, there's, I think, typically about seven non-execs in total on the Board, it is the basket of skills that the Non-Executive Directors bring as a cohort, so you don't necessarily need any individual Non-Executive director to have all of the necessary skills but you would certainly want one of the non-executives to have a good understanding of HR and an HR perspective; someone who understands finance. It's just trying to bring that basket of skills through half a dozen individuals who can bring that challenge function. 13:54 13:55 13:55 13:55

70 Q. When you were PS in Health, do you take a personal interest in the appointment of the Chair?

A. I would have tended to sit on the Panel for the recruitment of Chairs but not for the Non-Executive

Directors. Part of that is just the sheer volume of numbers that we have.

71 Q. Once a Chair is in place, are they subject to annual appraisal?

A. Yes. My senior colleagues at Grade 3 level in the Department and the sponsor for all Arms Length Bodies and the relative sponsor directorate, they would undertake the annual appraisal for the Chair and then I would countersign it. 13:56

72 Q. Mrs. Brownlee was appointed Chair of the Southern Trust in 2011 and she served all the way through until November or December 2020. Forgive me, I haven't got the precise date but it's around those months. Is it a four-year term or five-year term? I think you spoke earlier about the potential for extension at one point. 13:56 13:57

A. Yeah. Apologies if I have misled you. I referred to a four-year term, maybe it is a fie-year term, so apologies for that. I think in legislation it's 10 years in total so it's normally two terms.

73 Q. In terms of how Mrs. Brownlee performed her role, did you receive only positive feedback? Was there any concerns raised with you? 13:57

A. I can't recall any concerns ever being raised with me. Certainly I would have talked to Mrs. Brownlee from time to time on issues and certainly there was never a concern that sprung up in my mind in the context of any of the discussion I had with her. As we touched on earlier today, issues like the Board development days I thought were a very positive steps and the traits of a 13:57

good and effective leader at Trust level.

74 Q. Mr. Devlin has reflected to the Inquiry that, as he called it, one of the weaknesses of the Board was his relationship with Mrs. Brownlee, who he commented had become more involved in the operational delivery of the Trust and he found her approach to be overreaching and, in some cases, unhelpful. Plainly the relationship between the Chief Executive Officer and the Chair is pivotal to the success of the Trust. Is there a forum or an interface whereby the Chief Executive and/or the Chair can speak to you about relationship difficulties or practice difficulties such as this? 13:58 13:58

A. There isn't an established or mechanistic forum for it but certainly either of them at any stage could lift the phone to me if there was an issue they wanted to highlight, either a formal or informal conversation about. Certainly it wasn't a conversation that was ever prompted with me, any concerns about the relationship. 13:59

75 Q. Would you have wanted to have heard such concerns? Not that you want to hear concerns but would you like to be appraised of concerns if they arise if they are affecting how the work is being done? 13:59

A. Oh, absolutely. I think if the concerns are manifested to an extent that they are getting in the way of a proper conduct of the business, I think there is an obligation on my part to be made aware of -- or there is an obligation if I am aware of them to have the conversation to try and deal with them. Certainly my 13:59

advice to any -- I mean, I oversaw in my time the appointment of numerous Chief Executives, and I would have tended to have an informal chat or coffee with them shortly after appointment to talk about the way we would engage. One of the things I would emphasise is there is formal mechanisms for engaging with me but you have my number if there is anything that you ever want to talk about, if you need a bit of advice or guidance or you just want to sound off about something. Leadership is a lonely place, and as a chief executive in a Trust, you don't have a natural peer group within the Trust. That is the sort of thing I would mean without explicitly saying it, that as a chief executive, if there was a relationship issue with your Chair, I would be the person to go to. 14:00 14:00 14:00

76 Q. It appears from some of the materials which the Inquiry has considered that an important quality to be held by a Chair is the ability to act with integrity and, in that sense, to be able to manage any conflicts of interest that can arise. We've noted that the Department issued correspondence to the Trust Chairs in May 2017 perhaps by way of reinforcement of a message that would already have been delivered at the point of appointment. 14:01

A. Yes. 14:01

77 Q. Let me just refer to that correspondence, TRU-113435. I might just try to get by without this as it's coming. So on 24th May 2017, the Department wrote and referred the Trust Chairs -- there it is. I said May, it is

24th March 2017.

"The Departmental Board received a query. The author wishes to take the opportunity to remind Non-Executives of the requirement for Board members of public bodies to act appropriately when a conflict of interest situation arrives. All NEDs must discharge their duties in line with the seven Principles of Public Life. Any conflict of interest must be identified and managed in a way that safeguards the integrity of Board members and maximises public confidence in the organisation's delivery of public services". 14:03 14:03

The recipients of this correspondence are referred to other materials, including the Northern Ireland Audit OFFICE guidelines on conflicts of interest. 14:04

Was that message set out there something that you were confident was received loud and clear by public appointees? 14:04

A. Yes, but it wasn't something that I sort of sought to validate had it been received. You see the note, as it says, went to each of the Chairs. There was no comeback, no one sought any clarification or had any concerns with the guidance that we were pointing to so I assume it landed as it was intended. 14:04

78 Q. I just want to refer to what might be regarded as a cardinal principle and seek your views on it. It is the code of conduct for those the subject of public

appointments, and we can find it at TRU-113440, or at least the section I wish to refer to. It says:

"Chairs and Board members should act impartially and should not be influenced by social, political or business relationships. They should not use information gained in the course of their public service for personal gain or for political purposes, nor seek to use the opportunity of public service to promote private interests or those of connected persons, firms, businesses or other organisations. Where there is a potential for private, voluntary, and charitable interests to be material and relevant to the health and social care business, the relevant interest should be declared and recorded in the Board minutes and entered into a register which is publically available. When a conflict of interest is established, the Board member should withdraw and play no part in the relevant discussion or decision". 14:05 14:05 14:06 14:06

I described that as a cardinal principle.

A. Yes.

79 Q. It is a fairly common, I suppose, description of principles that apply in public life. Why is it important? 14:06

A. Well, it's important because all public business should be undertaken on the basis of the facts of the matter at hand and not, you know, be coloured or influenced by any personal relationships. You know, it's a core

principle that should apply not only to public life but to private life as well.

80 Q. In the case of Mrs. Brownlee, we know that she had a relationship with Mr. O'Brien that was initially born out of a patient-practitioner engagement, it then moved on to a degree of friendship and then had another layer in that she was instrumental in establishing a business for charitable purposes called CURE, and he was to play a part in that company of which she was, at one point, a director, company secretary and ultimately a committee member before apparently stepping away from those roles. 14:07 14:08

As I understand it, you, at one point, became aware of her connection to the organisation or the company called CURE? 14:08

A. Yes. That was the morning of 26th October.

81 Q. Yes. I am going to come and look at that and what it means in the context of this Inquiry in a moment. First of all, perhaps to articulate the concern that has been mentioned in the evidence before the Inquiry, the concern is that Mrs. Brownlee attended a meeting of the Board on 22nd October after the Department was aware of the Early Alert, after the Trust had sent the Early Alert and was concerned about Mr. O'Brien's practice. The concern is that she attended that meeting notwithstanding the various strands of her relationship with Mr. O'Brien and, according to the interpretation of some who were there, spoke on his 14:08 14:09

behalf. Advocated on his behalf is how it was put.

Now, let me show you some documentation. There was an area Board meeting in September 2020. Mrs. Brownlee didn't attend that meeting or didn't attend for the agenda item that discussed Mr. O'Brien. If I could bring up on the screen, please, WIT-90873. If you just go down to the third paragraph. In the third paragraph of this document, this is Mrs. Brownlee's witness statement to the Inquiry: 14:10

"Because of what could have been perceived as a conflict of interest, I spoke around July or August 2020 in a conversation with Pauline Leeson, Non-Executive Director, to explain that I did not wish to attend Board meetings where Mr. O'Brien was going to be discussed. I asked Pauline Leeson as a NED would she chair the Board meeting when this topic arose about Mr. O'Brien". 14:11

Moving to the next meeting, Mr. Pengelly, the October meeting. In advance of that meeting, she wrote to her NEDs. I just want to show you the email she sent, and it's at TRU-253705. Sorry, just scroll up, I think she's writing to Mr. Devlin primarily but copying in her Non-Executive Board members. What she is saying is that she is confirming that she will be staying in for the agenda item concerning Urology - that's item 7 of the agenda - concerning Urology and Mr. O'Brien. 14:12

"This is an extremely serious matter for the Board and I need to be present". She says: "I have a conflict with this particular matter, my past personal illness. I will try to overcome the emotions". 14:12

The final factual aspect I want to bring to your attention before asking you some questions about this is Mr. Devlin's role in it. He was obviously the Chief Executive at that time. He considers Mrs. Brownlee's 14:13 determination to attend the meeting, notwithstanding her earlier withdrawal from the issue in September. If we could look at what Mr. Devlin has said, it is at TRU-253074. He is asking his directors for some comment or answers in respect of what Mrs. Brownlee has 14:13 said. Dr. O'Kane says in response:

"My understanding from what the Chair has disclosed openly is that she has been a patient of this doctor in recent years. Given that we will be discussing the 14:13 impact on patients, potentially I am concerned."

Then Mr. Devlin says he is happy to discuss this. He corrects Mrs. O'Kane or Dr. O'Kane by saying:

14:14

"The Chair has not been a patient in recent years, she was a patient nearly 20 years ago. I think as Chair she needs to be part of the conversation and the whole Board need to be in the middle of this".

So as can be seen, he is in essence, on the basis of the information before him, approving Mrs. Brownlee's attendance. That's the context in which I want to ask you some questions.

A. Mhm-mhm. 14:14

82 Q. Matters have developed over the last 12 hours or so in terms of how Mrs. Brownlee puts the position but I think given the focus that's been placed on this issue in the evidence and the public interest perhaps in this, I should set out, so that you can comment, how 14:15 she initially put the position. If we go back to her statement at WIT-90872. She recalls in this statement that she spoke to you on two occasions, first of all sometime in the summer of 2020, and it was regarding her replacement as Chair. She says she remembers 14:15 interviewing in the Seagoe Hotel, Portadown, and stood out of the meeting to take this call. That conversation, she said, focused on her replacement. But then she said:

14:16

"I explained the investigation in to Mr. O'Brien, the situation that I was in, and that I did not wish to be involved in any meetings".

She then goes on to say that the second call was late 14:16 September, she can't recall the date and didn't take notes.

"Mr. Pengelly phoned me to ask about the CURE charity.

I explained the history behind the foundation and management of this charity. I told Mr. Pengelly that I had not been attending Board meetings with an agenda item on Mr. O'Brien. Mr. Pengelly told me that whilst I had a conflict of interest, it still was extremely important that I fulfilled my role and responsibilities as Chair. He reminded me that I should be careful that in my absence from Board meetings I was kept well informed and maintained control as Chair". 14:16

14:17

Let me bring you to another extract from her statement, and it's to be found at WIT-90874. This is where she tells us how she was influenced by that conversation with you. She says the next meeting of the Board was on 24th September. She declared an interest in that one and Pauline Leeson took the Chair. Then she goes on to deal with the 22nd October meeting. She says: 14:17

"The decision to attend was influenced by the second conversation I had with Richard Pengelly in late September 2020. I was mindful of my obligations and accountability as Chair of the Board". 14:17

So that was the position as she initially recorded it for the purposes of her Inquiry statement, that is she had a conversation with you at September ahead of the 22nd October Board meeting, and, based on what was discussed with you, she was influenced to attend that meeting. 14:18

Now, can we just have it for the record, we have it in your statement, but you disagreed with that?

A. Yes. I have no recollection of those conversations. The first that I became aware of the potential conflict of interest was when a Departmental colleague told me about the CURE relationship, which was on 26th October. A short time after that on the same day, I placed a call to Shane Devlin, and it was only on that call that Mr. Devlin told me about the personal relationship. So, 26th October, as I say, is the first time I ever had any conversation or any awareness of a potential conflict of interest. 14:19 14:19

83 Q. And that, of course, happened after the 22nd October that Mrs. Brownlee attended?

A. Yes. 14:19

84 Q. Just so that we can bring matters up to date, Mrs. Brownlee has now provided an addendum statement. In fact, she has provided two addendum statements. There was a version provided yesterday, Chair, which bears the reference WIT-105947. That statement has been revised today with some additional content so I am not going to go to the page referenced copy, I am going to work off the paper copy which everybody, and hopefully Mr. Pengelly has in front of him, together with a document which appears to be a telephone record which she comments upon. 14:20 14:20

So, as appears from the addendum statement, Mr. Pengelly, Mrs. Brownlee, as you can see from

paragraph 1 of this statement, now accepts that the second telephone call did take -- she says it took place on 26th October and not late September or not September as she had earlier indicated. She provides in a document which should be sitting behind that a record of a telephone call apparently placed with your mobile on 26th October at 1157. Can you confirm that that is your mobile telephone number?

A. Yes, it is.

85 Q. Just again looking at the addendum statement, paragraph 2 was initially drafted as - and I have read this out earlier - to include the sentence "the decision to attend was influenced by the second conversation I had with Richard Pengelly in late September". You can see in her revision that she has removed that sentence, and that would appear to be a withdrawal of the assertion that you had influenced her attendance.

Then finally at paragraph 3, she seeks to withdraw from, as inaccurate, the timeline which she had set out in her primary statement.

Just if we can, Mr. Pengelly, get it again from your perspective. She refers to two phone calls, one at some point in the summer where she introduces the idea that she was not going to meetings involving Mr. O'Brien, and then the second conversation, 26th October, when she doesn't say much about that conversation. Can you deal with the first telephone

call; can you remember a first telephone call?

A. I have no recollection of a first call. Again, if a call happened in September, I would have been aware in September about the potential conflict of interest, if we take Mrs. Brownlee's version of events. I still hold 26th October was my first introduction to any potential conflict. The only contextual point I think it is important to record is bearing in mind we are dealing with the early autumn of 2020 and, you know, for the other 23 hours of the day, I was dealing with Covid so it was a particularly frenetic period. So, I have to put the caveat I wouldn't have a complete and accurate record of every single conversation I had at that time but I am very, very clearly of the view that 26th October was my entry point to understanding any conflict of interest. 14:23 14:24 14:24

86 Q. Yes. Could I draw your attention to a notebook entry which you have helpfully sent to the Inquiry with your witness statement? I'll bring the Panel to the typed-up version of it, it's at WIT-105924. This is one of a series of notes that you've supplied to us. "Jackie, 26th October 2020". I understand that to be a reference to one of your officials, Mr. Jackie Johnston? 14:24

A. That's right. 14:25

87 Q. And he was employed in the Department at that time?

A. He is the Grade 3, so he would have been one of my deputies, a senior colleague in the Department. His area would have been the sponsorship of the health

Trust, so this was his area of work.

88 Q. Can you interpret what's going on here for us? It would appear to engage or record both a conversation or dealings with Mr. Johnston as well as Shane, I take to be Shane Devlin, so there is two parts to this? 14:25

A. Yeah. This is the typed-up version, I think the positioning of the text in the notebook is slightly different. But my clear recollection is on the morning of the 26th, Jackie contacted me to say, and it was as simple as the night before, he had been fiddling about 14:26 on Google, I think were his words, and he had come across through a Google search that Mrs. Brownlee had been a director of CURE, so he rang me in the morning to make me aware of that. In turn I put a call through to Mr. Devlin. The hyphen "Shane was not aware", I 14:26 think in the notebook it is slightly positioned differently. But that bit is a second conversation, a separate conversation with Mr. Devlin. Shane told me he wasn't aware of the CURE link but in that conversation, he made me aware that Mrs. Brownlee had 14:26 been a patient of Mr. O'Brien and a personal relationship had evolved since that. He also confirmed that there hadn't been any disclosure of the CURE dimension to it.

89 Q. So, dealing first of all with Mr. Johnston's 14:26 information to you. Did he explain it in those terms, he was fiddling about on the internet?

A. Yeah. Yes. Well, he didn't go into a huge amount of detail. On the one hand he said he was just doing

searches. The contextual point is Jackie is one of the most dedicated colleagues I have encountered, so the fact that he would be sitting at home on his own time putting some search items into Google to see if there is any information, that in and of itself wouldn't have come as a surprise to me; you know, an incredibly professional dedicated colleague. I don't know if there is anything other to it than that but that was my understanding as to the point.

90 Q. Plainly the meeting of the Board on 22nd October, judged by some of the evidence this Inquiry has received, created something of a stir, to perhaps put it at its mildest, in terms of Mrs. Brownlee's input to the meeting. Is it possible that her behaviours at that meeting were drawn to the attention of your departmental officials, causing Mr. Johnston to conduct some research? 14:27 14:28

A. I mean, all I could add is of course it is possible but it's not -- no one has ever said to me that that happened but equally nobody has ever in those terms said to me that that didn't happen. But it has to be a possibility, as you say, given the concerns that seemed to be present in the Board discussion. 14:28

91 Q. In terms of the note and your recollection of the conversation with Mr. Johnston, it is putting you in touch with the information that Mrs. Brownlee was or is a director or a secretary of CURE. Why is that of itself considered something worthy of comment? 14:28

A. Well, it was just the basis that it showed a

relationship between the two individuals, Mrs. Brownlee and Mr. O'Brien.

92 Q. In what way? How was that?

A. Well, this was a company that had been established and incorporated and registered in Companies House. Mrs. Brownlee, I believe, as you said, was the company secretary. The reference 4/97 to 7/12, my understanding is the company was incorporated and she became company secretary in April '97 and that ran through to July 2012. So, there was a long relationship there so that's why Jackie's interest was sparked by this. 14:29 14:29

93 Q. Your dealings with Mr. Devlin on the point, you've explained this in your witness statement. Can I take you to that because there is one or two points I am anxious for you to clarify for me in terms of Mr. Devlin's input. WIT-105893. At paragraph 7 you are explaining that later that day, 26th October, you telephoned the Chief Executive Shane Devlin about the issue and, in the course of the call: 14:30 14:30

"He advised me he had not been aware of the CURE link. Mr. Devlin also made me aware of the further potential conflict of Mrs. Brownlee, being both a friend and a former patient of Mr. O'Brien. I was not aware of this before that conversation. Mr. Devlin advised that he was uncomfortable with this, and particularly the specific fact that Mrs. Brownlee had not formally declared this as part of any Board discussion of the 14:30

Urology issue, including as regards her participation in the Board meeting on 22nd October".

Can I just park that there for the moment. He's expressing, according to your recollection, being uncomfortable about what appears to be the friendship and the former patient part of the relationship in the context of her participation in the Board meeting on 22nd October without it being formally declared. I've shown you already his email with Dr. O'Kane where he refers to the patient relationship; he doesn't refer to the CURE relationship, he didn't know about it. He may well have known the sense that there was a friendship there as well. But he appears to have approved her attendance to the extent that he can referee that and seemed satisfied that she should have attended. Was that something he brought to your attention? 14:31 14:32 14:32

A. No. What I've set out in paragraph 7 is my recollection of the conversation, and the recollection is that Mr. Devlin outlined to me he was uneasy with the known declaration and the intended participation in the discussion. It was only subsequently when I had access to the various statements that I saw the email that showed Mr. Devlin had been aware of it and essentially, as you say, acquiesced in her participation in the Board meeting. So I think there is something of a conflict between the two positions. 14:32 14:33

94 Q. I want to be entirely fair for him. He wouldn't have known to the CURE part of it, according to your

understanding. Could it have been the CURE element that was giving him further trouble as suggested or causing him to feel uncomfortable, or were you reading it as him coming to this entirely new and not feeling comfortable? 14:33

A. My sense in the conversation is that it was the relationship that had caused him discomfort. I think the CURE point is only an indication that there was a relationship, so the CURE point in itself I don't think was anything that could be treated differently or 14:33 separately from the relationship point. As I say, my sense was it wasn't that -- just to be absolutely explicit, I didn't get a sense in the conversation that he was comfortable with the relationship but was now uncomfortable with the CURE dimension to the 14:34 relationship, it was the relationship that had caused concern.

95 Q. Just finalising this paragraph, you indicated to Mr. Devlin that you agreed with his view that the issue should have been disclosed, and that seems to be a 14:34 reference to the relationship?

A. Yes, yes.

96 Q. "I recall outlining my further view that, in light of the potential conflict, Mrs. Brownlee should not be a party to any discussion of the issue". 14:34

Scrolling down, to resolve this going forward, you suggested that Mr. Devlin should speak to Mrs. Brownlee as matter of urgency and make this view clear to her.

You go on to say:

"I do not recall nor have a record of any follow-up call by me with Mrs. Brownlee on this issue".

Do you now accept, in light of Mrs. Brownlee's evidence of this afternoon, her statement of this afternoon, that a call had been placed by her with you?

A. Yes, unquestionably. The only -- and at the risk of dancing on a pinhead, I think her original statement said that I called her, I think the phone records are clear that she placed the call to me. Again, I don't have a note or record of that meeting. I suspect had the call been placed from me to her, I would have been at my desk and probably would have jotted down a few notes. The fact that she called me suggests that she probably called me on my mobile in transit between meetings and not in a position to take a note of it, as I tend to do with calls like that. 14:35 14:35 14:35

97 Q. Yes, yes. You also understand Mr. Devlin to have spoken with her? 14:36

A. I finished my call with Mr. Devlin that he was going to speak to her, so I am assuming that it was the call between Mr. Devlin and Mrs. Brownlee that prompted her to ring me. 14:36

98 Q. Do you have any recollection of your discussion with her?

A. I don't have a recollection of the specifics. I do, and I think I set it out in my statement, I have a

recollection of a phone call with Mrs. Brownlee which was more focused on the timeline for her replacement. But just, again to emphasise, I am not adopting a position that because I can't recall that issue being touched on in the conversation, I am not asserting that that didn't happen, I am just clarifying that I have no recollection of a specific conversation in this call that obviously took place on the 26th. 14:36

99 Q. I am not going to invite you to comment on Mrs. Brownlee's contribution to the 22nd October meeting, you weren't present at it. She has a particular perspective in terms of the language that she used. It maybe isn't shared by others but I think the best evidence comes from those who were participants at the meeting. 14:37

What I do want to ask you about is this: More generally, when a participant in a controversial discussion has the kinds of relationships of company with charitable aims and a patient relationship and a possible friendship, that is territory where the decision-maker or the person of influence has to tread carefully? 14:37

A. Yes. In terms of my observations on the Board meeting and the declaration and the participation, I think there is two dimensions to this. There clearly is a view from some of those who participated in the discussion that Mrs. Brownlee, I think the words were, was advocating on behalf of Mr. O'Brien. That clearly 14:38

would be a matter of concern and that clearly would underscore the importance of someone with a relationship not being part of the conversation. I would go slightly further and say if there was no sense from any participant that the contribution in any way influenced the discussion, I would still hold to the position that the perception of conflict of interest is a hugely important issue in terms of public confidence in the way we do business. Whatever the decision, if it subsequently transpired that there was a potential conflict of interest that was present in the room when a decision was taken, even if all parties to that decision were content and had no concerns, I could understand members of the public seeing that starting to doubt the legitimacy of that decision. That's the reasons why we talk about both conflicts of interests and the perception of conflicts of interests. I think both need to be avoided to underline the importance of objectivity of the work we do. 14:38 14:38 14:39

100 Q. Thank you for that. Can I move now to another of your notebook entries. 22nd October, a few days before. It's at WIT-105924. It is an aspect of this Inquiry's Terms of Reference, Mr. Pengelly, set out at paragraph B, that it must consider the communication and escalation of the reporting of issues relating to potential concerns about patient care and safety within and between the Trusts, the Health and Social Care Board, the Public Health Agency and the Department. 14:39 14:40

So, picked up on your note for 22nd October 2020. Now, by this stage an Early Alert had come in. By this stage there had been plenty of engagement between the Department and the Trust, getting towards the stage I think that there was to be a Urology Assurance Group established, and certainly the Department was in receipt of a report and possibly getting towards getting a second report from the Trust setting out the difficulties. 14:40

14:41

It says in the fourth bullet point, "previous issues about the same consultant in 2016 and query 2009." Can you help us first of all in terms of this note - maybe I should bring you to the handwritten note as well, if I can find a reference to that, maybe not so quickly - have you sense of who this conversation was with? 14:41

A. I think it was -- I'm not sure whether this was the first meeting of the Urology Assurance Group. I think it was maybe later than this. It was potentially the same sort of cast list we had for the formal Urology Assurance Group. It was myself, colleagues from the Chief Medical Officer's groups, I think a couple of colleagues from the Health and Social Care Board, and from the PHA. 14:41 14:42

101 Q. I am going to bring you to the handwritten note to see if that helps you. WIT-105905. Does that help us?

A. I think -- no, as I said, I think it was a meeting involving departmental colleagues, HSCB colleagues and

PHA colleagues, but possibly not including anyone from the Trust.

102 Q. Yes. Can you help us at all in terms of the reference to 2009 because, I mean, we are aware and the Inquiry is aware that issues of concern relating to Mr. O'Brien date back some years. There was a concern about his use of intravenous fluid management and benign cystectomies and various issues in 2009 which were addressed. Did you receive information about it? 14:43

A. No, and I am straining my memory a little. From recollection, it was a comment that was made by a medical colleague in the context of this meeting, an individual who I assumed had either been involved, was either aware or had been involved in the working out of 2016 or 2009 about previous concerns. 14:43

103 Q. Who was that, just for the record?

A. I can't, my memory... I can picture her face, I just can't actually remember her name. She was a senior medical colleague in PHA. Apologies, her name will come to me. I can ring a colleague in the Department and I will be prompted to it in a matter of seconds. 14:44

104 Q. I think we can leave it. If we need to follow up on it in writing, we will do so.

We know that in 2017 or late 2016, Mr. Pengelly, when the Trust decided that it would go down the MHPS route with Mr. O'Brien, the then Medical Director at the Trust wrote to Dr. McBride, the CMO. If we could just take a brief look at that, AOB-01339. This 14:44

correspondence in essence is telling the Chief Medical Officer that Mr. O'Brien had been excluded from practice from the work place, having taken advice from NCAS, and the purpose of the exclusion was to scope out the investigation process. 14:45

I needn't bring it up on the screen but the MHPS process doesn't talk specifically or explicitly about a requirement to notify the Department of an exclusion. What it says is that when the Department is informed of 14:46 an exclusion, it should check if NCAS has been notified, and may be it is implicit that there is an expectation there.

Do you think in general it is a prudent step for the 14:46 Trust, if it's excluding a senior member of staff at consultant level, to notify the Department of that?

A. I would believe so, yes.

105 Q. It may be that that's something that could be looked at in terms of making that more explicit within MHPS. We 14:46 don't have any awareness of any follow-up on the part of the Department, having been notified of this exclusion. Maybe it was just added to the record, and in the Department's mind and the CMO's mind it didn't necessarily bear a response. Bearing in mind how MHPS 14:47 investigations have a tendency to develop, they don't tend to be a quick fix, bearing in mind what I opened earlier with you from the two Trusts talk about the difficulties in bringing these matters to a conclusion,

do you consider that there might be benefit, whether it's the Department or whether it's the SPPG, in having perhaps some form of greater oversight or involvement in the outworkings of MHPS processes?

A. I think that would need to be considered in parallel with the overview at review of MHPS because I'm not sure about what sort of follow-up would take place or would have taken place in the context of this. The point that has always been made to me, particularly by colleagues in the Chief Medical Officer's group, is that the management of the medical staff within the Trust is part and parcel of their employer relationship and it is for the Trusts to do. I think as well as thinking about a process for oversight, we need to think carefully about what is the value proposition in terms of that oversight. My hesitation is I wouldn't want just another system to be put in place that doesn't offer demonstrable value to the management of some issues, because yet another system or process might get in the way of something where there is a very strong value. I think that would need to be looked at in the context of overall rewrite and refresh of the MHPS. 14:48 14:48 14:48 14:49

106 Q. We know, and it is certainly not a perfect analogy, that HSCB, as it then was, and the PHA are told about incidents, serious adverse incidents, and their outworkings are all considered by those organisations. The MHPS investigation self-evidently is of itself a contractual matter between the employee and the Trust. 14:49

Given how these things can develop, given the length of time to deal with them, the potential patient safety issues lurking beneath the surface, is there not some need for some superintendence of this, not necessarily getting into the factual aspects of the case but superintending the process to ensure that milestones are expedited and things are not allowed to drag out? 14:50

A. I think it is a 'yes but' answer. I can understand the sentiment behind it and the importance of that. At the same time, putting in place a procedure and a policy and asking Trusts to comply with it. I don't want to say simply the Department isn't resourced to do that. I mean, if the view was it was a fundamentally important thing to do, we should find a way of resourcing it. I'm not sure that marking the homework of every aspect of MHPS is the best use of resources. 14:50 14:51

I think I would find it very difficult to push back the need maybe for a system that has an overview line of sight on thematic issues that come through any MHPS processes because clearly whatever happens with one doctor in one Trust, there may be the potential for valuable learning for other issues. So it's not so much about managing a single process for a single issue, it is about an early opportunity to identify learning and maybe stop the recurrence of the issue in another place. 14:51 14:51

107 Q. Thank you. Let me bring you then to the events of the late summer of 2020 at the Trust. We can see at

DOH-00666 that an Early Alert issued. Some records show 31st July, others 1st August. An Early Alert goes from Dr. O'Kane's office at the Southern Trust to the Department. It takes, as its starting point, the events of 7th June 2020 when the Trust records it became aware of concerns that a consultant urologist, we now know to be Mr. O'Brien, having seen two patients at an earlier point, the handling of those patients in the eyes of the Trust gave rise to concerns that were then the subject of a lookback exercise. 14:52 14:53

Can I ask you do you have a clear memory of when the subject matter of this Early Alert was drawn to your attention?

A. I don't have a very clear and specific recollection. Reviewing my notes, the first reference I can see to it was on 9th October, I think I was made aware of it. So I have no recollection again of it ever being placed on my radar prior to that. 14:53

108 Q. We know you were copied into an email on 3rd August containing the Early Alert. I can bring that up on the screen. Does the fact that you're told about this not necessarily trigger your involvement? 14:54

A. As an Early Alert, because the Early Alert is being put on the Departmental radar there is a concern. As this sets out, work is on hand at the Trust and colleagues in the Department were reacting to it. There was nothing specifically for me to do. You mention that email, I have no recollection of that. As will be no 14:54

surprise to you, there tends to be an awful lot of email that are copied to me, most of which I try and read but not necessarily all of them.

109 Q. As we can see in front of us, the Early Alert takes its trigger from the events of 7th June, or discoveries of 7th June that are not further explained in any great detail in this document. 14:55

Now, Mr. O'Brien contests the proposition that there was anything to be discovered of an adverse nature on 7th June. Just for the Panel's reference, he sets out in his witness statement at WIT-82401 his view that what is said about 7th June is a totally untrue assertion, and that this led to the minister, who refers to this when he is making his statement to the Assembly, it led to the minister being misled and/or misinforming the assembly. 14:55 14:56

Could I ask you this: To what extent would the Department, having received an Early Alert and indeed the subsequent reports that came in from the Southern Trust on this subject matter, take that at face value, or would it carry out its own investigations and ask for, if you like, proofs of what is being said? 14:56

A. I think we would very much take them at face value. I mean, in the simplest terms this is a piece of paper where the Trust is saying to the Department "we have a concern". Certainly I would be uncomfortable if our first reaction was to push back and say are you sure 14:56

you have a concern. These are experienced colleagues. On the 7th June point, and apologies if I am in any way misunderstanding you, if 7th June was the trigger and there is a concern about that, the Early Alert was not sent on 7th June. The Early Alert happened. The 7th June didn't trigger an Early Alert, it triggered a piece of investigatory work which culminated in an Early Alert either end of July and start of August telling the Department we have looked, we have done a lookback exercise and there are concerns. I think the submission shortly after this that went to the minister was not telling the minister you need to be concerned about an event on 7th June, it was very much there is a concern on the back of the lookback exercise. I'm not sure I would accept that 7th June is in any way an event to get caught up on. 14:57 14:57 14:58

110 Q. Just to be clear, I think I understand the thrust of that answer but I suppose from Mr. O'Brien's perspective, he says what happened on 7th June was this: He put a number of patients, I think a list of 10 to 12 patients through for surgery, and that caused Mr. Haynes, a colleague, to go back to look at those patients, and Mr. Haynes' information back into the system was two of those patients were seen November the previous year and February of this year and their details are not up on the patient admin system, giving rise to a concern that those patients, from an administrative perspective, were placed at risk. 14:58 14:58

You're right to say that there was then a range of other inquiries and investigations and lookbacks conducted by the Trust. But the inaccuracy, or the invalidity as Mr. O'Brien would put it, was working from that base point on 7th June, which he says was wholly inaccurate and untrue. Your response to that?

A. I think it was the phrase I could borrow that I heard many times in the context of the Neurology Inquiry was you can't unhear something and you can't unknow something. Regardless of the entry point and on the basis of the Early Alert, we now know there are concerns about practice. I think if the Department response had been there are known concerns on the basis of a lookback exercise about clinical practice but the trigger point that caused us to be aware of that is somehow in question, let's not focus on those concerns, I would be beyond uncomfortable with that as an approach.

111 Q. Yes. Could I bring you then to your direct involvement. If we look at an email that Mr. Devlin sent you, TRU-262068. It's 9th October and Mr. Devlin is writing to you further to a telephone call that morning concerning Mr. O'Brien. Mr. Devlin says:

"I was concerned that there was a view that the Department of Health were not fully briefed or aware of this situation".

He then went and spoke to his team and they are

preparing a detailed brief for next Wednesday. He asked for an assurance that the Department of Health staff have been fully briefed through this process. He sets out within the email a table explaining the process of engagement. 15:01

If you just scroll down. Can you recall any sense of concern on your part that the Department wasn't getting the information it required from the Trust, as he seems to imply? 15:01

A. Yeah. Sorry, can I briefly... I've just seen the name. The name I couldn't recall earlier is on that, it is Brid Farrell. Just to deal with that.

112 Q. Thank you.

A. No, I can't recall a concern. When I was reading the papers for this, when I read Shane's email to me, my instincts were that when he refers to the conversation between the two of us, there was maybe something of an edge to that conversation where I was suggesting it. I think that telephone conversation is captured in my notebook on 9th October. When I look at my notes of that, there is no sense coming through those notes that I was in any way suggesting any unease or discomfort. So, reflecting on this, I wonder just was Shane concerned that maybe we had an unexpressed view that we hadn't been kept informed but I don't recall it was a view I held or put to him. 15:02 15:02 15:02

113 Q. If we look at your notebook entry for that date. It is at WIT-109523. It is 9th October. Again, Mr.

Johnston. Just scroll up to the top before we get to the Shane bit.

I am conscious of how you described your role and how you exercised your responsibilities earlier this morning. You don't tend to get involved in the minutiae or the smaller items, you tend to work on the bigger policy issues. Why were you becoming involved at this stage in this one? 15:03

A. I think it was the conversation on 9th October when Jackie Johnston came to me. From recollection, it was because I think Jackie's words to me were along the lines of he was worried about this, that on the back of our experience in neurology, and I think I reflected in the notes that it felt a bit like -- 15:03 15:04

114 Q. Scroll down, yes.

"Jackie feels Trust has tried their best to manage this. Have talked to Belfast Trust about the Watt case". 15:04

A. Yes. Sorry, forgive me for preempting something you want to get to. My involvement particularly, on experience we established the Oversight Group in the Michael Watt case with Belfast, and it was a very effective mechanism of bringing all the interested parties together on a regular basis and trying to keep a bit of momentum for what was a very, very big case. I think Jackie had engaged me on 9th October and I engaged with Shane on the basis that our instincts 15:04

were, based on what we knew at a very early stage, that that was the direction of travel of this case.

115 Q. I think you were dealing with a point earlier in terms of your discussion with Mr. Devlin, that your note doesn't suggest that you were concerned about them holding stuff back? 15:05

A. No.

116 Q. That was his concern. If we scroll down your note. So yes, this was your conversation with Mr. Devlin.

A. Yeah. As I say, my reading of this at some distance is that there wasn't a sense in the points I have recorded there that I had any unease with the way it was being handled by the Trust, or they weren't being open with us. 15:05

117 Q. We can see, as Mr. Devlin's email, which we looked at earlier, referred to, they are going to send a comprehensive report that had been recently presented to the Trust Board. 15:05

If we can go to that report. We can find it at TRU-262070. That's the report, I think, that was sent. It had earlier been before the Trust Board. We can see, if we scroll down four pages to 074 in the sequence, that they set out a timeline for you. The timeline commences. Just scrolling down; it's back the other way. The timeline that was set out in this report commences March 2016. It takes us all the way up to 2020. I don't wish to be unfair to you; do you have any memory or any sense that this was troubling 15:06 15:07

because of the length of time issues appear to be at large with the Trust with the same clinician?

A. I think, and I don't honestly know whether it was reading this report or the issue we talked about earlier, the meeting where there was reference to both 2016 and 2009, I think that in itself caused a feeling of unease, that this is a problem that clearly... 15:08

When ostensibly a problem started in either 2016 or 2009 and in 2020 we seem still to have a problem, without jumping to the conclusion that the problem has never gone away and it wasn't dealt with properly, was it a case that there was an issue that was successfully and appropriately resolved but now there is another issue. Again, I don't know, I hope this isn't rationalisation on my part; a key point here was at this stage Mr. O'Brien wasn't continuing clinical practice. I think the reaction, you know, that the concerns had been continuing might have prompted a slightly different reaction if it was a medical colleague who was continuing practice. I think that is, sorry, a very longwinded way of saying it didn't sit easily that problems had been identified a number of years before and here we are again, but not to the extent that we demanded answers to that question now because we knew the direction of travel we were on, we will deal with today's issues today. The issue is about why it was going on for this length of period and that is an issue we will come to in due course. 15:08 15:08 15:09 15:09

118 Q. Yes. The answer to that question why had it gone on so long, I'll take your view on this. The Trust had an answer to that question, it just didn't share it with the Department, on the face of it. I want to draw your attention to this. If we go along the timeline to page 80 in the series, about six pages further down, please. It is TRU-262080. You're told at the bottom of the page that on 1st October 2018, Dr. AK, the case manager, and he was the case manager with responsibility for the MHPS process, "met with Consultant A to outline the outcome of his determination that the case should be forwarded to a conduct panel under MHPS". Then the findings of the investigation are set out in the report. 15:10 15:10 15:11

In fairness to the Trust and to the author of this document, it's a detailed document and it does provide the reader with much information, but what's alluded to there in terms or referred to there in terms of outcome of the MHPS is only partly rehearsed. Could I draw your attention to this? Dr. Khan, in his report, sets out conclusions that speak to management failures. If we go to AOB-01918. Sorry, scrolling down. He is setting out the findings of the various aspects relating to Mr. O'Brien's practice. Then at AOB-01923 - go down five pages - in his final conclusions at the bottom of the page, he says: 15:11 15:12

"The investigation report highlights issues regarding

systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies that there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr. O'Brien. No one formally assessed the extent of the issues or properly identified the potential risks to patients". 15:13

He goes on in the next paragraph to say that he is of the view that there are wider issues of concern to be considered and addressed and that the findings of the report should not be solely focus on one individual, Mr. O'Brien. Then, finally, he commends the Trust to carry out an independent review of the relevant administrative processes, with clarity on roles and responsibilities at all levels within the Acute Directorate. 15:13 15:13

So, when I say the Trust had an answer to the wide question why had this happened, it had that answer in 2018 but in terms of the conduct of an independent review as suggested by the case manager, that didn't commence until 2020. The kind of report that you received from the Trust setting out the timeline, should it have been telling the Department about failures of management? 15:14 15:14

A. I think so, yes. Very much so. The points that are made there, I think they are concerning to the extent that they would need to be unpacked because it's

clearly pointing to the failures in terms of the oversight and management of this process. I think there is really important questions to be asked on the back of that at a system level; are they failings that were confined to the behaviour and attitude of certain individuals within the Trust or are they failings that were a reflection of a wider culture within the Trust, or are they failings that were representative of the wider culture across the health and social care system in Northern Ireland. I think we should have started to unpack those there. 15:15 15:15

At a minimum, even if they were confined to behaviour by a small number of individuals in one Trust, there is bound to be opportunities for learning and heading those sorts of issues off at the pass earlier. I think those points should have been escalated upwards and we should have started taking that forward at an earlier stage. 15:15

119 Q. The additional point is this: The Department appoint a Chair, they appoint Non-Executive Directors, as you said earlier, to hold the feet to the fire when it is appropriate to do so. This aspect of Dr. Khan's finding, his report, wasn't ever shared with the Non-Executive Directors, so the criticism which he focused on management behaviours that had allowed this problem to run over such a period of time was never in their in-tray to be able to use to challenge the Executive Directors and their managers. 15:16 15:16

A. Yeah and I think that was clearly a failing. I would also argue in terms of the wording there, you know. Maybe this is an attitude point but if we look at the Early Alert system, the Early Alert system is to give -- if you step back and try to rationalise why we have it in place, it is about issues that fundamentally fall within the remit of the Trust to respond to and to manage. It is about at an early stage putting them on the radar of the Department in case there are wider issues or thematic points to be learnt from it. It is all done in the context of patient safety and patient care. 15:17 15:17

You wouldn't have to work too hard to argue that the wording that is used there that suggests failing in terms of the oversight of clinical practice is arguably in the territory of an Early Alert, that the Department needs to be aware that taking forward the MHPS system in itself because of these failings could give rise to failings in patient care. Again, this is all with the wonderful benefit of hindsight but I think in the here and now anyone who reads that language, I think, should stop in their tracks and think long and hard about what actually that is saying. 15:17 15:18

120 Q. I suppose the obvious point to make is that the kinds of themes identified by Dr. Khan back in 2018, you know, two years before this all blew up, if they had been suitably addressed at that point, it may have removed the need for further heartache and risk to 15:18

patients and possibly the need for an expensive public inquiry. I can see in terms of your contribution, I think if we go to TRU-251227, and these are Mr. Stephen Wallace's notes of a meeting of the Urology Assurance Group. Just at the top of the page. This is attributed to you and I'm not sure if you recognise yourself in the note but it's been said by you that the work up to now has been regarding the scope, and because that is over on the clinical side "a big part of this response will be how was this allowed to happen. Issues that are systemic will be addressed via a Neurology Inquiry". You had a conversation with Mr Lockhart, Brett, from Neurology; he felt these two elements will be fairly closely tied together, though he was nervous regarding bringing the elements together as this would slow up the word greatly. 15:19 15:20 15:20

I think it is on down the page, on down the paragraph, you go on to say, "both issues", that's the neurology and the urology issues "started around the same time. The systems required to identify deviations is required", somewhat inelegantly recorded there. 15:20

Is the thrust of this paragraph, if you can recognise your voice in the note, is the thrust of your view that these kinds of issues around systems failures, about identifying deviations from good practice, that these are now the key issues to be addressed? 15:21

A. Yes, very much so because I think we place great

emphasis in terms of the quality of our services. The conclusion from these two issues must be that where we identify concerns, are we robust enough in the immediacy of our response. It's hard to conclude that we've got that right. 15:21

121 Q. Do you see this as exclusively a Trust governance issue? I think we looked at this this morning in the context of the saline bipolar issue. Do you see this in learning in all of this in terms of the whole health and social care system engage with governance issues? 15:22

A. I think there is. Based on the previous documentation and the process back in 2016, I'm still a little uneasy in moving too quickly to a process whereby the Trust as employer has primacy for a process and investigation, and somehow that is repeated by either at the time the 15:22 Board or the Department, but I think we need to find a way that there is some better transparency about a thematic overview of where -- we need to start distilling out of these. There is multiple levels of details about what an individual did in certain 15:23 circumstances but we need to start picking the bones out of that in terms of what are the opportunities for wider learning, and particularly what are the opportunities for earlier intervention to stop these sorts of things happening. 15:23

Again I emphasise this is in the context of a massively complex endeavour. The day-to-day job of clinicians is beyond most of us, it is so complex and so

evolutionary, but there are standard themes about the need for red flags to be red flags, and to react to them and respond appropriately and justify next steps. For me that is the place that we need to define really, really hard. I am absolutely of the view that there are opportunities for all of us to up our game in terms of dealing with that.

122 Q. Another part of the response - and just in the interest of brevity, I will deal with it quite quickly - another part of the Departmental responses as the further information came in from the Trust, and again in the interest of brevity, I don't wish to be unfair on the Trust, certainly further information was supplied in terms of additional discoveries around the Bicalutamide issue, which is a prescribing issue, and you were certainly given further information about the additional serious adverse incidents that were being triggered. But an additional part of the Department's response was to establish a Urology Assurance Group, as I mentioned. Was that something that the Trust accepted as useful or an assistance towards moving these issues along, or was there any pushback in that respect?

A. My clear recollection is that the Trust very much welcomed that. The very quick reasons we established them were we established one in the context of neurology; it worked very, very well. There is always a risk that in terms of a big issue like neurology, that for example the Trust and the Board will come

15:23 15:23 15:24 15:24 15:24

together, but then the Department needs to be kept abreast of what's happening so you then have to repeat the meeting they have in terms of engaging with the Department. Firstly, it was bringing all the relevant players together in one place at one time so you only have to have one discussion of the issue but it was an external way of applying just a little bit of pressure and saying to the Trust, you know, over the next week to 10 days we need to undertake these three actions and I will be back in 10 days time to chair a meeting to make sure they are done. There was that component in terms of driving the pace. 15:25 15:25

I also felt there was an opportunity, having spent a considerable period of time in Neurology Assurance Group, there was some learning for us, and certainly the Belfast Trust, I think there was a huge amount of learning. It was a quick way of saying to the Southern Trust, as well as an opportunity for you to keep us up to speed with what you are doing and us to put pressure on you, it's an opportunity for us to reflect back in real-time how we were dealing with the issues in the context of Belfast and neurology which might help this overall process. That was very much the spirit within which colleagues within the Southern Trust engaged. I think they came to it in an open and engaged basis, and I think it worked well. 15:25 15:26 15:26

123 Q. Again without seeking to prejudge any of this, what's happening in these four walls, given your sense of how

things arrived with the Department in the summer of 2020, leaving aside any of the particulars of the incidents of the care itself, what do you see as the big challenges? The way this came out into the open, what are the big challenges for the health and social care system and the way this developed and the way it happened?

A. Sorry, is your question in terms of moving forward, what have we picked up from this?

124 Q. Yes. What do you think the Department has picked up from this to date? 15:27

A. I'm not sure if there is anything uniquely from this issue because I think the Departmental learning probably came from neurology which preceded it, not by a very long period of time, so the learning is for the Department to engage. I think the big cultural point is create an environment, which we tried to do in the assurance group for both neurology and urology. We are creating a partnership. This is a problem facing the health and social care system. Whilst it's manifested itself in one case in Belfast and the other in the Southern Trust, it has to be a partnership and collaborative approach to respond to this, and it has to be the right response. Fundamentally, it has to find out what went wrong and how to prevent it in the future. 15:27 15:28 15:28

We need to change the cultural way from what went wrong so we can blame somebody. The thing that matters and

the thing that should keep people like me awake at night is how do we make the Health Service better than it was today and how do we stop any of this happening again. That is a cultural point I think we embedded on the back of neurology, and I think this just underpinned it.

125 Q. Okay. I have no further questions for you, Mr. Pengelly. Thank you for answering mine. The Panel may have some for you.

CHAIR: Thank you, Mr. Wolfe. I can't let you go just yet, Mr. Pengelly. Mr. Hanbury has a few questions. 15:28

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

15:29

126 Q. MR. HANBURY: Thank you very much for your evidence. I have a couple of clinical things on the dreaded subject of waiting lists and waiting times, both in Outpatients and Surgery, and the demand and capacity. I was interested in your management capacity, why are you not sharing, just as an aside there. But there seems to be a general sort of blind acceptance of everything that is referred should be seen and everything that is on awaiting list should automatically get done. I was just wondering whether you had a view on whether the clinicians ever talked to you, engaged with you, about should we really be doing everything? The things that struck me is that certainly in neurology there is some lower priority things such as subfertility, erectile

dysfunction, these things that we see on the clinical side. On the waiting list side, things we have seen examples of, things like vasectomy and sort of penile straightening surgery which one couldn't really argue is a high priority in most cases was there. I just wondered if, in your discussions with the chief exec and chairman, this applies to all surgical specialities, and I guess there are lower priority things, was that ever looked at as a way of, I guess, you politically prioritising what things we can and should be doing compared to what we shouldn't be offering? 15:30 15:30

A. Yes. Forgive me if I get the clinical aspects of this wrong. One of the examples you touched on, so going back, I think this would have been a year or two before I moved on from Health, we started the role out of vasectomies in primary care. I think that is the point you are alluding to, so those sorts of conversations and exploring opportunities. The difficulty -- and the other issues that I know there were many, many conversations about were the number of referrals that had to take place from primary care into secondary care because primary care physicians had no access to diagnostics technology, and the great frustration on their part. Again, that is a resourcing part. 15:30 15:31 15:31

Those conversations were all starting to happen but we were trying to contextualise them all as part of the broader transformation strategy. The difficulty we had

is we had a 10-year transformation strategy that was formally signed off by the Executive about a month before the Executive collapsed for three years. So we have some actions we took forward but we had three years where we weren't having the strategic policy-led discussion about how we identify and take forward the next phase of it. So, I think embryonic discussions in the space you are talking about, a recognition they needed to happen more, but I think we are behind where we should be. 15:31 15:32

127 Q. Do you think they may happen in the future?

A. Yes, they definitely will and should. Because the points you make, these are hugely important dimensions to it.

128 Q. Thanks. There is one. I was interested in your quotes about all paths lead to money and people, and doctors are mobile, and that sort of leads us to the dreaded recruitment aspect again. We've heard that there are various not barriers to recruitment but I guess disincentives, both financial and professional. Financial as in compared to England, there is this perceived lack of increments. Although the discretionary point thing has been updated now, that has seemingly been a disincentive, I guess, here compared to England. And on the professional side, the sort of specialist interest and the Belfast versus the rest of Northern Ireland in terms of rotational appointments. I wondered what your view about how would you address recruitment or the difficulties in 15:32 15:32 15:33

that context. Now is there any movement that you can see for the future?

A. It's the dreaded money point. Fundamentally, if you are going to recruit, you need to be an attractive employer, and being an attractive employer isn't just about the salary. Salary is a component and an important component but it is about workload, it is about work-life balance. I am a native of these parts, I happen to believe Northern Ireland, if you are talking in the UK context, has a great selling potential. You can have a great life in Northern Ireland; you can work in the city and live in the country. In mainly places in England, that journey would be just too high for people with younger children with an education system, we could say. 15:33 15:33 15:34

In terms of recruitment, I think we need to try and assemble what is a total lifestyle package because medics look at the lifestyle package, it is not just what happens on the job. What happens on the job is important. I am not offering a qualitative assessment on it but at the Hyponatraemia Inquiry, one of the key recommendations there was about a statutory duty of candour. Northern Ireland, as I understand it, would be unique in the UK. There is some emerging evidence that that might be counterproductive in terms of our ability to recruit individuals. So we need to survey the landscape and look at all those issues and try and work it forward. 15:34 15:34

It is also about lifestyle. Again, if I refer back to primary care, the last graph I saw, if you compare head count in terms of GPs, Northern Ireland is unique in the United Kingdom in that over the last number of years, our GP head count has increased whereas in every other jurisdiction it has gone down, but our GP whole time equivalent has decreased markedly. The new generation of our workforce are not working the same hours as I suspect you worked when you trained. We need to factor in all those discrete components and come up with a package that is attractive because we want the best to come and work in Northern Ireland. I don't think our package at the moment attracts them. 15:34 15:35 15:35

MR. HANBURY: Thank you very much. I would like to say we have a duty of candour even in England.

129 Q. DR. SWART: Can I pick you up on that point. Did you have a lot of discussions at that time in terms of, you know, you have got a relatively compact population here, clearly lots of things you can offer, clearly a big recruitment problem, clearly spending a lot of money on extra payments for people and locums or whatever; that costs a lot more than normal staff. How strong was the strategic emphasis on discussions, and how far did that actually go at the time, or did you feel you didn't have time to get to that? 15:35 15:36

A. There was some strategic discussions about it. I don't want to suggest that -- well, I don't want to say explicitly that transformation is somehow the silver

bullet to all our problems but it pretty much is in many ways, because aside from the financial package for attracting, particularly if you look at all professions involved in health and social care, particularly the medical profession, they are high-achieving, ambitious people who have spent a long time studying and they want to work in exciting and challenging work. The fragmentation of our service means there are many locations that we try to recruit to. If you are a doctor in training, you know that the package of work you are going to give isn't one that fully develops and stretches you and allows you to reach your potential. The transformation agenda where we are going for larger centres of excellence where you, as a doctor in training, will be exposed to a whole range of issues. So the conversations were part of that broader discussion as opposed to a separate and parallel set of conversations. 15:36 15:36 15:37

130 Q. I get that and you are absolutely right, but really what I'm saying is did you get enough oomph behind that; was it sidelined by other issues? Lots of people have referred to the transformation agenda and the need to accelerate it, shall I say. Now we have got the learning from Covid and others things. Was it your experience that that really got the momentum it should have had, or was there an impediment because of instability of government and so on? 15:37 15:37

A. The lack of government is clearly an inhibitor. The point I am making, that this is a personal frustration,

sorry for another rant. The media run the narrative that the Bengoa report was published late 2016, there was then the Executive's Delivering Transformation Strategy. There was then three years of no government so this all sat on the shelf, gathering dust. I can't remember the exact number but a double digit number of targets were in the transformation strategy to be delivered in the first couple of years. Within 18 months of the publication of the strategy, notwithstanding the collapse of government, we published a progress report to show we'd implemented all 18 actions, so we made process. The gap was that in parallel we should have been doing the strategic thinking at Executive level about what is the next batch of targets. So we've undoubtedly lost momentum there. 15:38 15:38 15:38

131 Q. That is kind of what I was getting at.

A. So there was absolutely a loss of momentum on that.

132 Q. The other questions are really around this emphasis on quality and safety. You robustly defended the importance of that at Department of Health level, the Trust would do the same at Board level, and yet quite a lot of people had expressed the view that we were just working to targets and we weren't measuring anything to do with quality and nobody asked us type of thing. 15:38 15:39

There is a big challenge obviously between the money and governance infrastructure and so on, but would you not accept that if you don't ask questions specifically

about quality and safety, and you don't measure things specifically, people might get the attitude, get the idea that it doesn't matter as much as the money and the performance target? If you might accept that, what discussions did you have about that particular issue? 15:39
I'm thinking about the work that's gone on, particularly in England which I am familiar with, which is basically to up the ante on the kinds of things that come out of national audits, not just for things that go wrong but for measuring standards and put that up 15:39
the agenda over time, which is quite time consuming and I would accept would be quite expensive. But what discussions were had about that? Because staff on the ground think the things that matters are the things that you ask them about and the things you measure and 15:40
the things you invest in?

A. I would find it very difficult to push back against that. I think it is fair comment that I could sit here and talk about quality being the single most important thing in my mind, but if the only conversation I have 15:40
with the Trust is about performance, I take the point what their view is.

133 Q. Did you have discussions about it? I think we can see this has happened and I can kind of understand why it's happened. Was there anyone pushing back, particularly 15:40
from, I don't know, the Chief Medical Officer, PHA and others saying actually, you know, we've talked about having quality indicators for services but we haven't got any; we've talked about these things but they are

not happening. Where did that discussion happen? This is just a question in terms of understanding that.

A. We've had some conversations because one of the things that I was very keen to do was to try and incorporate some more quality indicators within our performance measurements. The Health and Social Care Board developed a monthly reporting pack but it was all done on the quantitative targets. 15:41

134 Q. Which are important.

A. They are hugely important. But I think the point you are making is should we do more in this space; undoubtedly we should do more. Should we make quality more of a conversation? 15:41

There is an interesting short anecdote just about trying to tie up what I call quality and quantity. When I started in Health, knowing nothing about health I tried to get out and about and, you know, speak to lots of people. I went around ur emergency departments and the thing that struck me when I was speaking to consultants in emergency departments, there is a fixation on twelve-hour breaches and the four-hour target. The message I took from every ED consultant I talked to is that they couldn't get that excited about the four-hour target because, in their perspective, a clinically relevant time was six hours. They said, you know, the gap four hours to five hours but once you go from five and a half hours to six and a half hours, that becomes clinically relevant. 15:41 15:42

I have to say I then tried to start a conversation about let's open the debate about changing the four-hour target to a six-hour target where it has some clinical relevance, and there was a very strong pushback against that. The cynic I think might respond that having separation between the qualitative clinical target and the four-hour target in many ways allows an alibi against the four-hour target because it is not what you are fixated on. 15:42

135 Q. I think you probably need both.

A. I think you do.

136 Q. I think the question should be do you know the sickest patient in the department today and have they had the right treatment and things of that nature. If you don't put them together, you get exactly what you are talking about. 15:42

It was just do you recognise that perhaps more of those conversations should have happened, and was the barrier purely the volume of work and the money or, you know, is there a better way of organising people so that those issues come to the front more? 15:43

A. The volume of work and the absence of money was clearly a factor. But to your key point, that shouldn't excuse not having a conversation you should have. I think the point we both agree on, the quality conversation is so important, we need to move heaven and earth to make sure we have more of it. 15:43

DR. SWART: Thank you.

137 Q. CHAIR: Just a couple of questions from me, Mr. Pengelly.

One, going back to the whole MHPS process, which obviously we will be looking at and have been looking at, one of the strong messages that has come across to us is that this is an unwieldy process to be carried out by people who have a day job, who have to carry on with their clinics, whatever the case may be, and they also then have to find times in the diaries of other clinicians - I'm thinking now of the case investigator who carries out the investigations - and trying to get everybody together can lead to a delay. I am just wondering whether you see any merit in having an external body, perhaps situated within the Department, what I have called a flying squad, who could be drafted in to deal with any MHPS investigation, any SAI or whatever, and take that pressure off the Trust for having to carry out those investigations, get them done more quickly hopefully and get the learning out more quickly? 15:43 15:44 15:44 15:44

A. I think my concern with that approach, while there would be many upsides to it, this is a difficult piece of work. It requires skills and experience and it would be quite a decent sized team. So if, say, we had a number of cases bubble to the surface at one period of time, if the team was deployed to one of them, everything else would need to take a back seat and wait 15:45

if that was an approach. Equally, if the cases weren't coming forward, we would have a large, potentially highly skilled team, sitting in the Department waiting for the next crisis, and our resourcing position doesn't allow it. 15:45

138 Q. I think setting the responsibility in the Department perhaps in a small team with a pool of, say, retired people who could go in and do this work, for example, on a locum-type basis?

A. I think it's a conversation worth having but, you know, there is always a risk when you use retired people that their skills can erode if they are not being used on a full-time basis. 15:45

139 Q. I appreciate that. You know, it would need to be a combination of sort of people currently and retired people. Okay, thank you for that one. 15:46

I mean, as far as the more general question, why should there be an MHPS process? Why should doctors be treated differently to other employees in a Trust who go through a normal HR process? 15:46

A. Well, I think that is a very sensible question to be asked and you answer it as part of a review process. I don't know whether MHPS evolved across the UK, whether there were some particular complexities and nuances to that. I think it is an important question. 15:46

CHAIR: Thank you very much for your time. Sorry we got started late, as I said. Hopefully the weather will be -- I don't think it's going to be any more

clement tomorrow but I think I will on the road a bit earlier than 8.30. A half hour journey taking two hours is not to be recommended. See you all hopefully tomorrow. I should say that if anybody does have any difficulty, if there is some representative for each of the Core Participants who perhaps live nearby or whatever, I am quite content that not everybody attends just so you don't feel under any pressure risking your neck getting here. Thank you. 15:47

15:47

THE HEARING ADJOURNED TO 10:00 A.M. ON WEDNESDAY 17TH JANUARY 2024