Urology Services Inquiry

Oral Hearing

Day 44 – Thursday, 18th May 2023

Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

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

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1 THE INQUIRY RESUMED ON THURSDAY, 18TH DAY OF MAY, 2023
2 AS FOLLOWS:
3 CHAIR: Morning, everyone.
4 MR. WOLFE KC: Morning, Chair, morning, Panel. Your
5 witness this morning is Ms. Zoe Parks and I understand 10:01
6 she intends to take the oath.
7 THE WITNESS: Yes.
8
9 MS. ZOE PARKS, HAVING BEEN SWORN, WAS EXAMINED BY
10 MR. WOLFE KC AS FOLLOWS: 10:01
11 1 Q. MR. WOLFE KC: Now, Ms. Parks, in advance of today
12 you've kindly furnished us with a statement and then an
13 addendum statement to tidy up some additional matters.
14 Let's get those up on the screen, please. The first
15 document is dated 17th November 2022. It's your first 10:01
16 witness statement. WIT-90030. You will recognise that
17 as your first page. You can see at the top right-hand
18 corner, a reference to the fact that we received an
19 addendum statement from you, which we will turn to
20 presently. If we go to the last page of this statement 10:02
21 at 90081, and you can see your signature at the bottom?
22 A. Yes.
23 2 Q. And the customary question is do you wish to adopt that
24 statement as part of your evidence today?
25 A. Yes, please. 10:02
26 3 Q. Thank you. Then your addendum statement. It's to be
27 found at WIT-94910. This primarily deals with the
28 issue of Mr. O'Brien's intended return to work
29 post-retirement, an issue you hadn't dealt with in your

1 first statement?
2 A. That's right.
3 4 Q. We'll look at that towards the end of your evidence.
4 If we just go to the last page, please, at 913 in this
5 sequence. Again, your signature. Do you wish to adopt 10:03
6 that statement as part of your evidence?
7 A. Yes, please.
8 5 Q. Thank you. Now, as we can see from your statements,
9 you came into what was the Craigavon Hospital Group
10 Trust immediately after qualifying from university? 10:03
11 A. Yes. More or less, yeah. It was within a year or two
12 of finishing my degree, yes.
13 6 Q. And you took up a job there in January 2003 in the
14 Human Resources Department. After a project officer's
15 post, you took up a job as medical staffing manager 10:04
16 from 2nd February 2004; isn't that right?
17 A. Yes, is that right.
18 7 Q. That's essentially the same job you have remained in
19 ever since?
20 A. More or less. It's changed obviously with the 10:04
21 evolvement to the Southern Trust and the role has
22 grown, but yes, the same job.
23 8 Q. Yes. Your main duties similarly include providing
24 advice, support and guidance to all medical staff and
25 managers in relation to HR matters, such as recruitment 10:04
26 and selection, employee relations and contractual
27 issues. Is that a fair summary?
28 A. That's correct.
29 9 Q. Just so that the Inquiry can understand where this post

1 sits, yours is a specific medical-facing HR role; is
2 that right?
3 A. Yes. So we have a part of HR that looks after the
4 medical and dental staffing, so we look after all of
5 the HR-related issues concerning the medical and dental 10:05
6 staff in the Southern Trust.
7 10 Q. So, HR is obviously broader and bigger than medical and
8 dental, so you would have other of your colleagues
9 dealing with the other general HR issues?
10 A. Yes, that's correct. 10:05
11 11 Q. Yes. Is it all under the leadership now of -- oh, I've
12 forgotten her name?
13 A. Vivienne.
14 12 Q. Vivienne Toal, that's right. Is she ultimately your
15 line manager within the structure? 10:05
16 A. She is not my line manager but she is our director,
17 yes.
18 13 Q. Who do you report to?
19 A. So then, when Vivienne started there was a new deputy
20 director posted that was created. Siobhán Hynds, so 10:06
21 she would be my direct manager.
22 14 Q. Thank you. We can see from your statement,
23 particularly at paragraph 7.7, that you have been
24 involved in the development and updating of various HR
25 guidance policies and procedures relating to medical 10:06
26 staffing over the years; isn't that right?
27 A. That's right.
28 15 Q. To pick up on a number of examples, we will look
29 briefly this morning at your contribution to an update

1 to the guidelines for handling concerns about doctors;
2 isn't that right?
3 A. That's correct.
4 16 Q. That was 2017?
5 A. Yes. 10:06
6 17 Q. And that's a companion piece to the MHPS framework?
7 A. It is, yes.
8 18 Q. We will also look at, later this morning, a document
9 dealing with the reengagement of doctors
10 post-retirement. Again, your fingerprints, if I may 10:07
11 say so, are on that issue, that was something you
12 developed in 2020; isn't that right?
13 A. That's correct, yes.
14 19 Q. That's to take but two examples. There are many others
15 set out in your statement. 10:07
16 A. Mm-hmm.
17 20 Q. The first substantive issue I wish to address with you
18 this morning is the issue of job planning.
19 A. Okay.
20 21 Q. Let me pull up something that you've said as perhaps an 10:07
21 important reflection in the context of what you
22 understand to have been the issues in relation to
23 Mr. O'Brien.
24 A. Mm-hmm.
25 22 Q. We will look at that specific issue -- look at that 10:07
26 specific reflection and then move through job planning
27 more generally as a concept, and then come back to look
28 at particular job planning issues around Mr. O'Brien,
29 and we will ask for your observations in relation to

1 all of that.
2
3 If we could have up on the screen, please, WIT-90079.
4 You can see at 40.3, this reflection here comes at the
5 end of a long series of reflections about how the case, 10:08
6 if you like, of Mr. O'Brien could have been better
7 handled, and that's something we will come to later
8 this morning. But ultimately you come to this
9 important reflection, and you say:
10 10:08
11 "I do believe we failed to fully and robustly utilise
12 the contractual tools of job planning at our disposal
13 to ensure Mr. O'Brien discussed and agreed
14 a contractual annual job plan, even if this meant
15 pursuing facilitation and appeal mechanisms. This may 10:09
16 have helped inform a more cohesive model of management
17 as a repeated failure to comply with such obligations
18 and perhaps others like appraisal may have" - and
19 I think that should say "shone"?
20 A. Yes. 10:09
21 23 Q. "The light to indicate potentially a broader problem in
22 other areas of the doctor's practice."
23
24 Let me put that in context. When you are writing that,
25 you are aware that, at least from 2016 and perhaps 10:09
26 further back, until Mr. O'Brien walks out the door,
27 retired in 2020, he hadn't signed off on a job plan;
28 isn't that right?
29 A. That's correct.

1 24 Q. I mean, there were, as we will see in a moment, job
2 plans that were eventually worked out through
3 a facilitation going back earlier in his career. But
4 that's a reflection on the period from the commencement
5 of MHPS or around that period, right to the end of his 10:10
6 career?
7 A. Mm-hmm.
8 25 Q. We will bear that reflection in mind and explore it for
9 what it means shortly. But can you tell me from an
10 organisational as well as an individual practitioner's 10:10
11 perspective, what is the importance of job planning, in
12 your view?
13 A. I think it's really very important. It's the key
14 contractual document that should be a partnership
15 approach between the consultant and the Trust to 10:10
16 identify the supporting mechanisms that are needed to
17 allow consultants to deliver the work. It's an
18 opportunity for them to discuss with their clinical
19 manager what is expected of them and what they will
20 need to enable them to deliver that for the year ahead. 10:11
21 So, it's very much a performance management type of
22 tool in the sense of having those meaningful
23 discussions to decide how is it possible to deliver the
24 work that has been assigned, and it should also then
25 feed into demand and capacity information so that 10:11
26 that's driving the job planning discussions.
27 26 Q. You mentioned demand and capacity. Is job planning
28 a tool which can address that issue?
29 A. I believe it has the potential to. I think that's the

1 original intention of it in relation to it should
2 commence with a review of what the service needs to
3 deliver for the year ahead, with the service. That
4 should be considered and then designed into individual
5 or team job plans with job plan objectives to align, 10:12
6 taking on board what supportive resources or supporting
7 mechanisms a consultant may highlight at those meetings
8 that are needed to deliver the service. It allows then
9 the service to ensure that objectives are aligned and
10 job plans are aligned with the direction of travel that 10:12
11 the service has to deliver and commission to.
12 27 Q. Now, you've helpfully - and I should preface this
13 remark by saying we don't have the time this morning to
14 delve into the detail of this - but you have helpfully
15 set out for us some key job planning documents. If we 10:12
16 can just run through them on the screen just to
17 illustrate them. WIT-19840. That is a 2009 document,
18 Local Trust Framework on Job Planning For Medical
19 Managers. That was developed within the Southern
20 Trust; is that right? 10:13
21 A. It was, yes.
22 28 Q. Is that a product of your work?
23 A. Yes. I was involved with that, yes, along with the
24 associate medical directors.
25 29 Q. We have job planning for consultants, which is a BAUS 10:13
26 document, that is 2016, which you have referred us to.
27 WIT-83181. If we just open this one, but briefly. I'm
28 going to ask you ultimately to help us to better
29 understand and to distill for us how you go about job

1 planning to serve the objectives that you have just
2 outlined.
3 A. Mm-hmm.
4 30 Q. If we just look at 2.1 of this document. Sorry I don't
5 have a reference but if we just go through it. Yes, 10:14
6 thank you. Just before we do this, this is a 2016
7 document; does its advice or guidance remain pertinent
8 today?
9 A. As far as I understand, yes, I think it's still
10 available. 10:14
11 31 Q. Yes. You've set out some of this already in your
12 answers, that job plans are an annual agreement or they
13 should be --
14 A. That's right.
15 32 Q. -- between the employer and the consultants setting out 10:14
16 the work that is done for the Trust reflecting
17 a balance between operative outpatients and emergency
18 care, depending on the setting, I suppose?
19 A. Mm-hmm.
20 33 Q. "When/where the work is done; how much time you are 10:14
21 expected to be available for work; what will be
22 delivered for the employer, patients and the employee;
23 what resources are necessary for the work to be
24 achieved, and what flexibility there is around the
25 above". 10:15
26
27 Do they continue to be key guiding principles of what
28 the process is about?
29 A. Absolutely, and I think most of those are probably

1 replicated within the contractual documentation for
2 consultants as that's what job planning is all about.
3 34 Q. Yes. And it sets out some hallmarks of a successful
4 job plan.
5 A. Mm-hmm. 10:15
6 35 Q. And if it's undertaken in a spirit of collaboration and
7 cooperation, completed in good time, reflective of the
8 professionalism of being a doctor, focused on
9 measurable outcomes that benefit patients, and
10 consistent with the objectives of the NHS and the 10:15
11 employing organisation in the teams and individuals
12 with whom the urologist will work.
13
14 Again, is that in keeping with what you would
15 understand to be the requirements of a successful 10:16
16 process?
17 A. Absolutely, and again it's reflected in contractual
18 documentation.
19 36 Q. Yes. The third document that you've helpfully referred
20 us to is a more recent document, 2019, local Trust 10:16
21 framework for job planning guidance. WIT-89285. Again
22 we can see your name on the front of it, you are the
23 author. It sets out, having glanced at it, kind of
24 practical steps that are to be undertaken as part of
25 job planning? 10:16
26 A. Absolutely.
27 37 Q. Now, is the essence of a good approach that there would
28 be a specialty meeting, Urology, that demands on the
29 service would be recognised?

1 A. Mm-hmm.
2 38 Q. And articulated, and that an understanding would be
3 reached about how that should be equitably or
4 appropriately designated between the staff that you
5 have available to you? 10:17
6 A. Yes, absolutely.
7 39 Q. And is that the approach that, broadly speaking, is
8 adopted in the Southern Trust?
9 A. Yes. I am aware of many good examples of that
10 happening where the heads of service and the 10:17
11 operational directors -- I wouldn't be aware, I am not
12 involved in those meetings but I do know they occur, in
13 terms of looking at the service, what they need to
14 deliver, what they are commissioned for. They will
15 have discussions with the consultants around maybe what 10:18
16 external duties they are taking on for the year ahead
17 or what special interests they are wanting to focus on.
18 It's about balancing all of those requirements against
19 the needs of the service and then designing that into
20 job plans, and more recently into team job plans which 10:18
21 are very effective as well.
22 40 Q. Yes. Tell me about team job planning. We saw in some
23 of the documents you appended to your statement that
24 that, I think in 2009, became an issue raised, I think
25 was it by Dr. Rankin who wanted to have some work done 10:18
26 in relation to that? Have you been able to include
27 team as well as individual objectives into the job
28 planning process?
29 A. So, team job planning is not contractual so we can't

1 enforce team job planning, but it's certainly something
2 we would encourage and where we are trying to aim to.
3 We do have a number of good practice examples within
4 the Trust, and we are writing those up as case studies
5 to share with others specialties on how that is 10:19
6 managed, where a team have come together to consider
7 their specialty and then have designed team job plans.
8 I mean, it allows more flexibility within the team and
9 cross-cover and lots of different benefits to both
10 Trust and the consultants when they are signing up to 10:19
11 deliver a set number of activities for the Trust, which
12 is then fed in as objectives.
13 41 Q. Could I ask you just to rewind on that for the
14 uninitiated. What is team planning, team job planning,
15 as contrasted with perhaps the more traditional 10:19
16 individualised approach?
17 CHAIR: Ms. Parks, could you please slow down a little?
18 We don't have a stenographer present in the chamber
19 today. I am guilty of anyone as speaking very quickly
20 but if you could just slow down a little bit, please. 10:20
21 Thank you.
22 THE WITNESS: No problem.
23 MR. WOLFE KC: It's probably my fault as well.
24 42 Q. I was asking you just to help us better understand the
25 conceptual basis for the team approach, and contrast 10:20
26 it, if it's helpful, with the more traditional
27 individualised approach to job planning. What's the
28 merits of a team-based approach?
29 A. I think it probably promotes more openness and

1 transparency amongst the team as to what everyone is
2 doing. It allows them to work better as a team, to
3 align themselves with the service. It's, you know, a
4 very open, transparent, fair approach in terms of
5 everything is out on the table in terms of what has 10:20
6 been allocated in job plans. I think it just allows
7 that flexibility to be discussed about how they can
8 work as a team, you know, between certain days. It's
9 just that more enhanced level of job planning where
10 they can consider those things as a team, as opposed to 10:21
11 having individual discussions with their clinical
12 manager about their individual job plan.
13 43 Q. We have talked as well this morning about the
14 importance of job planning in perhaps helping to
15 address demand capacity issues. 10:21
16 A. Mm-hmm.
17 44 Q. Is it possible to see those two things as having
18 a relationship with each other if there is a service
19 such as urology facing significant demand capacity
20 pressures with a limited and, as we have seen in 10:21
21 evidence to date, a less than optimal consultant body
22 servicing that need? Is that particular environment or
23 particular context in which root job planning, team job
24 planning is helpful or potentially helpful?
25 A. I certainly think the specialty review meeting to 10:22
26 consider the demands on the service and the capacity of
27 the number of consultants you have, it highlights if
28 there's a huge gap in terms of when you consider all of
29 the programmed activities that you can have within the

1 consultants aligned to the service, then it allows the
2 clinical managers and their operational management team
3 to make the necessary business cases for more
4 consultants if there's a very obvious gap between the
5 two, or it allows the consultants to discuss how better 10:22
6 they maybe can use their programmed activities. I know
7 some specialties have chosen to reduce the programmed
8 activities to support the appointment of a new
9 consultant. It gives you those options to have some of
10 those discussions. 10:23
11 45 Q. Does team job planning also assist in getting to grips
12 with any quality issues that might exist within
13 a service?
14 A. I think job planning in general would allow for that in
15 terms of identifying what the expectations are and 10:23
16 building those into job plan objectives, because you
17 will always have variation between consultants, not
18 everyone operates on the same way. It allows you to
19 best match those and deal with those. I think it
20 allows you then just to build that into -- and it's 10:23
21 obviously having discussions as to best use the
22 resources you have to address some of those quality
23 measures you need to factor in.
24 46 Q. How successful do you think the Trust has been in using
25 job planning to deal with demand and capacity issues? 10:24
26 A. I think I would have to be honest and say it has been
27 challenging. I don't think we are alone in that
28 regard. I mean, I think there's been many an audit
29 report, both nationally and locally, looking at this

1 issue. So, I think it has been challenging. We have
2 -- I mean, we started in 2009 with the Chief Executive
3 chairing monthly meetings on job planning for probably
4 five years or more. I think they ran from 2009 right
5 to the end of 2014. Subsequently, it was chaired by 10:24
6 the medical director and HR director, with all of the
7 divisional medical directors and CDs coming to those
8 meetings to discuss job planning. So, there was a lot
9 of focus and effort in terms of the importance of it.
10 10:24
11 It's not without its challenges. It is a very
12 challenging process to continue to do this on an annual
13 basis, and the resources required to do it effectively
14 and well are significant. We were the first Trust in
15 Northern Ireland then to try and get a system that 10:25
16 would support them in terms of using an electronic
17 system for job planning, which brings benefits but
18 obviously is not easy for everyone to use as well
19 initially, so we've had a journey with that as well.
20 We have moved to a new system now that brings better 10:25
21 benefits in the sense that it's now accessible by more
22 of our operational managers, and so it's giving that
23 oversight to all of those operational managers who need
24 to understand what is in job plans to match against
25 their service plans as well with their clinical 10:25
26 managers in those meetings. So, it's been a journey
27 and I think there's been lots of guidance. We have
28 worked closely with our local negotiating committee and
29 we've agreed our guidance with the local negotiating

1 committee. I have run training, and we have training
2 videos up on our job planning hub, of how job planning
3 should be delivered. We continue to support our
4 clinical managers as best as we can to do it in the way
5 it's designed to do. 10:26
6 47 Q. I suppose, used properly, job planning, if it's
7 actually done, will leave the employee, the clinician,
8 with an understanding, and the manager would have an
9 understanding, as to what's expected, and failure to
10 deliver on what is expected will lead to questions or 10:26
11 challenges being posed; is that fair?
12 A. That's fair, yes.
13 48 Q. It provides a basis upon which inquiries can be made?
14 A. Absolutely.
15 49 Q. Those inquiries could potentially lead to 10:27
16 a disciplinary route; is that fair?
17 A. Yeah, potentially, yes. I mean it's a contractual
18 document so it's a contractual requirement on both
19 parties to participate in it.
20 50 Q. Equally, in some cases the failure to deliver on 10:27
21 objectives within a job plan might raise a wide range
22 of other issues, the need for help or assistance?
23 A. Absolutely, yes.
24 51 Q. It may lead to conclusions in relation to how well the
25 service, how well the employer is assisting the 10:27
26 employee, supporting the employee to deliver on the
27 plan. But it's important to have that baseline, isn't
28 it?
29 A. Very important, yes.

1 52 Q. You have said in a number of places within your
2 statement that there wouldn't have been a signed-off
3 job plan for every consultant in Urology, and indeed
4 wider afield; the annual process isn't always
5 completed? 10:28
6 A. That's fair, yes. That's true.
7 53 Q. Just before I ask why that might be, why is an annual
8 process viewed as important? Clearly such a process
9 will place some pressures on those who are required to
10 carry it out, notably the Clinical Director usually; 10:28
11 isn't that right?
12 A. That's right, yes.
13 54 Q. Has there been any thinking about planning on a
14 three-year basis or a two-year basis? Why is there
15 a requirement for a one-year approach? 10:29
16 A. Well, it's contractual, but it also offers the
17 opportunity to have a discussion with their line
18 manager on an annual basis. We have acknowledged that
19 if the services haven't changed and both parties are
20 willing parties, then the job plan can be rolled over 10:29
21 from the previous year to the next year if nothing
22 needs to change. So, it just gives that opportunity
23 for either party to bring something to the table that
24 maybe needs to be discussed for the year ahead. But
25 there is the opportunity, and there is opportunities 10:29
26 where they don't have to have a lengthy meeting if
27 nothing has changed and the job plan just stays as it
28 was before.
29 55 Q. The recognised failure which you have identified of job

1 planning not being completed across the board, how
2 widespread is that within the Trust?
3 A. I think it's been a challenge over the number of years
4 since the new consultant contract has been introduced.
5 I think a lot of effort has gone into try and encourage 10:30
6 more engagement. We certainly saw through our system,
7 and I can, I suppose, only go our system, because there
8 will be lots of systems happening about job plans. We
9 did have 90% of our job plans signed off in 2021-2022
10 year; we did have prospective plans in place. But 10:30
11 we're obviously just back to a new job planning year
12 because it goes from April to March every year. So,
13 every time the system will automatically put it into
14 the next round and it has to be discussed and agreed
15 again. It's a continuous process. 10:30
16 56 Q. Why, in your view, do some situations lead to -- I will
17 put this another way. Why, in your experience, are job
18 plans not completed in particular settings? Are there
19 a wide range of possible reasons to explain it?
20 A. I think it's -- my own view is probably I think most 10:31
21 people see the importance of it. I think it's probably
22 down to the increasing demand on clinical managers with
23 -- the new consultant contract introduced job planning.
24 It was always there historically but it's much more
25 prominent now in the new contract. It involves a lot 10:31
26 of those discussions. All of our consultants need
27 a job plan, all of our SAS doctors need a job plan, so
28 it's a significant number of medical staff across the
29 Trust. It's just probably the increase of that

1 requirement of work based on the clinical management
2 team to undertake that. I suspect that probably has
3 some influence.
4 57 Q. In Mr. O'Brien's case, you, as I have said at the
5 start, were probably aware that for a period of at 10:32
6 least four years, there wasn't a signed-off job plan.
7 Mr. Haynes wrote in respect of this in 2019. If we
8 just bring his e-mail up, please, it's WIT-55764. He's
9 highlighting to the then Medical Director, Maria
10 O'Kane, and Simon Gibson in the Medical Director's 10:32
11 office, and you are copied in, that:
12
13 "Mr. O'Brien does not have a signed-off job plan.
14 discussion has occurred and the job plan has been
15 awaiting doctor agreement since November 2018. 10:33
16 Mr. Haynes is second sign off, so he would not be
17 requested to sign it off until he and his Clinical
18 Director signed it".
19
20 So, have you any sense as to why Mr. O'Brien didn't 10:33
21 sign off on his job plan?
22 A. I don't know, the honest answer to that, in terms of
23 what his rationale for that job plan was. But I mean,
24 if it was anything in relation to his previous, it may
25 well be because he didn't feel I had given him enough 10:33
26 time to undertake the duties. But yeah, it's just
27 unfortunate that neither party then maybe pushed it on
28 to a facilitation to try to get to the bottom of those
29 reasons and get some sort of an agreement reached.

1 58 Q. Isn't that what you allude to in the quotation I read
2 from your statement at the start, there are contractual
3 tools available --
4 A. Yes.
5 59 Q. -- in order to press this to a conclusion? 10:34
6 A. Yes, that's correct.
7 60 Q. And either party can take it to facilitation to bring
8 the matter to an end?
9 A. Yes. Ideally, you obviously want the job plan not to
10 be enforced and to be agreed as a partnership, but if 10:34
11 that's not possible, then either party can refer the
12 matter to the Medical Director or facilitation.
13 61 Q. Why would this have been tolerated, do you think? Why
14 would this issue have been allowed to sit and sit and
15 sit for a number of years without the alarm button 10:34
16 being pressed?
17 A. I think that's a difficult one for me. I think it
18 should have been escalated sooner. What I can say is,
19 I mean, it has been -- it's not unique to Urology, it
20 is evident across the Trust in terms of... So, it's 10:35
21 understanding where there's actual issues as opposed to
22 just that the job plan is there and hasn't maybe
23 changed and just hasn't gone through the motions of
24 maybe getting it signed off again.
25 62 Q. Your view that it's an important tool, or potentially 10:35
26 important tool, together with something like appraisal
27 which may allow the Trust to better understand what's
28 going on in a clinician's practice, the challenges he
29 or she is facing, issues that perhaps lie beneath the

1 surface which have not yet been identified, all of
2 those things are potentially discoverable through
3 a good, robust job planning process?
4 A. Mm-hmm.
5 63 Q. The fact that this was let sit for so long and never 10:36
6 delivered, does that perhaps reflect a failure to
7 understand on the part of medical management the
8 potential wins or gains that can be achieved through
9 good job planning?
10 A. I think that's fair, yes. 10:36
11 64 Q. Is there any ongoing work, or any work in light of what
12 we know happened in Mr. O'Brien's case, around job
13 planning?
14 A. Yeah. There's constant work with job planning in terms
15 of working with our local negotiating committee and 10:36
16 providing training sessions, and lots of things to try
17 and see how we can support clinical managers because it
18 is an important task, but also ensuring that it's
19 a doable ask for them. But yes, we are trying to put
20 a lot of effort into -- because job planning is also 10:37
21 a tool to attract doctors to the Trust, and to use as
22 a retention tool as well. So, we are looking at how
23 job planning can be used imaginatively. It's
24 a professional contract between consultants and their
25 Trust, but to use it in a way that we can actually use 10:37
26 it as a retention tool and an attraction tool as well.
27 We are looking at it from all of those aspects.
28 65 Q. Just to explain to me a little further, how is it
29 useful to address a retention issue?

1 A. So, it gives opportunities for consultants to discuss
2 with their clinical manager if there's an area of
3 special interest they want to take on. Or similarly if
4 a consultant is maybe considering leaving the Trust
5 because they want to get extra experience. We have had 10:37
6 examples of Trusts then being able to negotiate
7 sessions in another Trust, for example, in one of the
8 bigger hospitals to get a bit of special interest. So,
9 rather than losing them all together from the service,
10 we are able to retain them in the service but maybe 10:38
11 allow a day out. So, all of those factors can be
12 considered to ensure that we are using job planning to
13 its fullest potential to allow for those opportunities
14 to be taken on board. It has all of those
15 opportunities as well, if there's full and open 10:38
16 discussions with managers, to address what is the needs
17 of the individual and then how that matches against the
18 needs of the service.
19 66 Q. Let me take this issue back specifically to a number of
20 scenarios around Mr. O'Brien. 10:38
21 A. Mm-hmm.
22 67 Q. I take it that you were, I suppose, speculating to some
23 extent as to why he didn't sign off in 2018 or 2019,
24 and you suggested maybe he was dissatisfied with the
25 time allowed. I mean, that appears to have been 10:38
26 a feature of at least two instances or incidents around
27 job planning during his career with the Trust.
28
29 If I could take you back to 2004. That was the year

1 you'd recently taken up a job in HR in the Craigavon
2 Trust?
3 A. Mm-hmm.
4 68 Q. A new consultant contract had been devised and was
5 being implemented. As you explain in your statement, 10:39
6 for example at paragraph 1.2, consultants had, as
7 a preface to this process, to complete a diary card to
8 show their activity, and we can see Mr. O'Brien's diary
9 card --
10 A. Mm-hmm. 10:39
11 69 Q. -- as an addition to the back of your statement.
12 You've said in your statement at WIT-90030 - just take
13 a look down at paragraph 2, I think. Yes - that
14 looking back on those diary cards and the
15 correspondence that came with them, that Mr. O'Brien 10:40
16 was saying that the service which he was working in has
17 been in crisis for years and that there was a gross
18 overburden of clinical work.
19
20 Thinking back to that, you were medical staffing 10:40
21 officer at the time, you were early career; that does
22 indicate, doesn't it, on Mr. O'Brien's part, that, in
23 the context of this new consultant contract, he, and
24 perhaps his colleague Mr. Young at that time, were
25 facing real struggles in their work in the delivery of 10:41
26 urology services?
27 A. Yes.
28 70 Q. Can you think of anything that was done on the part of
29 HR to better investigate that or to address it?

1 A. Well, I recall it being highlighted at the highest
2 level in the organisation. The Chief Executive was
3 aware of this and the Medical Director was very much
4 aware. We had an external facilitator that came down
5 from Belfast Trust who met with him as well to discuss 10:41
6 the job plan.
7 71 Q. It was Dr. Gaskin?
8 A. That's right, yes. Obviously then the implementation
9 of the contract was a retrospective process at that
10 point in time because it was going to be backdated, so 10:41
11 it was probably then a little bit more troublesome in
12 terms of working through that because you are working
13 through work already completed. So, I do recall that
14 the urologists were awarded the highest PAs in the whole
15 Trust in terms of recognition of the work they were 10:42
16 undertaking at that time.
17 72 Q. Yes. They were seeking 17 PAs and I think at one point
18 Mr. O'Brien pitched for 17.5. But in the context of an
19 ex gratia award of £30,000, he accepted, at the point
20 of facilitation without requiring facilitation to take 10:42
21 place, he accepted a PA award of 15.5; isn't that
22 right?
23 A. He did actually go to facilitation - Dr. Joe Gaston was
24 the facilitator - but he didn't go to appeal. So yes,
25 before the appeal he accepted the 15.5 programmed 10:42
26 activities.
27 73 Q. Dr. Gaston. If we just pull up WIT-90102. It's
28 recorded that:
29

1 "During the review of the diary card, it became
2 apparent that Mr. O'Brien spent a considerable amount
3 of time on patient administration. This was
4 significantly above the average for his colleagues and
5 the other general surgeons. Although no adjustment was 10:43
6 made, it was felt that this should be addressed in the
7 future".
8
9 Just dwelling on that, Mr. O'Brien, of course, wasn't
10 a general surgeon? 10:43
11 A. No.
12 74 Q. The comparison here, the appropriate comparison I
13 suppose, should only have been with Mr. Young; is that
14 fair?
15 A. That's fair, yes. 10:44
16 75 Q. Mr. Young was also awarded 15.5 PAs?
17 A. Yes, I believe so.
18 76 Q. What it says there about no adjustment being made but
19 it was felt that this should be addressed in the
20 future, I interpret that as a reference to 10:44
21 Mr. O'Brien's administrative workload or how he
22 approached his administrative workload?
23 A. I think what that refers to is the fact that when
24 Dr. Gaston was providing facilitation, he was looking
25 at the work that had already been completed. 10:44
26 77 Q. Yes.
27 A. So it was a retrospective review in terms of giving an
28 award of PAs. So he was making the point that whilst
29 he couldn't do anything to change what had gone before,

1 it was something that should be considered into the
2 future.
3 78 Q. Yes. Was any initiative taken to the best of your
4 knowledge by the Trust, or by HR specifically, in
5 relation to the issue of administrative workload? 10:45
6 Clearly Mr. O'Brien had his perspective and perhaps the
7 Trust had a different perspective. Whatever the views
8 might have been, can you recall any initiative taken to
9 focus on that issue?
10 A. I just remember it was passed back to the relevant 10:45
11 operational and the management teams but I'm sorry, I
12 don't know exactly what was -- how it was taken
13 forward.
14 79 Q. Because I think you will recognise this, that as
15 matters moved forward, administration on the part of 10:46
16 Mr. O'Brien, his delivery of administrative tasks and,
17 if I may say so, his failure or his inability to
18 deliver on those administrative tasks was to be a key
19 factor of consideration in the MHPS process; isn't that
20 right? 10:46
21 A. That's right.
22 80 Q. We can see the seed for that quite a long way back --
23 A. Mm-hmm.
24 81 Q. -- in his career within the Trust. Just before leaving
25 that, just the issue of the ex gratia payment, were you 10:46
26 unaware that such a payment had been made at the time?
27 A. I was aware, I didn't know any details around it.
28 I think from memory now there was correspondence
29 further back with -- between Mr. O'Brien about what

1 this was about. But at the time it was directly
2 a Chief Executive issue with him. I was involved
3 because I was involved in formulating the final offer
4 letters for consultants on the back of the consultant
5 contracts, so I was aware of it from that perspective 10:47
6 but I didn't know the context behind it at all at that
7 stage.
8 82 Q. Do you recognise now that it was paid to him pursuant
9 to an application made on the basis of the extra work
10 required of him in the early years of the service? 10:47
11 A. That's my understanding. There was an earlier letter
12 that he had written quite some time before around
13 working on his own or without a registrar, or something
14 along those lines, and I think it was something in
15 connection with all of that. 10:48
16 83 Q. Mm-hmm. But to put it in its proper context, it was
17 a recognition that he was carrying out a heavy burden
18 of work --
19 A. Yes.
20 84 Q. -- in the delivery of urology services? 10:48
21 A. That's my understanding.
22 85 Q. The 15.5 PAs that were awarded following facilitation
23 with Dr. Gaston were to be significantly reduced by the
24 time of the next facilitation in 2012; isn't that
25 right? 10:48
26 A. That's correct.
27 86 Q. You have commented in your witness statement at
28 WIT-90034, paragraph 1.13, how he was offered 12.75 PAs
29 with effect from 1st October 2011, to revert to 12 PAs

1 from 1st March 2012. Your colleague, Martin Clegg,
2 oversaw this process from a HR process?
3 A. That's correct.
4 87 Q. The reduction in PAs through that process, does that
5 suggest that the requirements of the job had reduced? 10:49
6 A. I'm not a 100% sure I have all the details in front of
7 me in terms of when they moved to that. I know they
8 got funding in 2012 for the five consultant models, so
9 there may well have been more consultants joining the
10 team. I wasn't involved with the facilitation so I'm 10:49
11 not sure that featured as part of it. Certainly there
12 would have been an expectation that what work was being
13 delivered was put into a job plan and that's what you
14 are asked to deliver. There's probably lots of
15 services where there's expectation to go over and above 10:50
16 that, but it's the contractual commitment that we want
17 to agree that that's what you are required to do. So,
18 I don't know anything further than that.
19 88 Q. You are aware that Mr. O'Brien accepted the outcome of
20 facilitation resignedly and not, if you like, with 10:50
21 a good heart?
22 A. Mm-hmm.
23 89 Q. What I mean by that description is reflected in the
24 correspondence he sent after the process was completed.
25 If we go to WIT-90292, you can see he wrote to 10:51
26 Mr. Clegg. The last paragraph reflects his concerns.
27 He says he now feels:
28
29 "... compelled to accept the amended job plan from

1 1st October 2011. Even know I neither agree with it or
2 find it acceptable, I have endeavoured to ensure that
3 management is fully aware of the time which I believe
4 is required to undertake clinical duties and
5 responsibilities included in the job plan to completion 10:51
6 and with safety. Particularly during the coming months
7 leading to the further reduction in allocated time, I
8 will make every effort to ensure I only spend that time
9 allocated whilst believing that it will be inadequate".
10 10:52
11 That is clearly firing a warning across to the Trust
12 about the doability of the work that was required of
13 him; isn't that right?
14 A. It appears. Yes, absolutely.
15 90 Q. Mr. Mackle wrote upon receipt of that. Could you just 10:52
16 look at that at WIT-90291. You can see Mr. Clegg is
17 copied into that. He is dealing with Mr. O'Brien's
18 response to facilitation. There has been some
19 correspondence already and the Trust's position is
20 reduced to: 10:53
21
22 "This will undoubtedly require you, Mr. O'Brien, to
23 change your current working practices and
24 administration methods. The Trust will provide any
25 advance and support it can to assist you with this". 10:53
26
27 Mr. Mackle arranged a meeting, it seems. He says that
28 the meeting was cancelled by Mr. O'Brien, and he writes
29 into the conclusion of his letter an assumption that:

1
2 "If you are not in contact with us, then we will
3 proceed on the basis that you do not require any
4 support to adjust your working practices".
5 10:53
6 Now, can you recall was that the subject of discussion
7 with you at any point?
8 A. I don't remember this. I can't say for sure but I
9 don't remember it at the time being discussed.
10 Obviously I have looked at it subsequently to coming 10:54
11 here but I don't recall being involved at the time.
12 I may well have been but I don't think I was copied
13 into those emails so --
14 91 Q. Mm-hmm.
15 A. -- I don't remember it. 10:54
16 92 Q. What we do know is that by December 2016, there are all
17 sorts of administration-type issues associated with
18 Mr. O'Brien's clinical practice which are so alarming
19 for the Trust, the Trust would say it necessitated an
20 MHPS process. 10:55
21 A. Mm-hmm.
22 93 Q. But what we can see is that from 2006/2007, at the time
23 of the original facilitation with Dr. Gaston, 2012
24 facilitation with Dr. Murphy with Mr. Mackle's
25 awareness and Mr. Clegg's awareness of a challenge from 10:55
26 Mr. O'Brien as to the viability of his job plan, and
27 doesn't it appear to have encouraged the Trust to come
28 up with a plan to address that challenge? Is that
29 a fair analysis?

1 A. Yes, I think that's fair.
2 94 Q. If that had been drawn to your attention, what would
3 you have been saying? What would you have been
4 thinking in terms of the options to address this?
5 A. I mean I can't say for sure but obviously thinking back 10:56
6 now, I mean, I would have had a very close working
7 relationship with both the Medical Director -- and
8 I know as far back as 2012 we would have used NCAS, at
9 least on five or six occasions, to undertake a detailed
10 action plan. So it sounds to me like that's what was 10:56
11 needed here in relation to identifying it early and
12 getting in there with a performance action plan to
13 ensure that it was set out in that formalised manner.
14 We successfully used those on a number of occasions as
15 far back as 2011/20 12, so I can only assume that that 10:56
16 might have been something we could have considered at
17 that time.
18 95 Q. You do draw attention in your statement to an event or
19 an incident or a series of incidents in 2013, where two
20 specialist registrars working within Urology were found 10:57
21 to be working in excess of 60 hours per week?
22 A. Mm-hmm.
23 96 Q. This was obviously not compliant with the Working Time
24 Regulations that were in place, and arrangements had to
25 be made with general surgery to provide cover to 10:57
26 address that problem?
27 A. That's right.
28 97 Q. This is paragraph 1.20 of your witness statement; we
29 don't need to bring it up to the screen. What I want

1 to ask you is this: Was there an appreciation that
2 Urology, and those who worked within the Service, were
3 finding it very challenging to deliver what was
4 required of them, or was Urology regarded as, I
5 suppose, no different to other challenging services? 10:58
6 A. I think at that time surgical services in general were
7 a challenge. We had the Board Liaison Group available
8 to us back then. There was our regional group that was
9 chaired by a medical director and had a medical project
10 officer on it, which would have been a junior -- a 10:58
11 senior junior doctor taking time out of practice to
12 work on the Board Liaison Group.
13 CHAIR: Ms. Parks, if I can just ask you to take it a
14 little more slowly. Thank you.
15 A. And they moved around Trusts to give advice on rotas. 10:58
16 We worked very closely with them in relation to
17 Urology. They would have come down and met with us and
18 discussed what options were available. It was a body
19 that then followed up with the Medical Director at the
20 time to see what was happening. We could apply for 10:59
21 funding from the Board Liaison Group. Unfortunately,
22 Board Liaison Group, it doesn't -- I think it last met
23 in 2014 so it's not a feature any longer, which is
24 unfortunate. But they were very helpful in terms of
25 addressing those sorts of things. They did come down 10:59
26 and help us with Urology and we then got a new working
27 pattern in place that was compliant for Urology.
28
29 We only had two training numbers in Urology, so we were

1 also relying on recruiting research fellows or clinical
2 fellows to work on that rota. So, it was a challenge
3 in terms of those factors but certainly it was very
4 much -- I think I remember it was on the Risk Register
5 with the Medical Director and HR Director at that time 10:59
6 until we got the new working pattern in place and
7 resolved for them.
8 98 Q. I want to turn briefly to look at the issue of how
9 Mr. O'Brien was managed and the extent to which HR knew
10 of any difficulties in management relations. You have 11:00
11 set out in your statement - if we just bring it up
12 briefly - at WIT-90036, and at the bottom of the page,
13 1.19 -- just keep it on the screen and I will do my
14 best to summarise. On 30th January, Dr. Rankin
15 directed you to a complaint that had come in from 11:00
16 Mr. O'Brien in respect of a financial issue?
17 A. Mm-hmm.
18 99 Q. He had made a claim for some extra-contractual work and
19 he hadn't been paid all that he believed he was
20 entitled to receive. Do you remember that? 11:01
21 A. I do remember that, yes.
22 100 Q. If we could briefly open his letter that you would have
23 looked at at the time, WIT-90380. That's him writing
24 on 30th January. Essentially he is saying that the
25 payments he was due to receive for Friday working had 11:01
26 been halved?
27 A. Mm-hmm.
28 101 Q. You looked at that issue; isn't that right?
29 A. That's correct.

1 102 Q. And you spoke to Mr. Mackle and Mrs. Trouton in respect
2 of it?
3 A. That's correct.
4 103 Q. As a product of your investigations, you were able to
5 establish that Mr. Mackle had authorised the reduction 11:02
6 --
7 A. Mm-hmm.
8 104 Q. -- in the claim made by Mr. O'Brien. He had done that
9 because he had interpreted the situation as arising out
10 of an understanding that some of this work would have 11:02
11 been covered by Mr. O'Brien's normal programmed
12 activities?
13 A. I believe that's the case, yes.
14 105 Q. But he accepted that he had not gone through the
15 appropriate process in making the deduction, and he 11:03
16 agreed that he should relent and Mr. O'Brien should
17 receive the full payment as claimed?
18 A. That's correct.
19 106 Q. Is that an appropriate summary? Is there anything
20 incorrect in terms of what I have said -- 11:03
21 A. No.
22 107 Q. -- just to get through this?
23 A. That's all correct.
24 108 Q. I'm obliged, thank you. You were then able to write.
25 I think we can see that at WIT-90379. You were able to 11:03
26 write to the salaries department, or the pay
27 department, I suppose?
28 A. Mm-hmm.
29 109 Q. And you explain there what had happened.

1 "These claims were changed by the Associate Medical
2 Director, Mr. Mackle. Spoken to Mr. Mackle and
3 Mrs. Trouton and it seems there's some misunderstanding
4 about what had been agreed against his job plan.
5 However, they agreed to concede as changes shouldn't 11:04
6 have taken place without prior discussion with
7 Mr. O'Brien".
8
9 Did you regard this issue as clearly a financial one?
10 A. I did, yes. 11:04
11 110 Q. There was no suggestion in how it was communicated to
12 you as being an issue to do with harassment or bullying
13 or anything like that?
14 A. No, there wasn't.
15 111 Q. Now, this was early 2012, and clearly the matter was 11:04
16 resolved, as you've described. At or about that time,
17 Mr. Mackle became aware of an allegation or a complaint
18 that he was being -- it was said of him, he was told,
19 that he had been harassing Mr. O'Brien. I just want to
20 show you what Mr. Mackle has said about that. It's 11:05
21 WIT-11769. At paragraph 92 of his statement, he says:
22
23 "Although I am unsure of the exact date in 2012", he
24 was informed that the Chair of the Trust, Mrs. Roberta
25 Brownlee: "Reported to senior management that Aidan 11:05
26 O'Brien had made a complaint to her that I", that is
27 Mr. Mackle, "had been bullying and harassing him".
28
29 He was called into an office on the administration

1 floor of the hospital to be informed of the accusation.
2 He was advised that he needed to be very careful where
3 he was concerned from then on. He recalls being
4 absolutely gutted by the accusation and left and went
5 down a corridor to Mrs. Corrigan's office. 11:06
6
7 "Mrs. Corrigan immediately asked what was wrong and
8 I told her of what I had just been informed. In
9 approximately 2020, I truthfully had difficulty
10 recalling who informed me. Martina Corrigan said that 11:06
11 I told her at the time it was Helen Walker, Assistant
12 Director of the HR. I now have a memory of same but
13 can't be 100% sure that it is correct. I recall having
14 a conversation with Dr. Rankin, who advised that for my
15 sake, I should step back from overseeing Urology and I 11:06
16 was advised that Robin Brown should assume direct
17 responsibility. I was also advised to avoid any
18 further meetings with Aidan O'Brien unless I was
19 accompanied by Head of Service or the Assistant
20 Director. As a result I instructed Robin Brown to act 11:07
21 on all governance issues regarding Urology, and in
22 particular any issue concerning Aidan O'Brien. At my
23 next meeting with John Simpson" --
24
25 He was the Medical Director; is that correct? 11:07
26 A. That's right.
27 112 Q. -- "I advised of the issue and the change in governance
28 structure in Urology. There was no formal
29 investigation of the complaints, and I checked with Zoe

1 Parks, Head of Medical HR, and she says that there's no
2 record on my file of the accusation".
3
4 Is that last bit correct, that he did at some point
5 check with you? 11:07
6 A. Yes, yes, he did.
7 113 Q. And before I ask you about that, and I want to set
8 Mr. O'Brien's recollections or an aspect of his
9 recollections aside, what Mr. Mackle has recorded
10 there. If we go to AOB-56083. This is a transcript of 11:08
11 a meeting that took place between Mr. O'Brien and his
12 son Michael O'Brien with a gentleman called John
13 Wilkinson, who is a Trust Board member --
14 A. Mm-hmm.
15 114 Q. -- and was the Trust Board member appointed to oversee, 11:08
16 if you like, the MHPS investigation. It dates from the
17 spring of 2017. Mr. Michael O'Brien, at the top of the
18 page. The context here is a discussion around the
19 March 2016 meeting between Mr. Mackle and Mr. O'Brien
20 at which a letter was handed over and Mr. O'Brien was 11:09
21 asked to provide a plan to address concerns about his
22 practice. Michael O'Brien says:
23
24 "There is also another issue with regard to this March
25 2016 meeting and that is that, whilst I don't want to 11:09
26 personalise the issue, Mr. Mackle should not have been
27 involved at all because my father had had a form of
28 grievance against Mr. Mackle".
29

1 Now, that grievance was effectively -- was stayed
2 effectively, I should say.
3
4 Mr. O'Brien says:
5 11:09
6 "I suspended it on condition that I could initiate it
7 again at any time in the future, which I haven't done.
8 And you know one can only speculate as to whether this
9 letter would have followed up with some kind of
10 informal attempt to resolve the issues had it been 11:09
11 someone other than Eamon but in a sense that's
12 secondary to the fact that there was no informal
13 process".
14
15 Just scrolling down the page so we can see the bottom 11:10
16 of the page. Mr. Michael O'Brien, towards the bottom,
17 says:
18
19 "It had also been agreed at the time or around the time
20 the grievances were being issued, that he would have no 11:10
21 dealings with him", - that's Mackle would have no
22 dealings with Mr. O'Brien - "again".
23
24 Mr. O'Brien then comes in and says:
25 11:10
26 "Yes, I sought and obtained an assurance from
27 Dr. Rankin and from Eamon Mackle himself, particularly
28 from Dr. Rankin, that I would have no more dealings or
29 meetings with him because I was on the point of

1 breakdown as a consequence of his treatment over
2 a period of years".
3
4 Just over the page, I think, just to finish this:
5 11:10
6 "Once this agreement before this letter" - that's the
7 March 2016 letter was issued - "absolutely years
8 before, yes".
9
10 So, some issues arising out of all of that, Ms. Parks. 11:11
11 First of all, as Medical Human Resources, were you
12 aware of any of this?
13 A. No awareness at all.
14 115 Q. Specifically were you aware of any complaint, formal or
15 informal, whispered, behind the scenes or however it 11:11
16 might be described, that Mr. Mackle had or was alleged
17 to have been bullying or harassing Mr. O'Brien?
18 A. No, I wasn't aware.
19 116 Q. Again, specifically were you told that there had been,
20 if you like, a change in managerial arrangements in 11:12
21 that the Associate Medical Director, Mr. Mackle, would
22 and should stand back because of advice given by
23 someone in HR from directly engaging with Mr. O'Brien
24 on any issue?
25 A. No, I wasn't aware. 11:12
26 117 Q. It does appear, marrying the two accounts together,
27 that something of that nature has happened?
28 A. Honestly, I have no recollection. Not to my awareness.
29 I'm not aware of anything.

1 118 Q. Yes. Plainly, if something like that had happened --
2 A. Mm-hmm.
3 119 Q. -- Medical HR should have been engaged on the issue; is
4 that fair?
5 A. Definitely, yes. 11:13
6 120 Q. As you've said earlier, you were dealing with, in 2012,
7 what you regarded as a purely financial issue?
8 A. That's right.
9 121 Q. Mr. O'Brien, in that transcript, has said that
10 essentially the grievance was stayed and he had 11:13
11 advised - he doesn't say who he advised - but he spoke
12 to the ability to be able to reignite or reinitiate
13 that grievance at any point in the future. Is that
14 your understanding of how it was brought to an end?
15 A. No. Reading back over his email now, I can see those 11:13
16 words were used, but at the time I didn't even view it
17 as a grievance because it didn't get to a grievance
18 panel. It was a matter that was brought to attention
19 and it was quickly resolved, so it didn't actually need
20 to go anywhere further than that. That was my 11:14
21 understanding. And certainly in my interactions with
22 Mr. O'Brien when advising him of the outcome, I was led
23 to believe he was content with that. I mean, obviously
24 if anyone has a grievance to raise, they can raise it
25 at any time in the future about any issue but there 11:14
26 wouldn't be a practice of holding a grievance on stay
27 like that. That wouldn't be a normal practice.
28 122 Q. It's fair to say, isn't it, as well that allegations of
29 harassment, if they are raised, should be investigated?

1 A. Investigated, absolutely.
2 123 Q. It would also be fair to say, would it, that a
3 chairperson of the Trust Board shouldn't be making
4 representations on behalf of a clinician of this nature
5 unless there had been some agreement with that 11:15
6 clinician to do so?
7 A. Sorry, I don't follow you there.
8 124 Q. It's suggested in what Mr. Mackle describes --
9 A. Oh, yes.
10 125 Q. -- that Mrs. Brownlee, chairperson of the Board, had 11:15
11 made these representations, alleging harassment on the
12 part of Mackle against O'Brien. That is not an
13 appropriate approach, is it?
14 A. No, it's not.
15 126 Q. In terms of medical management, we have seen, through 11:15
16 the evidence received by the Inquiry, that over
17 a period of several years of this, obviously leading to
18 the events of '16 and '17 and the initiation of the
19 MHPS process, that there were issues in relation to
20 Mr. O'Brien's practice that were causing the Trust 11:16
21 concern, and specifically Mr. Mackle concern?
22 A. Mm-hmm.
23 127 Q. He had engaged with Mr. O'Brien on a range of issues,
24 including triage, keeping notes at home. He dealt with
25 Mr. O'Brien in the context of an intravenous antibiotic 11:16
26 issue, a benign cystectomy issue. There was debates
27 about the ward for urology patients between Mr. Mackle
28 and Mr. O'Brien. There was an engagement between them
29 on the issue of his job plan, as we have seen.

1 A. Mm-hmm.
2 128 Q. Taking Mr. Mackle out of his role as Associate Medical
3 Director, if that's the way it happened, would have
4 left a less than optimal management arrangement where
5 it was most needed. Is that a fair thing to say? 11:17
6 A. I think that's fair, yes.
7 129 Q. You were the HR input into an investigation conducted
8 alongside Mr. Brown in relation to Mr. O'Brien's
9 admitted disposal of some extracts or sections from
10 a patient's chart, his disposal of those into a waste 11:18
11 bin?
12 A. Mm-hmm.
13 130 Q. That investigation took place, I think, in 2011; isn't
14 that right?
15 A. I think so, yes. 11:18
16 131 Q. You have said in your witness statement -- if we pull
17 up WIT-90034. You have said - if we scroll down,
18 please - that it was understood by you and Mr. Brown
19 that this was an isolated incident and resulted in an
20 informal warning. You go on in your witness 11:19
21 statement - if we go on down to WIT-90067 - at
22 paragraph 28.1, that you are concerned to read in the
23 context of the public inquiry that there were ongoing
24 issues with the management of patient charts with
25 Mr. O'Brien storing a large volume of these at home, so 11:19
26 an issue that is somewhat different in nature to
27 disposing of some part of a patient's record in a bin?
28 A. Mm-hmm.
29 132 Q. But your concern is that it's generally of the same

1 nature or same kind of concern, the confidentiality
2 aspect, perhaps, of patients' records. Is that the way
3 you were looking at it when you discovered this?
4 A. Yes, yes.
5 133 Q. We know, and you've undoubtedly been following aspects 11:20
6 of the Inquiry, that this patient chart issue,
7 Mr. O'Brien taking charts home to complete dictation
8 and storing them in his home, that had been an issue
9 for many years. It was eventually tackled as part of
10 MHPS. 11:21
11
12 Should that issue have been nipped in the bud, whether
13 informally, and if not resolved, formally, at an
14 earlier time?
15 A. I believe so, yes. 11:21
16 134 Q. Is that the kind of issue that should be drawn to the
17 attention of HR if the medical manager or the
18 operational manager is concerned about it and needs
19 direction on what steps to take?
20 A. Yes. We would certainly get contacts from clinical 11:21
21 managers about all sorts of issues ranging from low
22 level to more serious concerns, so, yes.
23 135 Q. Again, the evidence received by the Inquiry talks about
24 issues of triage over a long period of time. By 2015,
25 there were emergent issues around private patients and 11:22
26 Mr. O'Brien's management of them, emergent issues
27 around his dictation or failure to dictate following
28 clinical encounters. You have said in your witness
29 start - this is paragraph 17.2 - that the role of

1 medical HR is to respond to requests and provide advice
2 and support when concerns are supported. You say that
3 in hindsight, it is surprising that concerns were not
4 escalated and matters not referred to HR for advice and
5 guidance. 11:23
6
7 As the experts in the field of discipline of medical
8 performance, your office should really have been the
9 first port of call, shouldn't it?
10 A. I believe so, yes. 11:23
11 136 Q. What we also see from the evidence is that matters were
12 addressed by managers informally. There were e-mailed
13 escalations; there were colleagues asked to prevail
14 upon Mr. O'Brien; there were colleagues asked to help
15 out; he was granted extra time to respond to queries; 11:23
16 workarounds were developed such as a default process to
17 deal with triage and incident reports were raised. But
18 none of that was ever drawn to your attention?
19 A. No.
20 137 Q. How would you explain that? Is that explicable, that 11:24
21 issues would be troubling management for, let's call it
22 several years, and yet nobody saw fit to elevate it on
23 to a formal process until 2016? How is that
24 explicable? Does that tell us that managers didn't
25 understand? Does it say something about the culture 11:25
26 that prevailed in terms of how the shortcomings of
27 clinicians were to be treated? What's your best
28 assessment?
29 A. Potentially a factor of all of those, I think. I mean

1 they were aware there was a Medical HR Department, so
2 I think that that shouldn't have -- we should have been
3 contacted, and I don't know the reason why we weren't.
4 I think there's some work we need to do in changing
5 that culture, that you know maybe there's a feeling if 11:25
6 you contact HR, they're going to escalate things to
7 a formal matter whenever it's not necessarily about
8 that.
9
10 You know, there's lots of positive things that can come 11:25
11 from an MHPS process, it's not a negative thing.
12 There's lots of supportive measures that can be
13 considered; there's lots of structure and framework
14 that can be put around to support individuals to get an
15 early resolution. I think there's maybe a fear that if 11:26
16 you tell HR, that it's like pressing the button, a
17 nuclear button, and things will be escalated. Maybe
18 that's what we need to ensure is not engrained in
19 thinking. I'd like to think that's not a case now, we
20 are contacted very regularly by our clinical managers 11:26
21 about issues just for advice and reassurance in terms
22 of how they are handling things. But maybe back then,
23 there was more fear around that all.
24 138 Q. Was your office regularly the source of advice to
25 services within the Trust in relation to medical 11:26
26 performance or is that something that is only later
27 developed and matured in recent years?
28 A. I would say certainly it's an area that has grown.
29 Probably traditionally years ago they would have gone

1 directly to the Medical Director and had
2 a conversation. I think over the years we have had
3 a much closer working relationship with the Medical
4 Director. We have developed more formal mechanisms
5 through our monthly meetings and things to have 11:27
6 discussions around. I think that in itself has
7 generated then outside of those meetings, those
8 clinical managers would contact us much more regularly
9 just for day-to-day advice on how to handle things.
10 139 Q. Yes. Of course there was, as we saw earlier, an 11:27
11 opportunity for HR, from another angle back in 2012 at
12 the time of facilitation, to have involved itself in
13 addressing what Mr. O'Brien was saying were his needs
14 in relation to his job plan, and that crossroads
15 moment, perhaps, or fork in the road moment, perhaps, 11:28
16 wasn't grasped by HR when it was there in front of
17 them. Nobody saw fit, as you have suggested this
18 morning, to think of developing, in conjunction perhaps
19 with NCAS, an action plan?
20 A. Yeah. I think that's unfortunate. 11:28
21 140 Q. Yes. I mean, given the issues that were to come into
22 play as part of MHPS, I mean, looking back at that,
23 they were administrative-type issues directly linked
24 into the clinical practice of Mr. O'Brien. The MHPS
25 issues, they were potentially the issues that could 11:28
26 have been looked at at the point in 2012 when he was
27 clearly saying I haven't got enough hours here in my
28 job plan to deliver?
29 A. Mm-hmm, yes.

1 141 Q. You were on maternity leave, as I understand it, in
2 2016 when Mr. Mackle and Mrs. Corrigan sat down with
3 Mr. O'Brien on what it made clear to the Inquiry was
4 the first - I use the word "formal" advisedly - but the
5 first sit-down we're dealing with these issues with you 11:29
6 now and here is a plan, a request for a plan?
7 A. Mm-hmm.
8 142 Q. You were off at that time?
9 A. That's right, yes.
10 143 Q. So I will use "formal" in that context, and I know 11:29
11 that's not a terribly helpful word in that context
12 because it wasn't the start of a formal process, as
13 such.
14 A. Mm-hmm.
15 144 Q. But you have said in your statement - this is paragraph 11:29
16 38.2 - you believe that it would have been helpful for
17 management to have sought specialist HR advice at that
18 point in time. What could HR advice have brought to
19 the piece that you think, with the obvious benefit of
20 hindsight, might have enabled things to proceed better? 11:30
21 A. For me, the critical factor in managing concerns is
22 that initial scoping of the concern and really taking
23 a deep dive at that process to understand what was
24 going on. I think that's the role of the clinical
25 manager to assess the risk of what is facing them in 11:30
26 front of them, and understand from a bird's-eye view,
27 take a look, a wider look, to see what's going on so
28 that the risk to patients can be tackled at that point,
29 because obviously that's what it says, if you have

1 a concern about a practitioner's practice, the first
2 thing you ascertain is what you are dealing with and
3 establish the level of risk associated and then put
4 immediate plans in place to address that risk.
5 11:31
6 I think that would have been for me what should have
7 happened at that point, if not prior to that but
8 certainly at that point, in terms of getting a really
9 good idea of exactly what was going on and then ensure
10 there was a robust plan in place to address that. 11:31
11 I know certainly, because we had been working with
12 Dr. Simpson as Medical Director, we had been through,
13 as I said previously, at least five or so action plans,
14 which would have included consultant action plans. So,
15 something like that would have been something I think 11:31
16 we would have been considering, as opposed to letting
17 it drift on.
18 145 Q. If your office had been approached in March, the key
19 reflection you are offering is that you would have been
20 well-placed to advise on how this process should start, 11:32
21 if a process is to be started. You would have
22 suggested a need for a clear understanding of what the
23 problems are, and that would have necessitated what you
24 have called a deep dive?
25 A. Yes, I think, yes. 11:32
26 146 Q. Within your statement, you go on and deliver a number
27 of key reflections about what might have been done
28 better --
29 A. Mm-hmm.

1 147 Q. -- over the period of -- particularly before the
2 investigation starts, and you reflect a number of
3 specific practical as well as cultural shortcomings.
4 I think if we take a short break now, we will take up
5 with those just after. 11:33
6 CHAIR: A quarter to 12.
7
8 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
9
10 CHAIR: Thank you, everyone. 11:52
11 148 Q. MR. WOLFE KC: Now, just before the break, Ms. Parks,
12 you were outlining your view of what you would have
13 done if HR had been consulted in March 2016. I readily
14 appreciate you weren't at work at that time and you
15 wouldn't have been in a position to provide advice for 11:53
16 that reason, in any event.
17
18 If we turn to an important part of your witness
19 statement, which I know the Panel will consider with
20 interest. It's WIT-90075. At the bottom of the page 11:53
21 from paragraph 38, running, I think, all the way
22 through to paragraph 40, you set out some key learnings
23 from your understanding - undoubtedly with the benefit
24 of some hindsight and as a bystander as such - but some
25 key reflections of what you think could have been done 11:54
26 better in association with the investigation, or indeed
27 the beginnings to the investigation, into Mr. O'Brien's
28 practice. If we scroll down to the next page, please,
29 you say at 38.3, and this is sort of repeating what you

1 have said just before the break:
2
3 "It is incumbent upon a clinical manager to take
4 a deeper dive and scope to establish the full nature of
5 concern". 11:55
6
7 You borrow from the MHPS framework the need to take
8 into account the importance of the continued safety of
9 the patient or the member of the public, and, for that
10 reason, try to get to grips with every aspect of the 11:55
11 problem?
12 A. Certainly, yes.
13 149 Q. You say - scrolling on down at 39.1 - that, on your
14 understanding of what had happened, there was a need to
15 establish the facts but it is not clear to you what 11:55
16 action was taken following the meeting in March. You
17 don't believe that it was appropriate, given the
18 significant concerns, to ask for an immediate plan.
19 You think the threshold for an investigation had been
20 met and that's the area that should have been the 11:56
21 focus. Is that fair?
22 A. I think what I mean by that is when you establish
23 a concern, either you decide that you can handle and
24 manage it informally, but if you don't have all the
25 information and you need more information, then the 11:56
26 means to do that is through a formal investigation to
27 get to the crux of it. But I think, yeah, that proper
28 scoping at the outset would have facilitated the right
29 path to follow. Whether an action plan could have been

1 put in to address it or whether more formal method
2 would have been necessary, probably would have depended
3 upon that extent, the full extent of that scoping being
4 completed, and drawing all of the issues out at that
5 stage, if possible. 11:57
6 150 Q. Mm-hmm. Leaving aside this case, perhaps, the
7 specifics of this case and bring it up to the more
8 general, you talk about scoping quite a bit in your
9 statement?
10 A. Mm-hmm. 11:57
11 151 Q. You talk about the need to make inquiries and to
12 triangulate. We will go on in a minute perhaps to look
13 at the paragraph, but at paragraph 40.2, you say that
14 governance systems need to be strengthened to permit
15 the triangulation of data for clinical managers. 11:57
16
17 In the scoping context, bearing in mind your experience
18 of using MHPS, what, from a HR perspective, is possible
19 when performing scoping?
20 A. I think you are looking at all aspects of the 11:58
21 practitioner's practice. You are looking at all of the
22 information that's available to you in terms of all of
23 the various different information systems that the
24 Trust has, appraisal, job planning, you know,
25 complaints; all of those information systems. As 11:58
26 a clinical manager, you are trying to establish the
27 level of risk, so you need to consult as much
28 information as you can and look at what information you
29 have in front of you to help you to determine that

1 risk. There's probably not an awful lot mentioned in
2 MHPS about how that process is undertaken. I know we
3 have subsequently worked up some guidance on helping
4 clinical managers because it is a difficult decision to
5 use their professional judgment, but to possibly 11:58
6 utilise some of the tools around forming a judgment,
7 call around the level of risk and what action is
8 needed.
9 152 Q. I am just going to slow you up.
10 A. Sorry. 11:59
11 153 Q. This is possibly important stuff. What was
12 investigated here, if I may say so in the specific
13 case, what was in relatively plain sight, issues that
14 had been known about for years. Does your answer
15 suggest when you have issues of concern that are in 11:59
16 plain sight, that you are entitled, and indeed must,
17 follow your nose a little further and see what else
18 there might be of concern in a practitioner's practice
19 that may not just be as obvious?
20 A. I think that's the responsibility, yes, of a manager 11:59
21 who is looking after staff, if something comes to their
22 attention, that they establish is that all they need to
23 know about, so they do look a bit further just to get
24 their facts and get the root cause established.
25 154 Q. Does this involve -- and you put a great onus on the 12:00
26 immediate clinical manager, which I suppose can you
27 just define that for us? Is that the Clinical Lead or
28 is it the Clinical Director, or could it be either
29 depending on the circumstances?

1 A. It could be either but in management terms, I suppose,
2 it's the clinical manager who has the clinical
3 management responsibility for the staff.
4 155 Q. Yes. That's the Clinical Director, generally?
5 A. Yes. 12:00
6 156 Q. I mean, would such a scoping exercise possibly involve
7 speaking to people, speaking to colleagues who might
8 know things that they haven't revealed or said before?
9 A. I think, yes. I mean, at this stage they are just
10 trying to get a sense of what's going on, so they need 12:00
11 to make some inquiries to determine that.
12 157 Q. But it's on the basis, I suppose, of an established
13 concern?
14 A. Yes.
15 158 Q. I suppose from an employee perspective, it might be 12:01
16 frowned upon if an employer went poking its nose where
17 there was no grounds for suspicion; is that fair?
18 A. Yeah, it's not a -- it's not a, you know, I suppose
19 a whole-out investigation, going fishing for something.
20 It's just making some inquiries as a manager, do I have 12:01
21 all the facts in front of me.
22 159 Q. If we scroll. You say at 39.2 -- this is again a point
23 about a robust review being undertaken as part of
24 preliminary inquiries. Just scrolling down to the top
25 of that page, yes. You place the onus on the immediate 12:01
26 line manager, as you describe it. It's important that
27 the task of conducting this screening exercise, that
28 preliminary inquiries rests with that immediate line
29 manager to avoid what you describe as any possible

1 disconnect.
2
3 What does that phrase convey?
4 A. I think it's important that it's the immediate line
5 manager, they are closest to the practitioner, closest 12:02
6 to the service and to the patient and they understand
7 the local systems that are in operation within that
8 area, so they are the most likely person to understand
9 how to complete that screening appropriately and
10 thoroughly, and they understand what information will 12:02
11 mean in their area. I think it's important that it's
12 the clinical manager to undertake that for those
13 reasons, so that they, you know, have a good
14 understanding of what to look for and what the
15 information is telling them. 12:02
16 160 Q. I think you go on at 39.4, if we just scroll down, to
17 express your puzzlement that an assistant director in
18 the Medical Director's office was the person charged
19 with responsibility of carrying out a screening
20 exercise? 12:03
21 A. Mm-hmm.
22 161 Q. That's an inappropriate role for such a person, in your
23 view?
24 A. Yeah, it wouldn't be usual. That wouldn't be normally
25 how it's managed. 12:03
26 162 Q. Yes. Yet that was how it was set up or established by
27 a medical director, Dr. Wright, who has told the
28 Inquiry that he has significant experience in the
29 conduct of MHPS processes, and it was a role given to

1 Mr. Gibson which Mrs. Toal, albeit after the work had
2 been done, would have known about, and she's an
3 experienced HR professional.
4
5 Does this suggest, the fact that Mr. Gibson conducted 12:04
6 this role, suggest either that the requirements of MHPS
7 were not well understood or that people with
8 responsibility within the Trust felt that there was an
9 *à la carte* approach available to them when working
10 through an MHPS process? 12:04
11 A. Yeah, I think you are probably right. For me, the MHPS
12 processes don't replace the normal line management and
13 don't supercede those at any stage, or shouldn't. They
14 are essentially a HR process at the core for managing
15 concerns. But ongoing line management has to continue 12:05
16 throughout that whole process and it's a continuous
17 process, so they certainly shouldn't be lifted out as
18 a separate process. That's my view in terms of just
19 that the ongoing line management has to -- it's a
20 continuous process that should sit out right through 12:05
21 that. There's designated roles within MHPS to manage
22 a HR process of established concerns but that should
23 continue throughout that.
24 163 Q. Yes. While it's quite clear from the guidance which is
25 produced, and indeed within MHPS, that the role does 12:05
26 belong to the line manager --
27 A. Mm-hmm.
28 164 Q. -- it may be the case, however, in particular
29 circumstances that the process could be compounded if

1 the immediate line manager is too close or
2 disinterested or fails to engage on the issues. The
3 Inquiry has heard evidence that, while a decision was
4 taken by Oversight committee to follow a particular
5 process which had the MHPS label on it in September 12:06
6 2016, to the exclusion of the immediate line manager,
7 when this issue was raised with the immediate line
8 manager, that's the Clinical Director Mr. Weir, and
9 with the Associate Medical Director, Dr. McAllister,
10 that there was on the evidence so far - and I don't 12:07
11 prejudge where the case takes us - but there was,
12 expressed through some of the evidence we have heard
13 a decision to step away from MHPS and the process that
14 the Oversight Committee had determined. Some of the
15 explanations for that might be - and certainly it was 12:07
16 expressed in emails by Mrs. Gishkori - and I paraphrase
17 here, that these issues don't need to go in that
18 direction; Mr. O'Brien has delivered for the Trust in
19 the past, he's an experienced man and we feel that we
20 can - the local management - feel we can take this in 12:08
21 another way.
22
23 What I put to you is that there's a job of work to do,
24 is there, culturally around understanding when MHPS is
25 appropriate? 12:08
26 A. Yes, I'd agree with that.
27 165 Q. Particularly with local clinical managers to enable
28 them to understand that an MHPS process may be
29 necessary and may be in everyone's best interests and

1 not to fear it?
2 A. Yeah. I think for me, I mean, we don't end up with
3 lots of formal MHPS investigations, and we want to
4 create a more restorative learning culture moving
5 forward. I think for me the importance of establishing 12:09
6 and addressing risk to prevent any harm, and how that
7 has to be done robustly, cannot be understated how
8 important that is. If that's managed well and
9 robustly, then you can potentially then come to an
10 agreement as to how to address issues and manage issues 12:09
11 in a structured formal way but maybe not necessarily
12 through, you know, formal sanctions. So there's lots
13 of options. But it's the ability to assess and prevent
14 any future harm and address that risk appropriately
15 will be, I suppose, the crux and the importance of it. 12:09
16 It's probably not something that's mentioned in great
17 detail within MHPS currently. I'm conscious MHPS was
18 written quite a significant number of years before the
19 response to OSL regulations came in, and there's
20 greater responsibilities there as well. 12:09
21 166 Q. At paragraph 40.2, if you just scroll down, you talk
22 about the need to -- part of the learning has to be
23 around fostering and encouraging a more open,
24 transparent and fair culture for raising and managing
25 all concerns as they arise. You say: "It is not 12:10
26 appropriate to wait until one is sure there is
27 a concern before escalating".
28
29 Is that observation or reflection borne out of your

1 sense that managers, whether on the operational or
2 medical side, had waited too long here before putting
3 this on a proper footing?
4 A. Yes.
5 167 Q. In terms of the learning and what might be done to 12:10
6 foster the kind of culture you talk about - I mean, I
7 am sure Rome wasn't built in a day - what kinds of work
8 streams, what kinds of activities have taken place or
9 could take place to help to build that kind of culture?
10 A. We have put together a training on managing low level 12:11
11 concerns which we didn't have before, and we have
12 delivered that to 70 candidates to date and another 20
13 to go. So, that looks about -- to ensure, it's talking
14 about the restorative learning just culture, what that
15 means, what that looks like in practice. Then also how 12:11
16 to manage low level concerns early, and some of the
17 options and interventions that are available, obviously
18 promoting the fact that NHS Resolution can be contacted
19 at any stage. There's no threshold to contact them for
20 external advice, both by clinical managers and the 12:12
21 practitioners themselves.
22
23 It's about promoting a lot of that. It's about
24 following up with maybe skills clinics with our
25 clinical managers to ensure they feel well-equipped and 12:12
26 supported to tackle difficult issues and how to go
27 about that. Just improving some of the training and
28 support and skills that we can provide our clinical
29 managers to give them the necessary, I suppose, support

1 and encouragement to take on some of those issues.
2 168 Q. Thank you for that. Scroll down a little. I thought
3 it was paragraph 40.2, but you did use the phrase
4 "Governance systems need to be strengthened to
5 triangulate data for Clinical Managers". 12:12
6
7 Have you a sense of how that can be done? What needs
8 to be done within the Trust's governance processes, or
9 what perhaps has been done since this, to make the task
10 of the clinical manager easier when doing the kind of 12:13
11 screening or robust inquiries that your reflections
12 suggest are necessary?
13 A. It's maybe a little bit unfair for me to state that.
14 In my statement and with retrospect, I suppose for my
15 thinking I'm not aware of what those systems all look 12:13
16 like essentially, but I feel if there's any benefit in
17 terms of technology or analytical tools or
18 triangulation. I think it's a huge area in terms of
19 trying to ensure when a clinical manager is making
20 a decision, that the available information streams are 12:13
21 there to allow them. So, it's about ensuring that they
22 are fully informed about -- so we will ensure they are
23 fully informed about where consultants are with job
24 plans or where they are at with appraisals, you know,
25 so that they have all the information to hand. But I 12:14
26 am sure there's other information in terms of Datix,
27 patient complaints. I am sure the governance team are
28 working in relation to that in terms of just making
29 sure that it's easy to triangulate information.

1 169 Q. Mm-hmm. Some work has been done in light of the
2 experience of the Trust. They have been working
3 through this particular, Mr. O'Brien's process, to try
4 and improve matters; is that fair?
5 A. Yes. I think so, yes. We are all learning. 12:14
6 170 Q. We have heard from a number of managers, Mrs. Corrigan,
7 Mrs. Trouton, Mr. Carroll on the operational side.
8 They have told us variously that they really hadn't
9 heard of MHPS at all until this process started.
10 Mrs. Corrigan, in particular in her witness statement, 12:15
11 WIT-39881, said:
12
13 "I can confirm that after the concerns were raised
14 regarding Mr. O'Brien, I became aware that MHPS
15 Framework existed, and this awareness was mainly 12:15
16 through conversations with, in particular, Mrs. Hynds
17 and Mr. Gibson. However, I can confirm I was never
18 provided with a copy of the framework and I have never
19 read or received training with regard to it".
20 12:15
21 I know that training is now in place and I will look at
22 that with you in just a moment. Can you explain how,
23 from your HR perspective, awareness of the MHPS
24 framework wasn't built into management awareness,
25 management training, before all of this happened? 12:16
26 A. I think it should have been. Certainly, probably the
27 focus was down the clinical management line, and that's
28 unfortunate. It should have covered all operational
29 management as well because it would need to have been

1 aware that it was there.
2 171 Q. You have indicated in your statement -- and just bring
3 it up on to the screen. I think it's a document the
4 Inquiry has seen before when Mrs. Toal was giving
5 evidence. WIT-90655. This is the training plan. 12:16
6 I think you are the author of it --
7 A. Mm-hmm.
8 172 Q. -- which was developed last year and is being rolled
9 out this year, I think; is that right?
10 A. Yes, that's right. 12:16
11 173 Q. The Inquiry will know -- we don't need to look at this.
12 You have addressed the issue perhaps that Mrs. Corrigan
13 spoke about, in that training is now being provided to
14 Boards, Board members?
15 A. Yes. 12:17
16 174 Q. Case Managers?
17 A. Mm-hmm.
18 175 Q. Investigators, Clinical Directors, Clinical Leads and
19 Operational Assistant Directors; isn't that right?
20 A. And Heads of Service, yes. 12:17
21 176 Q. Yes. You also took up the role, after returning from
22 maternity leave in 2017, of working up new Trust
23 guidance to sit as a companion piece to MHPS, and new
24 guidance, I think, was published towards the end of
25 2017. If we just briefly look at that, it's TRU-21031. 12:17
26 Yes. That's the document with contributions from some
27 others that you put together?
28 A. Yes.
29 177 Q. Just in the interests of time, could you just distill

1 for us the key changes that you made to this guidance
2 originally published in 2010 by the Trust. Is it fair
3 to say that you had concerns around how the Oversight
4 Group was being used?
5 A. Yes. 12:19
6 178 Q. Concerns around the role of the local or lead manager,
7 and concerns around how informal approaches could be
8 used?
9 A. Yes, that's correct. Those were the two key things
10 that we had learned out of a number of cases coming 12:19
11 forward, that the informal approach is not really
12 mentioned at all within MHPS. So, we wanted to make
13 sure that was a bit clearer for clinical managers.
14
15 Then the role of the Oversight, we wanted to ensure 12:19
16 that it was very clear that that wasn't
17 a decision-making role, that the decision-making in the
18 context of formal investigation obviously sits with the
19 Case Manager, but they are there to provide a sounding
20 board and advice. It was just to clarify some of those 12:19
21 things that we were finding. The Case Managers were
22 maybe relying on the Oversight for decisions, so we
23 needed to ensure that that was corrected.
24 179 Q. Thank you. You have also spoken in your statement
25 about what you described as the complexity of MHPS and 12:20
26 how it has the potential to mislead those who have less
27 experience of using it leading to a lack of confidence,
28 you say, around handling concerns efficiently and
29 compliantly with MHPS?

1 A. Mm-hmm.
2 180 Q. Just in that context, you have said in your statement
3 that the Trust has been given authority recently to
4 appoint a Band 7 MHPS Case Manager?
5 A. No. What I mean is a HR manager within my team to 12:20
6 support, because probably any of the cases would have
7 been myself taking them forward. So, it's an
8 additional resource to work in my team so that we have
9 more people trained up in the handling so we can work
10 alongside our clinical managers when we are managing 12:21
11 a case.
12 181 Q. Okay. Is the idea that the appointment of someone like
13 that taking a specific interest in MHPS will enable
14 a smoother process to help advise the clinical managers
15 on how to conduct MHPS, to de-mystify it, perhaps? 12:21
16 A. Yes. I think it's additional capacity that we can
17 ensure that the training is rolled out and continues to
18 be rolled out; that there's more assistance with the
19 reporting that goes with it. So all of the -- just
20 making sure we have got a bit more capacity to actually 12:21
21 ensure that's fully embedded appropriately.
22 182 Q. If we go back to your statement at WIT-90073. At
23 paragraph 35.7, just scrolling down:
24
25 "There are factors within MHPS framework that need 12:22
26 greater clarity such as clear definitions of all the
27 roles referred to in the document".
28
29 You go on here to express concern that the framework

1 doesn't provide the clear practical steps or sufficient
2 clarity around the steps that a clinical manager needs
3 to perform?
4 A. Mm-hmm.
5 183 Q. You say that another issue is that it's unclear whether 12:22
6 a case manager can take soundings before reaching
7 a decision; that is have conversations, as we discussed
8 earlier?
9 A. Mm-hmm.
10 184 Q. And you do think it's appropriate? 12:23
11 A. Yes, absolutely.
12 185 Q. You point out that there's no adequate definition of
13 the word "concern", which is, as you have explained,
14 the trigger --
15 A. Mm-hmm. 12:23
16 186 Q. -- for moving forward?
17 A. Yes.
18 187 Q. Professional misconduct is not defined; intractable
19 problems isn't defined; various things like that. You
20 also say that it's not clear how far confidentiality 12:23
21 within the process extends?
22 A. Mm-hmm.
23 188 Q. Could I just have your final thoughts on that. In
24 terms of MHPS, is it fair to say that you think it
25 wasn't well used in this case? 12:23
26 A. I think that's fair.
27 189 Q. Are you now confident that the Trust is in a better
28 place in terms of its ability to use it compliantly --
29 A. Yes.

1 190 Q. -- going forward?
2 A. Yes.
3 191 Q. Just another feature of the improvements before we
4 leave it altogether. It says within the guidelines
5 that you have published in 2017 that there's 12:24
6 a obligation at the end of an MHPS process for
7 a medical director and the - is it the head of service
8 - to report to SMT for learning purposes about the
9 experiences of the particular process that was
10 undertaken; that wasn't well-used in the past? 12:24
11 A. No. It's something we have added as like a shared
12 learning, you know, for the Case Manager to summarise
13 in terms of shared learning that can go back and be fed
14 back to the director and the service; that they may
15 want to pick up on issues that maybe came out of an 12:25
16 investigation, maybe not necessarily resulting --
17 linked to that individual that's being subject to the
18 MHPS, but that would warrant some benefit of being
19 looked and shared widely across the service or across
20 the Trust as appropriate. So, each of our clinical 12:25
21 case managers would be asked to reflect on that at the
22 end of a case, at the Oversight meeting, to discuss
23 what needs to be fed back into the organisation, and
24 then that's captured on the reports that we send to the
25 governance committees. 12:25
26 192 Q. Now, we touched on it indirectly but you have some
27 observations to make about the lot of the medical
28 manager and the challenges that are faced in that role.
29 A. Mm-hmm.

1 193 Q. You say at paragraph 41.2 of your statement that,
2 "Consideration needs to be given to how medical
3 management role can work better and how it can be
4 better supported".
5 12:26
6 If we pull up WIT-90066. At 26.2, just in the last few
7 lines there, you are setting out the contextual
8 problems faced within this particular investigation
9 because of the changing in management roles;
10 Dr. McAllister taking on a second role -- 12:26
11 A. Yes.
12 194 Q. -- at that time. You say, I think more generally:
13
14 "There is a huge challenge in medical management posts,
15 as often in my experience they cannot give up their 12:27
16 clinical workload due to sheer work pressures and often
17 don't want to due to deskilling that can occur if out
18 of clinical practice for a period of time".
19
20 If we go down to page 72 on this sequence, six pages 12:27
21 further down, 90072. At 35.3, you make some practical
22 suggestions around how medical management can be better
23 assisted. You talk about the essential requirement of
24 developing clinical leadership induction training.
25 12:27
26 Has that now been done or is that something that's
27 a work in progress?
28 A. I think it's a work in progress. Yeah, there's no
29 national framework for clinical leadership; there's no

1 definition anywhere what a clinical leader needs to do
2 so there's huge variety across different Trusts in
3 terms of job description and roles and things. I think
4 that's something that would be beneficial because it
5 would maybe help make it a more attractive career 12:28
6 choice.
7 195 Q. Again, practical suggestions here. Administrative
8 support for clinical managers; whether management role
9 is also something that needs to be considered.
10 Paragraph 35.4: 12:28
11
12 "Ensuring enough allocated time within job plans to
13 facilitate clinical management. It's an ongoing matter
14 for the Trusts to deliver that", and you think it's
15 critical. 12:29
16
17 35.5: "Continue to build skills and competencies is
18 important to promote a proactive coaching culture where
19 all managers and staff know they have a clear
20 responsibility to ensure and assure themselves of 12:29
21 patient safety".
22
23 How would you reflect back on the process which you are
24 aware of as a bystander, not directly involved, how
25 would you reflect upon the challenges faced by the 12:29
26 medical managers in terms of their, as we now know,
27 limited involvement?
28 A. I think it would have been exceptionally challenging
29 for them. It's very difficult when you are having to

1 tackle an issue with a peer or with a colleague, they
2 are very closely aligned, you know. It's so important
3 that they have the support and skills and training to
4 enable them to do that, to allow those issues to be
5 addressed early and to ensure the necessary actions are 12:30
6 taken to avoid any -- and to protect patients, and also
7 to create good working relationships and good working
8 environments for everyone involved.
9 196 Q. Can you give an example of the kinds of circumstances
10 that you've seen pertaining where medical management 12:30
11 has worked best and has flourished? What has to be in
12 place, and have you seen it in the Trust?
13 A. Yes, absolutely. I have worked with a very -- a number
14 of Associate Medical Directors over the years. I think
15 those that have maybe chosen it, and opted to go into 12:30
16 it and have a passion for it, do work well, you know,
17 where they have a strong team within -- you know, like
18 a service-led leadership team where they work very
19 closely aligned to their operational leads and link in
20 for the necessary expert support around governance or 12:31
21 HR when needed. That can work well and I have seen it
22 work well on many occasions. I have seen many of our
23 associate medical directors take on very challenging
24 situations with some of their consultant colleagues and
25 manage them effectively. 12:31
26 197 Q. Why do we have a situation where, from some witnesses
27 who put their hands up to do a medical management role,
28 whether it's clinical director or associate medical
29 director, why does it appear, at least in some

1 situations, to be the case that senior medical managers
2 are coming in when they don't have the right amount of
3 time available to them, haven't had training, obviously
4 are unable to attend important meetings --
5 A. Mm-hmm. 12:32
6 198 Q. -- why does that continue to be a problem and one
7 which, if I may say so, the Trust has just had to
8 tolerate or accept?
9 A. I think the difficulty is medical management posts are
10 not commissioned, they are not funded, they are not 12:32
11 resourced. The responsibilities, I think, have
12 extended significantly in recent years as a result of,
13 you know, all of the different processes that are put
14 in to manage and that they are responsible for and the
15 demands on the service. Our workforce plans, I don't 12:32
16 believe, have taken into account, I suppose, the fact
17 that we need clinical managers leading and that,
18 therefore, then takes them out of their clinical
19 practice. I think the demands on the hospitals are so
20 significant that that's a very challenging thing to do. 12:33
21 But if it was properly commissioned and resourced and
22 training associated behind it, then I think you would
23 get individuals who are -- you know, we are seeing now
24 adept fellows is a thing which has been established
25 where junior doctors are taking time out of their 12:33
26 training scheme to buddy up with a line manager and
27 work on leadership projects, which is a really good
28 positive step forward we wouldn't have had in the past.
29 So that gives an introduction to management, but that

1 probably needs to continue and have the opportunity
2 that you are not just a consultant one day and clinical
3 director the next, but there's actually a formal
4 process and career path for clinical managers to
5 follow. 12:33
6 199 Q. Do you recognise the problem that I described, that the
7 Southern Trust has had experience of appointing medical
8 managers who, despite perhaps their best endeavours,
9 are not able to deliver the level of commitment that
10 the job self-evidently requires, but yet they continue 12:34
11 to be appointed to these roles, the roles are extended
12 over time? Is it simply a case of there's not enough
13 people putting their hands up to do it and the Trust
14 has to, I suppose, accept what they can get, or do you
15 not recognise the concern I paint? 12:34
16 A. No, I do recognise the concern you paint. I mean,
17 I think it is a challenge and I think it's a challenge
18 for all those reasons I have said in terms of the
19 ability to release; probably more so in the surgical
20 specialties which are known as craft specialties where 12:35
21 you struggle to get -- somebody has to make that choice
22 that they want to leave their clinical practice
23 somewhat behind and take on a management role. Or else
24 there will be an element of deskilling; that's maybe
25 less so in other specialties. It is difficult for 12:35
26 those to take on that role, understanding that they
27 then are moving into a management role which is a very
28 different skill set to clinical role.
29 200 Q. If there is one, is there a current big idea or big

1 project being pursued within the Trust around medical
2 management? What is the state of play in terms of some
3 of the practical suggestions that you have put in your
4 statement as being good ideas for improving the lot of
5 the medical manager? 12:36
6 A. I am probably not the best person. I know the medical
7 management structure sits under the Medical Director's
8 office and I know they have done a significant amount
9 of work. Dr. O'Kane did that, and I think our current
10 Medical Director is following that on and looking at 12:36
11 the structure of clinical management. I think they
12 might be better placed than me to sort of explain what
13 that looks like, but I do know they are looking at that
14 fairly...
15 201 Q. Can I ask you then some questions in relation to 12:36
16 Mr. O'Brien's retirement --
17 A. Yes.
18 202 Q. -- and the concern that he wished to be re-engaged, and
19 the circumstances and the reasons why that didn't
20 happen. You deal with aspects of this in your 12:36
21 supplementary statement, which we have received
22 recently. If we could put that on the screen, please,
23 WIT-94910. Just back to paragraph 1, please. You take
24 as your starting point 2018 and 2019 and increasing
25 numbers of consultants indicating they were considering 12:37
26 early retirement, something you think is to do with the
27 taxation policy --
28 A. Yes.
29 203 Q. -- of the Exchequer at that time. Within that context,

1 you were also starting to receive more queries from
2 consultants around retire-and-return options. You
3 explain in paragraph 2 that, I think towards sometime
4 in 2019, you were engaged in a conversation with the
5 BMA and this issue came up, and you learned that the 12:38
6 Western Trust had done some work around this and had
7 developed a set of guidance, and that guidance was
8 provided to you?
9 A. That's correct.
10 204 Q. Paragraph 3. You had some engagement early in 2020 12:38
11 with Mrs. Toal?
12 A. Mm-hmm.
13 205 Q. You wanted to discuss that guidance document you had
14 obtained from the Western Trust. Scrolling down. On
15 down, please. Mrs. Toal responded, and the upshot of 12:39
16 it was that this work could be taken forward and should
17 be taken forward?
18 A. That's right.
19 206 Q. We can see at WIT-94915 that by July 2020, a final
20 document, guidance document, had been developed. That 12:39
21 wasn't in place at the point in time when Mr. O'Brien
22 retired; is that right?
23 A. We didn't have a formal document, no.
24 207 Q. Could I just refer to one aspect of the document. It's
25 the next page, sorry, 916. Just scroll to the bottom 12:40
26 of the page. A process of reengagement is described.
27 It says:
28
29 "The Service Director may conclude that there's no

1 alternative but to ask the clinician if he or she is
2 willing to be re-engaged following their retirement.
3 This conversation must take place while the clinician
4 remains in the employment of the Trust and arrangements
5 put in place prior to retirement date. But before to 12:40
6 proceeding to re-engage a retired clinician, the
7 Service Director should, in conjunction with a senior
8 HR manager responsible for Medical HR, consider the
9 following: That there are no outstanding or unresolved
10 concerns regarding the clinician's overall performance 12:41
11 and conduct, and that the clinician is medically fit to
12 perform the role having demonstrated an acceptable
13 level attendance subject to DDA requirements".
14
15 A. Mm-hmm. 12:41
16 208 Q. So that's the piece. I will come back to that piece as
17 we look through the timeline here. Can I go back to
18 your statement in this respect in WIT-94911, and take
19 up paragraph 5, please. You recall that Mr. O'Brien
20 contacted your colleague, Mr. Clegg, in February, to 12:42
21 indicate that he was considering retirement. He
22 requested the relevant application forms. You say he
23 understands, having spoken to Mr. Clegg recently, that
24 during the conversation there was a brief discussion on
25 whether he could return to work post-retirement. 12:42
26 Mr. Clegg advised this would not be an automatic, it
27 would have to be discussed and approved by the
28 Associate Medical Director. You say HR had no further
29 involvement in these discussions at that time.

1
2 Now, if we look at TRU-01744. This is Martina
3 Corrigan, 13th April 2020. She is attaching
4 Mr. O'Brien's notice of retirement and she is asking
5 for advice, "Is there anything further that I need to 12:43
6 do with this, please?" You are one of the recipients
7 of this, along with Mr. Clegg.
8
9 So, is it fair to say that you knew from at least April
10 time that Mr. O'Brien wished to retire at the end of 12:43
11 June and then return in August?
12 A. I wasn't aware that he wanted to return. I knew that
13 he was planning to retire and had asked for the
14 application forms.
15 209 Q. Mm-hmm. But did his application forms not demonstrate 12:44
16 that he did wish to return?
17 A. Not that I'm aware. They don't come initially to me,
18 these are forms that go off to the pension office to
19 get the pension calculated. It wouldn't have indicated
20 on that, to the best of my knowledge, no. 12:44
21 210 Q. Yes. Then if we could look at TRU-258960. Just the
22 bottom of the page, please. This is two days later.
23 This is Mr. Clegg advising Mr. Carroll, Mr. Haynes,
24 Mr. Young.
25 12:44
26 "Mr. O'Brien's application for benefits is all in hand.
27 He will be processed as a leaver on 30th June. I just
28 need to know if it has been agreed for him to return to
29 work following retirement and, if so, from what date,

1 as we will need to reinstate him to the payroll?"
2 A. Mm-hmm.
3 211 Q. Certainly Mr. Clegg had an awareness, as a result of
4 receiving Mr. O'Brien's notice of retirement into the
5 HR office, presumably through Mrs. Corrigan's 12:45
6 correspondence --
7 A. Yes.
8 212 Q. -- that this was what Mr. O'Brien was proposing?
9 A. Yes.
10 213 Q. Just if we scroll up the page, please. Ronan Carroll 12:45
11 asked "If we are taking Aidan back? "Yes". Mark
12 Haynes, only copying Ronan and Martina in, not, it
13 appears, Mr. Clegg, has said:
14
15 "Needs more discussion than can be had at present. In 12:46
16 short yes but with strings attached and these strings
17 need to be clear and accepted before he is offered
18 anything".
19
20 Now, it's fair to say that at that point in time, you 12:46
21 were well aware, and indeed Mr. Clegg was well aware,
22 that there were processes unfinished in connection with
23 Mr. O'Brien's performance and/or conduct, the MHPS;
24 there had been a referral to GMC at that point?
25 A. That's right. 12:46
26 214 Q. The MHPS leading to a grievance but with a potential
27 for disciplinary; all those processes were still at
28 large with the grievance?
29 A. Mm-hmm.

1 215 Q. Then just working our way along the timeline. There
2 was a conversation between Mr. Haynes and Mr. O'Brien
3 in the presence of Mr. Carroll. I think it was
4 a telephone conversation on 8th June. Mr. O'Brien
5 recorded the conversation but we know, broadly, that he 12:47
6 was told that a decision had been made that he could
7 not return. Did you know that that conversation was
8 going to take place?
9 A. Between Mr. Haynes and Mr. O'Brien?
10 216 Q. Yes. 12:47
11 A. I don't recall. I mean, I know Mr. Haynes contacted me
12 to ask for my advice and obviously I advised him in the
13 way we always advise, that it's not an automatic right
14 to passage to return. Obviously consultant decides
15 when they want to retire, there's no retirement age, 12:48
16 they make a choice when they decide to go. If they are
17 wanting to return, the advice we always give is they
18 have to seek to discuss that with their Assistant
19 Medical Director and Director of Service because very
20 often consultants -- and it wasn't common in the past, 12:48
21 it was more common, as I said, because of the taxation
22 issues, but sometimes they want to come back maybe on
23 a lesser job plan, maybe not doing on-call. There's
24 lots of different factors that have to be considered.
25 It wouldn't have been automatic because there might be 12:48
26 trainees coming through and we were able to recruit and
27 it's not a hard-to-fill post. In other areas like
28 Urology, it obviously is. So, it's a discussion that
29 has to be had. I would have given Mr. Haynes the

1 advice in accordance with our guidance at that time. I
2 don't believe I was aware when or how or what was
3 discussed during the conversation.
4 217 Q. Yes. But there was a conversation, as I say, on 8th
5 June? 12:49
6 A. Okay.
7 218 Q. If we go to TRU-163341, you have sent an email on
8 9th June --
9 A. Mm-hmm.
10 219 Q. -- to Mr. Haynes. You've explained in your witness 12:49
11 statement at paragraph 6 - I don't need to bring it
12 up - Mark Haynes asked you to provide him with a form
13 of words, essentially, to allow him to respond to
14 Mr. O'Brien, who wanted to have his explanation in
15 writing? 12:49
16 A. Mm-hmm.
17 220 Q. Is it fair to call this a script --
18 A. Yes, it would be fair.
19 221 Q. -- that you provided to Mr. Haynes to send?
20 A. Yeah. I remember he asked me specifically could I put 12:49
21 a form of words together.
22 222 Q. So, in terms of the decision to not permit Mr. O'Brien
23 to return, you have known, or at least Mr. Clegg has
24 known --
25 A. Yes. 12:50
26 223 Q. -- from three or four months previously that there's an
27 interest in returning?
28 A. Mm-hmm.
29 224 Q. This is now 9th June. Why has it taken to 9th June to

1 advise Mr. O'Brien that the reason why he can't come
2 back is something you've always known about, that the
3 MHPS and GMC processes have not yet been concluded?
4 Why couldn't he have been told that back in April?
5 A. He should have been, is my view. He should have been 12:51
6 told earlier, he would have been able to be aware of
7 that at the earliest possible opportunity. I don't
8 know the reason why there was a delay or whether they
9 were considering it at any point. I am not sure of
10 that. 12:51
11 225 Q. Mm-hmm. You talk about speaking to Mr. Haynes about
12 this issue. Did you mean to suggest that you had
13 spoken to him in advance of this email to set out the
14 policy to him?
15 A. He phoned me and asked me could I put a form of words 12:51
16 in an email to him.
17 226 Q. Yes.
18 A. And that's exactly what he asked for, and then that was
19 a quick phone call to say, look, I need a form of words
20 in accordance with -- that I can respond; can you put 12:52
21 a form of words together. Obviously I used our
22 guidance as our guiding principles for how we would do
23 that and e-mailed that back to him.
24 227 Q. Yes. Back in April, he's thinking Mr. O'Brien could
25 return but with strings attached. We saw that email? 12:52
26 A. Mm-hmm.
27 228 Q. And on 8th June he is having this conversation with
28 Mr. O'Brien to say no, you can't return?
29 A. Mm-hmm.

1 229 Q. Is it your evidence that during that period, nobody in
2 HR engaged on that issue with Mr. Haynes?
3 A. No, the way -- I mean, normally what happens when a
4 consultant indicates that they are going and is there
5 an option, we very much say, look, that's for you -- 12:52
6 because they are ending their permanent contract with
7 us, they have given their notice, they are working
8 their notice and if they are wanting to negotiate to go
9 into a new contract, then that's very much left to them
10 to go and discuss with their director and AMD and we 12:53
11 will generally get advised by one or either parties
12 that that has been agreed and this is the job plan that
13 has been agreed for and this is the length of time that
14 the new contract has been agreed for. It's not
15 something we would proactively -- because, you know, 12:53
16 they have given us notice that their permanent contract
17 is ending, and until we are informed that an agreement
18 has been reached with the director and AMD that a new
19 contract can be formed, we wouldn't. I suppose we
20 would leave that to the service to have those 12:53
21 discussions.
22 230 Q. I am conscious that the guideline that we looked at
23 earlier didn't become live, if you like, until July.
24 If we just bring that up on the screen, please, again.
25 It's WIT-94916. It says, just reminding ourselves, 12:53
26 that under the process of reengagement:
27
28 "Before proceeding to re-engage, the Service Directors
29 should, in conjunction with senior HR manager, consider

1 the following".
2
3 Mr. Clegg, and perhaps yourself in April, knowing that
4 there were reasons why, looking at this policy, he
5 shouldn't be returning, are you saying that despite 12:54
6 this policy - I realise it didn't come into effect in
7 July - that you didn't and Mr. Clegg didn't see fit to
8 provide the advice that there are concerns about
9 Mr. O'Brien's practice so that a return isn't really an
10 option? 12:55
11 A. I think probably the purpose of having that in the
12 guidance is to ensure that managers check, you know,
13 for anything. I think the concerns were well-known
14 within the Director and the Associate Medical Director.
15 So, the checking mechanism, I suppose, in that 12:55
16 situation was probably not necessary because they were
17 fully aware of what those concerns were. I think
18 that's the purpose of that there.
19
20 But the decision would be under our advice, which is 12:55
21 the advice I give, but the decision is theirs in terms
22 of whether that's something considering the facts, but
23 we would be giving our advice around that.
24 231 Q. I already understand while general advice was given.
25 Ultimately this was a decision for Mr. Haynes and he 12:56
26 had a discretion, notwithstanding his awareness of
27 continuing issues yet to be resolved with Mr. O'Brien,
28 but he had a discretion whether to return him or not?
29 A. I think it's the Associate Medical Director and the

1 Service Director and the Medical Director would have to
2 be informed as well, given his responsibility as
3 Responsible Officer.
4 232 Q. Thank you very much. I have no further questions for
5 the witness. 12:56
6
7 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL
8 AS FOLLOWS:
9
10 CHAIR: Thank you very much. Thank you. I am going to 12:56
11 turn to my colleagues first of all to see if they have
12 some questions for you. Mr. Hanbury.
13 MR. HANBURY: Just a couple of questions from me.
14 Firstly on job planning, you kindly described -- it's
15 retrospective, so if you are doing it later after 12:57
16 appeal, from a PA's point of view, you are sort of
17 going back after a year and that puts the appeal
18 mechanism under a bit of pressure, I suppose, to
19 search. Is there any way of sort of forcing the
20 process so it's done in advance or a timely way in your 12:57
21 experience? How do you bring a reluctant consultant to
22 the table to discuss it?
23 A. Yeah. That has been -- I mean that was certainly an
24 experience in the early days, it was more
25 retrospective. I think we have definitely improved to 12:57
26 move towards prospective job planning. I think we have
27 still a way to go to have it in place on or before
28 1st April every year. Your point in terms of how do we
29 encourage it or, you know, provide that to happen more

1 frequently, I think it's about that cycle and aligning
2 the cycle with appraisal and job planning, and
3 appraisal comes first and feeds into the job planning
4 and it's trying to ensure those cycles are aligned with
5 each other to facilitate that and allow that planning 12:58
6 to take place on a prospective basis. I think it's
7 certainly something we have definitely moved greater
8 towards that, and we continue to do what we can to try
9 and encourage that.
10 233 Q. There was some comment about software being very 12:58
11 difficult. Has that eased now; is there a new better
12 system?
13 A. Yeah, we have just moved to -- we had a software
14 company since 2012 and we just moved to a new provider,
15 which its tag line is "power and simplicity", so it's 12:58
16 meant to be more simple. It was designed by
17 a consultant anaesthetist. It also allows us to add
18 clinical managers so that they are very much involved
19 in that loop. We are hoping -- it's just been rolled
20 out from February this year. We are hoping that that 12:59
21 will make the system easier for them to use. But it's
22 obviously teething problems when you implement a new
23 system, oh we will have to work through those, but
24 that's the intention behind it.
25 234 Q. Thanks. Just moving on to the charts at home, 12:59
26 Mr. O'Brien was sort of keeping notes and charts at
27 home, and your comment about had you been aware of
28 that, you might have sort of given some more robust
29 advice. What would that have been if you had, say,

1 just heard that as an isolated problem?
2 A. I think it's about the patterns that were maybe
3 evolving. Obviously I had been experienced in dealing
4 with the binned notes. If there was then a recurring
5 pattern, you know, you would have wanted to get to the 12:59
6 bottom of why it was happening and establish was there
7 systemic issues behind that or, you know, was it -- and
8 had he been told not to do it. It was about engaging
9 with the practitioner early to understand what was
10 going on, and try and ensure that that doesn't happen 13:00
11 and that they understand why that can't happen from
12 a patient point of view, from data protection, and put
13 the necessary measures in place. So, just to try and
14 get a bit more information as to why that was happening
15 and see what we can do to stop it. Hopefully, that 13:00
16 early intervention would avoid that but if you have
17 somebody doing it against what they have been told to
18 do, then obviously yes, taking them forward through
19 appropriate HR disciplinary process if needs be.
20 235 Q. Thank you. You mentioned briefly recruitment. We are 13:00
21 aware that Urology here was a hard-to-recruit service.
22 Is there any influence you have on that? You mentioned
23 job planning as a tool to try and keep people that --
24 A. Yes.
25 236 Q. Would you have any comments about recruitment as 13:00
26 a general feature?
27 A. I would say it's a significant challenge for us.
28 There's a number of factors at play in relation to
29 that, from my reading of it. Generally in Urology,

1 when we got commission funding and we advertise, we are
2 able to appoint. Unfortunately we did lose a number of
3 our consultant colleagues along the way; two of them
4 went to England and two went to the City, I believe.
5 13:01
6 England, you know, we have a difficulty with England in
7 comparison to Northern Ireland because we no longer
8 have a Clinical Excellence Award scheme in Northern
9 Ireland. That was ceased in 2009. Back in 2009,
10 I think we had maybe nearly 50% of our consultants held 13:01
11 some sort of a Clinical Excellence Award. That system
12 in Northern Ireland ceased back in 2009 and in England
13 it recommenced again. England and Wales recommenced
14 around 2012, I think, 2013. That allows consultants to
15 -- it gives them something to work towards in terms of 13:01
16 that award. Local awards, you know, anywhere between
17 one and nine awards, 3,000, or national awards between
18 30 and 70,000, and our consultants haven't had the
19 opportunity apply for that. That could have a bearing
20 on attracting consultants; our consultants going to 13:02
21 England. We know we lost some to England and some to
22 the City. The difficulty, I think, we have in terms of
23 competing with some of the bigger hospitals in Northern
24 Ireland is a lot of our consultants, and I know this is
25 a generalisation, live and work in around Belfast. If 13:02
26 they are coming to the Southern Trust, then if they are
27 on-call, they generally have to live in, and if they
28 are in Belfast, they are sometimes on bigger rotas,
29 they are maybe not as frequently on-call, they can

1 maybe live at home when they are on-call. So, there's
2 lots of challenges we have around that. We are trying
3 to do what we can, albeit sometimes we feel like
4 there's some things you can't change.
5 13:02
6 We know we can't really recruit from the south of
7 Ireland. I am sure you are aware they have introduced
8 a new contract there within the last number of months
9 which has starting salaries twice, nearly three times
10 what the starting in Northern Ireland are. That's 13:02
11 a huge challenge for us.
12
13 We do employ whatever techniques we can in relation to
14 recruitment, you know, and advertising far and wide.
15 Looking and asking our clinical managers, yes, to look 13:03
16 at our job plans to see how can we make them more
17 attractive, how can we ensure -- you know, when
18 Dr. O'Kane started, she made sure all of our new
19 consultants got extra SPA in their job plans to allow
20 them to come in, get up to speed, undertake their 13:03
21 mandatory training. All of that was built into their
22 job plans to facilitate that. So, there's lots of
23 things we are trying to think outside the box of things
24 we can change, but obviously operating within that
25 challenging environment in terms of being able to 13:03
26 attract consultants.
27
28 Another big pull factor for them is the number of
29 middle or SAS grade doctors that they have underneath

1 them. Obviously in bigger hospitals they will have
2 probably more. We had two training numbers in Urology
3 and then we are trying to recruit clinical fellows or
4 research fellows. That's difficult because if they are
5 on call, then they are generally first on call if they 13:04
6 have an inexperienced doctor underneath them. We
7 struggle to recruit through training schemes as well
8 for some of the comparisons with England and the new
9 contract that they have where junior doctors in
10 England, which was introduced in 2016. In Northern 13:04
11 Ireland, we are not on that contact, we are back on the
12 2002 contract. So that has a differential in terms of
13 the starting salaries for juniors because a lot of our
14 national -- our recruitment in Northern Ireland, our
15 training schemes are national recruitment schemes, so 13:04
16 we're recruiting from the national recruitment. I
17 think less than 50% or 50% of them are national. If
18 they are appointed to Northern Ireland, then their
19 starting salaries are not necessarily always
20 comparable. That's a challenge for us. 13:04
21
22 There's issues. Health Education England fund
23 relocation packages for junior doctors in England but
24 we are not eligible for those expenses in Northern
25 Ireland. So, I think I have highlighted there's huge 13:05
26 challenges that we can't fix but we are trying to do
27 what we can to fix them. We are looking at
28 international recruitment. We have set up -- and when
29 we get a new Deputy Medical Director, myself and her

1 set up the Southern Academy in the Southern Trust which
2 is focused on international doctors and providing
3 stimulation training for them, enhanced induction,
4 things that we can try and encourage them to come to
5 the Southern Trust to get some of those enhanced, and 13:05
6 have been working with some of our international
7 doctors and a group of really experienced and
8 interested doctors to try and develop that for us and
9 help that along. So, we are doing lots of things but,
10 as I said, there's some things we just can't control, 13:05
11 unfortunately.
12 237 Q. Thanks very much. No more questions.
13 DR. SWART: I was going to start with that one. Just
14 following on from that, is there a single person in the
15 Trust who is leading any sort of, you know, big idea, 13:06
16 innovative approach to recruitment for medical staff
17 specifically? Where does that sit?
18 A. Well, it probably sits within our HR Director's remit
19 in terms of, you know, we do have recruitment campaigns
20 -- 13:06
21 238 Q. But have you got a big strategic idea --
22 A. Yeah. I think it's something we are looking at.
23 239 Q. That the Board is involved in? I mean, this is a Board
24 issue really?
25 A. Of course. 13:06
26 240 Q. It is so significant. Is that there or --
27 A. We have it listed on our Corporate Risk Register in
28 terms of our ability to recruit medical staff.
29 241 Q. Have you got somebody saying I am in charge of this?

1 A. Yes. Possibly not.
2 242 Q. Okay. You described very eloquently potential uses of
3 job planning?
4 A. Mm-hmm.
5 243 Q. The challenges, which I think many Trusts face; you 13:06
6 would not be alone in that?
7 A. Yes.
8 244 Q. Again, have you an agreed strategic approach to this
9 for the future led by a senior doctor who is saying
10 this is what we are doing? 13:07
11 A. I think that's what we are moving towards. We have had
12 early discussions with our local negotiating committee
13 that this is the area we want to focus on, and our
14 Medical Director is fully behind that and that's the
15 direction we are going. 13:07
16 245 Q. Have you ever used job planning as the tool you
17 described it could be used as the basis for
18 disciplinary action, if somebody is not fulfilling
19 their job plan? Has that ever been done actually?
20 A. Not to date, no. 13:07
21 246 Q. Has it ever been done the other way around, to say this
22 consultant can't fulfil their job plan and they need
23 support?
24 A. Yes. No, I think that does happen, you know, in terms
25 of some of those areas which are very good at job 13:07
26 planning. I think our focus is we want to get back to
27 the importance of a job plan meeting and actually
28 having a face-to-face meeting.
29 247 Q. Have you actually taken a consultant to say you are not

1 fulfilling your job plan, this is a problem, you have
2 to do something, we have to do something together?
3 A. Yes. No, we haven't got to that stage, no.
4 248 Q. Another issue which has come through really in most of
5 the MHPS witnesses was around a certain lack of 13:08
6 transparency at the time that that happened. What I am
7 talking about is nobody really knew much about the
8 Oversight Committee; they weren't really sure what
9 happened when matters were escalated up and senior
10 people were talking about it. I think in your 13:08
11 statement, you've emphasised the need for transparency,
12 for fairness, for openness. Has that culture changed
13 and improved in the last few years? Are you still on
14 a journey? Is there a sort of definitive attempt to
15 improve that, to de-mystify it, do you think? 13:08
16 A. I think we are on a journey, would be the fairest
17 thing. I think the training that we have just rolled
18 out has very much covered that in terms of making
19 people aware of what the Oversight is, what the purpose
20 of it is and what it's all about. But yeah, I think 13:08
21 it's a journey about embedding some of that culture and
22 some of those messages right across the organisation.
23 249 Q. The other thing that has come out is a sort of secrecy
24 and mystery and all of that, but also a reluctance to
25 manage doctors, not just not to ring HR, which you have 13:09
26 described as perhaps due to fear of process. I am
27 presuming you are implying that HR is trying to be less
28 scary in that regard?
29 A. Yes.

1 250 Q. But there also seems to be a general reluctance for
2 doctors to manage doctors, for managers to manage
3 doctors. Is that something you have observed, and why
4 do you think that is?
5 A. Yeah, I think it probably has been something -- I guess 13:09
6 medical staff are -- they are so used to being
7 autonomous workers and independent workers. But it's
8 difficult. I mean, it's not something that I think --
9 I think it's a journey that we are on in terms of
10 ensuring that they are managed in the same way as 13:10
11 anyone else would be managed, and I think that's
12 important.
13 251 Q. Do you think that's improving?
14 A. Yes, I definitely do.
15 252 Q. You also mentioned that there are no standards for a 13:10
16 clinical leadership but there are standards, aren't
17 there? The GMC sets out standards. There's the
18 Federation Medical Leadership and Management Standards;
19 there's a range of competencies. Is the Trust
20 attempting to bring some formality to those 13:10
21 competencies in in its training programme, or is this
22 also still work in progress?
23 A. Yeah, I think that's something that's being considered
24 in terms of some of these development programmes for
25 clinical management leadership structures. That has 13:10
26 been covered in previous leadership training
27 programmes. I think when you have a cohort of staff
28 and changeover of medical managers, it has to be
29 ongoing continuous thing.

1 253 Q. It does, yes. You have got your retire/return policy.
2 Are you using that a lot these days?
3 A. More so than what we did in the past, but a lot of time
4 when someone chooses to retire, they don't want to
5 return. So we are not using it that often but there 13:11
6 would be some occasions.
7 254 Q. And has it been beneficial to have an actual policy?
8 A. Yes.
9 DR. SWART: Thank you very much.
10 CHAIR: You will be relieved I have nothing further 13:11
11 I want to ask you, Ms. Parks. Thank you very much.
12 Your evidence has been helpful to us. It's now ten
13 past one, let's say a quarter past two.
14
15 THE INQUIRY ADJOURNED FOR LUNCH 13:11
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1 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:
2
3 CHAIR: Good afternoon, everyone.
4 MR. WOLFE KC: Good afternoon, Chair, good afternoon,
5 Panel. Good afternoon, Sharon Glenny, who is your 14:17
6 witness this afternoon, Chair. She proposes to take
7 the oath, I believe.
8
9 SHARON GLENNY, HAVING BEEN SWORN, WAS EXAMINED BY
10 MR. WOLFE KC AS FOLLOWS: 14:17
11
12 255 Q. MR. WOLFE KC: I understand you are a bit nervous,
13 Ms. Glenny?
14 A. Yes.
15 256 Q. There's nothing to be worried about and we will take it 14:17
16 as slowly as you can. If the Chair frowns at you, it
17 means you are speaking too fast. If she frowns at me,
18 I will tell you off. Okay.
19 CHAIR: If you want a break at any time, just let us
20 know. 14:18
21 257 Q. MR. WOLFE KC: The first thing we need to look at your
22 witness statements. The first witness statement you
23 have given to the Inquiry is at WIT-81720. You will
24 recognise that as the first page. We have put a little
25 note at the top to indicate that there's a second 14:18
26 witness statement that has come in from you as an
27 addendum. Let's go to the last page of this one,
28 81795, and you have signed that electronically. Would
29 you like to adopt that witness statement as part of

1 your evidence?
2 A. Yes, please.
3 258 Q. Thank you. Then your addendum statement, WIT-94966.
4 That's the first page of it. Can we just scroll down
5 because I think we were advised yesterday - just stop 14:19
6 there - we were advised yesterday that there was
7 a typographical error in this?
8 A. Yes.
9 259 Q. When the statement came to us, I think this is how
10 it... Yes, I understand. So you moved or -- 14:19
11 A. I stayed where I was.
12 260 Q. Okay, that's a better way to put it. As is explained
13 there, your responsibility for Integrated Women's
14 Health Maternity Services has moved to somebody else?
15 A. Temporarily, yes. Just from April '23 there. 14:19
16 261 Q. And it's April '23, as it says in the last line, and
17 not April '22 which is highlighted in pink. April '22
18 was a typographical error. So, that tidies that up.
19
20 If we go to the last page then, it's page 71 of this 14:19
21 sequence, five pages down. Again, that's your
22 signature?
23 A. Yes, it is.
24 262 Q. Do you wish to adopt that statement as part of your
25 evidence? 14:20
26 A. Yes, please.
27 263 Q. Thank you. Now, you joined the Trust in October 2006
28 as a temporary project manager; isn't that correct?
29 A. Yes, although I did join the Trust in 1990 originally,

1 but from the time that I have been filling in there,
2 for the Inquiry purposes, that was my role then.
3 264 Q. Yes. We are not terribly interested in your temporary
4 project manager's role.
5 A. No. 14:20
6 265 Q. We are, however, interested in the two posts that you
7 have held since that time. Both of them were
8 Operational Support Lead posts; isn't that right?
9 A. Mm-hmm.
10 266 Q. You took up an Operational Support Lead post in Surgery 14:20
11 and Elective Care on 15th July 2007?
12 A. That's right.
13 267 Q. You stayed in that post until 31st March 2016; isn't
14 that right?
15 A. That's correct. 14:21
16 268 Q. That's when - and the Inquiry has heard evidence about
17 this already - Mrs. Gishkori, who was the Director of
18 Acute Services, decided that Assistant Directors and
19 their Operational Support Leads would move?
20 A. Move. 14:21
21 269 Q. So you went from SEC, from Surgery and Elective Care,
22 to Clinical Cancer Services; isn't that right?
23 A. That's right, and Integrated Women's Maternity Health.
24 The two together, yeah.
25 270 Q. Yes. And you have remained in that post ever since? 14:21
26 A. That's correct.
27 271 Q. Subject to the change that we talked about earlier --
28 A. Yes.
29 272 Q. -- just relatively recently; isn't that right?

1 A. Yes.
2 273 Q. Your report in the first of those posts, in SEC, was to
3 Simon Gibson until September 2009, and thereafter your
4 Assistant Director to whom you reported was Heather
5 Trouton? 14:22
6 A. Up until 2016, yes.
7 274 Q. That's right?
8 A. Yeah.
9 275 Q. Then when you moved across to Cancer Services and
10 Integrated Women's Health, it was, on the cancer side, 14:22
11 Barry Conway?
12 A. It was Heather initially until 2018 and then Barry
13 Conway from 2018.
14 276 Q. Yes. I suppose in both of those jobs, obviously
15 different settings but your main duties and 14:22
16 responsibilities were the monitoring, as you have
17 described, of the operational functions associated with
18 the performance of elective care pathways, and
19 supporting the Heads of Service and the Assistant
20 Director? 14:22
21 A. That's right.
22 277 Q. As you have said in paragraph 11 of your statement - if
23 you can just maybe bring it up, WIT-81748, at 11.1A -
24 "Monitoring of performance was against expected levels
25 of activity". Is that right? Is it right to describe 14:23
26 those expected levels of activity as the departmental
27 standards or access targets?
28 A. Yes. So, I suppose there was two things. There was
29 really the levels of activity that you were expected to

1 deliver, as well as the waiting times that you were
2 expected to deliver.
3 278 Q. Yes. So, it was numbers and times?
4 A. Yes.
5 279 Q. You have explained that there. Just briefly some buzz 14:23
6 words there. You had to take into account or you were
7 monitoring trajectories. What's that in this context?
8 A. So, throughout both the posts, I suppose the way we
9 monitor activity has changed over time. Initially, the
10 drive or focus was delivering waiting times, so when 14:24
11 the Integrated Elective Access Policy came in, it was
12 more about delivering what the standards were in the
13 Integrated Elective Access Policy. So, our nine weeks
14 for Outpatients, 13 weeks for in and days, and nine
15 weeks for diagnostics were pertinent to me at that 14:24
16 time.
17
18 It then kind of moved more into levels of activity as
19 well, as the waiting times. That was where our service
20 and budget agreements came in. So, that was the agreed 14:24
21 level that we had with our commissioners set for each
22 of our specialty areas to deliver each year. That,
23 then, kind of moved then into more trajectories. So,
24 if we thought we weren't able to deliver a level of
25 activity, then we had to traject what we were able to 14:25
26 do for each of those specialty areas for that specific
27 year. We moved to service delivery plans as in, you
28 know, that was the expected level. It may not have
29 been your commissioned level but it was an expected

1 level that we had to deliver within the year. More
2 recently then since Covid times, it's all been about
3 rebuild plans and trying to get services back online
4 and moving back to our pre-Covid levels of activity.
5 280 Q. Yes. Thank you, that's very clear. The mainstay of 14:25
6 your role -- that's maybe unfair, a key task for you,
7 possibly every day, was the production or the
8 contribution to the production of performance report
9 and dashboards; isn't that right?
10 A. Yes. 14:25
11 281 Q. We can see all that material attached to your witness
12 statement. They were important documents for keeping
13 the business area --
14 A. Mm-hmm.
15 282 Q. -- where you worked well-informed of what was going on 14:26
16 on a day-to-day, week-to-week, month-to-month basis, so
17 that everybody understood how well the service was
18 performing against the standards that you have talked
19 about; isn't that right?
20 A. That's correct. It also would have led to the looking 14:26
21 of trends and things, you know, where we were starting
22 to fall behind on areas, looking at referrals into the
23 service, trying to sort of place where pressures were
24 starting to take its toll on the service, and looking
25 towards trying to come up with reasonable ways of 14:26
26 trying to meet those challenges in conversations with
27 the Heads of Service and the clinical teams.
28 283 Q. And also in conversation with the Commissioner; is that
29 right?

1 A. Yes, yes. We would have met with them. It may not
2 have been me personally but I certainly would have been
3 provided information to the senior management team in
4 relation to those challenges and pressures --
5 284 Q. Yes. 14:27
6 A. -- around the delivery of those targets.
7 285 Q. Mm-hmm. I am going to ask you some questions about
8 delivery because I think it's important for this
9 Inquiry to understand the context in which clinicians
10 worked into which patients obviously had to fit to 14:27
11 receive treatment, and the pressures of the context.
12 You are obviously in a good position to know what was
13 going on; you were extracting the data and producing
14 the results. So, I want to ask you about how that
15 information was used, what was the response to the 14:28
16 pressures that was being felt. Obviously if you can't
17 address any of the issues, you just tell me.
18 A. Mm-hmm.
19 286 Q. One of the things you say, if we put it up, WIT-81726.
20 You say at 4.3A, if we just scroll down, that you were 14:28
21 responsible for monitoring the day-to-day operational
22 functions associated with performance via management of
23 patient target lists and waiting lists management
24 processes. Primary target lists, is that the same as
25 patient tracking lists? 14:28
26 A. Well, there is slight variation. A patient tracking
27 list is probably more in relation to our Cancer
28 Services post. Primary target lists are those patients
29 where you are trying to achieve your nine-week target,

1 your 13-week target, and they would have been very
2 focused on the list of patients to get your service to
3 that point by a certain month in time.
4 287 Q. Okay. So, particular kinds of patients --
5 A. Yes. 14:29
6 288 Q. -- are expected -- well, the Trust is expected to
7 deliver its service in accordance with those targets?
8 A. Yes.
9 289 Q. If we go down to 5.2.1. I will give you the page
10 reference number, WIT-81729. If we just scroll down a 14:29
11 little, you talk about exploring opportunities for
12 nonrecurrent funding bids in order to increase capacity
13 with the service. That's something that you monitored?
14 A. Yes. So I would have played quite a key role in the
15 development of plans around the funding aspects of 14:30
16 yearly money that was coming down from SPPTU Department
17 of Health in making those bids and what we felt was
18 a reasonable amount of waiting list initiative work
19 that we could complete within each of those services,
20 or what we thought we could secure out in the 14:30
21 independent sectors by ways of additional capacity.
22 290 Q. Okay, yes.
23 A. Those would have been done in relation to the Heads of
24 Service then to build up a plan.
25 291 Q. Yes. Thinking about Urology in particular, I suspect 14:30
26 is there a certain element of what you can do with
27 nonrecurrent funding that is in a sense inflexible?
28 You only have a certain number of personnel who can do
29 clinics or diagnostics or theatre work; you only have

1 certain access to theatre time?
2 A. Mm-hmm.
3 292 Q. In what sense was nonrecurrent funding useful when some
4 of your capacity constraints are inflexible and can't
5 be changed? 14:31
6 A. So, there certainly was limitation to what you could do
7 with nonrecurrent funding. The ideal thing would
8 obviously be to have recurrent funding into your
9 service that you could recruit through, and if there
10 was a recruitment pool out there to bring resources in 14:31
11 against. The noncurrent funding in Urology in
12 particular during my tenure in SEC, we did explore
13 options of trying to use much more independent sector
14 usage, and we did use some services across the border
15 as well with bringing in additional Outpatient elective 14:32
16 capacity.
17
18 In terms of what we could do with our existing
19 resources, there's only a certain amount of sessions
20 that those consultants were permitted to deliver, and 14:32
21 there were rules around the volumes that they were
22 permitted to deliver. We also were constrained by the
23 accommodation, theatre capacity, and access into
24 theatres. Certainly within Urology, the consultants
25 certainly did try their best to work around what was 14:32
26 available to them in terms of evenings and weekend
27 sessions and what they could do. So, we tried to make
28 as much use of what we could, and take as much of the
29 allocation down as what we could to deliver as much

1 service as we could to our patients.
2 293 Q. Yes. We will go on shortly to look at some of the
3 waits and the numbers of patients on those waits; one
4 feeding, no doubt, into the other?
5 A. Yes. 14:33
6 294 Q. But is it fair to say that noncurrent funding in the
7 context of Urology, while undoubtedly welcome, was not
8 really making a significant dent into the demand that
9 was out there for the Trust services?
10 A. It would be fair to say it was a sticking plaster over 14:33
11 what was a larger problem.
12 295 Q. Yes. If we go to WIT-81742, we will start to explore
13 some of the scale of that problem. At 10.3, just down
14 the page, you set out some of the waiting time targets
15 that you have alluded to already. Outpatients should, 14:34
16 in theory, receive a first referral appointment nine
17 weeks after the Trust receives the referral?
18 A. Mm-hmm.
19 296 Q. Elective inpatient or day cases should be progressed 13
20 weeks after the patient is added to the waiting list. 14:34
21 So they'd come in for their Outpatients appointment,
22 they may require some diagnostics and then they might
23 then be added to the waiting list. It's at that point
24 the clock starts to run; is that right?
25 A. That's right. So, from the date the patient is added 14:35
26 to the waiting list or the decision that a patient
27 requires elective surgery, the clock is ticking from
28 that point really and it's 13 weeks to have the
29 surgery.

1 297 Q. Yes. Then we looked at some of this yesterday, there's
2 the cancer targets, specific target for breast, 98%
3 should receive their first definitive treatment if they
4 have come through the 31-day. That's
5 consultant-to-consultant referral -- 14:35
6 A. Yes.
7 298 Q. -- the 31-day target. Then the 62-day target, the
8 Trust would expect or be expected, according to this
9 target, to deliver 95% of the patients through to first
10 definitive treatment by the 62nd day? 14:35
11 A. That's right.
12 299 Q. Yes. You then, at 10.4, explain where the service sat
13 by April 2016 when you moved into the cancer post,
14 having been an SEC?
15 A. Mm-hmm. 14:36
16 300 Q. So, the specific SEC target, 74 for an outpatient, 74
17 weeks for an outpatient appointment when, in fact, the
18 patient should be seen in accordance with the target --
19 A. It was nine weeks for first appointment.
20 301 Q. -- nine weeks for first appointment? 14:36
21 A. Yeah.
22 302 Q. The 120 weeks was the standing average then for
23 inpatient or day case procedures?
24 A. So, those would have been the longest waiting patients
25 on the waiting lists at that point when I was handing 14:37
26 over. Although the IEAP states nine weeks for
27 outpatients and 13 for elective, there would have been
28 interim targets that would have been sent through from
29 the Department of Health to say you are now going to

1 work an interim of 26 weeks or an interim of 52 weeks,
2 but the actual targets of the IEAP never actually
3 changed.
4 303 Q. Yes. So, the Department, not to be impolite, is moving
5 the goalposts with interim targets? 14:37
6 A. Well, I think they were recognising that there was
7 demands that the services weren't able to meet. So,
8 they were unrealistic targets within the IEAP at that
9 time but those were the targets that were being held
10 within the IEAP. 14:37
11 304 Q. Yes. What was the cause of the inability or the
12 failure to meet those targets?
13 A. In my view, there was a huge demand and capacity
14 deficit within Urology Services specifically. In fact,
15 it was across a number of the specialty areas that 14:38
16 I worked in at that time. The referrals to the service
17 were increasing at an ever-increasing rate. They still
18 only had the number of consultants in post that they
19 had more or less started out with. I think there was
20 two when I initially started working in Urology, it 14:38
21 moved to three. I am not sure how many there was
22 actually at the point when I was moving, but there
23 hasn't been a whole lot of change in the number of
24 consultant posts during that time. Certainly there was
25 huge pressures on the Urology Service to deliver those 14:38
26 targets.
27 305 Q. So, the inability to meet the targets was not due to
28 under-performance on the part of clinicians or those
29 working within the service, it was due to an inability

1 on the part of the Trust to meet the demand with
2 sufficient capacity?
3 A. I think yes, in one -- yes, in one respect, there was.
4 I think there had been a number of meetings with HSCB
5 to raise concerns about capacity issues in the service. 14:39
6 Certainly there would have been performance meetings
7 with HSCB throughout my tenures where the Assistant
8 Directors would have been attending and putting forward
9 concerns about the demands coming in. There was
10 certainly no downturn in any of the activity during my 14:39
11 tenures. The activity was still great for what the
12 service was providing, there was just too much demand
13 coming in.
14 306 Q. You continued obviously to monitor and track the demand
15 and your service's capacity to meet that demand, and 14:40
16 you have produced figures. What is the purpose of
17 monitoring performance in that sense when it's quite
18 clearly not a service that can deliver? Is it just to
19 keep the message alive, to ensure everybody understands
20 what's out there? What is the goal of it? 14:40
21 A. I suppose at that time it was twofold. It was, yes,
22 keeping an emphasis on the fact that the service was
23 under a lot of pressure, but we also used the
24 information to look at innovative ways to try and move
25 the service in a different direction, drilling down 14:40
26 into the demand to see, you know, even into more
27 treatment-type areas, particularly when we were brought
28 in the ICAT service at that time, trying to look at
29 what more innovative ways could we do this; is there

1 more specialist nurse services that we could bring in;
2 GP with special interest areas; other ways that we
3 could try and meet that demand knowing that there was
4 difficulties with recruiting consultants at that time.
5 307 Q. When the commissioners advised of the impossibility of 14:41
6 meeting the targets that they had set, did you go to
7 these meetings or was it fed back to you in terms of
8 what they were saying?
9 A. I didn't attend those meetings. I certainly would have
10 provided some of the preparatory work for those 14:41
11 meetings, and it would have been fed back to me. There
12 might have been more work required to set the scene for
13 some of those meetings. But it would have been more at
14 our Assistant Director level that would have been
15 attending those meetings and putting forward cases. 14:42
16 Certainly Martina Corrigan, Head of Service, might have
17 been at some of those meetings, as well as some of the
18 clinical teams I know did attend meetings with HSCB
19 around changes to models and looking at one-stop
20 clinics and things like that in the past as well. 14:42
21 308 Q. You provide a table at paragraph 10.6 of your
22 statement. This addresses the issue of Outpatient
23 referrals; isn't that right?
24 A. Yes.
25 309 Q. I know from your addendum statement, which I don't need 14:42
26 to bring up on the screen, it should be self-evident
27 here, but there's an error in this table and it
28 involves flipping the columns about, if I can put it
29 that way?

1 A. The columns, the two middle columns.
2 310 Q. So let me explain. The yearly commissioned Urology new
3 outpatient activity should be 3,588 for each of the
4 years; isn't that right?
5 A. That's correct. 14:43
6 311 Q. So on that left-hand column next to the fiscal year
7 column, that should contain a steady 3,588 of
8 commissioned activity each year?
9 A. That's correct.
10 312 Q. The other column, for example, 5,121, is the new 14:43
11 Outpatient referrals received?
12 A. That's the actual activity, so that's actually what the
13 team delivered.
14 313 Q. Right. And then it's a simple subtraction sum --
15 A. Yes. 14:44
16 314 Q. -- to show the gap between what was delivered and what
17 was commissioned; is that right?
18 A. Yes. So, you can see throughout that, all of the
19 years, that the service actually outputted much more
20 than what they were commissioned to deliver in an 14:44
21 effort to see those referrals.
22 315 Q. How was that achieved?
23 A. A lot of the clinics would have been overbooked. You
24 know, we did have the ICAT service there at that time
25 too, and they were seeing a lot more patients as well. 14:44
26 So, there was a lot of work done just within the teams
27 themselves to see that level of activity.
28 316 Q. Can I just be absolutely clear --
29 A. Yes, I see it's actually referrals. Sorry, it's

1 referrals.
2 317 Q. Yes. So 5,121 isn't the activity?
3 A. It's the referrals.
4 318 Q. Right. Okay. In other words, in that year, you
5 weren't able to care for 1,533 people -- 14:45
6 A. That's right.
7 319 Q. -- or at least that was the gap?
8 A. Yes.
9 320 Q. So, were you not able, in any of those years, to go
10 beyond the commissioned level? 14:45
11 A. Sorry, I actually don't think I have the activity
12 information on my Section 21 there, so I just don't
13 recall.
14 321 Q. Okay. Let's just rewind a little because I think you
15 went off on a -- 14:46
16 A. I did.
17 322 Q. -- false trajectory there, through no fault of your
18 own.
19
20 So, the Commissioner was paying each year for 3,588; is 14:46
21 that right?
22 A. Yes.
23 323 Q. What came into the Trust as new referrals was 5,121?
24 A. That's right.
25 324 Q. And that's the gap? 14:46
26 A. That's the gap.
27 325 Q. Okay. Do we know whether the activity was able to make
28 up that gap or was there always a shortfall?
29 A. No. The activity was never able to make up the gap,

1 there would always have been a shortfall. We certainly
2 would have been putting in our nonrecurring plans to
3 try and address some of that gap, but it never would
4 have addressed all of the gap.
5 326 Q. The fact that the commissioning on recurring funding 14:47
6 stagnated at that figure throughout each of those
7 years, stayed stationary, does that suggest that the
8 Trust received no positive response from the
9 Commissioner to concerns that might have been
10 articulated about its inability to address the number 14:47
11 of referrals coming in?
12 A. Normally, if there had been any business cases, or IPTs
13 as we would call them, that had been done and accepted
14 by the Commissioner, the outpatient activity levels
15 would have increased, you know, so the referrals that 14:48
16 you were commissioned to deliver would have increased.
17 It wouldn't appear that we were given any further
18 funding for those years. It remained the same.
19 327 Q. If we scroll down to 10.7 of your statement, you
20 explain the impact of this. You say: 14:48
21
22 "This had an impact on the waiting times for first
23 appointment and the number of patients waiting beyond
24 IEAP targets. Issues around capacity challenges,
25 including Urology capacity challenges, are discussed at 14:48
26 monthly Head of Service performance meetings with the
27 Assistant Director present. Notes of those meetings
28 were taken and would have been submitted for evidence
29 already to the Inquiry. These issues are also

1 discussed at the monthly acute SMT when performance
2 risks are presented by the Head of Performance".
3
4 You explain who was attending those meetings.
5 14:49
6 Can I ask you this: Obviously if you are not
7 commissioned to deliver, there's going to be
8 a struggle, unless nonrecurrent funding comes in, to
9 address the needs of your local population; people are
10 going to be on waiting lists for periods of time. Did 14:49
11 the Trust engage in any attempt to assess the risk
12 posed to patients waiting for long periods before their
13 first Outpatient consultation?
14 A. There was a risk raised on, I think it was the
15 Corporate Risk Register, in relation to outpatient, 14:50
16 inpatient, day case waits, which was more general, it
17 wasn't just specific to Urology. But it certainly
18 would have been raised on the Corporate Risk Register
19 regarding concerns with delays of treatment to
20 patients. 14:50
21 328 Q. The risk is perhaps obvious, it's a question of whether
22 anything was done about it. Was there any attempt to
23 go beyond the general recognition of a risk? If
24 a patient is not seen in accordance with the target,
25 then self-evidently it's a risk to their health. Was 14:50
26 there any effort to delve down beneath that to see what
27 kinds of risks there were and whether any mitigations
28 could be put in place to address them?
29 A. There would have been conversations through HSCB for

1 those performance meetings regarding patients waiting,
2 and if there was any appetite for referrals between
3 Trusts, and things like that, to try and get patients
4 seen. I know not just for Urology but for other
5 specialty areas, the other Trusts have been involved in 14:51
6 trying to see patients to bring -- to equalise waits
7 across the region rather than one Trust setting out as
8 compared to the other.
9
10 But again, it's my understanding that most Trusts 14:51
11 within the region in relation to urology have capacity
12 and demand issues, so it was felt that there was
13 probably very little could be done in the way of moving
14 patients around between Trusts. It certainly was
15 attempted. 14:51
16 329 Q. Other options like prescribing or doing preemptive
17 investigations; would they have been options that were
18 considered?
19 A. From a point of view of analysing review backlogs and
20 things like that, there would have been an ongoing 14:52
21 review of patients on waiting lists, which the
22 consultants had been involved with, as well as Urology
23 Nurse Specialists; going through patients on waiting
24 lists, checking to see if they had been seen since the
25 time they have been added to the waiting list; what had 14:52
26 happened to their care; if there was any information
27 update that they could give to the consultants in order
28 to try and move patients along the system. That work
29 had been ongoing for a number of years.

1 330 Q. If we look then at WIT-81742. Scroll down to 10.3,
2 please. So, it's to be recalled that departmental
3 waiting lists for first referral appointment are nine
4 weeks and then elective patients 13 weeks. At 10.4,
5 then, we can see what the state of play actually was. 14:53
6 At the point of you handing over to Wendy Clayton in
7 April of 2016, the waiting times for an Outpatient
8 appointment were sitting at 74 weeks, and 120 weeks for
9 inpatient day case elective procedure.
10 14:53
11 Now, there is a table sitting just below that at 10.8.
12 This shows across the period of time up to relatively
13 recently the state of play for inpatients. We can see
14 that for -- well, it's across a number of sectors but
15 just focusing on inpatient, for the year that you left 14:54
16 and moved across to cancer, the longest wait was 201
17 weeks. I think you had earlier said it was 120?
18 A. Yes. That particular -- the 201 weeks at that time,
19 this was a report provided by the information -- or
20 sorry, the performance team. That was an outlier on 14:54
21 their report which just needed validated. The position
22 I gave in the earlier one was the true reflection.
23 331 Q. Yes. There were 505 patients on that list?
24 A. Mm-hmm.
25 332 Q. As we can see from the data, the position doesn't get 14:55
26 any better as years pass. In fact, it gets a whole lot
27 worse. The waits are now sitting at over 400 weeks;
28 that's almost eight years?
29 A. Yes.

1 333 Q. Again, was the Trust engaged in any specific audit of
2 the risks faced by patients in that kind of situation?
3 A. I haven't really been working with Urology Services
4 from 2016. I know there has been a number of meetings
5 around Urology Services that Mrs. Corrigan, and now 14:55
6 Ms. Clayton, will have been involved with since that
7 time, certainly in terms of trying to build up the
8 service and how they would go forward with the service.
9 But I'm not close enough to the information to be able
10 to give you a proper answer on that. 14:56
11 334 Q. Yes, yes. We will move to your more familiar
12 territory, your more recent territory in cancer in just
13 a moment. I think you said earlier that in terms of
14 clinical output, there was no decrease in the level of
15 activity? 14:56
16 A. No, and certainly it was my experience that they did
17 meet their level of activity required on the SAVA?
18 335 Q. Yes.
19 A. Yeah.
20 336 Q. Do you have any sense of the impact on clinicians of 14:56
21 working in a context such as this where there is this
22 pressure of demand, an expectation, perhaps, that you
23 would go the extra mile in trying to provide
24 additionality so that matters don't get any worse? Do
25 you have any sense of that or were you, if you like, 14:57
26 siloed from --
27 A. Because I obviously would have had -- I did attend some
28 of the department meetings up until I moved tenures,
29 just to give positions on where we were with waiting

1 times and to discuss what we could do in terms of the
2 in-house additionality and things like that. There
3 would have been a sense among the team - all of the
4 team, not just the clinicians - so this would have been
5 the secretarial staff, the nurse specialists, in fact 14:57
6 everybody involved with the team - Martina Corrigan
7 herself included - you know, that they were trying
8 their best as they could, but the demands coming in
9 were just so large that they weren't able to meet
10 everything that was being asked for them. They did 14:57
11 work as much as they could cohesively together to try
12 bringing in additional capacity inasmuch as they could,
13 and they certainly done as much waiting list work as
14 they could to see as many patients above and beyond the
15 expected level of activity. So, yes, I suppose there 14:58
16 was a sense of frustration that they were doing all
17 that they could but these demands were still
18 ever-increasing.
19 337 Q. Let's move to the situation in cancer. You have
20 helpfully provided a comparative performance table at 14:58
21 WIT-81745. The next page, I think. Yes. Am
22 I correct, looking at the 62-day performance table,
23 does this show that the number referred to the Urology
24 Service with suspected cancer and who had their first
25 definitive treatment within 62 days was consistently 14:59
26 lower than compared with the other Cancer Services
27 within the Trust?
28 A. Yes, that's correct.
29 338 Q. While there was a neck and neck situation in 2016/2017

1 comparing Urology with the Trust's other Cancer
2 Services, there is a widening gap as time moves on;
3 isn't that right?
4 A. That's correct.
5 339 Q. Did you have an understanding of how that occurred? Is 14:59
6 it simply a case of Urology being under-resourced to
7 meet the demand?
8 A. Yes. Comparatively, the overall referrals into the
9 Urology Service had increased and, likewise, the red
10 flag referrals also had increased across all of those 15:00
11 years. Certainly from a cancer perspective, you know,
12 we would have been meeting on a bimonthly basis with
13 HSCB, now SPPG, where I would be aware that this is no
14 different than what it was across the rest of the
15 Trusts within the region as well, where the Urology 15:00
16 performance was, unfortunately, becoming much lower
17 than what it was with the regional performance.
18 340 Q. If we just scroll down, I think you suggest in the next
19 paragraph that -- you say:
20 15:00
21 "It is recognised that at times" - this is halfway down
22 this page - "that minimal action could be taken due to
23 ongoing capacity and demand difficulties within
24 specific sites including Urology".
25 15:01
26 You explain the capacity demands and difficulties
27 across the entire cancer pathway in Urology. Scrolling
28 down, you do suggest that there were some workarounds
29 possible, some mitigations possible?

1 A. Mm-hmm.
2 341 Q. So, those four items you are suggesting as being steps
3 that were taken, perhaps on occasion, to try to address
4 the pressure. But again, looking at those figures,
5 they don't appear to be putting much of a dent in the 15:01
6 demand for the service?
7 A. That's correct.
8 342 Q. Again, would that message that these patients are at
9 risk because they are not being seen within the target
10 timeframe, would that have been communicated to the 15:02
11 Commissioner?
12 A. Yes. The Commissioner would have had sight of all of
13 those waits. Certainly in advance of us meeting with
14 them bimonthly, they would have been providing
15 a presentation to us from the information that they 15:02
16 were analysing, which would have compared how we were
17 sitting as a cancer service, down to tumour site level
18 against the region and against other Trusts. So, they
19 would have been aware.
20 343 Q. I think if we go down to WIT-81759. At paragraph B 15:03
21 there, you refer to these bimonthly meetings with the
22 Commissioner?
23 A. Yes.
24 344 Q. You were attending those?
25 A. I didn't initially but then I did, yes. 15:03
26 345 Q. Yes. At these meetings, cancer performance is reviewed
27 across all tumour sites and those representing SPPG,
28 formerly the HSCB, are identified. Is that an
29 opportunity at that meeting to discuss risks?

1 A. Yes. When we would have, as a Trust, seen the
2 presentation that had been prepared, what normally what
3 happened was would have been Cancer Service would have
4 met with all of the acute areas to discuss the
5 information within the presentation. The Head of 15:04
6 Service would have had an opportunity to bring any
7 issues that they had to that meeting. Indeed, they
8 attended the bimonthly cancer meetings as well and
9 would have been raising their concerns around their
10 inability to meet the cancer targets and the concerns 15:04
11 that had within the clinical team.
12 346 Q. How is that articulated? Is it articulated in terms of
13 people will die here if we don't get this sorted out,
14 or is it much less personalised? Is it you just need
15 to find resource for us? How is it spoken? 15:05
16 A. It would have been much less personalised because it
17 would have been all eight tumour sites being discussed.
18 So it wouldn't have been -- Urology was one tumour site
19 amongst eight being discussed on most occasions.
20 Obviously, if you had serious concerns within one 15:05
21 particular area, you would have been raising that and
22 articulating that. But Urology was always one of those
23 areas that was discussed at those SPPG meetings.
24 347 Q. You have said that no notes were taken at these notes?
25 A. There was no notes taken. They were more -- it was 15:05
26 like an action came from those meetings. Sometimes it
27 was just an email after the meeting to say these are
28 the actions that each person is taking as part of that.
29 More recently, it was a table that came out to say the

1 action that had to be taken forward. It wasn't an
2 actual written note of the meeting.
3 348 Q. If no formal record is being made, maybe a follow-up
4 email, what does that say about how seriously these
5 issues are being regarded, or what does it say about 15:06
6 the nature of the meeting?
7 A. Well, from Cancer Service point of view, we took the
8 meetings very seriously and we would have been relaying
9 -- we would have provided information to them in
10 advance of the meetings to let them know some of the 15:06
11 areas that we would have been keen to discuss with them
12 and try and find a way forward with them in meeting
13 some of those demands, so... I am not sure how I can
14 respond on the part of HSCB.
15 349 Q. Yes, you answer the question as you best see fit. We 15:06
16 know, for example - we will come on maybe later and
17 look at it - that the Trust's requirements for extra
18 trackers was, after a period of time, recognised by the
19 commissioner and additional, initially nonrecurrent and
20 then some recurrent, money has come through. On the 15:07
21 whole, we can see from the statistics that not an awful
22 lot has changed in terms of compliance with the
23 targets. If anything, things have gradually got worse
24 so that the target is rendered almost meaningless such
25 as the non-compliance with it? 15:07
26 A. Mm-hmm.
27 350 Q. What, if anything, was coming out of these meetings on
28 a practical level to try and arrest the problem?
29 A. I suppose in more recent times since we had Covid,

1 I know they have been looking at regional diagnostic
2 centres to try and fast-track patients through
3 services; regional elective centres. All this kind of
4 information would have been relating into those kind of
5 discussions. Also, the equalisation of waiting lists 15:08
6 across tumour site areas, those kind of discussions.
7 So, I suppose there were bigger discussions that were
8 beyond me and I wouldn't have been involved in those
9 discussions. My main purpose of being there at those
10 particular meetings was to convey how we were 15:08
11 performing as a Trust, at those meetings. I suppose
12 the Head of Service and the Assistant Directors were
13 trying to get their points across around the challenges
14 and the pressures that they were feeling within their
15 particular service. 15:08
16 351 Q. Yes. To try to summarise your experience over the last
17 10 or 15 years in performance --
18 A. Mm-hmm.
19 352 Q. -- in measuring performance and trying to assess what
20 flows from it and what can be done about the 15:09
21 difficulties and pressures faced, is it the reality
22 that demand has outstripped, and continues to outstrip,
23 the capacity to address the needs of patients in your
24 local population across SEC as well as Cancer Services?
25 A. Yes, that's a fair enough reflection. It's not unique 15:09
26 to Urology, it's actually the case for a number of the
27 specialty areas.
28 353 Q. The Trust recognises that this places patients at risk
29 and has communicated that to the Commissioner?

1 A. Yes.
2 354 Q. What we have seen, or what you have seen, over a period
3 of years is a failure, some would call it, or an
4 inability, others might call it, to provide the
5 structures and the resources to get to grips with the 15:10
6 demand, and it's left to clinicians and those who
7 assist and support clinicians to do their level best,
8 and sometimes going beyond what is perhaps healthy, to
9 try to meet that demand as best they can but knowing
10 that, at the end of the day, there's going to be an 15:10
11 awful lot of people still waiting to get their service?
12 A. Yes.
13 355 Q. WIT-81775, if we just scroll down to that. Paragraph
14 26.5, please. You have said, in terms of the
15 consultant body, that: 15:11
16
17 "As the scheduling of elective patients for urology
18 took place in a team schedule meeting with all of the
19 consultants taking part in it and sharing the patients
20 across consultant theatre lists for chronological 15:11
21 management of patients in urgency order, I didn't have
22 any concerns".
23
24 Is that intended to convey that all surgeons in Urology
25 had an equal share of the elective burden? 15:11
26 A. The way the Urology team worked was one week in the
27 month, there would have been a rota meeting - it was
28 normally the first Thursday of the month - where they
29 sort of set up for the month what each consultant was

1 going to be doing, so you had -- at the end of that
2 meeting you knew what each consultant was going to be
3 scheduled for throughout the month. The following
4 Thursday, they would have had meetings where I would
5 have been providing a list of patients that needed to 15:12
6 be scheduled to meet the targets or that we were trying
7 to concentrate on, depending on what the clinical
8 discussion was at the time. During those meetings,
9 there would have been discussions around who was taking
10 what patients. Obviously the consultants who were 15:12
11 there had had an idea of the patients that they were
12 talking about, the complexities, the co-morbidities of
13 those patients and whether they were suitable to share
14 amongst other consultants or not share amongst other
15 consultants. We would have come away from those 15:13
16 meetings with a plan for the majority of those patients
17 and how they were going to be scheduled. That happened
18 a lot during my tenure. It didn't happen all of the
19 time but it happened a lot when we were trying to
20 achieve certain targets or work towards certain groups 15:13
21 of patients being scheduled. For example, we were
22 trying to target our resources at our urgent SEC
23 patients, or our red flag patients, I would come along
24 with those lists to try and help with the objective of
25 getting those patients scheduled. 15:13
26 356 Q. Is this referring to a period in time when you were in
27 the Surgery and Elective Care?
28 A. In surgery, so up until 2016.
29 357 Q. Yes. Could I just ask your comments on a particular

1 table. It is at WIT-81869. Can we highlight the top
2 table, please? We can see the names of the various
3 consultants identified. If we look at Mr. O'Brien's
4 inpatient numbers. So we can see his name, it's the
5 second name down and it's the third intended management 15:14
6 DCIP -- sorry, it's the second intended management.
7 It's IP. He has 213 patients across that 13-week
8 block. Other consultants have significantly fewer
9 inpatient numbers. Mr. Young, for example, at the
10 bottom of the page, has 82, and I think he's 15:15
11 Mr. O'Brien's nearest comparator.
12
13 Can you explain to us how does one clinician seemingly
14 have many more inpatients to address as compared to his
15 consultant colleagues? 15:15
16 A. I can't explain it, really. From a point of view of it
17 could have been that Mr. O'Brien was seeing more
18 patients at Outpatients or, you know, he just didn't
19 have as much access to theatre as what Mr. Young did,
20 although I don't recall that being the case. So, he 15:15
21 just seemed to have much larger waiting lists than
22 anybody else.
23
24 Some of the other consultants on that list at that time
25 would have been new into the Trust, so there would have 15:15
26 been a sharing around of patients when those
27 consultants would be coming in. On the whole, the
28 consultants would have sat on Mr. O'Brien's list until
29 those consultants agreed to take them, to schedule

1 them. So, he would have held a waiting list until they
2 moved around.
3 358 Q. Okay, thank you. I want to move on now to look at some
4 other discrete issues. Can I ask you about triage,
5 relatively briefly. 15:16
6 A. Mm-hmm.
7 359 Q. We have heard on Tuesday from your colleague, Vicki
8 Graham, who explained how she either asked for
9 referrals to be escalated because triage hadn't come
10 back or, when she took over the coordinator role, she 15:16
11 was cast in the role of escalating herself. You have
12 said at WIT-81722 that during your tenure in SEC, there
13 was an apparent issue with untriaged letters within
14 Urology, particularly with Mr. O'Brien. That's not to
15 say there weren't issues in other specialties, and you 15:17
16 have set that out fairly in your statement, for example
17 at paragraph 24.3.
18
19 From your job's perspective in looking after
20 performance, and we will maybe look at one or two 15:17
21 examples just now, why were you becoming involved in
22 escalations around unreturned referrals?
23 A. So, there is a target within the IEAP where triage
24 should be turned around within 72 hours. If they fell
25 short of the 72 hours, part of the process was that it 15:18
26 would be escalated up through the OSLs and Heads of
27 Service for them to try and find a resolution to get
28 the patient triaged. My role, I suppose, in that was
29 to make sure the Head of Service was aware that there

1 was actually an issue with the triage. I would have
2 forwarded on all of those escalations. The way that we
3 worked at that time, and still do, is that all of our
4 offices are on the same floor - in fact, my office was
5 across the way from Mrs. Corrigan's - and I would have 15:18
6 regularly went in and said to her, you know, there
7 seems to be a problem here with the triage again with
8 Mr. O'Brien. She would have, you know, said for me to
9 just leave it with her and she would be sorting it out
10 with him, or taking the necessary actions to take it 15:19
11 forward with him. So, yes, whilst -- and there did
12 seem to be a lot of it, unfortunately, with
13 Mr. O'Brien.
14 360 Q. We can see - and I don't think we need to open it up, I
15 think you will remember it perfectly well without 15:19
16 having to take the time to go to the screen - that
17 perhaps your first noted issue on the issue of triage
18 was back to 2008 --
19 A. Yes.
20 361 Q. -- when yourself and Mr. Gibson engaged in an email 15:19
21 conversation about the problem with Mr. O'Brien's
22 triage, as it was perceived. You had a particular
23 understanding of the detail and the lengths to which
24 Mr. O'Brien would go when performing triage, and it was
25 labour-intensive? 15:20
26 A. It was.
27 362 Q. And it was time-consuming?
28 A. Mm-hmm.
29 363 Q. By 2013, five years later, and even beyond that - but

1 I want to ask you about a particular intervention by
2 you in 2013 - the issue was seemingly still the same?
3 A. Mm-hmm.
4 364 Q. Was it something that really everybody in your world,
5 in your area of work, knew about and knew to expect, 15:20
6 that we are not necessarily going to get triage back as
7 quickly as the target requires?
8 A. It wasn't that you wanted to expect it; it was
9 happening, unfortunately. I suppose you still were
10 always hopeful that somewhere along the line, you know, 15:21
11 you would start to get those referrals back within the
12 time scales. Unfortunately, it just didn't happen. We
13 were following the process, we were adhering to the
14 escalation around those triages but just,
15 unfortunately, the behaviour hadn't changed. 15:21
16 365 Q. You eloquently described your role as the person who
17 escalates?
18 A. Mm-hmm.
19 366 Q. Not the person who has to do anything to address the
20 triage issue beyond that? 15:21
21 A. Mm-hmm.
22 367 Q. You bring it to the attention generally of the Head of
23 Service, Mrs. Corrigan, and you leave it to her good
24 offices to try to resolve?
25 A. Yes. 15:21
26 368 Q. But it was your targets that were being comprised by
27 the failure of the triage process; is that fair?
28 A. Well, yes, the targets were being compromised but also
29 we were very mindful that there were patients in the

1 back of that you were trying to get an outcome for, to
2 try and move on to clinics so you could actually get
3 the patients seen. Because whilst you were waiting for
4 those patients to be triaged, they weren't on any
5 waiting list, they were just still sitting on a primary 15:22
6 target list with nothing really happening with them.
7 So, you wanted to get them moved onto the correct
8 waiting list to get them seen in the correct part of
9 the service where they would get the care that they
10 needed. 15:22
11 369 Q. With that concern behind you, was there never any
12 opportunity for you to say, listen, Urology Service, we
13 need this sorted out once and for all, this is just too
14 bad, it's affecting our patients and placing them at
15 risk? 15:22
16 A. I suppose my sort of line was, you know, up to the Head
17 of Service to let them know, and they were taking
18 forward any of the changes that needed to be taken with
19 the service themselves. I also had a direct link in
20 with the Assistant Director as well, so I would have 15:23
21 worked very closely with the Assistant Director through
22 all those times. It would have been something I would
23 have been raising back with her as well, and him.
24 370 Q. If we look at WIT-81999. If we start at the bottom of
25 the page, please. Leanne Brown, she is in RBC? 15:23
26 A. Yes, Referral and Booking Centre.
27 371 Q. She is writing on 19th November to Andrea Cunningham;
28 who was she?
29 A. She was the service administrator in Urology at the

1 time.
2 372 Q. Yes. That was a normal escalation process?
3 A. Yes.
4 373 Q. She is saying:
5 15:24
6 "Below is a list of untriaged Urology referrals. Can
7 you please arrange for these to be triaged and returned
8 as soon as possible".
9
10 What lies behind this email is some 47 pages of well 15:24
11 spaced out names. What the number is, I didn't count,
12 but it's a significant number of patients. If we
13 scroll up the page, you are then copied in six days
14 later. You are being told that this list of untriaged
15 Urology referrals was e-mailed to secretaries on 15:24
16 11th November. Would that suggest that was the start
17 of the triage process?
18 A. Yes. So that would have been the initial forwarding on
19 to the secretaries to liaise with the consultants to
20 get them triaged. 15:24
21 374 Q. Yes. They should have been back within a maximum of
22 three days?
23 A. Three days.
24 375 Q. Yes. Then if we scroll up the page, please, you are
25 writing to Martina Corrigan. You are saying: 15:25
26
27 "I know this has already been escalated to you but do
28 you think we are at the point where we need to permit
29 the Referral and Booking Centre to send for these

1 patients despite not being triaged? It may mean we
2 have some consultant clinics with lots of andrology
3 rolling patients, but rather than lose any more
4 reasonableness of offer, do we need to consider this?"
5 15:25
6 This was essentially saying let's take the patients
7 forward without triage because triage hasn't come back
8 in time?
9 A. Yeah. So, back at that time obviously the waiting
10 lists weren't as long, patients were being seen quicker 15:25
11 than what they are now, for certain, and you were
12 trying to make sure that those clinics that had
13 available resources were being utilised to maximum
14 capacity. You needed your triage of your referrals to
15 happen in order to get them onto the appropriate 15:26
16 waiting lists for patients to be seen.
17 376 Q. Yes. You have described this in your statement,
18 I think at paragraph 28.2, as intended as a short-term
19 work around and as a mitigation of risk?
20 A. Yes. 15:26
21 377 Q. The risk being what?
22 A. The risk being that the longer the patient waits, the
23 more root space you have for something untoward to the
24 patient. Our aim was let's get the patient seen; it
25 may not be at the right type of urology type clinic but 15:26
26 at least the patient is getting seen and a management
27 plan starting with the patient.
28 378 Q. You must have been at the end of your tether to come up
29 with something as seemingly different or radical as

1 this?
2 A. Yes. Well, I can sense my frustration within the
3 email.
4 379 Q. We know that, I hesitate to call it the same approach,
5 but we know that something similar became the decisive 15:27
6 action of the Urology Service within the year. We have
7 called it the default triage approach. You have
8 mentioned it in your statement, I think. If we go to
9 WIT-81776. Let me just go back a page, please. Yes,
10 so if we stop there. You say at 26.3: 15:28
11
12 "In order to mitigate risk, a decision was taken by
13 Martina Corrigan, Head of Service for Urology, to
14 accept the GP priority code to avoid unnecessary delays
15 to patients receiving appointments, and to permit the 15:28
16 Referral and Booking Centre", it should say, "to
17 appoint patients to the relevant clinics".
18
19 The idea that you were putting forward in November 2013
20 appears to have, if not immediately, shortly 15:28
21 thereafter, taken hold within the service. You have
22 suggested that it was Martina Corrigan. I know that
23 you have corrected that --
24 A. Mm-hmm.
25 380 Q. -- in your addendum statement. Could you just explain 15:29
26 that?
27 A. Yes. So, Martina and I would have obviously worked
28 very closely together. It would have been Martina who
29 told me about it. I can't say that she actually was

1 the one made the decision. I am not actually sure who
2 made the decision but I was told by Martina that
3 a decision had been made to accept the GP priority code
4 to avoid those delays.
5 381 Q. Yes. For the avoidance of any unfairness to 15:29
6 Mrs. Corrigan, if we just look at what she said to the
7 MHPS process in relation to that. If you go to
8 TRU-00746, and at paragraph 13, please. She says that:
9
10 "It was agreed by Debbie Burns, Heather, Anita, 15:30
11 Katherine and I that the attempts to get the triage
12 done didn't work so we needed a way of ensuring that
13 patients were at least on a list so that they were not
14 disadvantaged chronologically, because by being on this
15 list then we were assured that they were always 15:30
16 allocated an appointment when it was their turn. By
17 adding these patients to the waiting list, it looked as
18 if they had been triaged, so it wasn't escalated to me
19 any more".
20 15:31
21 So, I suppose therein lies two things. First of all,
22 are you happy to accept that it wasn't necessarily
23 Martina Corrigan's decision but the product of the
24 input of a number of people, on her account?
25 A. Mm-hmm. Yes, happy with that. 15:31
26 382 Q. The second point she is making towards the end there is
27 that it looked as if patients were being triaged, but
28 that is clearly the downside of this arrangement which
29 you suggested in your email and which clearly was

1 ultimately implemented. It's one thing to use it to
2 get the patient into the system to avoid any delay, get
3 them their place chronologically within the appropriate
4 waiting list or at the appropriate service, but if this
5 isn't escalated, if the triage issue isn't pursued with 15:32
6 the clinician, there are clearly risks attendant to
7 that. Do you see that?
8 A. Yes. I suppose my initial email at that time back in
9 2013 was more to deal with that immediate 'let's get
10 these patients attended to' rather than it becoming 15:32
11 a replacement of the triage process. I don't think at
12 any point I would ever have foreseen that it would
13 replace triage. It would have been my thoughts that
14 the triage still should have happened. So yes, you
15 were moving forward with getting the patients seen but 15:33
16 you still ultimately would have liked the patients to
17 have been triaged in the background, so that if there
18 was a change and the triage had maybe upgraded a letter
19 or the patient needed to be seen more urgently, that
20 you would have had an opportunity to bring that patient 15:33
21 forward.
22 383 Q. You have reflected in your statement, if we go to
23 WIT-81789 - just at the bottom of the page, please -
24 that:
25 15:33
26 "On reflection, the learning is that Mr. O'Brien does
27 not appear to have been held to account for his
28 processes around untriaged referral letters and this
29 practice was able to continue", as you have referenced

1 at the continuing escalations.
2
3 Are you able to put your finger on why you feel
4 Mr. O'Brien was not effectively challenged?
5 A. Well, I didn't obviously know everything that was going 15:34
6 on in the background at that time but, I suppose, from
7 what I know now and what's been in my witness bundle
8 and things like that, I do know that some measures were
9 put around trying to address those situations with
10 Mr. O'Brien, and that maybe behaviours changed for 15:34
11 a short period of time and then, unfortunately, those
12 behaviours, they seemed to come back into play again,
13 and it took a while then for those to be acted upon
14 again.
15 384 Q. You have reflected as well at paragraph 24.5 of your 15:34
16 statement that when you raised matters through the
17 escalation process, you didn't receive any response.
18 Typically you were, if you like, out of the loop or
19 kept out of the loop in what was being done or what had
20 been done. Do you feel that more feedback to teams on 15:35
21 the ground carrying out your kind of role would have
22 been useful?
23 A. Yes. It would have been useful to know -- obviously we
24 don't need to know everything that's going on and some
25 of those things were confidential, but it would be -- 15:35
26 even just to know that, you know, we are dealing with
27 it and take our reassurance that we are dealing with
28 it, because there was a feeling that we were
29 continually escalating things; we were, if you like,

1 adhering to our side of the process but we weren't
2 really sure what was happening outside of that. So
3 yes, it would have been nice to know that.
4
5 From my point of view, Urology wasn't the only service 15:36
6 I was working in at that time, I was working in a lot
7 of services. So, when I was escalating things on, you
8 were almost moving on to the next thing because that
9 was the challenges of the role. Once you had moved it
10 on, you were like, okay, somebody else knows about that 15:36
11 now. You might have popped into the office and said "I
12 have sent you that and you need to look at that email",
13 and you knew that person was dealing with it. That's
14 where you left it because you charged it over to
15 somebody else to deal with. So, you didn't necessarily 15:36
16 chase it up, just with the operational challenges of
17 being in our kind of roles.
18 385 Q. Yes. Chair, I probably have another 45 minutes to an
19 hour. Would it be convenient to take a short break
20 rather than go all the way through? 15:36
21 CHAIR: We will take maybe ten minutes.
22
23 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
24
25 CHAIR: Mr. Wolfe. 15:48
26 MR. WOLFE KC: Thank you.
27 386 Q. If we could have up on the screen, please, WIT-81770.
28 If we go down the page to 24.6. Just a discrete issue
29 I want to explore with you concerning dictation and

1 backlog reports, and the system that was in place
2 during your time in SEC to monitor that area of work
3 involving administrative and clerical staff.
4
5 The Inquiry's concern is that in late 2015, leading 15:49
6 into an investigation into Mr. O'Brien's practice,
7 a concern arose that he wasn't dictating on clinical
8 encounters as quickly or as effectively as was expected
9 by the Trust at that time. My questions are designed
10 to explore with you what system you had in place -- 15:49
11 A. Mm-hmm.
12 387 Q. -- that might have assisted in that respect. As you
13 say just here at 24.6, you had responsibility for
14 administrative and clerical staff within the division
15 until 31st May 2013, and that included Urology. After 15:50
16 that, responsibility for secretarial and audiotyping
17 moved to Katherine Robinson; isn't that correct?
18 A. Yes.
19 388 Q. If we go down the page then to 24.7, you say:
20 15:50
21 "In relation to delays with dictated triage
22 information, I do not recall this ever being raised as
23 an issue with me by the secretarial staff".
24
25 You use the phrase "dictated triage information". Was 15:50
26 there ever a wider concern raised with you about delays
27 or failures to dictate other types of clinical
28 encounter?
29 A. So, the Backlog Report that I have attached in with

1 this statement there, it actually encompasses all
2 dictations, so it wouldn't have been just triage. It
3 would have been dictation of any nature really within
4 Urology at that time. I don't recall any issues being
5 raised with me regarding dictation specifically to do 15:51
6 with Mr. O'Brien.
7 389 Q. Yes. Let's just look at the kind of backlog risks
8 matrix report that you had in place to track how your
9 typing resource was performing. I will ask you what
10 the purpose of this document is when we just have had 15:51
11 a look at it. If we go to WIT-82317. If you look down
12 the left-hand margin, we are going to look at Urology
13 but we want to see the headings at the top as well.
14 Maybe I will just start by asking you what is this
15 document and what was its purpose? 15:52
16 A. So, there had been an admin and clerical review
17 initiated back in 2010. In fact, all members of admin
18 and clerical were involved in that review. Part of
19 that review, and obviously with us as managers involved
20 in that review as well, we wanted to be more aware of 15:52
21 what was happening within secretaries' offices, what
22 were the issues that they were having to deal with,
23 where were the bottlenecks with their work and what
24 they were trying to deal with. Back at this time, we
25 didn't have the infrastructure that we now have in 15:53
26 terms of systems with digital dictation and things like
27 that. So, this was an attempt by the admin managers at
28 that time to get a better handle on what was happening
29 with issues around workload and secretaries, with

1 secretaries and in secretaries' offices.
2
3 The purpose of this particular report was that each
4 secretary would complete it and send it back to their
5 service administrator, identifying numbers, volumes, 15:53
6 dates, with their workload in that, the numbers of
7 charts that they had to type and the number of charts
8 that they had sitting in their office that required
9 dictation. I suppose the expectation would have been
10 at that stage if they knew of charts that were sitting 15:54
11 within their consultants' offices also that would have
12 been included.
13
14 Most secretaries at that time were in very close
15 proximity to their consultants and, in fact, a lot of 15:54
16 consultants actually used the secretaries' offices to
17 store their charts for dictation and things like that.
18 So, that was the purpose of it. Just getting back --
19 390 Q. Just to cut across you slightly. So, if there was
20 a bottleneck in place A, you could reallocate the work 15:54
21 or one of the managers could reallocate the work to --
22 A. Yes, so the service administrators and I would have had
23 a look at this together. We would have looked to see
24 which particular area has a difficulty on this week.
25 We had a number of audiotypists within the division at 15:54
26 that time, and we would have allocated those
27 audiotypists to where we felt the greatest need was.
28
29 The report was also discussed back at the Head of

1 Service meetings, and this would have been shared with
2 the Head of Services. If there was any particular
3 concern in relation to the consultants with their
4 dictation, that would have been evident from the
5 columns actually identified there in yellow on the 15:55
6 reports, and they would have been aware of that to take
7 that back to have a conversation with the clinician.
8 391 Q. Yes. This is obviously a random month in June -- or
9 week in June 2012. We can see the top line in the box
10 that James has helpfully pulled up for me, Mr. Young's 15:55
11 secretary was Paulette Dignam. Going all the way
12 across to the yellow, he had 155 charts awaiting
13 dictation?
14 A. Yes.
15 392 Q. By contrast below that, Mr. O'Brien, whose secretary is 15:55
16 Monica McCorry, had zero?
17 A. Yes.
18 393 Q. The next column to the left of that assumedly is charts
19 that have been dictated but have yet to be typed?
20 A. Yes, that's correct. 15:56
21 394 Q. And Mr. O'Brien's secretary had typed 162, or there was
22 162 pieces of work outstanding --
23 A. Yes.
24 395 Q. -- for typing. And Mr. Young, 113. This was
25 pre-digital dictation days? 15:56
26 A. It was.
27 396 Q. Again, is my assumption correct when I say the
28 populating of the information or the data into this
29 depended upon the compliance or the cooperation, the

1 accuracy, of the secretary who is returning it?
2 A. It would, yes. The secretary was completing this and
3 sending it in and we were taking at face value what the
4 secretary was telling us.
5 397 Q. Yes. But at least there was provision, at least the 15:57
6 question was being asked are there charts awaiting
7 dictation?
8 A. Yes.
9 398 Q. Yes. One thing we will perhaps explore with other
10 witnesses is whether that system by which you are able 15:57
11 to record charts awaiting dictation, whether it was
12 removed subsequently. I want to just ask you if you
13 can help us on that. If we go to TRU-255967. Just
14 scroll down, please. We can see that this is an email
15 Katherine Robinson is sending to Anita Carroll. It is 15:58
16 20th December 2016. It's in the lead-up to a meeting
17 that would decide that Mr. O'Brien should be subject to
18 a formal investigation under MHPS. Information is
19 being gathered about various alleged shortcomings with
20 Mr. O'Brien's practice, and one of the issues that 15:58
21 comes to the fore is the question of dictation. I will
22 read the first paragraph; a list is attached to it.
23
24 "This is the list of clinics that Mr. O'Brien has not
25 dictated on and hence no outcome for some of these 15:58
26 patients. There is a risk that something could be
27 missed so I am escalating to you although I know a lot
28 of the time Mr. O'Brien knows himself what is to happen
29 with patients. Unfortunately, this was not highlighted

1 on the Backlog Report. The secretary assumed we knew
2 because there has always been issues with this
3 particular consultant's admin work from our
4 perspective".
5 15:59
6 When she says "unfortunately, this was not highlighted
7 on the Backlog Report", I take her to be saying that
8 the failure to dictate on what was a lengthy list of
9 patients is not something that was recorded at that
10 time -- 15:59
11 A. Mm-hmm.
12 399 Q. -- it had ceased to be recorded perhaps at some point
13 after you had left that part of the service, or at
14 least after you had handed the administrative
15 responsibilities over to Mrs. Robinson. Can you help 15:59
16 us on that?
17 A. I am not sure what her report actually looked like.
18 I know certainly at the time --
19 400 Q. Just scroll down. I think it's behind this email. No,
20 it might be above it. Can you go right up? No. Okay, 16:00
21 sorry.
22 A. I'm not sure what the report itself actually looked
23 like and what her columns on the report were.
24 Certainly, even on the report that I have given as
25 evidence, there was a column to the right for risk. 16:00
26 So, if a secretary had some concern that we hadn't
27 covered off in any of the columns that we were asking
28 about, there was opportunity for them to fill that in
29 and let us know of anything that they were concerned

1 about. They could, of course, have come to us at any
2 time and let us know if there was something they were
3 worried about or concerned about if they didn't want to
4 be filling it in on a report, and we would have
5 listened to them and taken that forward. So, I can 16:00
6 understand her saying, you know, that they would have
7 expected the secretary to highlight it rather than
8 waiting for a formal report to come around and collect
9 the information.
10 401 Q. Yes. Thank you for that. Can I move then to just 16:01
11 a number of discrete questions around cancer tracking.
12 A. Mm-hmm.
13 402 Q. The Inquiry heard substantial evidence from, again,
14 your colleague, Vicki Graham, on Tuesday, so we don't
15 need to go into the fine detail about it. Just one or 16:01
16 two issues. If we go to WIT-81762, and if we go down
17 to 22.7, please. What you have said here is that:
18
19 "Importantly, it has been [your] view over a number of
20 years that the cancer tracking team were inadequately 16:01
21 staffed and inadequately funded by HSCB, the SPPG, to
22 fully track the volume of patients on cancer pathways".
23
24 The implications of that for the service were what?
25 A. So, if we are not fully funded and fully resourced to 16:02
26 track patients on cancer pathways, we are obviously
27 working against ourselves in trying to track our
28 patients along our pathways. The ultimate aim is that
29 every patient who is on a cancer pathway will be

1 tracked at least once in that week to ensure, you know,
2 exactly where they are in the pathway, what's happened
3 to their care since the last time you looked at them,
4 and that you are able to give an update on those
5 patients on the CaPPS system. 16:02
6
7 When I came into post or moved over to Cancer Services
8 in 2016, we were only funded for 3.9 cancer trackers.
9 We did have 6.6 in post at that time, so the Trust had
10 already gone ahead and funded some at risk. But even 16:03
11 at that, we still weren't at the level that we needed
12 to track the patients on the 31- and 62-day pathways.
13 403 Q. Just to help you on this answer, if you go down to
14 22.9. You have explained that in January 2019, you
15 raised a concern with your line manager, Mr. Conway, in 16:03
16 respect of that?
17 A. Yes.
18 404 Q. Isn't it fair to say that that came after the HSCB
19 conducted a study themselves which recognised across
20 a number of Trusts that there was a shortfall in 16:03
21 tracking?
22 A. Yes, and I would have been involved in providing some
23 of the information for that piece of work that was
24 done. They were taking the tracking levels that were
25 completed for 2017 and analysing that to see what was 16:03
26 the required level of staff required to fully track the
27 patients on the 31- and 62-day pathways. At that stage
28 it was felt that we needed 8.6 full-time equivalents to
29 do that, based on the 2017 figures. At that stage we

1 were asked to submit a business case, or an IPT, to put
2 forward for one additional tracker, bringing up our
3 funded resource to 4.9, so we still were short of what
4 we required in terms of tracking. However, the Trust
5 did go at risk in bringing what we actually needed to 16:04
6 track the 31- and 62-day pathways at that stage.
7 405 Q. Putting at risk again, just so the public understands,
8 you didn't have recurrent budget for this?
9 A. That's correct.
10 406 Q. Did you have any budget for it when you go at risk? 16:04
11 A. At times, no, you might not have a nonrecurrent funding
12 stream for that either. The Trust obviously sees
13 a risk to patient care and they will decide to go
14 a financial risk to the Trust to actually appoint those
15 people and bring them into post. 16:05
16 407 Q. Yes. You have reported more recently in your addendum
17 statement, I suppose some good news --
18 A. Yes.
19 408 Q. -- around tracking, if that's not too exaggerated too
20 much. Maybe we will just go to it; WIT-94967. You say 16:05
21 at paragraph 4 that there's been fresh allocations of
22 money?
23 A. Yes.
24 409 Q. Is some of it recurrent and some of it nonrecurrent?
25 A. Yes. The exercise that was carried out in 2018 was 16:06
26 repeated, and that was done for all Trusts. At that
27 stage, it was seen that the Southern Trust required
28 14.03 full-time equivalent tracking staff to complete
29 the 31- and 62-day pathways. We were asked then to

1 submit another IPT to bring up our tracking resource by
2 another three, so we now are funded for 11.6. Because
3 we had already gone ahead and put those staff in post,
4 they came back and gave us nonrecurrent funding then
5 for the remainder. So, we actually do have the 16:06
6 required number of staff in that we need to track the
7 31- and 62-day pathways.
8 410 Q. Yes. I suppose I am now thinking about the SAI
9 recommendation which was for tracking through the whole
10 patient pathway. This funding, just to be clear, only 16:07
11 allows you to continue to track to first definitive
12 treatment; is that right?
13 A. That's correct.
14 411 Q. Yes. I think if we go back to your original statement
15 at 81763. Wrong page. Just go back one page. You say 16:07
16 at 22.7:
17
18 "As with all other Trusts in the region, we currently
19 track patients to first definitive treatment only on
20 cancer pathways. That is if a patient required longer 16:07
21 treatment and cancer support, no Trust is funded to
22 support this level of tracking".
23 A. That's correct.
24 412 Q. It's perhaps convenient to deal with it here but I'm
25 going to come to look at the reforms that are on-stream 16:08
26 and your role in the Task and Finishing group in just
27 a minute or so.
28 A. Yeah.
29 413 Q. But while we are looking at the issue of tracking, how

1 is the Trust proposing to address, if at all, the
2 recommendations of the SAI reviewers in respect of
3 tracking beyond first definitive treatment? Do you
4 have an answer to that?
5 A. Well, I know from having discussions with my Assistant 16:08
6 Director, Mr. Conway, that there has been discussions
7 ongoing with the commissioners around the issue of
8 tracking. At this stage there is no resource to move
9 beyond first definitive treatment. There is work going
10 on in the background try and understand what that would 16:09
11 look like. We would need to know what that model is;
12 how we are going to take that forward as a region. I
13 suppose since I have been involved in the Task and
14 Finish group as well, I have been raising it up through
15 our own cancer operation links, which is where the 16:09
16 cancer managers come together once a month and have
17 discussions. And there's no Trust that I am aware of
18 at the minute who is tracking fully beyond a 62-day
19 pathway.
20 16:09
21 The CaPPS system itself is not set up to track beyond
22 first definitive treatment either, so the whole system,
23 the information system that's around there to support
24 the tracking of patients isn't there, the
25 infrastructure wouldn't be there to allow us to do it. 16:09
26
27 We know that one of the Trusts do set notifications for
28 patients, so beyond first definitive treatment they
29 maybe set an alert if a patient is being discussed at

1 MDT and something was to happen. We have since adopted
2 that and we now do that for all our pathways. That's
3 something additional that we do that we are not
4 commissioned for.
5 414 Q. Yes, okay. Maybe we will touch on aspects of that in 16:10
6 just a moment when we reach the SAI report. Briefly,
7 just before we get there, during your time in Cancer
8 Services you have been aware of the problem that the
9 Urology MDT has experienced in achieving regular
10 attendance by Oncology and by Radiology at the weekly 16:10
11 MDMs?
12 A. Mm-hmm.
13 415 Q. We can see an example of that that I think you had some
14 input on in September 2016. WIT-89477. It is the
15 case, isn't it, that you were fairly aware of quorate 16:12
16 problems, particularly around Radiology but perhaps
17 because the radiologist came from your own Trust, the
18 oncologists were supplied from Belfast; isn't that
19 right?
20 A. Yes. So, Radiology also sits within Cancer and 16:12
21 Clinical Services. We do have weekly meetings with the
22 Radiology team, and if I was aware of issues around
23 difficulties with Radiology attendance, I certainly
24 would have been putting them forward for discussion at
25 the Radiology meetings. I know that I have been copied 16:12
26 into a few emails where there was issues around quoracy
27 of Radiology as well.
28 416 Q. How would you diagnose the problem around Radiology, in
29 particular in terms of being unable to secure the

1 attendance of the sole radiologist as regularly as was
2 required by the MDTs?
3 A. When I came into post in 2016, we were ten consultant
4 radiologists short within our Radiology team. There's
5 been a significant improvement in that, in that we are 16:13
6 now down to two radiologists short within the team.
7 I think one of the challenges from 2016 has been
8 actually securing a radiologist who had interest in
9 urology and was able to attend the MDT. We have been
10 fortunate now that we have that person in post, and he 16:13
11 has been attending the MDTs from, I think it's May
12 2012. Since that time, we have had much better quoracy
13 with our MDTs in respect of Radiology. I think this
14 year in particular, for the calendar year 2023, there's
15 only one that hasn't had a radiologist present. So, 18 16:14
16 out of the 19 have had a radiologist present.
17 417 Q. The example I was going to draw to your attention from
18 2016 - and I apologise, I can't locate the reference -
19 but it was of a female patient whose discussion at MDT
20 had to be deferred on, I think, three occasions -- 16:14
21 A. Mm-hmm.
22 418 Q. -- because of the absence of Radiology. It required
23 radiological input at the meeting before a decision
24 could be arrived at. That's the impact in a particular
25 case of the absence of that resource. 16:14
26
27 The issue was a long-running sore. The absence of
28 Oncology from the meetings was arguably worse --
29 A. It was.

1 419 Q. -- in terms of percentage terms?
2 A. Mm-hmm.
3 420 Q. Were those issues issues that the Commissioner was made
4 aware of, and did you receive any assistance from the
5 Commissioner or is that not the Commissioner's role? 16:15
6 A. The Oncology absence, I suppose, was higher than my
7 level in that I know that Mrs. Reddick, who is the Head
8 of Service for Cancer, was involved in IPTs and
9 business cases revolving an Oncology and stabilisation
10 plan, given that the regional resource was so small, 16:15
11 and looking at other areas where we could move to maybe
12 more nurse practitioner ways of delivering cancer care
13 and treatments and things like that. I would have seen
14 those business cases and IPTs more from putting in
15 resources and things from an admin point of view. But 16:16
16 yes, the Commissioner was fully aware of that, and that
17 would have been escalated back through our bimonthly
18 cancer meetings with the SPPG as well.
19 421 Q. Can I turn finally to the SAI report and the response
20 of the Trust to it. As you know, the overarching SAI 16:16
21 Review looked at the cases of nine patients?
22 A. Mm-hmm.
23 422 Q. Some eleven recommendations were made and action
24 planning around those recommendations was suggested;
25 isn't that right? 16:16
26 A. Yes.
27 423 Q. You were one of quite a number of people appointed to
28 the Trust's Task and Finishing group, or Task and
29 Finish group, in order to take those recommendations

1 forward; isn't that right?
2 A. Yes.
3 424 Q. That group exists under the leadership of Sarah Ward.
4 Is she still --
5 A. Yes, she is still there but the Task and Finish group 16:17
6 has now been stood down.
7 425 Q. It's been stood down. If we just look at the terms of
8 reference for that group, WIT-82158. So the terms of
9 reference set out succinctly at the top.
10 16:17
11 "The group is charged with implementing all the
12 recommendations and providing assurance and evidence to
13 the Urology Oversight Group".
14
15 We can see you named among the members on the 16:17
16 right-hand side. The role of the Task and Finish group
17 is set out there, and completion of the work will be 12
18 months.
19
20 Has it been stood down because it's considered that the 16:18
21 work is complete?
22 A. No. The work is certainly not complete, and we are
23 maintaining an ongoing look at implementing a lot of
24 those changes that were recommended. I just think the
25 larger group itself has been stood down. Certainly 16:18
26 within Cancer and Clinical Services, as well as the
27 specialty areas, so in particular Ms. Clayton, as Head
28 of Service in Urology Services, is still continuing to
29 take forward the improvement work, as is Mr. Conway

1 within Cancer and Clinical Services.
2 426 Q. Do you have a continued role in taking matters forward?
3 A. Yes, yes. We do discuss all of the implementation plan
4 at our Cancer Management meetings. We look at the
5 improvement plan, which we have dovetailed with the 16:19
6 recent NCAT audit that was taken of all our cancer
7 MDTs, and tried to make sure that the recommendations
8 from the SAI, as well as the audit that was taken of
9 all our MDTs, has put together in one improvement plan,
10 which we meet and discuss and are trying to move 16:19
11 forward as best we can. There are still some inroads
12 to be made there.
13 427 Q. Yes. Can I make for your assessment of how much
14 progress has been made against the recommendations of
15 the SAI? I mean, if it assists, there were eleven 16:19
16 recommendations. There was a degree of overlap between
17 them. I suppose the headlines might be that there was
18 a perceived need for a comprehensive pathway audit;
19 there was a requirement to address the issue of
20 quoracy; there was a requirement to address the issue 16:20
21 of tracking. It was perceived in the recommendations,
22 or it was, more appropriately, found within the
23 review's report that there was a disconnect between
24 Cancer Services and the MDT itself, the MDT being
25 largely staffed by Urology professionals who reported 16:20
26 within that side of the service and not to Cancer
27 Service.
28
29 Amongst those kinds of issues, are you able to comment

1 on what has been achieved and moved forward?
2 A. I think we have come a long way forward from where we
3 were. I think the one surprising thing that came out
4 of the SAIs was the lack of line of sight that we
5 really had across all of our cancer MDTs in terms of 16:21
6 assurance checks and around the effectiveness of our
7 MDTs. We were very much, from a performance side,
8 looking at our delivery of our cancer targets but when
9 it actually came to delivery of assurances around our
10 MDT effectiveness, we maybe weren't so much good at 16:21
11 that.
12
13 One of the main changes that have been brought in is
14 actually to have an MDT administrator role brought into
15 the Trust, which isn't commissioned but which the Trust 16:21
16 has again gone at risk to bring in, which should bring
17 some assurance around the effectiveness of our MDTs.
18 428 Q. Okay. Is that Mrs. Muldrew?
19 A. That's Angela Muldrew, yes.
20 429 Q. Just so I understand that, she has got the job title of 16:22
21 MDT -- I thought I had it written down. What's her job
22 title?
23 A. She is the Cancer MDT Administrator and Projects
24 Officer, so it would have projects specifically within
25 cancer area. 16:22
26 430 Q. Yes. Does she still have a tracking role as did at the
27 MDT coordinator before her in terms of monitoring
28 tracking?
29 A. It was felt, because a lot of the issues were raised

1 were in relation to cancer tracking and things around
2 cancer tracking, that it would be advantageous to have
3 the cancer trackers reporting to Angela, given that she
4 was going to be the MDT administrator. She does now
5 regularly meet with the cancer trackers, discuss areas 16:22
6 with the cancer trackers. So, it sat quite well with
7 her role.
8 431 Q. What makes her role more impressive or more sympathetic
9 to the needs of the MDT as compared with what went
10 before, which was the MDT coordinator sitting and 16:23
11 preparing for the meetings as well as having a tracking
12 role? What has changed? Is it simply a name change or
13 is it much more than that?
14 A. No. The cancer tracker and MDT coordinator is still
15 there. The cancer tracker still provides all of the 16:23
16 support to the tracking of the patients as well as the
17 MDT preparation. Angela's role is more around the
18 effectiveness and assurance of processes that are there
19 in behind the scenes. So, we have started off our
20 audits around our MDT outcomes, and we have since 16:24
21 brought in a cancer informational audit officer as well
22 to support that.
23 432 Q. That's Mr. Quinn, is it?
24 A. That's Mr. Quinn.
25 433 Q. He commenced his work at the end of November? 16:24
26 A. Just at the end of November. We have already started
27 monthly Urology MDT audits to assure ourselves that
28 those audits are being taken forward appropriately.
29 They are spot-check audits at this stage, random

1 selected, of patients being discussed at audit. We
2 just don't have the full resource to do all of the
3 audit we would like to at the moment, but we are on
4 a road to actually try and implement those kind of
5 audits, and also roll it out across some of the other 16:24
6 tumour sites also.
7 434 Q. If I could summarise. Where the SAI was bemoaning this
8 disconnect between one service and another where it was
9 saying there was a lack of support for the MDT, the
10 response to that has been to carve out a specific role 16:25
11 focused on those issues, and that's what Mrs. Muldrew
12 is addressing?
13 A. Yes.
14 435 Q. Where the SAI complained, or concluded, that there was
15 virtually no audit, no monitoring of how this MDT was 16:25
16 performing across a range of issues, the appointment of
17 Mr. Quinn is dedicated to that concern?
18 A. Yes.
19 436 Q. Are there any early indications of how all of these
20 changes are bedding down and whether you are yet in 16:26
21 a position to say whether noticeable positive changes
22 have arisen?
23 A. Well, there has been some positive change in that even
24 from the NCAT audit that was carried out on all of the
25 tumour sites with the Clinical Leads, the information 16:26
26 that was clearly coming out was that there was no --
27 for MDT principles around how an MDT should be carried
28 out. We are now developing an MDT principles document,
29 which clearly sets out what's required of an MDT;

1 things like an MDT pro forma that's to be completed to
2 bring your patient for discussion, which brings a much
3 better, you know, information awareness around the kind
4 of things that were going to be discussed at MDT. It's
5 a minimum data set to bring your patient forward for 16:27
6 MDT. That's been developed also in partnership with
7 the MDT leads and chairs. A communication policy as
8 well, where there was a felt need that we needed
9 a communication policy. So, responsibilities for each
10 member involved in an MDT process for what they should 16:27
11 be doing pre, during and post-MDT in terms of
12 communication out to patients.
13
14 Mrs. Muldrew has also been involved with trying to take
15 forward information on CaPPS, on changing CaPPS so that 16:27
16 we can start to record if a key worker has been
17 allocated to patients. We are still in the early
18 stages of that as well in that now we can record and
19 say yes, they have been allocated. We also would like
20 to take it a step further and further enhance the 16:28
21 module within CaPPS for Cancer Nurse Specialists so
22 that they can actually fill it in themselves and record
23 that they have been allocated who they are and what
24 information has been provided to the patient as part of
25 that key worker interaction and consultation. 16:28
26 437 Q. Thank you. In terms of the key challenges that remain
27 to be addressed arising out of the recommendations, you
28 have highlighted already the difficulty that might
29 affect more Trusts than the Southern Trust in dealing

1 with the tracking issue. Is that the key challenge or
2 the most difficult recommendation to comply with?
3 A. I think actually the whole thing around the audit of
4 MDT, I'm not sure that any Trust is resourced to
5 provide the level of audit that we would like to do. 16:29
6 In regards of assurance around processes and systems of
7 the MDT, and we have talked about it as a group of
8 cancer operational managers, that it is definitely
9 something that we would all like to do; we just haven't
10 been resourced to do it. I know Southern Trust has 16:29
11 gone at risk to appoint our two posts in, and we will
12 see the benefit of all those posts in time. But it's
13 at starting point, and we certainly would like to do
14 much more audit than what we currently do.
15 16:29
16 In particular around the key worker side of things, we
17 also would like to audit and ensure that the key
18 worker, in relation to those recommendations, they are
19 actually doing what we say they are, you know, in that
20 they are allocated, they have provided the information 16:29
21 and those kind of things. We are not just resourced
22 yet to do that.
23 438 Q. Yes. You mentioned at the very start when we were
24 looking at your addendum statement how your
25 responsibilities towards the maternity and women's 16:30
26 health side of your role have been temporarily removed
27 from you?
28 A. Yes.
29 439 Q. Somebody has been employed to do that part of what was

1 previously in your job description; isn't that right?
2 A. Yes.
3 440 Q. Why is that? Is that to allow you to respond in some
4 way or a more focused way to the issues raised by the
5 recommendations of the SAI, or is it some other reason? 16:30
6 A. Yes, that is one of the reasons. I suppose there's
7 recognition that the role that I'm in is actually quite
8 a large role. It is a large role, it covers a number
9 of areas, not just cancer; we have a large profile of
10 work. That was one of the reasons. 16:31
11
12 The second reason was that Mr. Conway did feel that in
13 light of all of the improvement work that we were
14 trying to bring into Cancer Services, it would be good
15 to have me focused on that for a period of time to help 16:31
16 move this forward as quickly as we can and get these
17 things in. So yes, it's twofold.
18 441 Q. But you think it's indicative of the commitment of the
19 Trust to try to address these matters?
20 A. It is, yes. 16:31
21 442 Q. Okay. I think that's all I have for you, you will be
22 glad to know. If I could just give the Panel the
23 reference I was struggling to find for the three
24 deferrals for the cancer patient. It's WIT-89947. We
25 don't need to bring it up. 16:31
26
27 Thank you.
28
29

1 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL
2 AS FOLLOWS:
3
4 CHAIR: Thank you, Ms. Glenny. I am going to ask
5 Mr. Hanbury if he has some questions for you. 16:32
6 MR. HANBURY: Thank you very much for your evidence.
7 Just a few things which hopefully should be
8 straightforward. The very long Outpatient waiting
9 times, was there ever an initiative from the clinicians
10 or anybody else to maybe not see everybody or have 16:32
11 a discussion about groups of patients or a recognition
12 that they can only perhaps see red flags, the urgents
13 and others maybe not? I mean, did that ever come over?
14 A. Yes. In fact, probably since Covid all the clinicians
15 really are seeing are red flag patients and 16:32
16 time-critical urgent patients. So, really during
17 triage, they are identifying the reasons for referral.
18 If it's not clear that it's a red flag which we are
19 able to code as a red flag and that it is urgent, if
20 it's somebody who must be seen within a certain time 16:33
21 period, that will be recorded on the Outpatient waiting
22 list to say that they must be seen. So, they are doing
23 an element of that.
24 443 Q. The very routine, say someone requesting a vasectomy,
25 for example, has a higher-up decision maybe not to see 16:33
26 that group of patients?
27 A. The routine patients, unfortunately, are not being
28 seen, as I understand it, currently. Very few of them
29 would be seen, if at all.

1 444 Q. It must have been very depressing bringing your 62-day
2 figures to the regional performance review. When you
3 discussed that - I accept other departments had these
4 problems - were there any solutions generated from that
5 forum? 16:33
6 A. Not always. I suppose they would have been looking to
7 us to see if we had any ideas of how things could be
8 improved or innovated. There would have been obviously
9 the NICaN regional groups as well where discussions
10 would have been ongoing amongst the clinical team. We 16:34
11 would have been hearing feedback through those meetings
12 as well as to some of the ideas or information that
13 they had. I just think there was very little that
14 could be done in the way. You know, everybody was
15 trying to do as much as they possibly could. 16:34
16 445 Q. You mentioned as a throwaway line, regional diagnostic
17 centres; is that a thing now?
18 A. It is --
19 446 Q. What's the state on that?
20 A. It has just opened recently. At the moment it is just 16:34
21 seeing patients on a vague symptom pathway. They are
22 patients who don't necessarily meet the red flag
23 criteria but a GP is concerned about those patients and
24 has a gut instinct more or less that there's something
25 sinister happening, and they can refer into those 16:35
26 diagnostic centres. The view is that diagnostic
27 centres, because they will have imaging behind them,
28 that we will be able to use those imaging facilities to
29 start to see some of our longer waiting patients on the

1 imaging waiting lists, which will ultimately help our
2 red flag pathways.
3 447 Q. That's not specifically Urology, that can be --
4 A. Oh, no, it can be anything.
5 448 Q. Lots of things, more generic. Okay, thank you. 16:35
6
7 Moving on to waiting list management, you mentioned the
8 once a month Thursday meetings, and who is going to do
9 what in the next, and all consultants having different
10 arrangements? 16:35
11 A. Yes.
12 449 Q. Is there a role for more of a centralised waiting list
13 office type set-up, or what's your view on that?
14 A. Yes. Whilst I was in SEC, I actually was tasked with
15 setting up what we call the scheduling team, so it was 16:35
16 on the premise of trying to have a centralised waiting
17 list office. There were a number of specialties who
18 came on board with that at the time. Unfortunately,
19 Urology wasn't one of them at that time. I know it is
20 something that the current Head of Service, 16:36
21 Ms. Clayton, is thinking about trying to involve with
22 for certain particular maybe procedures like your
23 flexible cystoscopies, day cases, things like that that
24 would be more able to be scheduled in that way. It is
25 being considered at the moment. 16:36
26 450 Q. The main theatre cases are still done independently by
27 the individual urologists?
28 A. Yes. The ones where they feel they need to be involved
29 with, or for co-morbidities or where they have been

1 involved in long period of time, yeah.
2 451 Q. Thank you. A couple more. The full pathway training.
3 You mentioned a module on the CaPPS system involved the
4 CNSes. What about another module for the final
5 definitive treatment; is that a possibility? Is it 16:37
6 a system that can lend self to additional --
7 A. I am going to put my hands up and say I am not sure,
8 because I don't sit on the CaPPS user group so I am not
9 sure of the limitations of the system. I do know that
10 the CNS module is one that they have talked about. 16:37
11 I think it's actually there, it's more a matter of
12 trying to get it into use.
13
14 I don't know if there's modules that move it beyond
15 first definitive treatment, I don't think there's 16:37
16 anything there on the system at the moment but I don't
17 know enough about the system to say that for sure.
18 452 Q. Thank you. MDM. You have said the situation is better
19 in the Radiology grade. What about Oncology, is there
20 an improvement there? 16:37
21 A. Oncology is slightly better. There's not as many
22 patients or there's not as many MDMs that haven't been
23 attended as with Oncology as what there had been in
24 previous years. It does still happen because it is
25 still a regional service and they still are having 16:38
26 significant recruitment issues within Oncology. So
27 it's still, unfortunately, a problem.
28 453 Q. So, approximately what proportion of not --
29 A. I think there was six during the last 18 where there

1 was no oncologist available.
2 454 Q. So, roughly three-quarters -- which is great
3 improvement?
4 A. A great improvement on what we had.
5 455 Q. Thank you. Just one very short one. We saw one or two 16:38
6 cases where MDM safety nets have unexpected positive
7 pathology for cancer diagnosis have slipped through the
8 net. Maybe that's not your role, but do you think that
9 has been tightened up; is there a better system now?
10 A. Yes, sorry, I forgot about that one. We do now have 16:38
11 a pathology checklist in place. That was something
12 following one of the recommendations that we had
13 explored and looked into. We now have a weekly
14 pathology checklist that comes down from the region.
15 Then, Mrs. Muldrew compares that against the CaPPS 16:39
16 system then to see if there's any patients that are not
17 registered on CaPPS. That's brought forward to the
18 cancer tracker and the MDT lead, if need be.
19 456 Q. Thank you. Very helpful.
20 DR. SWART: Just a few things, you will be pleased to 16:39
21 know. I just want to take you back to the Health and
22 Social Care Board. You have attended those meetings,
23 if I understand it correctly?
24 A. Yes. For the cancer meetings, yes.
25 457 Q. And you presented a lot of data generally to the 16:39
26 meetings over the whole waiting list portfolio as well?
27 A. Yes. So for those meetings, we would have had to
28 prepare breach reports for patients who were breaching.
29 So, I would have had conversations in advance of those

1 meetings with members of the HSCB to discuss those
2 breach reports, talked about capacity issues, what the
3 challenges were, and give slide updates then on the
4 performance to the meeting.
5 458 Q. In those meetings, was there ever any focus on anything 16:40
6 other than performance? Did they talk about, for
7 example, the consequences of all those breaches for
8 patients in any form?
9 A. There would have been discussions about, yes,
10 consequences from the point of view of them trying to 16:40
11 look at maybe bigger pictures in or around what they
12 could do within HSCB to try and help that.
13 459 Q. I am talking about, you know, examples of patients who
14 had waited a long time and had come to grief, or
15 patient stories, or any discussions to say what has 16:40
16 happened to the patients who have waited, say, 120 days
17 for their cancer treatment. Did they ask you about
18 anything like that is what I'm after?
19 A. Yes. In preparation for those meetings, we have been
20 asked to provide the breach reports for every patient 16:40
21 who had breached.
22 460 Q. Did they ask you to assess the harm to the patient?
23 A. No. We probably weren't asked to, but everything would
24 have been in the breach report to describe what
25 happened in that patient's treatment and care. 16:41
26 461 Q. At these cancer meetings, did they ever ask about the
27 quality of services in the context of are you meeting
28 Peer Review standards or anything of that nature, or
29 was it purely numbers?

1 A. I don't recall any discussion around Peer Review
2 standards.
3 462 Q. Any other qualitative things brought up in those
4 meetings, or was it really just about targets?
5 A. Really, it was a performance meeting. 16:41
6 463 Q. Yes. You have described your role in the Task and
7 Finish group, and there's clearly a lot of work that's
8 ongoing. If I had to ask you what conversations do you
9 have now at your cancer meetings that you didn't used
10 to have before all of this, what would those 16:41
11 conversations be like now that are significantly
12 different and you are perhaps a bit proud of?
13 A. So, we have actually changed the format of how we meet.
14 Yes, we do still have our cancer performance meeting,
15 a monthly cancer performance meeting, where we meet 16:42
16 with all of the specialty areas and they are all
17 invited. We do go through all the performance reports.
18 We do also then talk about things that are happening
19 with each of the service areas, what in particular is
20 causing challenges to each of the services, any issues 16:42
21 they may have, which we log as a cancer team. We now
22 share that up through the senior management lines and
23 give them line of sight on what the issues are.
24
25 As a cancer team ourselves, we now meet every Thursday, 16:42
26 and one meeting will be about performance, and one
27 meeting, the next week, will be about things that's
28 happening within our areas, our improvement work, what
29 we are doing. We will go away with our actions. We

1 look at things like our incidents or anything that has
2 been brought to light in that last time. So yes, as
3 a service, I suppose we are more -- we are looking at
4 ourselves much more inwardly in how we are delivering
5 our services. 16:43
6 464 Q. Does that feel better?
7 A. Yes, it does.
8 465 Q. Would that be the thing you are most proud of after the
9 Task and Finish, or is there something else that you
10 would highlight as being a fantastic thing? 16:43
11 A. I think all the improvement work that's been put in
12 since, because it was a difficult read to read the
13 report and to know the effects that it had had on
14 patients. So, to come away after it and take a step
15 back and sort of reflect on some of the things, and 16:43
16 what we could do here to try and improve those things
17 and actually see those improvements now happening, and
18 happening in a relatively short period of time as well
19 since we have all became aware of it, I think that's
20 something to be proud of. 16:44
21 CHAIR: You will be glad to know I don't have any
22 questions for you, Ms. Glenny. I think we will end on
23 that note and thank you very much for coming along to
24 us. It's a quarter to five. Then next Tuesday, ladies
25 and gentlemen, and 10:00, I think. 16:44
26
27 THE INQUIRY WAS THEN ADJOURNED TO TUESDAY, 16TH MAY
28 2023 AT 10:00 A.M.
29