Urology Services Inquiry

Oral Hearing

Day 85 – Thursday, 8th February 2024

Being heard before: Ms Christine Smith KC (Chair)

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

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

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WITNESS PAGE

MRS. SHARON GALLAGHER AND MR. PAUL CAVANAGH

DIRECTLY EXAMINED BY MS. MCMAHON 3

QUESTIONED BY THE PANEL 156

1 THE HEARING COMMENCED ON THURSDAY,
2 8TH DAY OF FEBRUARY, 2024 AS FOLLOWS:
3
4 CHAIR: Good morning, everyone. Ms. McMahon.
5 MS. MCMAHON: The witnesses this morning, both 10:04
6 witnesses to give evidence on behalf of HSCB and SPPG.
7 We have Mr. Paul Cavanagh, who is the Director of
8 Hospital Care, Strategic Planning & Performance Group
9 in the Department of Health; and Sharon Gallagher, who
10 is a Deputy Secretary, Health Service Operations Group 10:04
11 in the Department of Health, and also the Chief
12 Executive of the SPPG. They are represented this
13 morning, and I'll just let Mr. Henry introduce himself
14 for the transcript.
15 MR. HENRY: Good morning, Madame Chair and Panel 10:04
16 members. My name is Philip Henry and I'm instructed on
17 behalf of the SPPG and I'm with Ms. Vivienne O'Neill,
18 my instructing solicitor from the DSO.
19 CHAIR: Thank you very much, Mr. Henry.
20 MS. MCMAHON: I understand Mr. Cavanagh will affirm and 10:05
21 Mrs. Gallagher will take the oath.
22
23 MRS. SHARON GALLAGHER, HAVING BEEN SWORN, WAS DIRECTLY
24 EXAMINED BY MS. McMAHON AS FOLLOWS:
25 10:05
26 MR. PAUL CAVANAGH, HAVING AFFIRMED, WAS DIRECTLY
27 EXAMINED BY MS. McMAHON AS FOLLOWS:
28
29 1 Q. MS. MCMAHON: Thank you both for coming in today to

1 give evidence for the Inquiry. We decided that you
2 would both possibly be more useful giving evidence
3 together; we have received Section 21s from both of you
4 and, by the very nature of them, they overlap in
5 certain degrees, but I know you both have expertise in 10:06
6 different areas that are of interest to the Inquiry, so
7 you've kindly agreed to give your evidence together.
8
9 I just want to go to your Section 21s, first of all, so
10 that they can be properly put before the Inquiry as 10:06
11 evidence.
12
13 If I start with you, Mrs. Gallagher, your response to
14 your Section 21 notice, no. 66 of 2022, can be found at
15 WIT-66157, and that's dated 14th July 2022, and if we 10:06
16 go to WIT-66179 -- I'll have to come back to that. If
17 we just confirm the signature page on that one.
18 We'll go to Mr. Cavanagh's statement, WIT-104243.
19 I hope we have better luck with this one. Yes, there's
20 your name at the top of it. The notice is dated 10:07
21 5th July 2023 and your signature should be found at
22 104366, WIT-104366. Do you recognise that,
23 Mr. Cavanagh, as your signature?
24 A. MR. CAVANAGH: I do.
25 2 Q. And it's dated 3rd November 2023. And do you wish to 10:07
26 adopt that as your evidence?
27 A. MR. CAVANAGH: Yes.
28 3 Q. I just need to confirm the signature page for
29 Mrs. Gallagher, so if I could ask Ms. Horscroft just to

1 confirm that for me. Just while that's happening,
2 Mr. Cavanagh, perhaps you could give us a brief outline
3 of your background and your career to date, to the
4 point that -- your role in the SPPG.
5 A. MR. CAVANAGH: Sure. I started my career in the 10:07
6 voluntary sector. In 2002, I came to the Health
7 Service, initially as a Health Action Zone Manager in
8 the Western Health and Social Services Board. I worked
9 in a number of senior management roles, and then in
10 SPPG -- or, sorry, in the Health and Social Care Board 10:08
11 - that's going to confuse me throughout the day,
12 apologies - in the Health and Social Care Board, I was
13 Assistant Director in 2009, of commissioning,
14 specifically with responsibility for the Western Area,
15 and I also developed some regional responsibilities 10:08
16 through that term, including commissioning an ambulance
17 service regionally. And then, in 2020, I became
18 Interim Director of Planning and Commissioning, and
19 then, in 2022, became Director of Commissioning, and
20 subsequently that has become Director of Hospital Care, 10:08
21 as a Director of Commissioning role is largely looking
22 at hospital issues, so we felt it was more appropriate
23 for that to be the title.
24 MS. McMAHON: Thank you for that. I know what you are
25 going to say because I get told it as well. There is a 10:08
26 transcript being taken, and we have to be mindful that
27 people are trying to transcribe what we say.
28 CHAIR: We tend to speak very quickly in Northern
29 Ireland, but if you could just slow down --

1 MR. CAVANAGH: I will do my best, Chair, of course.
2 CHAIR: Thank you. It is just for the stenographer,
3 who I could see was struggling slightly with the speed
4 of your speech. Thank you.
5 MS. McMAHON: We'll both keep an eye on it from each 10:09
6 other and we'll see how we get on.
7 MR. CAVANAGH: Of course.
8 4 Q. Mrs. Gallagher, if I could just come back to you in
9 relation to your signature. If we could go to
10 WIT-66272, and you'll see the signature at the end of 10:09
11 that statement. Do you recognise that as your
12 signature?
13 A. MRS. GALLAGHER: I do.
14 5 Q. And the date is 17th October 2022, and do you wish to
15 adopt that as your evidence before the Inquiry? 10:09
16 A. MRS. GALLAGHER: I do.
17 6 Q. Thank you. And I wonder if you could do the same, give
18 us a summary of your career to date and your current
19 position.
20 A. MRS. GALLAGHER: Of course. So I have been a civil 10:09
21 servant for over 35 years, I am a senior civil servant.
22 For the last 11 years, I have worked for the Department
23 of Health. I moved to take over what was the Health
24 and Social Care Board in September 2020. At that
25 stage, it was an Arm's Length Body, so I held the role 10:09
26 of Deputy Secretary in the Department and Chief
27 Executive. With the closure of the Board, I'm no
28 longer a Chief Executive, but I remain a senior civil
29 servant in the Department of Health.

1 7 Q. And with responsibility of SPPG?
2 A. MRS. GALLAGHER: That's correct.
3 8 Q. Now, just at the start of the evidence, I wonder if you
4 could just give us a brief understanding of the way in
5 which HSCB became SPPG and what was the thinking behind 10:10
6 that?
7 A. MRS. GALLAGHER: I can, yes. I have been involved,
8 actually, in this work since the outset in 2015 when
9 the Minister made a decision to close the Health and
10 Social Care Board and review the model of commissioning 10:10
11 in Northern Ireland. It has been a little bit stop and
12 start since that point because we have had the
13 administration down on a number of occasions, twice,
14 and, of course, we have had Covid in between. The
15 rationale behind the closure of the Board and the 10:10
16 review of commissioning was primarily based on the
17 Donaldson Review of 2015, but also, as I understand,
18 from the Minister's observations at the time, which was
19 that the system in place was overly bureaucratic and
20 complex and that there needed to be more responsive 10:11
21 decision-making and accountability.
22
23 Additionally, the commissioning process was based very
24 heavily on the NHS process, which was on competitive
25 tendering, and that wasn't something that was conducive 10:11
26 within the Northern Ireland context, primarily because
27 of the size, but also, of course, because of the demand
28 capacity deficit, which was growing at that time, and
29 the constrained financial position.

1
2 So, in effect, we were purchasing services from Health
3 and Social Care Trusts who weren't able to deliver, and
4 the principle was that you purchased services from the
5 best provider, but there was no prospect of moving from 10:12
6 one provider to another. So a very clear rationale and
7 mandate at that time in 2015. As things emerged, it
8 was decided to decouple the closure of the Board and
9 the new commissioning model and that was primarily to
10 derisk any potential negative impact on the 10:12
11 commissioning of services, so to protect service
12 provision.
13
14 In terms of the closure of the Health and Social Care
15 Board, the legislation for that was passed in 2022, and 10:12
16 the closure was effected from 1st April 2022.
17
18 In terms of that legislation, that stood down the
19 process for commissioning, so we had a commissioning
20 plan direction, a commissioning plan, Trust delivery 10:12
21 plans and service and budget agreements, which was
22 ostensibly the contract between the Commissioner and
23 the providers, so that process was stood down under the
24 legislation. And at present, we're currently working
25 through a new process for commissioning under the 10:13
26 auspices of the Integrated Care System Framework, which
27 sets the broad framework for commissioning in Northern
28 Ireland moving forward.
29

1 So we're very much still in transition, despite the
2 genesis of this work since 2015. However, I would say
3 very strongly that the practice of how we commission
4 services hand in glove with the Public Health Agency
5 remains very much in place, because at the time of 10:13
6 inception of the Health and Social Care Board and the
7 Public Health Agency, there was a view that there would
8 be a single organisation, and the Minister at the time
9 decided to split those organisations, but one
10 organisation cannot discharge its responsibilities 10:14
11 without the other. So I do not employ people with
12 professional experience to input to the commissioning
13 process, that comes from PHA, and equally, we provide
14 the administrative and the financial skill and
15 experience in terms of PHA and how they commission 10:14
16 their services. I'm sorry, that was a little bit
17 long-winded, but it is very, very complex, and I'm more
18 than happy to answer questions as we go on in that
19 regard.
20 9 Q. That's very helpful. That's about my first 20 10:14
21 questions dealt with! But rather than unpick it at
22 this point.
23 A. Yes, Ms. McMahon.
24 10 Q. Well, we're both on form today. So, what we'll do is,
25 I'll take that as your complete answer, but probably 10:14
26 unpick some of that as we look through what happened
27 and some of the procedures and processes. Just at the
28 outset, before I do ask questions around that, have you
29 had the opportunity to watch any of the Inquiry

1 proceedings or to read any of the transcripts, if you
2 could answer separately?
3 A. MRS. GALLAGHER: I have, yes.
4 11 Q. And you, too, Mr. Cavanagh?
5 A. MR. CAVANAGH: I have watched a number of hearings 10:15
6 online and I have read quite a number of the
7 transcripts, yes.
8 12 Q. So you'll have an idea and obviously a significant
9 overview of what the issues are, and some of the
10 evidence that's come before the Inquiry, it would 10:15
11 perhaps be too high to say critical, but certainly
12 questions some of the HSCB involvement and some of the
13 decisions around that and the potential for better
14 working relationships, and you'll understand that the
15 Inquiry's focus is to find out what happened, to inform 10:15
16 recommendations, so the questions are asked within that
17 context, and I will put some transcript and statement
18 extracts to you for you to comment on, as appropriate,
19 and I might touch upon some of the issues that you have
20 just mentioned. 10:15
21
22 Just taking a step back under the old guise of the
23 HSCB, the roles and responsibilities, and they have
24 been set out in Mr. Cavanagh's statement at WIT-104255.
25 Just to give a little bit of background to that at 10:16
26 paragraph 30. So you say at paragraph 30:
27
28 "The HSCB had responsibility for commissioning Health
29 and Social Services and for putting in place systems to

1 monitor performance against ministerial targets and
2 using indicators provided by the Department with a view
3 to improving those services, as well as ensuring finite
4 resources were used efficiently."
5 10:16
6 Now, that paragraph seems to encapsulate a lot of both
7 the functions of the HSCB but some of the issues that
8 some people take issue with. And I just want to ask
9 you, in general terms, before we get into the detail,
10 you've mentioned the issue around commissioning, and 10:17
11 I wonder if you could explain to the Inquiry the role
12 that the HSCB has in considering the effectiveness of
13 governance processes by Trusts through which services
14 are commissioned?
15 A. MRS. GALLAGHER: So, the Health and Social Care Board 10:17
16 or the Strategic Planning & Performance Group has no
17 oversight on the governance arrangements within Trusts.
18 Whilst the Department has set the legislation, and
19 that's clearly set out within the 2011 Framework, which
20 is still extant, it is the responsibility of the Trust, 10:17
21 as an Arm's Length Body, with its own Executive team
22 and Board, to ensure that there is the appropriate
23 clinical and corporate governance arrangements in
24 place.
25 13 Q. So maybe the onus is on the Trust to have their house 10:17
26 in order, as it were?
27 A. MRS. GALLAGHER: It is.
28 14 Q. And does that mean that, in real terms, HSCB, SPPG rely
29 on assurances given by the Trust as to the

1 effectiveness and robustness of their own systems?
2 A. MRS. GALLAGHER: I guess it's fair to say that Health
3 and Social Care, as you know, is a very complex system.
4 There are multiple organisations, as is set out in
5 terms of how we work together as a system. The 10:18
6 responsibility lies with the ALB, with the Trust, as
7 we've just described, in relation to its own
8 arrangements. In terms of the services that we
9 commission, we commission on the basis of safe
10 services. I mean, paramount in all of our thinking 10:18
11 within the Health and Social Care system is safety. So
12 we commission safe services in our service
13 specifications, we set out the safety standards and the
14 clinical standards and guidelines that we would expect
15 working with the Public Health Agency, but it is up to 10:18
16 the Trust to ensure that services remain safe and are
17 delivered with the utmost attention to the safety of
18 the patient and putting in place the environment and
19 the governance arrangements to ensure that that's the
20 case. 10:19
21
22 In saying that, we don't rely on the assurance of the
23 Trust in itself, so we work with the Public Health
24 Agency in terms of our performance management approach
25 and our broad approach to working with Trusts to 10:19
26 secure -- so we have clinical networks, for example, in
27 place in practically all specialties, and that brings
28 together Clinicians, Commissioners, including ourselves
29 in SPPG, and the PHA and service users and carers, in

1 order to improve our service delivery and maintain
2 quality in the services. We regularly work with peer
3 reviews and audit teams in England, so we recently have
4 had GIRFT reviews on a range of issues, including
5 Orthopaedics, Urgent and Emergency Care, are two of the 10:20
6 most recent ones, and we are involved and take part in
7 audits regularly in terms of giving us information and
8 intelligence and understanding the quality of services
9 within Northern Ireland.
10 10:20
11 In addition to that, we oversee the process for Serious
12 Adverse Incidents and complaints and we have a role in
13 monitoring and triangulating that information in order
14 to ensure system learning -- organisational learning,
15 first of all, and then system learning and, of course, 10:20
16 we have the RQIA, who undertake reviews and will advise
17 the Department in relation to the Trust's quality of
18 services and the environment in which those services
19 operate, including its governance arrangements.
20 15 Q. Thank you for that. We'll come on to look at the SAIs 10:21
21 and the process around that and the efficiency and
22 efficacy of that process. But I wonder if I could just
23 take a step back and look at the HSCB. If we carve
24 that off, that was the dominant body at the time
25 relevant for the purposes of the Inquiry. I know SPPG 10:21
26 is now the new iteration of that. But if we look at
27 HSCB as it existed at that time, our understanding is
28 that it was an Arm's Length Body equivalent to RQIA,
29 the Trusts' PCC, PHA, all of the organisations

1 mentioned in both the Framework Document and the
2 grounding legislation, they all came around at the same
3 time, April 2009. And given that they were on the same
4 level, if I can put it that way, did that present any
5 difficulty in oversight, when you look back now, given 10:22
6 the reconfiguration of SPPG, that HSCB had such a
7 significant role in commissioning, in guaranteeing safe
8 services, do you feel now that that structure perhaps
9 hindered HSCB in carrying out their role in that way?
10 A. MRS. GALLAGHER: Pre the closure of the Board or -- 10:22
11 16 Q. Yes.
12 A. MRS. GALLAGHER: I don't believe so. The Health and
13 Social Care Board was mandated, as we've just
14 described, to commission services, to commission safe
15 services, and that was a dual mandate with the Public 10:22
16 Health Agency. Akin to the description in relation to
17 the Trusts and other organisations, they had systems
18 and structures. The Health and Social Care Board had
19 systems and structures in place to ensure that safe
20 services were commissioned and that the oversight 10:23
21 arrangements, including the Board of the Health and
22 Social Care Board, were kept abreast of how the Health
23 and Social Care Board was discharging its
24 responsibilities in that regard.
25 17 Q. And you mentioned a few moments ago the Framework 10:23
26 Document. We've heard a little bit about that both
27 from PHA and in other evidence. Now, that's dated
28 September 2011, and it is reflective, I think, of what
29 was anticipated to be the outworking of the legislation

1 at the time, 2009. Now, given that the legislation has
2 changed, 2022, and certainly from evidence from the
3 Public Health Agency this week and from evidence that
4 you will give from both your statement and
5 Mr. Cavanagh's, there's been what could be described as 10:23
6 a fairly significant change around the restructuring
7 and the commissioning in Northern Ireland. Does that
8 mean that that Framework Document is out of date and a
9 new one is imminent, or what's the position so that
10 bodies will understand what's expected from them and 10:24
11 what their duties and responsibilities are in
12 healthcare?
13 A. I think it's a very reasonable comment, Ms. McMahon,
14 that the Framework Document needs to be updated, and
15 that process is currently in place and well-advanced. 10:24
16 The main provision that was removed from the
17 legislation in terms of the process for commissioning,
18 is clearly set out in the Framework and, of course,
19 that is no longer valid. So it was not possible to
20 update the Framework Document in advance of agreeing 10:24
21 the final arrangements for how commissioning would take
22 place, which is currently coming to a conclusion in the
23 consideration of how ICS NI, the Framework For
24 Commissioning, would play out in the future. So the
25 work to finalise the new commissioning arrangements is 10:25
26 taking place and that will allow, then, the ultimate
27 updating of the Framework Document.
28
29 I would add, however, that whilst that process is still

1 continuing, there is absolute clarity in terms of both
2 my mind, and I think you heard Mr. Dawson say earlier
3 this week, we work very closely together, our teams
4 work together in joint enterprise in terms of
5 commissioning safe services every day. What isn't 10:25
6 clear and what needs to be clarified is the Framework
7 Document setting out that approach moving forward.
8 A. MR. CAVANAGH: Maybe, Ms. McMahon, if I can add, I
9 mean, yes, some of the elements of the commissioning
10 process have changed; we don't have commissioning plan 10:25
11 direction, we don't have commissioning plan, so,
12 therefore, there's no formal document, as such, is
13 signed off each year in the way that was. But in terms
14 of the day-to-day work that someone like me does, in
15 terms of working with Trusts where services might be 10:26
16 vulnerable, where there are challenges in delivering on
17 the -- kind of, the requirements that we have, we work
18 so closely with PHA, it would be impossible for me to
19 be talking to Trusts without having liaised with PHA -
20 indeed, have them in the room with me to have those 10:26
21 conversations, having someone with a public health
22 medicine background, with a nursing background, and so
23 on, that adds to someone like me, who doesn't have a --
24 I'm not a Health and Social Care professional, but it
25 adds, then, to the discussion and debate and ensures 10:26
26 that we actually are asking the right questions and
27 coming to the correct conclusions in terms of how we
28 take forward some of the challenges facing Health and
29 Social Care.

1 18 Q. I think the Inquiry heard evidence from the Public
2 Health Agency that would suggest their involvement in
3 probing some of the SIAs, and some of the
4 investigations --
5 A. MR. CAVANAGH: Absolutely. 10:26
6 19 Q. -- led to other avenues of concern being highlighted
7 and addressed. So if the Inquiry thinks that evidence
8 shows the importance of PHA, then that can be
9 reflected. But just on that point, while we're on the
10 point of the PHA and their particular role, we heard 10:27
11 about their clinical expertise and their health
12 professional expertise across the board and how
13 valuable that is, and we see the outworking of that in
14 some of the examples. But just as the 2009 legislation
15 was reflected in the 2011 Framework Document, we can 10:27
16 anticipate that the 2022 legislation will be reflected
17 in the new Framework Document and, indeed, the way in
18 which services are delivered and commissioned?
19 A. MRS. GALLAGHER: Absolutely, absolutely.
20 20 Q. Now, you will know, I think, that the wording of the 10:27
21 2022 legislation does change slightly in relation to
22 PHA. There had been an understanding or a requirement,
23 it was mandatory in the 2009 legislation that both PHA
24 and HSCB would approve commissioning together, a
25 sign-off that would be -- both organisations would 10:28
26 agree on. That seems to have changed under the 2022
27 legislation and, while PHA clearly have a role in
28 informing, advising and contributing, the ultimate
29 decision around sign-off on commissioning lies with

1 SPPG. I wonder if you could just give us a little bit
2 of background around that and what, in real terms, that
3 means for commissioning in Northern Ireland?
4 A. MRS. GALLAGHER: Yes. And maybe if it's helpful to the
5 Panel, I led on the legislation, in line with the work 10:28
6 that I have been doing on the closure of the Board and
7 the renewal of the -- or the revision of the
8 commissioning approach. It was never the intention and
9 is not the intention to have a first amongst equals and
10 that SPPG will have ultimate autonomy. So the 10:28
11 intention is that PHA and SPPG will continue to work
12 closely and to commission service in joint enterprise.
13 The provision -- the detail in that, in terms of the
14 process, we are currently working through, and, as you
15 quite rightly say, Ms. McMahon, that will be reflected 10:29
16 in the Framework Document. But, in practice, whether
17 it is set out clearly in the Framework Document or,
18 indeed, in legislation regarding a sign-off, it is
19 impossible for SPPG, for me, to commission services, me
20 or any of my team, to commission services, without the 10:29
21 imprimatur, without the experience, without the
22 intelligence of the Public Health Agency. And if we
23 look at some recent examples in terms of example Long
24 Covid or even services that are significantly changing,
25 so maternity services in the Northern region, for 10:29
26 example, those recommendations, the recommendation on
27 the change in services in the Northern region, came
28 conjointly from myself and the Chief Executive of the
29 PHA, Aidan Dawson. So that reinforces and evidences

1 our shared responsibility in relation to both
2 commissioning and decommissioning services.
3 21 Q. I suppose from the outworking of the expectation around
4 using each other's experience, that properly reflects
5 the process that will be undertaken? 10:30
6 A. MRS. GALLAGHER: Absolutely.
7 22 Q. But from a purely legal perspective, if we look at the
8 legislation, it's clear that the ultimate decision lies
9 with the SPPG?
10 A. MRS. GALLAGHER: I think you have made a very valid 10:30
11 point and, in reflecting and amending the Framework
12 Document from 2011, we will need to be absolutely clear
13 that the responsibility, in terms of commissioning, is
14 very firmly a joint enterprise. Ultimately, there may,
15 and I can't think of any circumstance to hand where PHA 10:30
16 and SPPG might come to a different view, but,
17 ultimately, the Department will have a role in terms of
18 listening to views, understanding the perspective and
19 taking the advice and understanding of the
20 professionals in the Department at that stage. 10:31
21 23 Q. And the previous body, the HSCB, it existed, as other
22 Arm's Length Bodies, with a sponsorship branch at the
23 time, and do you recall which one it sat under?
24 A. MRS. GALLAGHER: Which of the civil servants? At one
25 point, it was myself. It has been various colleagues 10:31
26 at given points in time.
27 24 Q. And there was a Board as well for HSCB, an Executive
28 Board?
29 A. MRS. GALLAGHER: Indeed.

1 25 Q. And commissioning then would have gone to both Boards,
2 PHA, HSCB --
3 A. MRS. GALLAGHER: That's correct.
4 26 Q. -- and they ultimately would have signed it off? Now,
5 the Panel is aware that the ultimate accountability is 10:31
6 with the Department, with the Minister. But the
7 situation now, as I understand it, is that SPPG doesn't
8 have a Board; it is direct line with the Permanent
9 Secretary, with the Minister, is that correct?
10 A. MRS. GALLAGHER: That's correct. 10:32
11 27 Q. And your experience, and I understand it's early days,
12 but in your experience of that particular model of
13 accountability and decision-making that has moved from,
14 arguably, a layer of oversight, removed from having a
15 Board, which you may say not, you may say it allows for 10:32
16 greater oversight, but I'll let you answer the
17 question; what's your view on the efficiency and the
18 benefit of the model that's now in place, SPPG,
19 directly with the Permanent Secretary, with you as, as
20 I understand it, a Grade 3, what do you think are the 10:32
21 benefits of that?
22 A. MRS. GALLAGHER: I suppose the one thing that I would
23 say, very clearly, is, my accountability hasn't
24 diminished in any way. I'm accountable to the
25 Permanent Secretary and ultimately to the Minister, 10:33
26 accountable to the Departmental Management Board also
27 in terms of discharging my responsibilities, and
28 I report directly to the Permanent Secretary in terms
29 of my area of work. So there's very clear governance.

1 It isn't the governance as set out through an ALB
2 arrangement with the Board, but there are very, very
3 clear governance arrangements post the closure of the
4 Board.
5 10:33
6 I have some experience, actually, of having worked
7 within the Department when the Board obviously was
8 still open, and at one point I was the Director of
9 Performance Management, and there was a Performance
10 Management Directorate, obviously, in the Health and 10:33
11 Social Care Board, and that represented double-running,
12 a duplication of effort. So when I took up that post,
13 and I have some experience in other departments working
14 in Performance Management and as Director of
15 Performance, my first, I suppose, priority was to 10:34
16 understand my role vis-à-vis the role of the
17 performance team in the Department, and it was very
18 unclear, and, in actual fact, routinely, the role, my
19 role and the role of my team, was to take the
20 information and the insight and the understanding from 10:34
21 the Health and Social Care Board and put that in a way
22 that, if you like, in a formation that would be more in
23 line with the Civil Service, so in making a submission
24 to a Minister, for example. But I would have used
25 their intelligence, their understanding and their 10:34
26 workings, and all I was doing was providing the
27 administrative support around that. So there was,
28 very, very clearly, duplication of effort there,
29 double-handling and that involved a senior civil

1 servant, myself as a Director, an entire team of
2 people, that was, in essence, replicating the efforts
3 of the Board. So, before the closure of the Board,
4 I put forward a recommendation, which was agreed in the
5 Department at the time, that, actually, we would 10:35
6 dissolve or close down my role as Director of
7 Performance, and the Director of Performance in the
8 Health and Social Care Board reported directly into the
9 Department to reduce that layer of duplication because
10 it was adding no value. 10:35
11 28 Q. Now, the restructuring of SPPG, just before I move on,
12 because you've mentioned the structure and the way in
13 which it now operates, we've heard evidence from some
14 Arm's Length Bodies, and we'll hear more in the next
15 sitting of the Inquiry, around people's perception that 10:35
16 they could only go so far with what they knew or what
17 they could influence, that groups butted up against
18 each other, almost. So, for example, the PHA took
19 things as far as it could, but couldn't actually tell
20 the Trust 'get your house in order', if it wanted to 10:36
21 say that; there was no sanction, there was no way of
22 trying to influence beyond its own statutory remit and
23 the Framework Document. Does the SPPG, now moving or
24 now sitting in a slightly - these are my words -
25 elevated position beyond the other Arm's Length Bodies 10:36
26 and with direct ministerial accountability and with you
27 at the helm, is there any potential or possibility that
28 there will be a greater influence if there are clear
29 governance issues from a Trust that may require more

1 than just letters or advice or conversations, is there
2 a greater possibility that you would have powers to try
3 and ensure that issues around governance, that it would
4 be clear to you, perhaps, are being addressed, rather
5 than just trying to persuade people to address them? 10:36
6 A. MRS. GALLAGHER: So I think it's important that,
7 because I'm a civil servant, I still understand my role
8 and responsibilities and discharge that with respect to
9 the Strategic Planning & Performance Group. It is key
10 that all of us understand our responsibilities, not 10:37
11 just in terms of performance but in terms of safety and
12 quality, governance, financial management, and I have
13 no -- personally, have no additional responsibility,
14 now that the Board is closed, in that regard as it
15 relates to the Trust and their delivery of services and 10:37
16 their governance arrangements. I'm saying this quite
17 clumsily, I know, as I say it, but the complexity or
18 the federation of the system of Health and Social Care
19 is set out and built on the basis that there is
20 responsibilities on all of us and all of us discharge 10:38
21 that responsibility. Clearly, either as a Health and
22 Social Care Board or as a Strategic Planning &
23 Performance Group, if something arises or if we learn
24 about something that we are concerned about, it is our
25 responsibility to take action in that regard and that 10:38
26 wouldn't matter whether it had been the Health and
27 Social Care Board or SPPG.
28
29 So I don't have any elevated status simply because I'm

1 a civil servant and work to the Permanent Secretary,
2 but I would equally have a responsibility, as a senior
3 leader, as all of us have in Health and Social Care, to
4 be mindful of and responsive of issues as they arise
5 and how they are being dealt with. But the primacy in 10:39
6 terms of dealing with issues within the Trust, remains
7 with the Trust arrangements, the Trust Executive Team
8 and the Trust Board, ultimately, and, of course, the
9 Chair of the Board reports to the Minister, ultimately;
10 that's a ministerial appointment. So the 10:39
11 responsibility of the Board and the Board's Chair is to
12 ensure that the governance is in place and that the
13 organisation is agile, responsive and puts safety and
14 quality as key within their operational focus.
15 A. MR. CAVANAGH: If I might add, Ms. McMahon, to describe 10:39
16 it as hierarchical, I think is probably missing some of
17 the complexity, in my view, because a lot of what's
18 required, and indeed the 2011 Framework talks about a
19 duty of cooperation for all of the organisations, and
20 that cooperation is key in all of this. So we may come 10:39
21 to the table and feel that a service could be delivered
22 in a different way or there are different ways of
23 organising ourselves, but it's incumbent on us to
24 actually bring the evidence and to actually show that
25 good practice is working elsewhere which could be 10:40
26 applied here, or that a Royal College has saw, sort of,
27 an approach which we could replicate and draw upon, so
28 it's incumbent upon us to have that evidence. We also
29 look to opportunities for clinical cooperation as well,

1 and some of the cooperation goes on through our Cancer
2 Network Clinical Reference Groups, through
3 multidisciplinary teams and so on, so all of that is
4 important, but, ultimately, it's about recognising that
5 all of us have roles. So it's not, as such, first 10:40
6 among equals hierarchy; it's about each of us being
7 clear about our roles, and I think what we have tried
8 to do is come with a kind of weight of argument and a
9 weight of evidence in order to actually, then, engage
10 with Clinicians, engage with managers, to ensure that 10:40
11 we do actually deliver the change that we believe is
12 required, but also recognising that there's compromise
13 and there's understanding some of the nuances as well
14 within our individual services within Northern Ireland
15 more generally, and I think we have, throughout 10:41
16 the years, been much more responsive to that, rather
17 than necessarily being, sort of -- you know, calling
18 on, this is a must-do, this is a cooperative system
19 that needs to work together in order to meet the
20 challenges that we have. 10:41
21 29 Q. Yes. And the Inquiry has heard around the importance
22 of collaboration and listening and communicating and
23 the factors that influence that, both weaknesses in
24 processes but also in individuals' use of processes --
25 A. MR. CAVANAGH: Yeah. 10:41
26 30 Q. -- if I can put it generally to you like that. But is
27 it the case, given your answers, that you consider that
28 the systems in place are appropriate to deal with
29 governance concerns arising?

1 A. MRS. GALLAGHER: I think the evidence from both the
2 Hyponatraemia and Neurology Inquiries would suggest
3 there's more to do in relation to governance, in
4 relation to workforce, in relation to safety and
5 quality, in relation to systems and information, and 10:42
6 there's always learning. There are processes,
7 policies, procedures in place, but there's always the
8 human element in that, and it is how people adopt those
9 policies and adhere to them, and I guess one of the
10 things that has come out very strongly is the principle 10:42
11 of being open and encouraging people to speak up and
12 encouraging people to be open and honest, including,
13 and most importantly, clinical professionals. So
14 there's always more to do, and I couldn't stand here
15 today and say, given recent experience and given why 10:42
16 we're here today, that there isn't always a focus on
17 learning.
18 31 Q. Thank you. And given the HSCB role and SPPG role in
19 commissioning services that are safe, I think you have
20 mentioned patient safety is paramount, reduction of 10:43
21 risk and anticipation of risk and having some vision
22 around that and reducing that, they are all expected,
23 I presume, within the commissioning process. When you
24 became aware of the extent of the problems through the
25 Inquiry and that the Inquiry have been dealing with, 10:43
26 what was your reaction? How did you feel about that?
27 A. Hugely concerned, hugely concerned for both the
28 patients, the families, and a very real responsibility
29 to understand how we put it right, and we were

1 transparent in that regard. At the time, the previous
2 Permanent Secretary, Mr. Pengelly, set up the oversight
3 arrangements, the Urology Assurance Group, and the
4 Panel may know that I am a member of that, as is Paul,
5 and that was to oversee the process, to ensure that the 10:44
6 process was handled efficiently and effectively and as
7 quickly as possible and sought to assure those impacted
8 by what's happened in this. So I think the overriding
9 feeling was, yes, concern.
10 32 Q. And, Mr. Cavanagh, what was your reaction? You had 10:44
11 experience dealing with some of the SAIs, you probably
12 had more direct contact with Trust staff than anyone
13 else in SPPG or HSCB, when you realised the extent or
14 the issues, the breadth of the issues and perhaps the
15 depth of some of them, the long-standing nature of 10:44
16 them, what was your reaction?
17 A. MR. CAVANAGH: I think similarly concerned. I mean,
18 just in the first weeks of, really, in August 2020,
19 trying to understand what had happened and trying to
20 work out just how many patients were of concern and 10:44
21 also then those patients who may have come to harm.
22 I think I really was very focused on trying to get to
23 grips with the extent of the problem and also, I think,
24 to think about how we, as a system, could have and
25 should have known earlier, but the reality was, it came 10:45
26 in the way that it came, but there were various routes
27 into the Trust over the years where I would have
28 thought there may have been opportunities for these
29 issues to be raised, but they weren't raised, because

1 I've checked through all of our records. But that
2 sense of concern and that sense, as well, of also
3 trying to get a handle on exactly what had happened,
4 I think was quite challenging in those early weeks
5 around the issues. But I think we were focused on very 10:45
6 much supporting the Trust at that stage and also trying
7 to understand what was happening at that stage as well,
8 but it was very concerning and very worrying, and
9 ultimately, and as it turned out, there was 2,112
10 people who were in the first cohort for the lookback 10:46
11 back to January 2019. You know, every one of those
12 individuals will have had worries, will have had
13 contact from the Trust; some were found to have had
14 clinical and non-clinical concerns, and each one of
15 those individuals, as well, have families and so on. 10:46
16 And I think there was just a sense that we need to act
17 as quickly as we possibly can to reassure people and
18 also ensure that their clinical care is appropriate and
19 safe.
20 33 Q. And can I take from your answer that it is your 10:46
21 position - and, Mrs. Gallagher, you can answer this as
22 well - that you could have been informed of these
23 issues earlier and you should have been?
24 A. MR. CAVANAGH: Whether we should have been, I think we
25 were informed at the point when the Trust felt that an 10:46
26 Early Alert should be raised.
27 34 Q. And that was 2020?
28 A. MR. CAVANAGH: And that was 2020. Up until then -- and
29 I have, as I have said before, looked at transcripts,

1 and so on, and I've read some of the things that
2 various Trust colleagues were dealing with through that
3 kind of ten-year period up to 2020. But, I mean, given
4 that there was issues in terms of kind of reduction in
5 the Consultants' sort of, you know, clinical time, and 10:47
6 so on, during that period, I would have thought there
7 would have been opportunities to mention that there was
8 a Clinician who was on restricted duties, for example.
9 I don't think that was ever raised, so --
10 35 Q. Do you think it should have been? 10:47
11 A. MR. CAVANAGH: Well, given that that was an impact on
12 the Trust's capacity, I would have thought that it
13 should have been, that particular issue. The issue of
14 why that was, was not really our concern, but there was
15 no doubt that there was an issue that a Clinician's 10:47
16 capacity had been reduced for a period due to sort of
17 HR issues, or whatever that might have been within the
18 Trust, but we didn't require to understand exactly what
19 was happening with that Clinician, but we did need to
20 understand that the service was continuing to be 10:48
21 delivered in the way that we had commissioned it, to
22 the extent that the Trust could deliver it with the
23 capacity they had available.
24 36 Q. And that means that patients are kept safe?
25 A. MR. CAVANAGH: And that means that patients are kept 10:48
26 safe. Safety happens at the point of care, so we have
27 got to ensure that, at the point of care, that the
28 services that are being delivered do actually deliver
29 safe services. We want to ensure that we are

1 commissioning quality services that lead to that safety
2 at a point of care, and that's why we do all that we
3 can to ensure that the services that we commission are
4 evidence-based, are based on best practice, based on
5 good clinical guidelines. 10:48
6 37 Q. Sorry, go ahead, Mrs. Gallagher.
7 A. MRS. GALLAGHER: Sorry, I am not sure if Paul had
8 finished, but I just wanted to answer your question,
9 Ms. McMahon. In terms of should we have been informed,
10 we should not or we would not have expected to be 10:48
11 informed in terms of the Clinician or the
12 Clinician's -- or any potential issues in terms of the
13 way he conducted his services. That's a matter for the
14 Trust. So there's systems in place around that,
15 including the annual appraisal, the role of the 10:49
16 Responsible Officer, which is primarily to ensure that
17 a Clinician provides safe services and then,
18 ultimately, the MHPS procedure. So we would not have
19 expected to have been cited on any of that, that is
20 absolutely internal to an organisation and, as the 10:49
21 employer, the Trust has responsibility in that regard.
22
23 In terms of the SAIs, we would expect to be apprised,
24 we were apprised in terms of the SAIs, and the learning
25 from this and also from both the Neurology and 10:49
26 Hyponatraemia Inquiries has allowed us to consider our
27 approach to information that we receive through SAIs
28 and complaints and Early Alerts and how we strengthen
29 our role, as SPPG, in terms of our response to that.

1 So I suppose, in answer to your question, it depends
2 what it is that you are asking would we expect to have
3 known, because, on any level, I would not expect to be
4 cited on a Clinician, on any issues in relation to a
5 Clinician. 10:50
6 38 Q. And a slight caveat to your answer may be that you're
7 working on the basis that any internal processes that
8 are undertaken by the Trust, are undertaken properly
9 and efficiently and effectively and, if that were not
10 to be the case, that's a matter for the Trust, you say? 10:50
11 A. MRS. GALLAGHER: That's a matter for a Trust, and, you
12 know, no pun intended, but you have to operate on a
13 basis of trust, but trust within a construct that sets
14 out clear roles, responsibilities, policies, guidance,
15 and you have to operate on the basis that the Board of 10:51
16 the Trust pays attention to that and responds to issues
17 as it arises. The role of RQIA gives the Department an
18 independent assessment, of course, and that is another
19 mechanism for us to understand whether there may be
20 challenges. And equally in terms of governance and how 10:51
21 a Trust and the Trust Board conduct themselves, you
22 know, there is an accountability process back into the
23 Department and, every six months, there is an assurance
24 statement to the Department which sets out compliance
25 with the agreed policies and guidance and procedures 10:51
26 and that provides assurance to the Department in that
27 regard.
28 39 Q. Do you have anything to add to that at this stage,
29 Mr. Cavanagh?

1 A. MR. CAVANAGH: No.
2 40 Q. I just wonder then, given what we now know and what you
3 now know from the Inquiry and from the evidence and
4 given that I think we've agreed that the patient safety
5 and reduction or elimination of risk is the foundation 10:52
6 of your commissioning intention, what's the tipping
7 point for SPPG, what's the tipping point for you to be
8 informed of concerns? When would you think it
9 unreasonable for the Trust to try and manage things
10 in-house, given your focus on patient safety? 10:52
11 A. MRS. GALLAGHER: I'm not sure there is a tipping point,
12 as such. I'm not sure, because of the complexity and
13 the range of services, that it could be as
14 straightforward as, here's the point at which. I think
15 very hugely important that, within the Clinical 10:53
16 Governance arrangements within a Trust and their
17 broader oversight, fundamentally it is the role of the
18 Board of the Trust to oversee and ensure safe services.
19 So, where issues arise and there are a number of
20 escalations obviously between the senior team, then the 10:53
21 Committees of the Board and then up to the Board, but
22 the Board would need to be satisfied themselves that
23 their organisation is providing safe services.
24
25 Where, through intelligence, either SAIs or through 10:53
26 audits or work, for example, on GIRFT, we become -- we,
27 in terms of SPPG, become aware of issues, we will
28 absolutely work with the PHA to engage with that Trust
29 to outline those concerns and they will have been

1 involved in that process, and to put in place
2 improvement plans in order to ensure that services are
3 safe.
4 41 Q. So it really does require each link in the chain to be
5 strong: the Trust Board, the Trust, the Senior 10:54
6 Management Team, people looking from the outside in,
7 everyone has to adhere to what's expected from them?
8 A. MRS. GALLAGHER: It's absolutely a federated model. I
9 mean, we all work, and that's while it's called a
10 Health and Social Care system, all of us play a part, 10:54
11 all of us have a responsibility, and, you know, the
12 golden thread through all of that is safe services.
13 You know, the systems in place for governance are akin
14 to any other organisation, in that you would look at
15 corporate governance, performance and finance. That 10:54
16 would be your three core areas for any organisation,
17 public sector/private sector, voluntary and community
18 sector. Within health, there is another element added,
19 and that's safety and quality. So our Governance
20 Framework asks for assurance on all four areas, and 10:55
21 organisations are held to account on those four areas
22 equally, with safety and quality taking equal standing
23 to performance, to governance and to finance.
24 42 Q. Now, you have mentioned the Hyponatraemia Inquiry and
25 the Neurology Inquiry, and obviously this Inquiry will 10:55
26 have recommendations of its own based on the evidence.
27 A. MRS. GALLAGHER: Indeed, indeed.
28 43 Q. I just wonder what the plan is around those
29 recommendations; as far as I understand, they are not

1 all implemented. Is there a plan or funding or
2 assistance plan for Trusts to bring those into the
3 reality of their governance processes? What's the
4 current position?
5 A. MRS. GALLAGHER: So I'm conscious I talk with two hats, 10:55
6 as Head of SPPG but also a part of the Senior Team in
7 the Department and a member of the Departmental
8 Management Board. The Department has set up an
9 Inquiries Implementation Programme Management Board,
10 and what it is doing is bringing together the 10:56
11 recommendations from the Hyponatraemia Inquiry and the
12 Neurology Inquiry. The Neurology Inquiry, as you know,
13 had 76 recommendations. A plan has currently been
14 developed and, importantly, there is a plan and an
15 Assurance Framework that has been developed and will be 10:56
16 published very, very soon. And the role of the
17 Inquiries Implementation Programme Management Board is
18 to oversee the implementation of those recommendations.
19 The reason why we have brought together the
20 recommendations from both previous Inquiries, and 10:56
21 I would offer that any recommendations from this
22 Inquiry would equally be seen in that context, is so
23 that we can look at the cross-learning between the
24 Inquiries and ensure that we put in place actions that
25 actually meet the desired intent, and that's why, for 10:57
26 the first time ever, as I understand, we have developed
27 an Assurance Framework co-produced with patients and
28 with patient representatives and carers, to ensure that
29 the actions are delivered and meet the required

1 outcome.
2
3 In terms of your question about money, money is a vexed
4 issue, as we know, and we're in a very challenging
5 financial position. Not all of the recommendations 10:57
6 need additional funding. Obviously, there will need to
7 be resource input to that, be that through civil
8 servants or Health and Social Care personnel and
9 expertise, but, in the main, many of the
10 recommendations point to review of current procedures 10:57
11 and processes that sit at the heart of Health and
12 Social Care. So, for example, review of the Early
13 Alert system, review of SAIs, there would be an open
14 framework that we're looking at, all of those are, in
15 some guise or another, already in place, and it is 10:58
16 about refreshing those and revising those with the
17 insight of those that use our services and also,
18 obviously, the recommendations from the Inquiries and,
19 indeed, RQIA as it relates to SAI. So money is a
20 factor, but not the only factor, and it shouldn't be a 10:58
21 restricting factor for us.
22 44 Q. And in that context, is it anticipated that the Trust
23 may receive funding specifically in relation to
24 recommendations that require it in order that they may
25 implement them, given that this will be the third 10:58
26 Health Public Inquiry making recommendations broadly
27 around governance?
28 A. MRS. GALLAGHER: I mean, our financial position is
29 challenging. Clearly, when a Trust -- and, as you

1 know, part of the responsibility of the Strategic
2 Planning & Performance Group is the resource
3 management, so understanding the allocations to each
4 Trust and how it uses that funding. There's roughly
5 around 10% overhead of any service delivered that goes 10:59
6 to the overheads around that, the supporting
7 mechanisms, if you like, which would include management
8 overheads, audit overheads and others. The systems and
9 structures are in place. What seems to have come out
10 of previous inquiries, and it is for this Inquiry 10:59
11 obviously to provide their recommendations in terms of
12 the evidence that it will hear, but it is the adherence
13 to some of the policies and processes that we have in
14 place and how we create a culture where people call out
15 early and loudly where they see action or behaviour 11:00
16 that they think will cause harm or has the potential to
17 cause harm. I guess I go back to the human factors in
18 that and the culture around that, because systems and
19 policies and processes, in itself, will not solve that.
20 45 Q. Now, the Inquiry has heard, and will hear more 11:00
21 evidence, I think, alleging that Urology Services was
22 not appropriately resourced, not appropriately funded,
23 in comparison to other services generally, but
24 specifically not to meet the demand capacity that was
25 in existence from the review in 2009, and we'll move on 11:00
26 to look at HSCB involvement in the review and other
27 issues. But just as a general point, what's your
28 understanding of the funding around Urology and whether
29 there's any merit in the suggestion that it wasn't

1 properly resourced or funded from the outset and the
2 problems just got worse?
3 A. MRS. GALLAGHER: So I think it's a matter of public
4 record that there is not enough money at the minute to
5 meet the demand. I mean, we are in a demand capacity 11:01
6 deficit. Waiting lists in Northern Ireland are longer
7 than anywhere else in either England, Scotland or
8 Wales, and that is something that, as a Senior Team in
9 the Department, we pay huge attention to. Over 50% of
10 the block grant is allocated to health, so around 11:01
11 7 billion a year is allocated to health. When
12 I developed the Delivering Together Strategy back in
13 2016, which was to be a ten-year long-term plan, what
14 it said at that time, and what the Executive agreed, is
15 that we needed enough money to run services and we 11:02
16 needed additional money to transform services over and
17 above what was needed to deliver services. We simply
18 have not had that investment and that funding. So it
19 is a matter of public record that no service is
20 currently achieving or receiving the funding that's 11:02
21 required to meet the deficit, and, in that regard, it
22 is really important that we balance -- that we provide
23 safe services, because the provision of throughput or
24 access does not come at a premium to safe services.
25 And as part of the approach in terms of how we deal 11:03
26 with waiting lists and how we manage priority, it is
27 based on clinical need.
28 46 Q. I suppose the question perhaps was badly worded, but it
29 is more from the inception of Urology Services, from

1 the point when there were different teams set up and
2 there was an understanding, at least then, of the
3 demand, or the demand has increased significantly,
4 obviously, and the -- perhaps the funding and the
5 ability to meet that has clearly reduced, but there is 11:03
6 a suggestion that things were not right from the start
7 and they could never possibly get right as they were
8 always playing catch-up; is there any merit in that?
9 A. MR. CAVANAGH: If I might. I mean, the Inquiry knows
10 that our demographics in Northern Ireland are changing 11:03
11 rapidly from a very young society, we're an ageing
12 society now; therefore, our demand on Health and Social
13 Care services is increasing, I suppose, in line with
14 that shift from a younger society to an older society.
15 In all of our Acute Services, indeed in all of our 11:04
16 Social Care Services as well and our Primary Care
17 Services, we have considerable increases in demand, and
18 every part of our system is under pressure and looking
19 for more resources. Urology has been attended to,
20 I think, over the last 15 years, considerably, in 11:04
21 comparison to other acute specialties, who might also
22 say, 'well, I wish we had got what Urology investment
23 was put in'. Some 13 million has gone in over the last
24 10/15 years for Urology Services. So, on that basis,
25 we have recognised that Urology was an emerging 11:04
26 specialty in the 1990s, required a considerable amount
27 of attention from about 2007/2008 onwards, and has
28 received that attention, and I think it's been attended
29 to considerably with investment. Wouldn't it be great

1 to put yet more money on the table, but we are a
2 financially-constrained system, we are having to make
3 choices between this service and that service, but
4 I think Urology has done considerably well in a very
5 challenging environment. I think only one other acute 11:05
6 specialty has received more funding in the last
7 15 years than Urology, and I think that gives you a
8 sense that it is very much one where a fair amount of
9 work has gone into it. But as with all of these
10 things, even when you put money on the ground, when we 11:05
11 have the investment to make, the challenge then is
12 actually to use that money and to use that investment
13 effectively to recruit the staff and to actually
14 develop the services. We also have a considerable
15 workforce crisis not only in Northern Ireland, the UK 11:05
16 and Europe, but worldwide - a workforce crisis where we
17 can't actually recruit the Consultants that we require.
18 I mean, we have invested, in the Southern Trust, in six
19 Consultants, and it's been a challenge to have six
20 Consultants in work throughout that period. We also 11:06
21 have funding available for a seventh Consultant, should
22 the Trust be table to recruit, but haven't, at this
23 point, been able to recruit. So I think a fair amount
24 of attention has been given to Urology. Yes, it would
25 be great to offer more funding, but the funding just 11:06
26 isn't there, but the choices we have made is where we
27 have prioritised Urology over other Acute Services, for
28 all the right reasons, given the demand and challenges
29 that they faced, but there is always going to be a

1 challenge as demand is rising so fast.
2 47 Q. And given what you now know about the issues that arose
3 in Urology within the Southern Trust, was -- on
4 reflection, was there ever a point at which HSCB was
5 approached on the basis that funding was needed to 11:06
6 mitigate against anything that has subsequently
7 emerged?
8 A. MR. CAVANAGH: Not specifically in that way. There was
9 more funding required because demand was rising and the
10 service needed to grow, but nothing specifically in 11:06
11 relation to that.
12 A. MRS. GALLAGHER: Ms. McMahon, just in terms of Paul's
13 comments there where he said that Urology probably was,
14 I can't remember the words he said, but 'I wouldn't
15 want that' -- 'I wouldn't want the investment in 11:07
16 Urology and our priorities in that to assume that
17 Urology took first order amongst other specialties'.
18 The investment in Health and Social Care is very finely
19 balanced and considered across all specialties and,
20 indeed, in relation to primary care, community care and 11:07
21 hospital care, and it is a very challenging financial
22 position. So all areas need to be given due attention
23 and there is a very considerable thought process and
24 consideration given to the allocation of funding,
25 because whatever you give to one area means that you 11:07
26 cannot give to another, so that balance is really
27 important, and I am sure Paul's reflection --
28 A. MR. CAVANAGH: That's right, that's right.
29 A. MRS. GALLAGHER: -- didn't mean that, but it's very

1 important that that comes across.
2 48 Q. And I think that we are very conscious of the fact that
3 we're concentrating on Urology and there is an entire
4 Trust and, indeed, an entire health system across
5 Northern Ireland that has to go into the complicated 11:08
6 algorithm of funding, but obviously our lens is
7 slightly skewed in that respect, and any context you
8 can give to help us understand that is always welcome,
9 so thank you for that.
10 11:08
11 Just as a narrow point at this stage, you mentioned the
12 Donaldson Report, I think, and there have been a few
13 other - Bengoa - other reports, and we're jumping about
14 a bit, but just while it triggers in my mind to ask you
15 the question. There has obviously been lots of 11:08
16 suggestions around reform of healthcare and possible
17 models that might improve, given the constant reduction
18 in funding, or at least the funding not being as
19 certain as you would perhaps like it; what's the
20 position around that now? Given that they may be seen 11:09
21 to be slightly out of date, but now we have a new
22 Minister in place, there's an opportunity, I suppose,
23 for senior members of the Department like yourself to
24 have a more global look at this, what's the thinking in
25 the room around the Health Service? 11:09
26 A. MRS. GALLAGHER: In relation to Delivering Together,
27 which was, as I say, the Strategy developed in 2016,
28 the burning platform remains exactly the same, and the
29 Strategy that set out at that time, in terms of

1 reconfiguration and transformation, those things are as
2 valid now as they were then. The problem is that
3 things have got considerably worse in the meantime.
4 Since that point, I mean, there's common parlance or a
5 common view that nothing has happened, that these 11:10
6 things, these documents have sat on the shelf, and that
7 couldn't be further from the truth. With a Minister,
8 and under the Minister's imprimatur when there has been
9 no Minister in place, as the Department and as a Health
10 and Social Care System, we have continued to take 11:10
11 forward improvements and service developments across a
12 range of areas. Our Cancer Strategy, we have an
13 oversight group and we're bringing forward many of the
14 actions there. Some clear examples in terms of
15 elective, so we have centralised sites that deal with 11:10
16 day cases for elective surgery and overnight elective
17 surgery, in order to provide centres of excellence that
18 will increase our throughput. Multidisciplinary teams
19 in primary care have been set up to allow social
20 workers and physiotherapists and others to address 11:11
21 patients' needs within the community at local level,
22 and there are a plethora of other initiatives that we
23 have brought forward.
24
25 I guess the challenge remains. We have operated in the 11:11
26 space of the art of the possible, but there is a
27 frustration for all of us within Health and Social
28 Care, and beyond, that, without the sustained
29 investment to transform services in the long term, that

1 you can put part of a new system in place, but, without
2 all of it, you don't yield the benefits. So the steps
3 that we have brought forward, the interventions that we
4 have brought forward, are positive, but are not
5 delivering the expected gains that whole system 11:11
6 approach would provide.
7 49 Q. We'll probably come back to some of those particular
8 issues towards the end of the evidence, but I asked all
9 of that scene-building in order that we can look at,
10 then, what happened within Urology, look at some of the 11:12
11 detail of that and, as far as you can, explain to the
12 Inquiry or provide reassurance around whether that
13 could happen again or what's now in place that
14 mitigates against the possibility of information being
15 missed or not being asked for. 11:12
16
17 So, just given I'm going to move on to that, I wonder,
18 Chair, if it would be appropriate to have a break at
19 this point?
20 CHAIR: We'll take a short break now and come back at 11:12
21 half past eleven.
22
23 THE HEARING RESUMED AFTER THE SHORT BREAK AS FOLLOWS:
24
25 CHAIR: Thank you, everyone. Ms. McMahon. 11:34
26 50 Q. MS. MCMAHON: Just before we move on to look at some of
27 the detail of the engagement with the Trusts, I just
28 want to clarify something. You will know we're dealing
29 with a transcript, a live transcript, and I'd asked you

1 a question around could you and should you have known,
2 and, Mr. Cavanagh, you'd said about you might expect to
3 know if a Consultant was on restricted duties. Now,
4 it's been changed; it was "unrestricted", "un", as
5 opposed to "on", and that's been changed. But just to 11:35
6 clarify that factually.
7 A. MR. CAVANAGH: His duties were restricted, is my
8 understanding from the various transcripts that I have
9 read.
10 51 Q. Well, in actual fact, he was either in work or not in 11:35
11 work --
12 A. MR. CAVANAGH: Yeah.
13 52 Q. -- rather than restricted while he was in work. But
14 I just want to put that on the transcript and make that
15 point clear, but we're both clear now about what you 11:35
16 said and my understanding of it, so I just wanted to
17 correct that.
18 A. MR. CAVANAGH: Okay.
19 53 Q. If we look now, if we go back to your statement and
20 look at WIT-104269, paragraph 88. I am just bringing 11:36
21 you to this because I want to ask you about the
22 monitoring arrangements that are mentioned in this, so
23 I just want to put that in context. And you say in
24 your statement, Mr. Cavanagh:
25 11:36
26 "I have extracted the HSCB Commissioning and
27 Performance Management processes from the 2011
28 Framework Document which were used to ensure quality
29 and safety in secondary care services below. At

1 section 4, it states: 'The HSCB and PHA must maintain
2 appropriate monitoring arrangements in respect of
3 provider performance in relation to agreed objectives,
4 targets, quality and contract volumes'."
5 11:36
6 Now, we'll look in a moment on the issue of targets and
7 performance and other matters that witnesses have
8 commented on. But just in relation to the HSCB having
9 appropriate monitoring arrangements, could you just run
10 us through what those are or what they were at this 11:37
11 time?
12 A. MR. CAVANAGH: Sure. I mean, there was probably a
13 number of levels that monitoring would have happened at
14 this time in, sort of, the 2011 period through,
15 perhaps, to mid that decade. There would have been 11:37
16 performance meetings with each Trust on a regular
17 basis. I mean, I can't recall whether it was sort of
18 monthly or bi-monthly, but certainly, on a regular
19 basis, each individual Trust would have met with the
20 Health and Social Care Board and with PHA in meetings 11:37
21 at Director level to discuss their, I suppose, their
22 progress against the various objectives and the various
23 targets that have been set and also whether that was an
24 opportunity for Trusts to also explain where there was
25 any deficiency in delivery, as to why that was, and 11:37
26 that could be for a whole range of reasons.
27 54 Q. And given the reconfiguration in the process that SPPG
28 now sits, is there any change in monitoring
29 arrangements currently or is it effectively the same

1 process of engagement?
2 A. MR. CAVANAGH: Probably -- I mean, in many ways, much
3 the same process. I suppose our Directorates have
4 changed to some extent. Sharon has already mentioned
5 about the strategic performance piece now being much 11:38
6 more directly into the Department, even before SPPG
7 came into being. But there is ongoing meetings at
8 Director level with the Trust on issues of performance,
9 at which PHA would also be in attendance.
10 A. MRS. GALLAGHER: If I could add to that, Ms. McMahon? 11:38
11 55 Q. Yes, please.
12 A. MRS. GALLAGHER: So the new structures in terms of SPPG
13 has -- the Director of Performance also has safety
14 within her area of responsibility, so that there is a
15 triangulation of not just meeting agreed access 11:38
16 targets, but also in terms of safety and quality. In
17 terms of the frequency of meetings, at Director level
18 that would be less frequent, as you would imagine.
19 Below that, in terms of Service Leads, so the people
20 that manage the detail of the commissioning, that 11:39
21 happens day and daily, and actually, the Performance
22 and Transformation Executive Board, which is chaired by
23 the Permanent Secretary and which I sit on, colleagues
24 from the Department and all of the Trust's Chief
25 Executives, including the Public Health Agency, has a 11:39
26 report every month which has an analysis of our
27 performance and, also -- it has the position on the
28 performance and the analysis around the performance, so
29 the expectations and how we're delivering. So there's

1 a whole machinery in terms of not just the day-to-day
2 routine engagement, which will include looking at
3 service improvements and supporting improvement plans,
4 but also that escalation and line of sight right
5 through to the senior cohort across Health and Social 11:40
6 Care.
7 56 Q. And is that a new arrangement for communicating?
8 A. MRS. GALLAGHER: That is a new arrangement. PTEB was
9 set up, so, in 2020, during Covid, the Minister at the
10 time, there was an addendum to the Framework which 11:40
11 moved us into more command-and-control situation to
12 manage Covid. The Rebuild Management Board was set up
13 at that stage for two years. After that, we had the
14 Performance and Transformation Executive Board, which
15 was set up, and that looks at how we recover from Covid 11:40
16 and how we manage our performance right across Health
17 and Social Care.
18 57 Q. And what's the benefit of that new structure? What
19 does that replace that wasn't there before? What's
20 more enhanced now? 11:40
21 A. MRS. GALLAGHER: So I guess the most significant
22 change, or evolution, actually, because this started
23 some years ago, and I talked about ICS NI and our new
24 commissioning approach, it's long been recognised that
25 we need to operate in a collaborative way; that, with 11:41
26 restricted resources, scarce resources, we need to work
27 together in order to optimise the resource that we have
28 in a relatively small geographical area and with a
29 relatively small population size, and that sits at the

1 heart of the ICS Framework and our approach moving
2 forward. In that context, then, the leadership, in
3 terms of not just the Department and SPPG and PHA, but
4 the Trust Chief Executives regularly engage in relation
5 to the strategic issues and challenges that we face, 11:41
6 because we see this as shared problems that will need
7 shared and collaborative solutions, so that's the key
8 evolution. And PTEB not only looks at performance, but
9 it also looks at transformation. So the points that
10 you made earlier about, has anything changed and is 11:42
11 anybody looking at waiting lists and whatever, we have
12 a line of sight into the activity and a strategic
13 oversight of the broad activities that we're trying to
14 advance in a very constrained financial environment.
15 A. MR. CAVANAGH: And worth also adding in that we will 11:42
16 have regular bi-monthly cancer performance meetings, so
17 it's specifically focused on the non-issues in relation
18 to cancer across all of the various tumour sites and
19 also the modalities. And we also then, since 2015,
20 have had a Urology Planning Implementation Group, where 11:42
21 we actually talk about the specific issues around
22 Urology, some of those improvement opportunities and,
23 also, some of the performance challenges.
24 58 Q. I'll probably take a slight advantage of having you
25 here with two hats on, just to ask you the questions 11:42
26 around commissioning. You've mentioned the integrated
27 care system - sorry, I just had a blank for a moment -
28 and I think you said about a collaborative and a
29 more -- effectively, a more global look at needs and

1 service provision. Does that, in effect - I mean,
2 moving away from the old commissioning model - does
3 that, in effect, mean that you have greater
4 flexibility -- or your team and the team you work with
5 have greater flexibility about identifying where 11:43
6 services may more properly be focused so that waiting
7 lists effectively can be dealt with by providing
8 service efficiently where needed, rather than trying to
9 provide them across the entire region?
10 A. MRS. GALLAGHER: There is probably, I would suggest, 11:43
11 two separate issues there, Ms. McMahon. The first one
12 in terms of optimisation or maximising the resources
13 that we have, and that's something that we do day and
14 daily, in terms of, I referenced earlier the clinical
15 networks, but also my team, and, in particular, looking 11:44
16 at things like theatre utilisation, for example, DNAs,
17 and in terms of optimising the services that we're
18 delivering at the minute and ensuring that we look at
19 our pathways to make sure that we optimise the access,
20 given the very scarce resource. One example, for 11:44
21 example, for new outpatients - we have around 347,000
22 people waiting for their first outpatient assessment -
23 over the last year-and-a-half we've reduced the
24 percentage of DNAs by 1%, which doesn't sound a lot but
25 it actually translates to 18,000 access, additional 11:44
26 access for patients. So there's that focus in terms of
27 safety, but, also, I mean, we have what many would
28 regard as a very significant budget, but it's not
29 enough, and part of my responsibility is making sure

1 that we do the best we possibly can with the money that
2 we have available.
3
4 So, I guess from that point of view, a real focus in
5 terms of performance management and ensuring we do more 11:45
6 for less, and if you forgive me, I've forgotten your
7 question and I am going to have to ask you to repeat.
8 59 Q. It's okay, everybody does that, and I've forgotten it
9 as well, so I should listen to myself.
10 CHAIR: Flexibility. 11:45
11 MS. McMAHON: Flexibility. Thank you, Chair.
12 A. MRS. GALLAGHER: Thank you very much, Chair. I am
13 going to use my pen and write down next time.
14 60 Q. Me, too.
15 A. MRS. GALLAGHER: So the other piece in terms of 11:45
16 flexibility, I suppose it is worth saying that 97% of
17 the health budget is recurrent, in that it goes to
18 baseline position, because most of our health budget is
19 to -- is on staff, is on staffing. So there's limited
20 flexibility in terms of new services, for example, or 11:46
21 new initiatives. And our focus is, again, on looking
22 at the resource that we have across specialties or
23 across any area, not just in Acute Services, but in
24 Primary and Community as well, to understand where best
25 we can make those investments in order to get the best 11:46
26 outcomes for the money available. So I think this
27 moves to the role of PHA and ourselves working together
28 in relation to ensuring safe services, ensuring quality
29 services, but also the counterbalance in terms of

1 making sure that we are as effective as we can with the
2 scant resource that we have.
3 61 Q. I have had to ask other witnesses the impact of having
4 no Minister in place and you're the first one I have
5 been able to say, now that we have a Minister in place, 11:46
6 is it anticipated that that will accelerate the
7 potential for the advances that you say would best
8 deliver healthcare in Northern Ireland or perhaps
9 provide more funding, or is the funding pot already
10 established around that? 11:47
11 A. MRS. GALLAGHER: So, I mean, we know that it is a very
12 challenging financial position across the public
13 sector. It is, of course, welcomed that we have a
14 Health Minister and indeed an Executive in place,
15 because there are very difficult decisions that will 11:47
16 need to be made. Ultimately, there is a lead-in time
17 for any significant change, and I talked earlier about
18 Delivering Together some nearly ten years ago and the
19 need to maintain current services, because you cannot
20 put a new service in place and leave a gap in service 11:47
21 provision, so you need to keep a service running in
22 order to bring forward a new service, and that needs
23 additional money. We're not in that space at the
24 minute. And what I guess is important to us is how we
25 make best use of that resource. One of the things that 11:48
26 we have introduced, and Minister Swann, of course, was
27 our previous Minister, but Minister Swann put in place
28 arrangements to allow the Regional Prioritisation
29 Oversight Group, which brings together senior

1 Clinicians to make decisions about the prioritisation
2 of resources across the region, so that we don't have a
3 postcode lottery in terms of each of the Trusts and
4 their waiting lists and that we look at it from a
5 regional perspective in terms of either moving patients 11:48
6 or moving Clinicians to provide services and manage
7 waiting lists at a regional level, and that's the
8 emphasis and I suppose one of the key changes played
9 out in the way commissioning was and the way it is now,
10 because if you think that we were -- if you can 11:49
11 imagine, under the previous arrangements, we would have
12 held a Trust Chief Executive to account specifically
13 for the service that they provide locally, and whilst,
14 of course, that is still important to understand
15 activity and performance at a local level, we now look 11:49
16 at that much more through a lens of how we can operate
17 as a regional system in order to make sure that a
18 cohort of patients right across the province are seen
19 on a basis of equality -- or equity, I should say.
20 62 Q. And when you look back now at the previous arrangement, 11:49
21 and you have mentioned about the Chief Executives, you
22 have mentioned about Directors around the table and the
23 importance of collaboration and communication, when you
24 look back, and the Inquiry's evidence has been that
25 there was a significant turnover in Chief Executive in 11:49
26 the Southern Trust over a relatively short period of
27 time, and also some staff movements, some perhaps key
28 staff movement at times that may have, arguably, let
29 intelligence around issues fall through the gaps at

1 points, do you have a view as to the importance of
2 stability around leadership in a Trust and, also,
3 specifically in relation to the Southern Trust, do you
4 now, in hindsight, looking at that, feel that that
5 contributed in some way to the issues, before the 11:50
6 Public Inquiry, not coming to the surface sooner?
7 A. MRS. GALLAGHER: I don't think I can speak with
8 authority about how it impacted in relation to the
9 Southern Trust. I think, as a general rule of thumb,
10 all of us would prefer stability in leadership 11:50
11 positions, particularly in very complex areas, but,
12 having said that, you know, I said at the start I'm
13 over 35 years in the public sector, I have very rarely
14 enjoyed a position where we have been in a stable
15 environment, and I suppose in that scenario it is key 11:51
16 that people understand the roles and responsibilities
17 that are attendant to their job at any point in time,
18 but I can't comment in particular in relation to the
19 Southern Trust.
20 63 Q. Mr. Cavanagh, you had more experience dealing with 11:51
21 Trust staff. Did, at any stage, you feel that perhaps
22 the absence of continual leadership at the helm or
23 movement of some Directors impacted on your
24 relationship with the Trust or your ability to engage
25 with them on issues of concern? 11:51
26 A. MR. CAVANAGH: I suppose I was engaging with the people
27 that were there at the point in that way. I mean,
28 certainly the Trust had challenges at Chief Executive
29 and Director level. At Assistant Director level,

1 Service Manager level and so on, there actually was a
2 fair amount of consistency and constancy in relation to
3 that, so there were people who had actually an ongoing
4 sort of relationship with Urology Services and with
5 governance issues and so on, so, in that way, there 11:52
6 were people who I was able to actually engage with
7 through the process who were actually there seven,
8 eight years before and did actually have, I suppose, an
9 ongoing sort of knowledge of the issues.
10 11:52
11 That said, I think the Directors who came into place
12 did seem to get a grasp on what was happening, did come
13 up to speed. And I suppose the thing that I would
14 constantly emphasise is, at the point that we were
15 looking at this issue with the Early Alert in July 11:52
16 2020, we were in the midst of a pandemic, and it was a
17 very challenging pandemic, and Southern Trust and every
18 Trust in Northern Ireland were considerably challenged
19 to continue to provide services. So trying to look at
20 that as well. I think I saw it from my perspective, 11:52
21 and I was a new Director at that stage as well, but had
22 a fair amount of experience, too. I think it was also
23 that we were trying to support each other through a
24 pandemic, whilst also recognising that other issues
25 were happening within the Health Service, such as the 11:53
26 Urology issue, which we were also trying to manage in
27 tandem. So it was a time both where we were keen to
28 ensure our roles, but we also knew that we had to work
29 together and ensure that we actually got through what

1 was going to be, I suspect, the most challenging time
2 of any of our careers.
3 64 Q. Well, we will look at the SAI process and the awareness
4 of HSCB around that in a moment, which predates Covid,
5 and obviously, with the benefit of hindsight, which we 11:53
6 have now, things may seem more clear, but I'll give you
7 the opportunity to comment on that.
8
9 There has been general comments from some staff, and
10 perhaps criticism as well, that there was too much of a 11:53
11 focus on performance and outcomes on the data, rather
12 than the detail behind it, perhaps, and that there was
13 possibly a failure to look at the quality as opposed to
14 the quantity of service provision -- the quantity as
15 opposed to the quality. I think I said that the wrong 11:54
16 way round. But I just want to look at what some
17 witnesses say in relation to that.
18
19 Just, first of all, as a description in the way in
20 which information was provided back, if we go to the 11:54
21 Section 21 of Paula Clarke, at WIT-37594, at
22 paragraph 53.2, and she says:
23
24 "I recall that compliance with time limits for Urology
25 Services against the protocol was monitored through 11:55
26 performance reporting within an overall Performance
27 Management Framework."
28
29 Then, she says:

1
2 "As advised in my response to question 51, performance
3 on the access targets was reported at every public
4 Board meeting and compliance with elective access
5 targets was also the subject of regular performance 11:55
6 meetings with HSCB and DHSSPS, as performance across
7 all Trusts was reported regionally in their Board
8 meetings. I recall that compliance with the IEAP was
9 an ongoing issue for assurance from Operational
10 Directors into performance reporting, that I became 11:55
11 responsible for as Director in September 2009. An
12 example of this can be referenced in the monthly
13 performance report for October 2015, presented to the
14 Board on 26th November 2015."
15 11:55
16 Then, if we move down, she just mentions about other
17 avenues of providing information.
18
19 Now, clearly there is a defined mechanism by which
20 performance targets are fed to the Board, HSCB, and, 11:56
21 under the auspices of commissioning, you properly have
22 regard to those figures, but as a general proposition
23 that there was too much focus on targets, what would
24 both of you say about that?
25 A. MRS. GALLAGHER: I would say that there's an emphasis 11:56
26 on performance management, and that's performance
27 management not just in terms of targets but also in
28 terms of safety and quality. As I said earlier, it is
29 absolutely imperative that we provide safe services.

1 The performance targets that are set within Health and
2 Social Care, if you look at the cancer access targets,
3 they are targets that we monitor and performance-manage
4 constantly because those targets dictate and allow
5 access arrangements for those with cancer. So it's 11:57
6 important that we monitor targets across all areas
7 because access is as important for safety or for
8 reducing further harm and minimising the potential for
9 further harm. So the very strong view put across on
10 occasion is that we were only interested in performance 11:57
11 management from a, if you like, a throughput type of
12 way, as if we were in the business of, say, a factory
13 or something, and I would absolutely refute that. That
14 couldn't be further from the truth.
15 11:58
16 The sad reality is that since I have been involved in
17 health, some 11 years, we haven't met the ministerial
18 targets, and we have worked with providers to ensure
19 that we can do the best with what we have, given the
20 demand position. In 2017, we brought a new Performance 11:58
21 Management Framework, which, in the first place, put
22 the onus on performance management within the Trust,
23 which is where it should be as part of the Framework,
24 but, also, it set out a new arrangement for performance
25 improvement trajectories which were agreed with the 11:58
26 Trusts and that acknowledged the fact that the previous
27 targets could not be met because of the demand and that
28 we were acknowledging that and working with the Trusts
29 on what was reasonable in relation to what they could

1 deliver, so stretching targets but deliverable targets.
2
3 Equally, in terms of Covid and our recovery from Covid,
4 the targets set there have been agreed with Trusts and
5 they have been under the purview of, firstly, the 11:59
6 Rebuild Management Board, as I've described earlier,
7 and then the Performance and Transformation Executive
8 Board, but the targets that we monitor are agreed with
9 the providers on the basis of what is safe and what is
10 possible. 11:59
11
12 So I would absolutely refute the fact that we have a
13 singular focus on one aspect of a very complex,
14 multifaceted area of work, because, fundamentally,
15 what's important to us, all of us within Health and 11:59
16 Social Care, is safe service, but making sure we do as
17 much as we can with the resource that we have
18 available.
19 A. MR. CAVANAGH: And building on that, and I agree fully
20 with Sharon's point; I mean, the IEAP, the Elective 12:00
21 Access Protocol, is about fairness in the way that we
22 manage our waiting lists, so it's about, firstly, being
23 clear about the clinical priority of a referral, as to
24 whether that patient is red flag suspect cancer,
25 whether they have an urgent need that is non-cancer, or 12:00
26 whether they are a routine patient and where their,
27 I suppose, their daily living is being impacted upon,
28 they tend to be within the routine category. We manage
29 then, firstly, on that clinical prioritisation, and

1 secondly, then, chronologically, so the date that the
2 GP sends in the referral becomes the date that you're
3 on the waiting list across those categories. So that's
4 about fairness, and I think that's the reason that we
5 introduced it, because, in the past, it hasn't worked 12:00
6 in that way, and I think it was important there was a
7 consistent approach across the region in relation to
8 that, too.
9
10 We talk about our Service and Budget Agreements as 12:00
11 well, and the Service and Budget Agreements are the
12 things that we signed with Trusts, which very clearly
13 said this is our expectation of delivery. As Sharon
14 has already pointed out, they didn't always deliver
15 against that; indeed, one of the targets in '19-'20 was 12:01
16 that they would begin to increase their delivery
17 towards their commission volumes, but part of that SPA
18 also look at the number of patients who would be
19 reviewed. So review patients are not a target, but it
20 is important that we ensure that people on their 12:01
21 pathway are actually seen in a timely way as well, so
22 our clinic templates tend to be new outpatients and
23 review outpatients as well. We also build in some
24 outpatients with procedures so that if a patient comes
25 in who can actually be dealt with on that day with a 12:01
26 bit of additional time, that allows a Clinician to do
27 that as well.
28
29 So, again, it's multifaceted, but it is not as simple

1 as to say we are purely focusing on the targets. The
2 targets are important, because, from the public's point
3 of view, they want to ensure that they get timely
4 access as best as we can in the constrained system that
5 we have, but also, importantly, to ensure that we 12:02
6 actually are looking at the way that the service is
7 being provided, the challenges faced by the Trust to
8 provide those services, that's what those performance
9 meetings or those cancer performance meetings, those
10 meetings of Clinicians and Clinical Reference Groups 12:02
11 within our Cancer Network, that's what those
12 discussions are about; they're about quality and about
13 the challenges, and increasingly, then, through some of
14 the newer structures that we have, it's also about
15 trying to manage at a regional level to ensure that 12:02
16 there isn't a postcode lottery in the way that we
17 provide services as well.
18 65 Q. And are Clinicians involved in setting targets?
19 A. MR. CAVANAGH: They are, they are, absolutely.
20 66 Q. Are they asked about the reality of the targets? 12:02
21 A. MR. CAVANAGH: Targets come from clinical advice. You
22 know, this is the -- they are based on clinical advice
23 from Royal Colleges, from various sort of bodies who
24 are Clinicians on the ground. So it's not that we just
25 create those targets; these targets are based on 12:02
26 clinical advice. There is a reason why we want to
27 see -- why a patient who has suspect breast cancer, why
28 we feel that they should be seen within 14 days,
29 because, clinically, that is the optimal access that

1 that individual needs, and, when we miss those dates,
2 that means that the optimal access has been lost and,
3 therefore, the opportunity to provide the best care is
4 also diminished in relation to that. Targets are
5 important because they are clinically based. 12:03
6 67 Q. So if it was the case that Clinicians were informing
7 the Trust or, via the Trust, the Board, that the
8 targets weren't possible because of capacity, are you
9 saying that the targets are effectively immovable
10 because they are dictated by clinical expectations 12:03
11 around care?
12 A. MRS. GALLAGHER: I think that's the problem we find
13 ourselves in at the minute. We have a demand capacity
14 gap and it's a huge worry for all of us in terms of
15 ensuring that those that need to access services, do so 12:03
16 in a timely way.
17 68 Q. Are you trying to maximise the treatment for people but
18 you are confined by the clinical outcomes, given how
19 they present, so you can't keep changing the turnaround
20 or the timeframes? 12:04
21 A. MR. CAVANAGH: Yeah, and I mentioned the three levels
22 of clinical prioritisation. So a routine patient may
23 be appropriately a routine patient today, but if they
24 can't be seen for a year, they will be going back to
25 their GP, they may end up in an emergency department 12:04
26 and it may actually be that they will be raised to an
27 urgent patient or maybe even a red-flag patient. So
28 the reality of waiting long also means that the
29 person's condition may deteriorate and then they may

1 need to be reprioritised, but there is a clear process
2 in relation to that and that's why we need to also sort
3 of meet our demand, but, as Sharon says, that is the
4 challenge, that is the pressures that, day and daily,
5 the Health Service is facing in Northern Ireland. 12:04
6 69 Q. And there is evidence that elective care is not
7 happening, that there is -- there are people who are on
8 the waiting list who are not deemed to be urgent or red
9 flag?
10 A. MR. CAVANAGH: Our capacity is such -- 12:04
11 70 Q. That you're not getting to those people?
12 A. MR. CAVANAGH: We are certainly not getting to those
13 people in a timely way and, increasingly, as our demand
14 increases, it is becoming more challenging to reach
15 them at all. 12:05
16 A. MRS. GALLAGHER: I think elective care, absolutely, is
17 happening, and we're back to pre-Covid levels in most
18 areas and there is an absolute focus. I have a full
19 team dedicated to supporting the Trusts in terms of
20 elective care activity and how we optimise services 12:05
21 there. I talked earlier about the regional approach to
22 prioritisation because we do have a challenge in terms
23 of, sometimes we have money but we can't recruit, and
24 there are many areas where we have challenges in terms
25 of our ability to recruit doctors, nurses and those 12:05
26 that work within that specialty and we have to do the
27 best with what we have, but elective activity is
28 happening but we have to prioritise based on clinical
29 need.

1 71 Q. Just so I'm clear because I asked the question, is that
2 across all Trusts that elective care is effectively
3 being carried out?
4 A. MRS. GALLAGHER: Absolutely.
5 A. MR. CAVANAGH: Yes. 12:06
6 A. MRS. GALLAGHER: Absolutely.
7 72 Q. And there's no restriction on that at the moment?
8 A. MRS. GALLAGHER: The only restriction is in relation to
9 resource, the financial and the human resource, in
10 order to do that, which is why we're working as a 12:06
11 collaborative under the purview of the Performance and
12 Transformation Executive Board, to make sure that, as a
13 system, we understand the broader position on waiting
14 lists right across the piece and that they are being
15 managed to best effect. 12:06
16 73 Q. And when you mention about the new Integrated Care
17 System, and we talk about waiting-list times, targets,
18 that in the Trust, and perhaps other Trusts, were not
19 met, even though it was anticipated that they probably
20 couldn't be met, given the targets that existed the 12:06
21 year before some of the plans. So, for example, in
22 2018, there was -- Urology was clearly under pressure
23 with its figures being very high, but the plan in
24 2019/2020 didn't seem to reflect that, the figures were
25 expected to meet the designated targets. It seems a 12:07
26 bit of an end-sum game to expect targets to be met,
27 when you know in advance that they are not going to be
28 met. How do you get out of that cycle?
29 A. MRS. GALLAGHER: I think that's one of the things that

1 we recognised, and we talked about the Service Budget
2 Agreements; the reality is, they were very rarely
3 agreed and signed off, and the length of time it took
4 to work through that commissioning system of, you know,
5 the Commissioning Plan direction, the Commissioning 12:07
6 Plan, the Trust Delivery Plans, it took nearly a full
7 year, and at that stage it was redundant, it was out of
8 date. So where we are at the minute is, in terms of
9 our approach moving forward, is understanding what
10 'good' looks like at a regional level. So much more in 12:07
11 the benchmarking rather than getting down to the
12 micromanagement of activity at Trust level. So you
13 talked earlier about more flexibility; we want to give
14 Trusts more flexibility in terms of how they use their
15 resource to better meet patient outcomes, because they 12:08
16 have the Clinicians and the team of people, the
17 logistics around them, the environment around them,
18 they will know best how to manage their areas. So it
19 is very much a move away to micromanagement and very,
20 I would say, a very low level -- or high level of 12:08
21 scrutiny down to target level and more about how we
22 manage the shared resource within Northern Ireland to
23 meet the demand that can't be met at the minute.
24 74 Q. And one of the characteristics of the shared resources
25 has been, and you can inform us if it is going to be 12:08
26 going forward, non-recurrent funding and the challenges
27 that presents and some of the complications. I just
28 want to ask you a couple of questions about that, but
29 I just want to let you know what some of the other

1 witnesses have said about that. If we go to WIT-35950,
2 and this is Aldrina Magwood, paragraph 34.2. And she
3 says, just at the end of the first sentence:
4
5 "I can confirm that, during my tenure in a range of 12:09
6 roles in the Trust, the scale of the deterioration in
7 Trust performance against ministerial targets coincided
8 with reductions in non-recurrent funding allocations
9 from the HSCB that enabled the Trust, at specialty
10 level, to purchase additional capacity to mitigate 12:09
11 risks. The Performance Team in the Trust, working with
12 the Assistant Director of Finance, had a role in
13 liaising with the HSCB and securing independent sector
14 capacity and/or additional in-house waiting list
15 capacity, with non-recurrent funding allocations made 12:10
16 available by the HSCB. For example, in 2009,
17 when I first joined the Trust from the Southern Health
18 and Social Care Board, the waiting time targets were
19 being achieved across all specialties in Northern
20 Ireland, but were fully reliant on non-recurrent 12:10
21 funding to do so. Between 2009 and 2014, the Trust
22 received its share of system level non-recurrent
23 elective care funding and there were further plans to
24 allocate this recurrently non-recurrent funding on a
25 recurrent basis, to put this on a more stable footing 12:10
26 in Trusts, including the ability to secure permanent
27 recruitment solutions, etc. These plans were developed
28 and led by Michael Bloomfield, the then-Director of
29 Performance and Service Improvement at the HSCB.

1 Regrettably, this was not progressed when new
2 Department of Health leadership arrangements were put
3 in place as part of the closing of the HSCB and, also,
4 from 2015 to 2019, the funding allocations for elective
5 care reduced and the unscheduled care demand increased. 12:11
6 Regrettably, when I left the Trust in 2022, the
7 Southern Trust's position from 2015 with respect to
8 elective care waiting times has moved from a relatively
9 better position (compared to other NI Trusts) to having
10 among the longest waiting times for outpatient, 12:11
11 inpatient day case and diagnostic services. At the
12 same time, the Trust continues to have significant
13 over-performance against service and budget agreement
14 activity in unscheduled care."
15 12:11
16 Now, the point that Ms. Magwood is making there is that
17 there was an anticipated recurrent/non-recurrent
18 funding model that it was hoped would try and deal with
19 some of the issues, given the waiting times and the
20 escalation in delays, and that didn't carry itself 12:11
21 across to the new arrangement. Could you give us a
22 background of that or what the thinking was, if that
23 had been identified as a possible solution at that
24 time, why it didn't find itself in the new regime?
25 A. MRS. GALLAGHER: I guess what I would say, 12:12
26 non-recurrent money is non-recurrent money, and, in the
27 main, the money secures staff, Health and Social Care
28 staff. If that money isn't recurrent, then any Trust
29 will leave itself in a position where they will have

1 to -- they will be in an overspend position at the end
2 of the year because they are using non-recurrent money.
3 So the point that Ms. Magwood makes, in terms of
4 non-recurrent money have an impact in terms of your
5 ability to plan ahead and to employ staff on a 12:13
6 sustainable basis, is absolutely correct.
7
8 The closure of the Board, to my mind, has had no impact
9 in terms of the recurrency of non-recurrent money
10 because you simply can't make non-recurrent money 12:13
11 recurrent and, in the main, the non-recurrent money has
12 been used for waiting-list initiatives, which have been
13 targeted and developed in conjunction with the
14 Department, the Board/SPPG and the Trusts, and that is
15 still the case to this day. So there has been a 12:13
16 ring-fenced amount of money for waiting-list
17 initiatives, which has reduced over the years, but the
18 key to that is using that money to best effect, and
19 that routinely means the use of the independent sector
20 once we have exhausted the in-house options available. 12:13
21
22 I suppose the other point that I would make, in reading
23 Mrs. Magwood's evidence, is that there is a difference
24 in performance levels and backlogs and longer backlogs,
25 because Trusts and individuals can be very, very 12:14
26 effective and performing at a very high level, but the
27 demand is such that waiting lists will continue to
28 grow. So even though a team could be hugely effective
29 and doing their utmost in relation to patient care on

1 any level, the demand capacity gap, that is
2 well-rehearsed, continues.
3 A. MR. CAVANAGH: Could I add maybe to dig down a little
4 further, Ms. McMahon. I mean, we work on annual
5 budgets, so, each year, there is one pot. It's not 12:14
6 that there is a non-recurrent kind of, sort of, annual
7 pot. There is just one pot of funding. The funding
8 that we cannot spend recurrently can then be made
9 available in that year non-recurrently, and often that
10 is for waiting-lists initiatives. Now, sometimes 12:15
11 in-house waiting-list initiatives, so Consultants in a
12 particular Trust will do extra clinics using that
13 additional non-recurrent money, or the independent
14 sector, so we can actually sort of send some out to the
15 services that are available at that time. So that kind 12:15
16 of annual pot is there. Our preference is, as much as
17 possible, to use that funding recurrently, for us to
18 put in place the services that we want to deliver year
19 on year for the future, rather then -- but,
20 unfortunately, either where a Trust can't recruit, for 12:15
21 example, that will lead to some slippage, which could
22 be used non-recurrently where a particular Trust
23 underspends, and the Southern Trust, for several years,
24 did underspend in this period as well, that some of
25 that also becomes slippage which, potentially, can be 12:16
26 used in that way.
27
28 So, on that basis, you know, non-recurrent funding is
29 useful, it certainly does help to get you through the

1 year in terms of trying to manage the waiting lists,
2 but as we increasingly have used that funding
3 recurrently for those services, bringing in workforce,
4 and so on, to actually deliver services on an ongoing
5 basis, it means there's less and less money 12:16
6 non-recurrently. Occasionally, a little extra money
7 might come from another Department, which offers some
8 help, but in the environment we now find ourselves,
9 there just is not that kind of slippage across the
10 whole of the public sector. So it is a challenging 12:16
11 environment, but I understand the point that
12 Mrs. Magwood is making, but, at the same time, it's
13 also a reflection, I think, of some of the challenges
14 of actually getting workforce on the ground and
15 delivering services on a consistent year-on-year basis. 12:16
16 75 Q. Now, you have mentioned an underspend during that
17 period of time.
18 A. MR. CAVANAGH: Sure.
19 76 Q. What way does that work for Trust? What's their
20 ability to move money around or to redirect it? 12:17
21 A. MR. CAVANAGH: Yes, at the start of the year, a Trust
22 will obviously bring forward its financial plan, which
23 would come to HSCB to consider, would be agreed, there
24 might be some debate, and so on, in relation to it, and
25 a Trust will then embark on that plan on the assumption 12:17
26 that they will spend the funding that they have
27 available in that year. Sometimes, their plan -- in
28 recent years, they are actually showing overspend, so
29 they may actually need to make savings throughout that

1 year, but in those earlier years the Southern Trust
2 would have actually been, I suppose, planning to use
3 all of their funding without overspending, but as the
4 year goes on, either because you can't recruit or
5 because a particular service hasn't been able to be put 12:17
6 in place, or for a whole range of reasons, you might
7 find that your plan to spend hasn't led to spending it
8 in the way that you had hoped to. And I think in
9 Southern Trust case for a number of years, they
10 actually found themselves in a position where they had 12:17
11 to actually, I suppose, give back some of the funds
12 that were available to them, for all those kind of
13 operational reasons.
14 77 Q. So just going back to Ms. Magwood's comments around the
15 funding and her understanding of what was to happen, 12:18
16 and subsequently didn't, in her view. Just as a
17 general issue, is there any change in the way in which
18 funding will be allocated? Is there any potential for
19 recurrent funding to become -- to deal with the waiting
20 lists to be activated, or is it just trying to work out 12:18
21 the pot and to see what's needed and direct it as the
22 Trust indicate they need it?
23 A. MRS. GALLAGHER: I suppose there is a couple of layers
24 on this. There is the annual budgets, which we have in
25 place at the minute, which can be restricting in terms 12:18
26 of, you can't plan for the longer period, so we have
27 annual budgets; in the main, that will be recurrent
28 funding. So, recurrent from the point of view, if
29 we -- we know, for example, next year, we should get in

1 and around the same amount of money as this year. The
2 non-recurrent allocations over previous years that came
3 through the Executive, through the Department of
4 Finance, have been ring-fenced for particular
5 initiatives, mostly relating to waiting-list 12:19
6 initiatives. Then, there is the underspends in terms
7 of the budget allocations through the normal budget
8 process, and that is where that money is recycled, if
9 you like, within the system, in order to meet demand,
10 where we can, in other places, but the non-recurrent 12:19
11 money that was allocated through the Executive, through
12 the Minister, is separate to our normal budget
13 arrangements.
14 78 Q. Thank you for that explanation. I'll just take you to
15 something that Shane Devlin, the former Chief Executive 12:20
16 of the Trust, said in his Section 21, WIT-00091, just
17 at the bottom. Just at the bottom box, can you see
18 that on the screen, just on the right, "The
19 commissioning process" the sentence begins? The
20 question was asked: 12:20
21
22 "What has been your experience of the efficacy, or
23 otherwise, of the bodies set out at (i) to (x)
24 above..."
25 12:20
26 Which are Arm's Length Bodies.
27
28 "... in assisting or promoting service provision, good
29 governance, clinical care or patient safety within the

1 Trust? What could be improved?"
2
3 And in relation to the Health and Social Care Board, he
4 says:
5 12:21
6 "The commissioning process, through the HSCB, has
7 struggled to deliver high quality services. This was
8 recognised in 2015 by the then-Minister for Health,
9 Simon Hamilton, when he announced that the HSCB should
10 be closed. Since then, in my opinion, the HSCB has 12:21
11 struggled to retain staff and has lost direction. To
12 that end, the precision that was envisaged for
13 commission has slowly died and the HSC has not had as
14 much clarity as it should have had. In my opinion,
15 this has been detrimental to service delivery." 12:21
16
17 Then, just to complete that, although we'll move on to
18 SAIs shortly, he also says:
19
20 "With regard to regional SAI management, the systems 12:21
21 and processes from within the HSCB have been slow and
22 often ineffective. It is my understanding that the
23 RQIA are soon to publish a new regional approach to SAI
24 management, to be implemented across the HSC."
25 12:22
26 Can we just go back up, please. So, the first part,
27 Mr. Devlin considered that:
28
29 "... the HSCB has struggled to retain staff and has

1 lost direction. To that end, the precision that was
2 envisaged for commission has slowly died and the HSC
3 has not had as much clarity as it should have had."
4
5 I just want to ask you to comment on those remarks from 12:22
6 Mr. Devlin.
7 A. MRS. GALLAGHER: I guess it brings me back to the
8 evidence I gave earlier about the reason for the
9 closure of the Board and a review of the commissioning
10 model, so it is well being acknowledged that there was 12:22
11 a layer of bureaucracy in the system, but, in fact,
12 that the commissioning model, which was based on the
13 purchase or provider model, wasn't effective. I don't
14 recognise the description as put forward from
15 Mr. Devlin, with respect. In terms of the transition 12:22
16 from the Health and Social Care Board to the Strategic
17 Planning & Performance Group, as I mentioned earlier, I
18 was appointed or put into that post in September 2020
19 in order to manage the smooth transition and we
20 decoupled the closure of the Board and the review of 12:23
21 the commissioning model to protect services.
22 I described earlier the enhancements to performance
23 management, enhancements in - and we'll come on to the
24 SAI position - but there has been an absolute focus to
25 work in collaboration with the Public Health Agency in 12:23
26 order to plan services in a way that's achievable.
27
28 I referred earlier to 97% of our budget is rolled over,
29 year on year, for service provision on the ground.

1 What is missing from Mr. Devlin's evidence is the role
2 and the responsibility of the Trust in managing the
3 money allocated in delivering the service in their
4 corporate responsibility on the four elements that
5 I talked about earlier, two of which include 12:24
6 performance management and safety and quality. And the
7 2017 guidance firmly states that the provision of
8 services, performance management, sits at a primary
9 responsibility within the Trust. So I don't recognise
10 the description as evidenced by Mr. Devlin. 12:24
11 79 Q. Anything to add to that?
12 A. MR. CAVANAGH: I mean, like Sharon, I don't recognise
13 it, either, because the reality is, so much of what we
14 have been doing has been about promoting quality, not
15 just in Urology Services but more generally, because 12:24
16 the way that we're investing is very much in
17 partnership with Clinicians, talking to Clinicians
18 about how these services could be developed and
19 ensuring that, actually, we are taking as much of that
20 into account as is possible in the constrained 12:25
21 environment that we find ourselves. That's why we
22 have, sort of, Cancer Clinical Reference Groups for
23 Urology and many other services, that's why we have the
24 Planning Implementation Group for Urology; an
25 opportunity for us to sit down with Clinicians and 12:25
26 genuinely discuss how services can be made as high
27 quality as we possibly can in the constrained
28 environment that we find ourselves.
29

1 So, on that basis, I think there are many instances
2 where we have looked to support the development of
3 quality services and we have set aside our need to
4 ensure that targets are met. I mean, one example that
5 springs to mind is, in 2014, we said to the Southern 12:25
6 Trust at that stage, we will set aside the requirements
7 under our Service and Budget Agreement in order for you
8 to blue-sky think, as the then-Director of
9 Commissioning termed it, in order for you to blue-sky
10 think in a way that will actually look at transforming 12:26
11 your service and developing your service, and the Trust
12 brought forward plans which did genuinely look to be an
13 opportunity for us to make a step-change in that
14 service and further investment was provided at that
15 stage. So I think it's incorrect and I just don't 12:26
16 recognise it in that way and, in many ways, I think
17 it's a bit of a two-dimensional sort of reading of the
18 work of Health and Social Care Board and certainly,
19 now, of SPPG.
20 80 Q. I suppose to be fair to Mr. Devlin, he is no longer 12:26
21 around as Chief Executive to see the outworking of some
22 of the plans that were anticipated.
23 A. MR. CAVANAGH: Sure.
24 81 Q. But certainly that was his view at the point of his
25 Section 21. I think you want to say something else? 12:26
26 A. MRS. GALLAGHER: Indeed. And I suppose just to remind
27 ourselves that the commissioning process was stood down
28 in 2020 before the closure of the Board, for the
29 reasons that I set out earlier; we were in the middle

1 of Covid and our focus was on utilising our resource to
2 best effect in managing and responding to Covid for
3 two years. After that, we went into a Rebuild
4 Programme, and I talked about this earlier, where we
5 worked with Trusts in terms of agreeing our recovery 12:27
6 from Covid.
7
8 In terms of the delivery of high-quality services,
9 I mean, we've talked about this earlier. That sits
10 within the purview of the Health and Social Care Trust, 12:27
11 so the targets are part of the picture, but safe
12 quality services sits within the domain of the Health
13 and Social Care Trust. In Mr. Devlin's defence, our
14 demand capacity gap has increased. That was made even
15 worse by Covid. So the provision of high-quality 12:27
16 services, as described by Mr. Devlin, had, of course,
17 diminished because we were in a position with
18 ever-increasing waiting lists and, you know, during a
19 period of Covid and recovering from Covid. So I can
20 understand why his perception would be that these 12:28
21 things had conflated, but as I mentioned earlier, this
22 is a very complex working environment, with many, many
23 factors coming into play, and it is easy -- or one --
24 human nature tries to have a cause and effect; very
25 rarely it's that straightforward - in Health and Social 12:28
26 Care, it is multifactorial, as I mentioned earlier.
27 82 Q. Thank you for taking the opportunity to comment on what
28 Mr. Devlin said. I just want to look at some of the
29 ways in which you gather information or have

1 information fed to you in order to inform your roles
2 and responsibilities. One of the groups that you
3 engaged with was the Northern Ireland Cancer Network.
4 I think, Mr. Cavanagh, were you involved directly with
5 that? 12:29
6 A. MR. CAVANAGH: Mm-hmm.
7 83 Q. And that actually sat under HSCB until March 2022.
8 Could you just outline to us your level of engagement
9 with the Network and what way they informed your views
10 on commissioning or planning generally? 12:29
11 A. MR. CAVANAGH: Sure. I mean, NICaN - the Northern
12 Ireland Cancer Network - was hosted by the HSCB, as you
13 say, and, throughout that period, HSCB, I think,
14 benefitted from having a structure like NICaN to draw
15 upon because it was a place where Clinicians came 12:29
16 together involved in cancer care, both generally and
17 also in relation to individual tumour sites and
18 services, and was able to then look at extant clinical
19 guidance at that time and developed some quite
20 groundbreaking, in my view, pathways and clinical 12:29
21 guidance for services across a whole range of Acute
22 Services in relation to cancer care. So we have a
23 fairly sophisticated process now available to
24 Clinicians; they are guidelines by their very nature,
25 but they are developed by Clinicians, so, in that way, 12:30
26 we look to Clinicians to implement those and use them
27 as the basis of their practice. So it is an important
28 organisation. It also was an organisation that was
29 able to support a peer review process, largely because

1 we were able to piggyback a little on what NHS England
2 were doing. We are a relatively small country here,
3 there's only so much we can do in relation to peer
4 review, so whenever we can link with countries in
5 Britain, I think there is a real opportunity for us to 12:30
6 learn and also to draw on some of their expertise
7 around peer review.
8
9 So, peer review, throughout kind of the -- right up to
10 about 2019, there would have been a process both of NHS 12:30
11 England coming and visiting services here, but also of
12 them reviewing self-assessment by Trusts as well, of
13 how they felt their services were going, and a range of
14 recommendations were raised through that. Some of
15 those recommendations included issues around 12:31
16 multidisciplinary teams, around attendance and quoracy
17 and multidisciplinary teams. They also related to how
18 we sort of had referrals from GPs and whether those
19 were following extant guidelines as well and also how
20 we triaged them at the secondary care level as well. 12:31
21 So, an important organisation, very much a
22 Clinician-driven organisation, but the Board then was
23 able to benefit from all of that knowledge and actually
24 then were very much advocating for the approach that
25 NICaN guidelines were -- I suppose had developed. 12:31
26 84 Q. And the guidelines and protocols that came through
27 NICaN, or from them, based on, I presume, evidence base
28 and care pathways, were evidence-based --
29 A. MR. CAVANAGH: Very much so.

1 85 Q. There's no compellability on the Trust or Clinicians to
2 act accordingly or to endorse those, but was there an
3 expectation from HSCB that, given that they were
4 evidence-based and coming from that source, that they
5 would be taken on board? 12:32
6 A. MR. CAVANAGH: They were co-produced by Clinicians, and
7 so the various sort of MDTs would have been involved in
8 the Clinical Reference Groups that were developing the
9 guidelines. So, on that basis, I think there was an
10 expectation that the Clinicians would also bring those 12:32
11 back and advocate to their teams in relation to them,
12 but, yes, they are guidelines, but they are guidelines
13 that represent best practice and represent sort of what
14 the clinical community felt was the best approach to
15 delivering services. 12:32
16 86 Q. Was there ever any pushback from any of the Trusts or
17 Clinicians, as far as you are aware, around guidelines
18 or protocols or anything emanating from NICaN?
19 A. MR. CAVANAGH: Quite the reverse, in fact; I think they
20 were embraced by Clinicians and by teams. 12:32
21 87 Q. I think it was confirmed - I just want to give the
22 Panel the reference - it was confirmed at a NICaN Board
23 meeting in February 2018 that:
24
25 "It is the responsibility of individual Trusts, all of 12:33
26 which are members of the Urology CRG, to adopt
27 guidelines and protocols."
28 A. MR. CAVANAGH: That's right.
29 88 Q. So it falls to the Trust, and that NICaN Board minute

1 is at WIT-105092. What's the responsibility of HSCB
2 generally in relation to guidelines and standards that
3 are expected? We heard some evidence that it's a joint
4 approach; Mr. Pengelly indicated that clinical
5 standards to that extent are a joint approach - PHA, 12:33
6 HSCB - and I say that with a slight nuance because the
7 question was around the particular issue, but is there
8 a responsibility on HSCB, or SPPG now, around ensuring
9 that guidelines and protocols are adhered to by the
10 Trust or adopted by them? 12:34
11 A. MR. CAVANAGH: I mean, there is a range of guidelines,
12 and it is important to emphasise that. We have some
13 NICE guidelines, as they are called - National
14 Institute for Health and Care Excellence - which we do
15 seek Trusts to adopt. The likes of our Cancer Network 12:34
16 Guidelines, we feel are best practice and we will seek
17 Trusts to adopt those as well. And Royal Colleges, and
18 so on, will develop guidelines and I think we will take
19 those into account, but they are not automatically
20 adopted in that way, although Clinicians, obviously, 12:34
21 have the opportunity to draw on that and indeed will be
22 involved in some of the Royal College and other
23 guidelines as well. So, on that basis, guidelines are
24 the coming together, obviously, of the views of the
25 clinical community and also the views of organisations 12:34
26 delivering healthcare, and, in that way, I think they
27 represent the standards that we want to work towards,
28 and we generally will use those, then, as the basis of,
29 I suppose, keeping under review that services are

1 delivered against those, should then represent quality.
2 89 Q. Yes. And they fall into the expectation of good
3 governance that the Trust has to put in place itself --
4 A. MR. CAVANAGH: Certainly, from a Clinical and Social
5 Care governance point of view, I think they are an 12:35
6 excellent tool for Trusts to use in terms of assuring
7 themselves that they are meeting, I suppose, the
8 requirements of good governance.
9 A. MRS. GALLAGHER: If I might add to that, Ms. McMahon?
10 90 Q. Yes, of course. 12:35
11 A. MRS. GALLAGHER: In terms of the role of the
12 Department, the role of SPPG and PHA and then the role
13 of the Trusts, so, clearly, the Departments sets the
14 standards and issues the guidance. In terms of SPPG
15 and PHA, guidelines are guidelines and obviously some 12:35
16 are more easily introduced and will need to be
17 considered, you know, in terms of their individual
18 application. We would use the clinical networks - we,
19 as in SPPG and PHA, would jointly use, for example,
20 some of the clinical networks to consider the 12:35
21 implications of the guidelines, because, you know,
22 there needs to be a consideration about how you
23 introduce it. Some might require a resource
24 implication, some might require a change in terms of
25 the team, the multidisciplinary team, so there are 12:36
26 many, many different guidelines that need to be
27 considered, and some we need to support in terms of how
28 that's implemented.
29

1 In relation to the Trust assurance, we have -- we work
2 on a risk-based approach, so where there are clinical
3 guidelines or other guidelines that we feel are hugely
4 important in terms of -- there's the difference between
5 safety and quality. So the guidelines generally fall 12:36
6 into the good quality, which doesn't -- so a
7 high-quality service is one that we all aspire to, but
8 in the current environment, we need a fit-for-purpose
9 service at the minute, but safety is absolutely top of
10 the agenda. So, again, in the context of implementing 12:37
11 guidelines, we need to consider what's feasible and
12 possible with the resource that we have, human resource
13 and financial resource.
14 91 Q. And if there is a resource implication for a guideline
15 or a protocol that is to be implemented, is that 12:37
16 something that's front-loaded by your understanding of
17 that resource implication and, therefore, funding, or
18 do the Trust have to identify that resource implication
19 and ask you for funding for it?
20 A. MRS. GALLAGHER: Regrettably, it's not the case that, 12:37
21 with new guidelines, there is additional funding
22 associated with that. So part of the responsibility of
23 the SPPG, supported by PHA, is to work with the Trusts
24 in terms of understanding any financial impact on that,
25 and, you know, it may or may not be possible to provide 12:37
26 the additional funding, but, invariably, we're
27 competing for funding across many areas, but funding
28 doesn't follow with any new guidance.
29 92 Q. So the Trust have to deal with resource implications

1 from guidelines out of their existing pot?
2 A. MRS. GALLAGHER: In the main, yes, and that's where the
3 balance comes in in terms of the extent to which
4 guidelines can be incorporated or introduced and how
5 you manage risk, because at times you might not be able 12:38
6 to fully implement the guidance, and it is about risk
7 management and the extent to which you can bring
8 forward the guidelines in the way that were
9 anticipated, but remembering, of course, that these are
10 guidelines. 12:38
11 93 Q. So would it be a transparent process if guidelines
12 weren't to be implemented because of resource
13 implications, would everyone be aware of that? For
14 example, if I was in the Trust and I said we haven't
15 the capacity, the funding, to bring this guideline into 12:38
16 reality, you, as the SPPG, would be aware of that from
17 the outset?
18 A. MRS. GALLAGHER: So, in the first instance, then, the
19 Trust would be acknowledging that, understanding that,
20 and the Trust team and their Clinical Governance 12:39
21 arrangements and their Leadership Team, both medical
22 and non-medical, would understand the guidelines and
23 would put in place arrangements in order to -- to the
24 extent that they have the resource to do that. If it
25 was something fundamental to safety and that was fed 12:39
26 back to us, then that would be a consideration that we
27 would need to give serious thought to.
28 94 Q. And that applies to NICE guidelines as well as anything
29 coming through NICaN, any guidelines at all?

1 A. MR. CAVANAGH: Yes, that's right.
2 95 Q. MRS. GALLAGHER: Any guidelines.
3 96 Q. In relation to your Complaints Procedures and
4 Standards, you have referred to these. If I could go
5 to it at WIT-104277, at paragraph 119, and you say: 12:40
6
7 "The HSC Complaints Procedures and Standards are set
8 out in two documents: Complaints in HSC Standards and
9 Guidance 2009 and HSC Complaints Procedure."
10 12:40
11 And then, at paragraph 120, you mention that you
12 formulated your own policy on the management of
13 complaints. And if we go to 121, please, and you say -
14 sorry, Mr. Cavanagh, this is your Section 21, if
15 I haven't made that clear: 12:40
16
17 "As well as dealing with complaints against HSCB, the
18 Board also analysed complaints made about Trusts, with
19 a view to sharing, on a regional level, any learning
20 from that analysis." 12:40
21
22 I just wonder, do complaints about Trusts come through
23 HSCB/SPPG, do you get that information --
24 A. MR. CAVANAGH: No, Trust provide us with a report on
25 the complaints that they have received, so they don't 12:41
26 directly come to us.
27 97 Q. And then you analyse those complaints and look for
28 themes?
29 A. MR. CAVANAGH: Hmm.

1 98 Q. So this is something akin to an SAI process, but
2 obviously of a different ilk?
3 A. MR. CAVANAGH: Mm-hmm, that's right.
4 99 Q. And in relation to information that's provided by the
5 Board around complaints, do they include complaints 12:41
6 generally in relation to service or individuals or
7 both?
8 A. MR. CAVANAGH: I mean, the ones that come through
9 Trusts -- sorry, are you asking me about Trusts?
10 100 Q. Yes, the ones that you receive from the Trusts that you 12:41
11 analyse --
12 A. MR. CAVANAGH: So the ones that come through Trusts
13 will generally be relating to patient experience, so
14 that a patient has maybe -- you know, it can be issues
15 around access to care, it can be issues around their 12:41
16 experience of receiving care and, indeed, it can be
17 issues around just kind of the environment, and so on,
18 that they have received care in, so it's a fairly wide
19 range of issues that people will raise with Trusts.
20 101 Q. You, also, if we go to paragraph 123, you say: 12:42
21
22 "The HSCB would review to identify any trends of
23 concern or clusters of complaints. However, the
24 information the HSCB received from Trusts was
25 anonymised (both the complainants and the 12:42
26 practitioners). Therefore, if complaints kept arising
27 in respect of the same practitioner, unless this detail
28 was specified by the Trust in the body of its report,
29 the HSCB would not be directly alerted to this. The

1 HSCB's role was to identify trends in the more general
2 sense. When identified, any resulting learning was
3 shared on a regional basis."
4
5 So, like the SAI process, there's anonymity built in? 12:42
6 A. MR. CAVANAGH: Mm-hmm.
7 102 Q. Just in relation to the rationale for the anonymity for
8 complaints through the Trust to the HSCB, what's your
9 understanding of why it would be anonymous at your
10 level? 12:43
11 A. MR. CAVANAGH: So, I mean, the complaints process, and
12 indeed the SAI process, are about learning, so we're
13 trying to learn from, I suppose, the experiences that
14 people have in terms of complaints and, also, we're
15 looking at learning, sort of, where staff are involved 12:43
16 and so on, so, in that way, it's about encouraging
17 learning. The complaints process is anonymised because
18 it's a report on the complaints that a Trust have
19 received for the period that a report relates to, and,
20 as I say, they are about learning, so, from the 12:43
21 complaints, we will look at if there are any particular
22 trends and we will issue learning letters, newsletter
23 articles, and so on, in relation to those.
24 103 Q. I know you listened to the Public Health Agency
25 evidence and you will know that I asked them about the 12:43
26 wisdom of that, if there are complaints about one
27 individual or one area. Do you have any view on that,
28 as to whether, if there was a theme and the theme was
29 an individual, then you could readily see how that

1 would be missed entirely by the process of anonymity,
2 but do you have at a view on that?
3 A. MR. CAVANAGH: It's unlikely that we will, sort of,
4 find out about an individual through that process. It
5 is about learning, so, on that basis -- 12:44
6 104 Q. But you wouldn't find out about them through the
7 process because it's anonymous?
8 A. MR. CAVANAGH: No -- absolutely, that's correct, of
9 course, but it is about learning, but remembering that
10 the Trust will know about if an individual practitioner 12:44
11 is involved and they have the necessary processes for
12 them then to engage with that practitioner.
13 105 Q. But you have to know, do you not? Does the HSCB say,
14 well, if the Trust know, they can tell us, and if they
15 don't tell us, then that's up to them, is that -- 12:44
16 A. MR. CAVANAGH: The Trust don't have to tell us, but the
17 process is about learning, so we want to learn.
18 I mean, one of the issues that springs to mind from the
19 complaints process is, mealtimes, protected mealtimes;
20 a number of patients came and said 'when we're in 12:45
21 hospital, we actually find it difficult to get our
22 meals because we're off getting a diagnostic at
23 mealtime, and things like that, and we're missing
24 meals', so that was a really good example of where the
25 complaints process led to us issuing a learning letter 12:45
26 to Trusts asking them to protect mealtimes. So the
27 processes are there to learn. The Trusts have a
28 different role as employers and they will have learned
29 something about an individual practitioner through

1 their process.
2 106 Q. If we go to WIT-104282 of your statement, paragraph
3 137, just to read this in, and you say:
4
5 "The HSCB did receive anonymised complaints concerning 12:45
6 the Urology Service in Southern Trust as part of the
7 monitoring process. No trends of concern or clusters
8 of complaint were identified within those complaints."
9
10 Then, you say at 138: 12:46
11
12 "As part of the review of Urology Services, a lookback
13 of complaints was undertaken by a nursing professional
14 for the year 2014/'15 (as distinct from the more recent
15 lookback exercise). The 2014/'15 lookback involved a 12:46
16 review of Urology complaints regionally from all
17 Trusts."
18
19 And the information has been provided, for the Panel's
20 note, at WIT-73243 to WIT-73244. 12:46
21
22 "No concerns, patterns or clusters of complaints were
23 identified from the information reviewed by the nursing
24 professional."
25 12:46
26 Now, given the information that's been provided to the
27 Inquiry and the length of time during which some of the
28 issues existed, I can see that there was no clusters or
29 concerns identified, but do you think if there had have

1 been a way in which, where the issues emanated from, in
2 other words, from a clinician, for example, then there
3 may have been clusters or concerns that would have made
4 themselves available on this preliminary lookback in
5 2015? 12:47
6 A. MR. CAVANAGH: I mean, I can't say, in terms of that
7 review in 2015, whether -- whether that did relate to
8 an individual clinician, and so on. It clearly related
9 to a range of complaints relating to the Urology
10 Services and, from that, there were no trends that were 12:47
11 found. So, on that basis, the process was designed to,
12 if a Responsible Officer from the likes of the Public
13 Health Agency actually identifies that there is a
14 number coming in from Urology, therefore it is
15 reasonable to have a look, at that time, at those 12:47
16 complaints and see whether or not any clusters or
17 themes are emerging, they did that and they didn't see
18 any, so, on that basis, that was the process and that
19 was the process that was followed.
20 107 Q. Yes. I'll just give you another opportunity around 12:47
21 this. Are you saying that even if the Consultant was
22 named and there was a theme, you don't mind that that
23 didn't reveal itself, that anonymity must dominate this
24 process?
25 A. MR. CAVANAGH: Look, I can't say in this case; it's 12:48
26 years.
27 108 Q. But as a proposition to you, if the revelation of a
28 Consultant, for example, or any health professional,
29 was a familiar name during some of the issues, would

1 that information not, of itself, reveal a theme, and do
2 you not think that that has the potential to prevent
3 you having information that might be important around
4 patient risk?
5 A. MR. CAVANAGH: The professionals looking at that would 12:48
6 be, in my view, keeping that in mind, so, on that
7 basis, if it had looked like that was what was
8 emerging, they would have identified that and followed
9 it accordingly.
10 109 Q. And do you feel that was done in this case, now that 12:48
11 you know what you know, and we're standing in a Public
12 Inquiry, do you feel that the professionals did
13 identify that and --
14 A. MR. CAVANAGH: But the fact that we are able to say
15 that, at this time, a professional saw that there were 12:48
16 a number of complaints coming in around Urology,
17 reviewed those complaints and concluded that there were
18 no themes or concerns emerging, that's a sign that the
19 system was doing what it was designed to do.
20 110 Q. With respect, I'll have to push you just a little bit 12:49
21 on that, given that we are standing in a public
22 inquiry?
23 A. MR. CAVANAGH: Sure.
24 111 Q. If you consider that the system did what it was meant
25 to do, does that mean the system is useless? 12:49
26 A. MR. CAVANAGH: But it is designed for learning.
27 112 Q. And what was the learning -- what was the learning
28 then?
29 A. MR. CAVANAGH: There was no learning because there was

1 no patterns or concerns raised. Had there been
2 patterns or concerns raised, that would have led to
3 learning which may then have lead to a learning latter,
4 a newsletter article and so on.
5 A. MRS. GALLAGHER: If I might add to that, Ms. McMahon. 12:49
6 Clearly the system didn't do what it was meant to do or
7 we wouldn't have the situation we are in today. We are
8 very keen to understand the learning in that. We have
9 already made changes in terms of our own processes
10 within SPPG to triangulate learning, to understand 12:50
11 learning. Just to go back to the different processes
12 where an individual is concerned or a medical
13 practitioner is concerned, the wraparound on that in
14 terms of the appraisal system, the revalidation system,
15 which uses SAIs, which uses patient experience, which 12:50
16 uses the views of colleagues in order to assess whether
17 or not a clinician is providing a safe service, all of
18 those factors come into play. The clinical governance
19 around that, the management systems around that in
20 terms of MHPS, it is the primary responsibility of the 12:50
21 Trust and the Trust Board to make sure that that
22 organisation provides safe services and employs people
23 who provide safe services.
24
25 The Responsible Officer arrangements were put into play 12:50
26 in 2011 and that was primarily to make sure that every
27 doctor, if you like, had an external consideration in
28 terms of safe practice. So there are many, many
29 systems and processes and procedures at play here.

1 Clearly something went wrong. The SAIs, as my
2 colleague has said, relates to system learning. We
3 would not have expected an individual to be named. In
4 fact the process dictates that they aren't named. To
5 your question, if either inadvertently or not we were 12:51
6 made aware of the potential for harm or harm by any
7 professional, of course we would take action. There is
8 absolutely no doubt we would take action, whether it
9 sits within the current protocol or not. But the SAI
10 process is really about system learning as opposed to 12:51
11 managing the conduct or the practice of any individual
12 medical practitioner or clinical practitioner.
13 113 Q. Yes. The Panel has heard evidence around the different
14 parts, they are all moving parts, there is a menu of
15 things available, including the MHPS you mentioned, 12:52
16 there's obviously GMC, internal disciplinary, there are
17 lots of oversight mechanisms that allow Trusts to deal
18 with that?
19 A. MRS. GALLAGHER: Indeed.
20 114 Q. I'll take it your answer is premised on a belief that 12:52
21 those systems should be operated as expected?
22 A. MRS. GALLAGHER: Indeed, indeed. Again, the role of
23 the Board and their committees and obviously RQIA, as
24 I pointed to earlier, can also undertake reviews in
25 terms of -- where we would have concerns, for example, 12:52
26 from the Department's perspective, if we were alert to
27 concerns or if we understood that there may have been
28 failings, then we would ask RQIA to investigate and to
29 take a look at that.

1
2 I might just add that the '22/'23 quality and safety
3 report that we produce in concert with PHA shows that
4 there were 120,000 adverse incidents so those are
5 handled at Trust level, 539 of them serious adverse 12:53
6 incidents. So it points to the importance of Clinical
7 Governance and learning at Trust level because all of
8 those might point to indications of individuals or
9 practices or environments that need to be addressed,
10 that need to be developed and need to be changed. 12:53
11 That's why the primacy of safety and quality, in
12 particular safety, needs to sit at the seat of where
13 clinical practice happens within Trusts.
14 115 Q. You have mentioned SAIs and some of the figures there
15 and the high volume of those, now each of PHA, HSCB, 12:53
16 RQIA all are responsible collaboratively for looking at
17 SAIs and seeing about learning, which is obviously the
18 key aspect of that, but we have heard some evidence
19 around the delays of SAIs to the Trusts and I presume,
20 or perhaps you can say, and not confined to the 12:54
21 Southern Trust, that there are delays in SAIs, what's
22 your understanding of the logjam around that? Are
23 there plans to try and - I know we have the review,
24 I know there has been some movement at a high level to
25 look at this overall - but on the ground operationally 12:54
26 when these potentially serious concerns are waiting and
27 waiting, what's the plan to try and do something about
28 that in the more immediate term?
29 A. MRS. GALLAGHER: So when I took up post, one of the

1 areas that I looked at in the first number of weeks
2 actually was the number of outstanding SAIs.
3 Interestingly, for an SAI to happen it needs
4 Clinicians, it needs those people that are delivering
5 services. Given the demand capacity gap and given the 12:55
6 competing priorities, it can be very, very challenging
7 to get the resource that's required to conduct the
8 audit, to conduct the review. As at today there are
9 539 SAIs in the system and many of those are
10 experiencing delays. I put in place a process where we 12:55
11 risk manage the SAIs that are outstanding so that we
12 constantly review and understand to see where the risk
13 lies. In the main, 80% of SAIs are your first tier
14 but, for Level 2 and Level 3, we keep a very close eye
15 in terms of the action that is required, the priority 12:56
16 of those and work very closely with Trusts. So we now
17 meet Trusts every two months to have the discussion
18 about outstanding SAIs and the activity that they are
19 taking to do that.
20 12:56
21 I wrote to Trust Chief Executives around two months
22 ago, again outlining our shared concern, because I know
23 that Trust Chief Executives and the Trust teams are as
24 concerned about backlogs as I am. That is why there is
25 a joint and concerted effort to manage the risk on 12:56
26 that, but it will take some time to meet the backlog
27 because that backlog accumulated throughout Covid as
28 well and recovery from that is challenging.
29

1 We have enlisted clinical leadership solutions actually
2 to support the Trusts in order to undertaken some of
3 the Level 1 reviews, the SAIs, but also to train Trust
4 personnel and indeed our own personnel in SPPG and PHA
5 to support the SAI process in terms of understanding 12:57
6 the best way to manage and to deal with SAIs. If you
7 might let me describe a little bit about the
8 arrangements that we have undertaken within SPPG and
9 PHA on SAIs.
10 12:57
11 So we now have a nominated officer that reviews both
12 early SAIs and early alerts as they come in every day,
13 that's a health professional that's based in PHA.
14 Those notifications are issued to all of the directors
15 and the senior officers to understand what has been 12:58
16 received. There's a weekly group that reviews the new
17 SAIs and Early Alerts to understand what's happening,
18 'is this something that we know about, if not does
19 urgent action need to be taken'. There is a further
20 meeting by directors and professionals, a 12:58
21 multidisciplinary team that meets weekly to understand
22 escalated issues, so where there's concerns. Once a
23 quarter now we have put in place a multidisciplinary
24 team at director level that looks at the triangulation
25 of complaints, Early Alerts, SAIs and any other 12:58
26 information that we have, including information, for
27 example, from the Patient Client Council to take a
28 temperature check and understand if there are emerging
29 themes or issues. And, in addition to that, we have a

1 monthly forum between the PHA and the SPPG that
2 Mr. Dawson and I co-chair that has two agenda items and
3 two agenda items alone. That is performance management
4 and service improvement and safety and quality. On the
5 back of that we produced for the first time our safety 12:59
6 and quality action plan last year which has now been
7 added to the business plan in the Department, so sits
8 under the purview of the departmental management Board
9 and we are currently in the process of considering the
10 review of last year, what went well and what we might 12:59
11 plan in terms of addressing safety and quality issues
12 and promoting learning for next year.
13
14 So there's been a huge emphasis. We've taken the
15 learning from the Inquiries, we've taken the emerging 12:59
16 information coming from this Inquiry and we have really
17 made a concerted effort in terms of ensuring that the
18 procedures and processes are as robust as they can be,
19 but, more importantly, that we identify risk early and
20 we manage that risk. Because it is not possible to -- 13:00
21 it would be a simplistic view to say that we can simply
22 deal with that backlog and take care of what has been
23 generated over a period of years, particularly
24 throughout Covid. But I can assure the Inquiry Panel
25 and yourself here today that we have taken quite 13:00
26 significant steps in that regard to reinforce the work
27 that we do.
28 116 Q. Just from an operational perspective, the issues
29 arising around individuals who perhaps know the

1 individual involved or are perhaps very close to the
2 service provider or have other very competing clinical
3 demands, is that part of the package of looking at that
4 to see if that is an effective way of carrying out the
5 preliminary investigation? 13:00
6 A. MRS. GALLAGHER: So I think there's an important point
7 to be made in terms of, you know Ireland/Northern
8 Ireland is a small place, health and social care is a
9 small place, everybody knows everybody and this is part
10 of what we heard through both Neurology and 13:01
11 Hyponatraemia and what will undoubtedly, I am sure, be
12 under the consideration of the Inquiry Panel here today
13 in terms of people feeling that they can raise concerns
14 without prejudice and raise concerns without fear of
15 retribution or anything else. So one of the key 13:01
16 strands - and I mentioned earlier the Inquiry's
17 Implementation Programme Management Board that the
18 Permanent Secretary chairs - one of the key strands
19 under the safety and quality theme is looking at being
20 open, how do we support people to be open and how do we 13:01
21 support people to call out behaviour even if they are
22 not sure. Because all of us, I suppose, as human
23 beings, there's a reluctance sometimes quite naturally
24 to call out things in case you're overreacting or in
25 case you're not seeing the full picture. But part of 13:02
26 what we want to try and promote is that, if you are
27 concerned, even if it turns out not to be the case, we
28 need to be open, we need to promote that culture.
29 MS. MCMAHON: Thank you for that context. I will be

1 moving on to more of the detail of the SAIs, but
2 perhaps that's a convenient moment?
3 CHAIR: Yes, we'll come back at five past two everyone.
4
5 LUNCHEON ADJOURNMENT 13:03
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1 THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT
2 AS FOLLOWS:
3
4 CHAIR: Thank you, everyone. Ms. McMahon.
5 MS. MCMAHON: Just before we get back on track in 14:04
6 relation to the evidence, I just want to ensure it's on
7 transcript. When I had asked you, gave you the
8 reference that Mr. Devlin had said in his statement
9 about the Trust's responsibility for patient safety and
10 his views on the HSCB, I just want to put on record - 14:04
11 you may not have seen the entirety of Mr. Devlin's
12 Section 21, I don't know whether you have or not, but
13 the Panel will know, and for the purposes of my
14 question, that Mr. Devlin does address the
15 responsibility of the Trust around patient safety 14:05
16 throughout his statement and deals with that issue, so
17 just on that discrete point, I just want to -- because
18 I didn't think you had seen all of his statement, so
19 I didn't want to ask you if you were aware of the
20 contents, but the Panel will be aware of that and they 14:05
21 have heard evidence from Mr. Devlin on that issue.
22
23 Just before we go into the SAIs and have a look at some
24 of the issues that arose that the Board were aware of,
25 I just want to look at some of the concerns prior to 14:05
26 July 2020, and we can find this, for information
27 purposes, we can bring it up at WIT-104304, and
28 starting at paragraph 230, just for the Panel's note,
29 effectively, because I'm going the summarise this.

1 This is just the involvement of the HSCB from the
2 inauguration of the Regional Urology Services, both in
3 Craigavon and throughout Northern Ireland, in 2009,
4 with the Regional Review of Adult Services, which was
5 undertaken then by the DHSSPS, as it was, Service 14:06
6 Delivery Unit. And subsequent to that, there was a
7 Regional Stocktake of Adult Urology Services, and that
8 was commissioned by the HSCB, and Mr. Cavanagh deals
9 with that at 231, and I'll just read this out:
10 14:06
11 "In December 2013, the HSCB Director of Commissioning
12 requested a Regional Stocktake of Adult Urology
13 Services in Northern Ireland to assess what progress
14 had been made in the five years since the review. The
15 stocktake was undertaken in February 2014 and examined 14:06
16 individual Trust performance..."
17
18 And then you have accompanied that with a copy of the
19 Terms of Reference.
20 14:07
21 "The narrative report on the Urology Review Stocktake,
22 which included suggestions for continuing to improve
23 Urology Services, was shared with Trust Directors and
24 HSCB ADs of Commissioning in May 2014."
25 14:07
26 Now, the Panel have looked at this previously, but just
27 in relation to that, being, like, a five-year window,
28 almost, since the beginning of Urology Services, would
29 that have been custom and practice and is it still that

1 you revisit something that's new starting up and have a
2 look to see what's going on and what might need to be
3 done further?
4 A. MR. CAVANAGH: Urology Service predate 2009, just to
5 emphasise that, Urology Services in Northern Ireland 14:07
6 have been around since the 1990s, so the work that was
7 done in 2009 was an effort, I suppose, to look at
8 transforming and developing Urology Services, given
9 that they had grown considerably in the previous
10 decade. And then the stocktake, I think, at that 14:07
11 stage, was, given the significance of the 2009 Review,
12 an opportunity then to look back on what had been
13 achieved and what was yet to be achieved.
14
15 I mean, I suppose it depends upon the area of work that 14:08
16 we're looking at, but generally we will seek to keep
17 under review where a review has made recommendations
18 which requires implementation plans in order to
19 progress those, so we'll keep that under review and, on
20 this occasion, obviously, the Director of Commissioning 14:08
21 chose to do a much more formal stocktake, which was
22 reasonable in the circumstances, I suspect.
23 117 Q. You go on to say at paragraph 232:
24
25 "Following the stocktake, the Director of Commissioning 14:08
26 wrote formally to all HSCB Trusts in July 2014 asking
27 the Trusts to bring forward proposals for the
28 establishment and maintenance of a robust, sustainable
29 model for Urology provision through the submission of

1 an Improvement Plan."
2
3 Then, in paragraph 233:
4
5 "The Southern Trust submitted a Urology Improvement 14:08
6 Plan to HSCB in September 2014, was subsequently given
7 approval to begin implementation of the model."
8
9 Which we know started in December 2014.
10 14:09
11 At paragraph 234:
12
13 "The HSCB agreed that the implementation of the
14 Improvement Plan by the Trust would take precedent for
15 a period over delivery of agreed activity required 14:09
16 within the SBA as noted in correspondence."
17
18 Now, just that particular sentence:
19
20 "The HSCB agreed that the implementation of the
21 Improvement Plan by the Trust would take precedent for
22 a period over delivery of agreed activity required
23 within the SBA... "
24
25 You couldn't just explain what that means, in practical 14:09
26 terms, for the Trust?
27 A. MR. CAVANAGH: Well, the SBA obviously has volumes of
28 delivery expected in relation to outpatients,
29 inpatients, surgery, day-case surgery and so on, so, on

1 that basis, what the Director at that stage was,
2 I suppose, saying, was that we would set aside,
3 I suppose, monitoring those, I think, for about an
4 18-month period, from memory, and allow the Trust some
5 space to actually do some of their improvement and 14:10
6 development that was required in order to progress the
7 services, as outlined in their Implementation Plan.
8 118 Q. And is there any downside to that, if you move your
9 vision slightly across to something else for that
10 period of time? Is it your experience or was it, in 14:10
11 fact, in any way significant on what subsequently
12 happened around outcomes?
13 A. MR. CAVANAGH: It's likely the amount of capacity
14 delivered would have reduced, which means, obviously,
15 when you reduce the amount of capacity delivered, 14:10
16 that's going to increase your waiting times, so there
17 is a downside, but I don't actually know the detail as
18 to what that looked like.
19 119 Q. In June 2015 then, subsequent to the service commencing
20 in the way that was envisaged by the 2009 Plan, the 14:10
21 Regional Urology Planning and Implementation Group was
22 established and the purpose of that was to develop a
23 system-wide approach to the organisation of Urology
24 Services across Northern Ireland. There was a lot of
25 activity in 2015; it was subsequently, then, that NICaN 14:11
26 carried out a commissioning review, and then, in 2015,
27 the Southern Trust Local MDT Peer Review. Just before
28 we move on to the MDT Peer Review, NICaN's involvement
29 in that period of time, June 2015, was that a way of

1 them informing themselves of the position so that they
2 could best feed good practice back, or were they
3 looking at the service from a critique point of view at
4 that point?
5 A. MR. CAVANAGH: Yeah, the Cancer Network, I suppose they 14:11
6 were developing guidelines through the period up to
7 2015 across a whole range of acute specialties and
8 tumours sites, so what they were doing in 2015 was
9 taking an opportunity to do, I suppose, effectively
10 another stocktake, a peer review, as it was called, to 14:11
11 see the extent to which those guidelines that had been
12 developed in the previous five to seven years, were
13 actually becoming embedded in the services.
14 120 Q. And you speak to the Southern Trust Local MDT Peer
15 Review at paragraph 243, which we can find at 14:12
16 WIT-104307, just down at the bottom, 243, please. And
17 you refer -- the headline is:
18
19 "The 2015 Southern Trust Local MDT Peer Review."
20 14:12
21 And you say at 243:
22
23 "While I have been unable to locate a copy of the
24 relevant outcome letter, the key themes arising across
25 Cancer Services in the Southern Trust were summarised 14:12
26 in the overview of the findings from the 2015 National
27 Peer Review of Cancer Services in Northern Ireland."
28
29 And then you list the issues as follows:

1
2 "Procedures being undertaken outside specialist centre
3 or by Consultants who are not members of or attend the
4 appropriate MDT; absence or inadequate Clinical Nurse
5 Specialist provision; delays in seeing routine 14:13
6 referrals; shortage of Consultants in the specialty or
7 overreliance on locum Consultants; absence of core
8 membership of, or lack of attendance at MDT, leading to
9 a significantly low percentage of MDT meetings being
10 quorate; and lack of specialist Radiologist Or 14:13
11 Histopathologist input to the services of MDT."
12
13 Just move down, please. Thank you. Then, you say at
14 244:
15 14:13
16 "In accordance with the agreed process, the Trust would
17 take forward the local issues. The regional issues
18 relating to Urology were taken forward via the Urology
19 PIG and HSCB commissioning and are set out at
20 paragraphs 252 to 256." 14:13
21
22 If we just go to paragraph 252, please. These are the
23 steps:
24
25 "The delays for routine and urgent Urology appointments 14:14
26 was taken forward by the Regional Urology PIG.
27 Nephron-Sparing Surgery being undertaken outside of
28 specialist MDT, Peer Review emphasised that this
29 surgery was taking place in too many sites. In

1 response, HSCB commissioned the introduction of
2 radiofrequency ablation for renal cancer in Belfast
3 Trust as a treatment option and that the relevant
4 interventional radiologist would join the specialist
5 MDT as necessary. The Consultant Urologist in Southern 14:14
6 Trust also in-reached to Belfast to undertake surgery
7 within the specialist MDT; inadequate time for Urology
8 specialist MDT, this issue was considered by the HSCB
9 in conjunction with the Belfast and the South Eastern
10 Trusts, ultimately leading to additional recurrent 14:14
11 funding being made available to support additional
12 capacity from November 2015, as outlined above; the
13 development of regionally agreed referral destinations
14 and referral guidance on the CCG, i.e. the electronic
15 system used by GPs to make referrals; a medical 14:15
16 workforce plan for Urology which was completed in 2017;
17 expansion of the Urology capacity across the region -
18 recurrent funding was allocated to Trusts in 2019 to
19 increase the Urology Clinical Nurse Specialist
20 workforce. In terms of the Southern Trust, this 14:15
21 allowed the development of 8.5 clinical sessions for
22 urodynamics and LUTS service and a further 8.5 clinical
23 sessions for prostate biopsies and nurse-led PSA
24 follow-up service."
25 14:15
26 Now, I read that in because I think it shows the
27 benefit of the relationship between the HSCB, the
28 Trusts and review outcomes being worked on
29 collaboratively, and also to show that these things

1 seem to take a bit of time. You have got the 2014/'15
2 information, then there's some action at the time,
3 I presume there's some sort of filter system where you
4 do what you can immediately, but clearly, some of this
5 required funding, an identification of needs. 14:16
6 A. MR. CAVANAGH: Mm-hmm.
7 121 Q. So, 2017. And it wasn't until 2019, when the Clinical
8 Nurse Specialist workforce was funded, I don't think it
9 was funded fully to the extent it was needed, but it
10 was certainly enhanced at that particular time. 14:16
11
12 So if we could look at WIT-105622. Now, this is a
13 Trust's own Peer Review Self-Assessment of Urology MDT
14 in 2016, and we'll see at the top the network is NICaN,
15 the organisation is Southern Trust, and the date of 14:17
16 validated self-assessment is 30th September 2016 and
17 the MDT Lead Clinician is Mr. Aidan O'Brien. And if we
18 could just go a couple of pages down, is this a
19 document you're familiar with, the Self-Assessment
20 Report? 14:17
21 A. MR. CAVANAGH: Yes.
22 122 Q. And is this something that's routinely done, or what's
23 usually the chronology for this?
24 A. MR. CAVANAGH: It was done within this process, in that
25 we were working with NHS England, they were supporting 14:17
26 process, so this is a form that they designed, which
27 then was provided to Trusts then to complete. I think
28 it was used over a four-year period, up until about
29 2019.

1 123 Q. And this then finds its way to the Board, presumably
2 from the Trust?
3 A. MR. CAVANAGH: Yes.
4 124 Q. Yes. But it's not -- the Board don't direct this to be
5 done or -- 14:17
6 A. MR. CAVANAGH: No.
7 125 Q. -- you are really just a receiver of this information.
8 And is this one of the ways in which you receive
9 information that, broadly, without being too specific,
10 it broadly reassures you about what's happening and you 14:18
11 can gain some assurance about the service being
12 provided?
13 A. MR. CAVANAGH: So the Peer Review process, completed by
14 NHS England but sponsored by the Cancer Network, which
15 we obviously were the host organisation for, so, in 14:18
16 that way, the Cancer Network, with all the Clinicians
17 engaged in this, were committed to this process, so
18 this is -- I suppose it comes to us, yes, as
19 reassuring, but it also comes to us in the knowledge
20 that there is a number of key issues that need to be 14:18
21 addressed by the Trusts, so, on that basis, there's
22 also something of sort of understanding how that
23 progresses in the coming years as well.
24 126 Q. And I suppose the context of my question was, this is a
25 way in which the Trusts can let you know what's 14:18
26 happening?
27 A. MR. CAVANAGH: Yes.
28 127 Q. So, for present purposes, if there were existing
29 concerns at that time that were impacting on patient

1 safety, whatever way we want to characterise the route,
2 be it administrative or clinical, you would expect it
3 to be reflected?
4 A. MR. CAVANAGH: Yes.
5 128 Q. If we just go to the end of the document. So the way 14:19
6 in which this document seems to be set out -- so the
7 concerns are usually set out, "immediate risks
8 identified" and then "immediate risks resolved",
9 obviously their own inbuilt sort of triage process, for
10 the reader then to become immediately aware of anything 14:19
11 that requires attention. Then "immediate risks
12 resolution", "serious concerns identified", "not
13 identified" in this case. Just move down, please.
14 "Serious concerns resolution", obviously not applicable
15 because there were no serious concerns resolved. 14:19
16
17 So, under the last category of concerns, the following
18 is on the form:
19
20 "Availability of the Clinical Oncologist and 14:19
21 Radiologist at all of the MDT meetings. The highest
22 percentage increase in red flag referrals across the
23 region. Operating theatre capacity and operator time."
24
25 And the "General Comments" say: 14:20
26
27 "The Urology MDT is a well-structured and attended MDT
28 which is full constituted with core and extended
29 members. Whilst the attendance by Urologists and

1 Pathologists, Palliative Care and Clinical Nurse
2 Specialists has been very good, that of Radiologists
3 and by Clinical Oncologists has been unsatisfactory.
4 The MDT has been made every attempt to have this issue
5 addressed and resolved. This has been a difficult and 14:20
6 challenging year for the team due to the competing
7 pressures of achieving targets with increasing
8 referrals. A work programme has been developed which
9 outlines the work for the incoming year. However, this
10 is viewed positively as it includes many aspects to 14:20
11 improve the quality of the service provided to our
12 patients."
13
14 Then, the summary of the validation process:
15 14:21
16 "A Working Group was established to examine
17 documentation. The group consisted of Urology Clinical
18 Lead, Clinical Nurse Specialist, Urology Head of
19 Service, the Head of Cancer Services and Service
20 Improvement Lead. At regular intervals, the 14:21
21 documentation was circulated to MDT members for review
22 and comments. Feedback was received and documents were
23 adjusted accordingly. The Self-Assessment was carried
24 out by the Clinical Lead for Colorectal MDT, the
25 Colorectal Nurse Specialist, the Head of Service and 14:21
26 the Lay Reviewer. The Lay Reviewer also reviewed the
27 Patient Information Evidence Folder."
28
29 Then, the Organisational Statement says:

1
2 "I, Aidan O'Brien, Lead Clinician on behalf of the
3 Southern Trust, agree that this is an honest and
4 accurate assessment of the Urology local MDT measures."
5 14:21
6 And that's agreed by Francis Rice on 28th September
7 2016. Mr. Rice was the then-Chief Executive.
8
9 So, just given the steps that I've read out from your
10 statement, and presumably they flow from what's in this 14:22
11 as well, that there was an attempt to plug some of the
12 gaps, and we have heard evidence that plugging the gaps
13 in relation to workforce specialty is a particular
14 challenge, both in Radiology, Oncology and Urology,
15 I think, across all of those specialties. But given 14:22
16 the, one might say, limited nature of the specific
17 feedback on the form around difficulties in MDT, would
18 it be fair to say that HSCB took that at face value;
19 you can't go behind that, you're expecting the Trust,
20 the Clinicians involved and the Multidisciplinary Team 14:22
21 to give you the information you need in order to assess
22 risk?
23 A. MR. CAVANAGH: And the NHS England team, in their final
24 report for the whole region, also reflected that issue
25 of the MDT as well. 14:23
26 129 Q. What is the position around MDTs at the moment? There
27 has been a lot of evidence around that and outcomes,
28 and I know you have referred to it in your statement,
29 about cancer trackers, and I think you have been

1 involved in trying to address that issue. Could you
2 just give us a little bit of background about that and
3 where we are at the moment?
4 A. MR. CAVANAGH: About the trackers?
5 130 Q. Yes, please. 14:23
6 A. MR. CAVANAGH: So trackers is something that I think
7 we've been developing again probably for eight,
8 nine years, and it's been -- you know, it's an
9 important element of the, I suppose, the cancer team,
10 in that you're looking for administrative staff who can 14:23
11 follow a patient through their cancer journey. It's a
12 challenging-enough role, as you can imagine, but an
13 important role because it ensures that, at various
14 parts of the journey -- the journey is complex, there's
15 diagnostics, there's various points where they are seen 14:23
16 for outpatient reviews, outpatient appointments and,
17 indeed, potentially, surgery, radiotherapy,
18 chemotherapy and so on, so a complex journey, so
19 important, as much as possible, to deliver that. So we
20 have grown the cancer tracker resource and it probably 14:24
21 has got us to the point where we're now tracking well
22 to first sort of treatment. But then, beyond first
23 treatment, I think we're looking to the wider team to
24 actually support, kind of, the ongoing journey of
25 staff. So I think cancer tracking is something that we 14:24
26 have brought to a good place to this point, but more to
27 be done as well because we need to do it in the future
28 also, be tracking the whole journey, which I think is
29 one of the challenges for us going forward.

1 131 Q. Because some of the concerns that have arisen in the
2 Inquiry extend beyond that point, and obviously the
3 Panel are likely interested in what provision there now
4 is in place to prevent a recurrence of that. Is it the
5 case that the tracker provision is not fully in place 14:24
6 and is it Trust-dependent, are the Trusts making
7 decisions on their own around do we have the capacity
8 financially to fill some of these posts and juggling
9 their finances as you described earlier?
10 A. MR. CAVANAGH: In terms of what we are committed to, in 14:25
11 terms of putting, I think, eleven trackers, or
12 thereabouts, in Southern Trust, we have now provided
13 enough funding for Southern Trust recurrently to have
14 eleven trackers. I think we know that, given the rise
15 in demand and also given the complexity of the pathway, 14:25
16 we may want to go further with that, but, to this
17 point, I think we have fulfilled what we set out to do
18 a number of years ago.
19 132 Q. So, at this remove, would you be content that the
20 issues that the Panel may consider arose as a result of 14:25
21 MDT recommendations, perhaps, not being followed
22 through as robustly as they might be, you think that
23 that is unlikely to have the potential to recur?
24 A. MR. CAVANAGH: Trackers are part of the cancer team.
25 They are not the only sort of people within the team 14:26
26 who are following the patients' journey. You know, we
27 have invested in additional Clinical Nurse Specialists,
28 we have also invested in additional Consultant staff,
29 medical staff and so on, so it's about looking at the

1 team approach, but we know that cancer trackers provide
2 a particular administrative function, which is useful
3 in terms of tracking the patient and ensuring that --
4 I think about once a week, that a patient is kind of
5 checked in on to see where they are in relation to 14:26
6 their pathway, but I think given the rise in demand,
7 given the complexity of care as well, and care, as each
8 year goes by, becomes a little more complex in a cancer
9 space as well. I think we know that we have got to
10 continue to grow the cancer team and look at how we 14:26
11 develop that, in the knowledge that we also have
12 financial constraints that is going to make that very
13 challenging.
14 133 Q. I suppose from a sort of simplistic point of view, the
15 process of cancer tracking is administrative -- 14:26
16 A. MR. CAVANAGH: Mm-hmm.
17 134 Q. -- in that regard. I know there are other Clinicians
18 and healthcare professionals involved, but from an
19 administrative point of view, and forgive me because
20 I'm not involved in that, but it seems that it would be 14:27
21 something that could be fairly easily done, and I don't
22 minimise the people who do that, of course, by saying
23 that, but the actual process of following up and
24 checking that people have had their results, that they
25 know their next appointment, the results are in, that 14:27
26 what was anticipated would happen to them, did happen,
27 and, in that regard, are you content that, if the Panel
28 were to consider that some of those issues didn't take
29 place because of the evidence they've heard, are you

1 content that that is unlikely to be repeated?
2 A. MR. CAVANAGH: Again, I'm a little lost in your
3 question, if I'm honest, but I think --
4 135 Q. Well, I'll put it perhaps more simply.
5 A. MR. CAVANAGH: Sorry. 14:27
6 136 Q. Are there enough cancer trackers to track people who
7 are getting cancer treatment?
8 A. MR. CAVANAGH: So there are enough cancer trackers to
9 take us to first treatment, but, beyond that, I think
10 the wider cancer team is looked to, to ensure that that 14:28
11 ongoing treatment is there. I think we now need to
12 reflect on whether or not we need to develop cancer
13 trackers further than what we have done to date, but we
14 have reached where we set out to at this stage, but
15 there is potential for us to go further. I mean, 14:28
16 I wouldn't underestimate how challenging the cancer
17 tracker role is as well, from talking to colleagues in
18 relation to it. These are challenging roles, despite
19 being administrative. So, on that basis, I think they
20 have to be seen in the wider team because it's not 14:28
21 really about the individuals, as such; it's that the
22 cancer team is appropriately tracking patients and the
23 cancer trackers have a role within that.
24 137 Q. And it sounds like it's been evolving for --
25 A. MR. CAVANAGH: For some years, yes. 14:28
26 138 Q. For quite a period of years?
27 A. MR. CAVANAGH: Yes.
28 139 Q. And continues to evolve. Now, are you informed by the
29 evidence you have heard at this Inquiry of the

1 particular concerns around tracking and the issues that
2 arose because of that, has that informed your
3 deliberations and your plans?
4 A. MR. CAVANAGH: It has, but I should also emphasise that
5 Trusts also raise these issues with us; you know, we 14:29
6 have been growing trackers as a resource for
7 some years. We recognise the value of trackers and
8 I think we are looking at how we might develop that
9 further.
10 140 Q. And just generally, the position in MDTs, is the 14:29
11 current position, would that provide any more comfort
12 to the Panel, given the quoracy issues that have arisen
13 in the past around specialists being available and
14 attending?
15 A. MR. CAVANAGH: I mean, it is a challenging issue. I 14:29
16 mean, I have never managed an MDT, so I can only tell
17 you from a bit of a distance in relation to it, but if
18 I think about Oncology, Clinical Oncology involvement
19 in an MDT, which was raised during the 2015 Peer
20 Review, both regionally and also specifically with 14:29
21 Southern Trust, you know, we -- since then, since about
22 2018, we have put in place an Oncology-Haematology
23 stabilisation plan, put a significant amount of funding
24 into that to grow the Oncology workforce as well as the
25 Haematology workforce. So I would like to hope, with 14:30
26 those additional roles now in place, those additional
27 staff now in place, that some of those issues have been
28 resolved, but I can't be sure, at the same time,
29 because we haven't done any direct review in relation

1 to it. In relation to Radiology, we are very conscious
2 of, we have quite a number of vacancies within
3 Radiology, it's been a problem for some years now, so
4 that Radiology challenge has been, I think, something
5 that all Trusts have been faced with, and I think there 14:30
6 will need to be some thoughts about how Radiology input
7 can be done differently if there isn't enough sort of
8 resource available to actually attend MDTs, but I think
9 that's certainly an important issue.
10 14:30
11 And Pathology, the Histopathologist that's mentioned as
12 well, I think, again, Pathology has had its own
13 workforce challenges, but all of those -- across the
14 whole system there are workforce challenges. It's
15 about trying to make the MDTs function as best they 14:30
16 can. The best way for them to function is, everyone in
17 the room together talking about the individual patients
18 on the agenda for that day, but, if that won't work,
19 they will need to think also creatively about are there
20 other ways to get those inputs on those patients at the 14:31
21 point that it is required.
22 141 Q. And when these discussions are happening, both within
23 your organisation and with the Trusts and perhaps other
24 organisations, are they framed in the context of
25 patient risk and patient safety? 14:31
26 A. MR. CAVANAGH: In terms of the MDT discussions or
27 discussions about MDTs?
28 142 Q. Well, both, effectively. Is there --
29 A. MR. CAVANAGH: I can't speak to what happens within an

1 MDT. As I say, I have never been directly involved in
2 an MDT; it's a clinical forum in --
3 143 Q. Well, in relation to the absence of some services, some
4 personnel and perhaps trackers, are these being spoken
5 about in a patient safety and risk context? 14:31
6 A. MR. CAVANAGH: Absolutely. I mean, MDTs are the focal
7 point of cancer pathways. They are essential to ensure
8 that patients are receiving the best care that is
9 possible, so they are important. We are looking at
10 them. I mean, as well, off the back of the 14:32
11 recommendations from the nine SAI Overarching Review,
12 which took place in 2021, we have also been looking at
13 MDTs through that process as well, so MDTs are
14 something that we are focussing on, we wanted to more
15 work in relation to them as well, but they are crucial 14:32
16 for cancer care, and that's why we need to actually do
17 all that we can to make them work as effectively as
18 possible.
19 144 Q. I wonder if we could look at Paula Clarke's statement
20 at WIT-37595. So this is a Pathway Review carried out 14:32
21 by the HSCB. Paula Clarke describes it at 52.2 as
22 follows:
23
24 "I have been reminded by reference to documents
25 provided to me by the Trust Public Inquiry Team that, 14:33
26 in January 2015, when I was Director of Performance and
27 Reform, the HSCB had completed a short pathway review
28 to assess the systems and processes currently in place
29 for the booking of Outpatient Services regionally, to

1 ensure they support the consistent application of the
2 integrated elective access protocol. The performance
3 against chronological management at specialty level
4 within each Trust was analysed and those specialties
5 with a higher percentage of routine new outpatients 14:33
6 being seen out of chronological order, were selected
7 for review. In addition, specialties where there was a
8 particular concern regarding patients currently waiting
9 over nine weeks, were also selected for review. Five
10 specialties were identified for review across the 14:34
11 region, including Urology. The report from this audit
12 was sent to Mrs. Aldrina Magwood, as Acting Director of
13 Performance and Reform, in June 2015/2016, by
14 Mr. Michael Bloomfield, HSCB Director of Performance
15 and Corporate Services." 14:34
16
17 I just want to make sure I get the right reference.
18 53.3, please. So, this is again reference to -- it
19 just provides more detail further along in her
20 statement, and she says at paragraph 53.3: 14:35
21
22 "In 2015/2016, during my tenure as Interim Chief
23 Executive, the Pathway Review completed by HSCB and
24 referenced in paragraph 52.2 assessed the systems and
25 processes in place for the booking of outpatients in 14:35
26 Urology Services against the Integrated Elective Access
27 Protocol, with a specific focus on performance against
28 chronological management. Key findings from that
29 report were follows:

(a) Regarding triage times, it was reported that 'For the majority of Urology referrals, daily triage is now achieved, but there is a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff'.

(b) Regarding clinic templates, it was reported generally that clinic templates 'are carved out to new urgent, new routine and review slots in line with best practice'. For Urology specifically, it was reported that 'Since December '14, all clinic slots are designated red flags. Unallocated slots are notified to the Referral and Booking Centre who book with patients from the PTL, selecting urgent patients first and then proceeding to routines. Urgent patients are mostly being booked within four to six weeks, but the waiting time for new routine patients is currently at 40 weeks .

(c) With respect to chronological management, it was reported that 'In some specialties, for example, Urology and Ophthalmology, the Referral and Booking Centre will be contacted by referrers with information about a change in clinical priority and a second referral usually sent in. Staff will administer this on the system, retaining the patient's original date, but amending the clinical priority and appointment

1 time. This can mean that sometimes urgent patients
2 will appear to have waited longer than routines'.
3
4 (d) Regarding booking processes, it was reported that
5 'The process for booking new routine and review 14:37
6 patients is in line with regional guidance. In the new
7 Urology model, all patients are now telephone-booked'."
8
9 53.6. Sorry, I just want to find a particular part of
10 this. So we'll see at point (a) that I read out there 14:37
11 at WIT-37595:
12
13 "'... a long-standing issue with turnaround time from
14 one consultant and referrals not returned from triage
15 continues to be a key issue for booking staff'."
16
17 I am conscious that, with hindsight, that jumps out at
18 us, because it should do at this remove, but given the
19 specific reference to that in the Peer Review and an
20 indication that there's, potentially, a theme with one 14:38
21 individual, if I put it like that, around the triage,
22 this was a report that HSCB received. I don't know if
23 you were directly involved in the receipt of this?
24 A. MR. CAVANAGH: No.
25 145 Q. But is that something that should have caught someone's 14:38
26 attention? I know that we have talked about the Trust
27 and the demarcation of governance accountability and in
28 general terms about what's expected from each player in
29 the healthcare provision, but would you expect that to

1 be something that somebody might be curious about and
2 say, well, if it's one source, what are you doing about
3 that?
4 A. MR. CAVANAGH: I mean, I suppose there was enough
5 curiosity to write this in a report, that there was one 14:39
6 Consultant who was out of sync with other Consultants
7 and not achieving what was set out in the IEAP, but,
8 ultimately, it was for the Trust to consider how they
9 would, I suppose, bring all of their Consultants up to
10 the same level that was required. I don't really think 14:39
11 it was for us to become involved in that. I mean, I
12 remember, while not being directly involved in this,
13 whenever we were talking about developing clinic
14 templates, when we were looking at rebasing our
15 capacity, for example, there was a lot of debate among 14:40
16 Consultant teams about whether or not it was realistic
17 to have X number of new patients, X number of review
18 patients, and some Consultants were more conservative
19 than others. But ultimately, that kind of a debate was
20 useful for us to be involved in but still needed to go 14:40
21 back to the team and to the Trust for them to resolve
22 and to actually have a degree of consistency in the
23 services that they needed to deliver on.
24 146 Q. Well, going back to the question around this, would you
25 accept at all that this is a potential point of 14:40
26 knowledge on the part of the HSCB, that there is
27 perhaps a specific issue around one Consultant that has
28 been highlighted in this report?
29 A. MR. CAVANAGH: Of course.

1 A. MRS. GALLAGHER: If I might add, Ms. McMahon?
2 147 Q. Yes, of course.
3 A. MRS. GALLAGHER: I should, quite rightly, say it with
4 the benefit of hindsight, that absolutely is stark.
5 However, in terms of the turnaround time for one 14:40
6 Consultant, you know, that could be for any amount of
7 reasons at the time and there would be an expectation
8 that the Trust would put in place whatever practice or
9 whatever arrangements needed to take place to address
10 that. So it's just to stress the benefit of the 14:41
11 hindsight issue, as you quite rightly said, in terms of
12 that coming out.
13 148 Q. And I appreciate that, but just slightly in the context
14 of, if we, even hypothetically, work from a position
15 that the Trusts were aware of this, this is a slight 14:41
16 leaking outside the Trust of this information and --
17 well, I'll ask now. If that was reflected in a report
18 you received now, would that be something that people
19 would say, 'okay, we need to ask some questions around
20 this', would it be more of a curiosity? 14:41
21 A. MRS. GALLAGHER: I think it's fair to say that if an
22 individual, or even not named, was singled out in that
23 way, we would want assurance in terms of what action
24 was being taken in that regard, as part of the overall
25 improvement plan. 14:42
26 149 Q. Sorry, I think I might have a digit out, I am just
27 checking. I am sorry about that. If we just move down
28 slightly. So Ms. Clarke says this at paragraph 53.5:
29

1 "I have some recollection of being generally aware of
2 the issues raised in this report regarding daily triage
3 and that the reference to turnaround time for one
4 Consultant referred to Mr. O'Brien, as well as a
5 general awareness of the recommendation that I believe 14:43
6 was made by HSCB to five Trusts in the region, to agree
7 a process for using the referral priority grading for a
8 patient where the three-day turnaround standard was not
9 being met."
10 14:43
11 Now, do you have any knowledge of that particular
12 process where there was a change in approach when the
13 turnaround wasn't being met?
14 A. MR. CAVANAGH: No, unfortunately, I don't.
15 150 Q. Just for the Panel's fuller note, the name of the 14:44
16 report author seems to be Maria Wright from HSCB and
17 she spoke to members of staff, and that's given in
18 evidence by Aldrina Magwood at TRA-06022, and, in fact,
19 I do want to go to that because I want to put it on
20 record what she says about other individuals as well; 14:44
21 it wasn't just Mr. O'Brien mentioned, I think. So,
22 TRA-06022. So it starts at the bottom:
23
24 "Do you know where the HSCB got that information from
25 that informed their report? Where did they find out 14:45
26 this bit about 'a long-standing issue with turnaround
27 time from one Consultant and referrals not returned
28 from triage continues to be a key issue for booking
29 staff'?"

1
2 And Ms. Magwood said:
3
4 "I think that would have been from Maria, who would
5 have done the report, and I'm assuming that even having 14:45
6 a heard and read Katherine Robinson's evidence here to
7 the Panel, I don't think the Team would have been
8 holding back with an honest issue if they had a
9 challenge. They would have been reporting that."
10 14:45
11 She is then asked:
12
13 "So you think Maria Wright from the HSCB went out and
14 spoke to members of staff and took evidence
15 effectively." 14:46
16
17 And she replies:
18
19 "I think that was part of the review she was working in
20 amongst the team, that would have been my understanding 14:46
21 of how it was conducted."
22
23 So if we go to TRA-06027. So if we just go down to the
24 line that says: "You have said", at line 11:
25 14:46
26 "You have said that it wasn't just Mr. O'Brien, do you
27 think that that was an unfair representation in that
28 report?"
29

1 And she says:
2
3 "I do in the sense of I think, like I said, I mean.
4 Again I have to go back, it's some years, but I do
5 recall that it uncovered quite a lot of issues we had 14:46
6 in paediatrics, for example, and attention going into
7 the work from the Director of Children's Services at
8 that time to sort of address some of the challenges
9 there. So those to me were the bigger system issues
10 that needed addressed. 14:46
11
12 Naming one individual, I mean it's like anything from
13 an information perspective, if you say one individual
14 you know it is clearly naming an individual. For a
15 report that was to do a review of an entire system 14:47
16 I thought it was unusual, it's an unusual comment."
17
18 I read that in for two reasons, first of all to inform
19 the transcript and others that this was a wider review,
20 dealt with other specialties, it wasn't just on 14:47
21 Mr. O'Brien. But that she said she thought it was an
22 "unusual, an unusual comment". Is it possible, and
23 I know you weren't involved, but is it possible that
24 the inclusion of that comment was to identify that this
25 was a very live issue for the Trust and that there were 14:47
26 concerns more broadly?
27 A. MR. CAVANAGH: It's something I have been discussing
28 with colleagues in recent weeks, Ms. McMahon.
29 Maria Wright does work for SPPG and did work for the

1 Health and Social Care Board but she also worked for a
2 period for the Southern Trust. And I'm concerned that
3 there's been a bit of confusion as to when Maria was
4 working for Southern Trust and when she was working for
5 the Health and Social Care Board. Now I'm keen to 14:48
6 clarify it but I can't clarify it today. But I'm more
7 than content, if the Panel wishes, to come back with
8 further information. But I think there has been some
9 confusion about Maria in particular because she did
10 work for Southern Trust for a period around about this 14:48
11 time.
12 151 Q. Well, that would be helpful to know who she was working
13 for when she wrote this but it doesn't take away from
14 the fact that the HSCB saw this report, that is not
15 interfered by your needing to fact check whether 14:48
16 Aldrina Magwood is correct in saying that it was HSCB
17 staff, but we can do that?
18 A. MR. CAVANAGH: Sure.
19 152 Q. But the ultimate point was really about the potential
20 knowledge and the timeline for that. 14:48
21 A. MR. CAVANAGH: Sure. Of course.
22 153 Q. But I don't think that's displaced by that information.
23 I want to look at the SAIs. The Panel have heard a lot
24 of evidence and from many, many witnesses around the
25 SAIs so it would seem, having looked at the evidence 14:49
26 through the HSCB lens that the main issues around when
27 you were told, when you were informed and delays around
28 that, certainly from the outset. I want to, if we go
29 to WIT-104313. What I'm going to do is just summarise

1 the issues that arise from the various SAIs. Just move
2 down please. That's where you start them in your
3 evidence, at paragraph 261. And the first one is
4 SAI RCA [redacted].
5 14:50
6 Now what's the expected time in which you're notified
7 about an SAI, what is the current standard around that?
8 A. MRS. GALLAGHER: I believe it's 42 hours, 48 hours.
9 MS. McMAHON: Is it 72 hours after the incident, does
10 that sound familiar? 14:50
11 A. MR. CAVANAGH: I'm actually not sure because that
12 sounds like the Early Alert timeframe.
13 154 Q. Just at the top of that page, sorry I was trying to
14 prompt you just so you will remember your evidence, but
15 it says: "As per the SAI procedure outlined in section 14:51
16 3 of this statement Trusts are required to inform the
17 HSCB within 72 hours of the incident..."
18 A. MR. CAVANAGH: Yes, apologies.
19 155 Q. That's fine, that's fine. "...of the incident being
20 discovered." So there is that expectation that within 14:51
21 three days of the incident, or I presume earlier,
22 depending on the serious nature of it, but 72 hours
23 seems to be the outlier time?
24 A. Yes.
25 156 Q. This particular SAI you were notified via the SAI 14:51
26 mailbox on 22nd March 2016, which was ten weeks after
27 the date of the incident. The final RCA report for
28 this SAI, [redacted], was due to be submitted to HSCB within
29 12 weeks from notification of the SAI, in other words

1 by 14th June 2016 and the report was not received until
2 16th March 2017, which was 39 weeks after the agreed
3 date of receipt. Just given those examples around both
4 the initial notification and the subsequent report and
5 given now that that's a relevant SAI for our purposes 14:52
6 what, if anything, actions are in place for HSCB to
7 take when timeframes are not met or do you have any
8 sort of internal process by which you keep an eye on
9 things and then go back to the Trust and say you are
10 well out of your timeframes here and say what's 14:52
11 happening?
12 A. MRS. GALLAGHER: If I could maybe pick that up, Ms.
13 McMahon.
14 157 Q. Yes, of course?
15 A. MRS. GALLAGHER: I think the improvements that 14:52
16 I described earlier will absolutely address those
17 points, so in relation to the notification, the ten
18 week delay, should that happen we would absolutely pick
19 that up and we would be engaging with the Trust to
20 understand the reason for the delay and that would be 14:53
21 picked up in the bimonthly discussions in terms of
22 escalations. In terms of the time elapsed to complete
23 the review the risk process that we have put in place
24 now, because I think I have described to you there are
25 still delays within the system because of the need for 14:53
26 the appropriate resource to investigate and take
27 action. So I can't say that there wouldn't be delays
28 to that extent now but what would happen is that those
29 cases would be risk managed to make sure that any early

1 learning was put in place and that we understood we're
2 cited on and had mitigated against the risk of a delay.
3 158 Q. Just so we understand if there was an opportunity lost
4 within that timeframe, for example that SAI given the
5 nature of the delay, what action does HSCB take? 14:53
6 I know you have now indicated a process by which risk
7 is identified and managed early on, is that by way of
8 learning both within the Trust or the location that the
9 SAI emanates from but also more widely across
10 Northern Ireland or what would your reaction be? 14:54
11 A. So one of the initial actions when the alert is
12 received it's allocated to the DRO. But part of that
13 consideration is what is the immediate learning both at
14 Trust level and more broadly. So there's learning
15 along the way rather than waiting on the final review. 14:54
16 159 Q. Another example is SAI [redacted], it has also got the
17 reference [redacted]. This was a further SAI notified to
18 the Health and Social Care Board on 21st September
19 2017. That notification informed that the
20 Southern Trust had become aware of the incident on 14:55
21 12th May 2017, which was four months before the
22 notification, and the report referred the concerns
23 about the care of four patients during 2016.
24 Now the DRO forwarded queries to the Trust seeking
25 assurances, and we can look at that at WIT-73691. If 14:55
26 we just move down slightly just so we can see the
27 author and the recipient. So the topic is "serious",
28 it's from "serious incidents", I presume that's a
29 mailbox from your internal staff, "21st September 2017,

1 SAI notification form", and it is SAI ██████, and it
2 says:
3
4 "Lindsey, please see below DRO queries in relation to
5 the above. The DRO requests an urgent response. What 14:56
6 action has been taken to prevent further referrals
7 slipping through processes like this? Has the Trust
8 assured itself that there are no other Urology
9 referrals have slipped through? Have they considered
10 if this is likely to be a problem in other specialties? 14:56
11 Also the DRO wishes to draw the Trust's attention to
12 the attached SAI, which has a HSCB reference of S8146,
13 and check if the cases in SAI below were found
14 following a review prompted by this SAI as the case is
15 not on the list of new ones?" 14:57
16
17 Now the Trust response to that is at WIT-73693.
18 so WIT-73693, just two pages down, 73693. It is
19 29th September 2017, 10:40 from Corporate Governance in
20 reply, and it says: 14:57
21 "Response to DRO queries.
22 1. What action has been taken to prevent further
23 referrals slipping through processes like this?
24 (A) electronic referral process is being piloted which
25 makes triage more accessible and timely. It allows 14:57
26 easy identification of referrals that have not been
27 triaged & reporting of same.
28
29 2. Has the Trust assured itself that there are no

1 other Urology referrals have slipped through?
2 (A) There has been a lookback exercise within Urology
3 to identify any other referrals which were not triaged.
4 This review is complete.
5 14:58
6 3. Have they considered if this is likely to be a
7 problem in other specialties?
8 (A) If Consultants fail to comply with the IEAP process
9 and there are delays in triaging this is escalated to
10 the HOS and AD for action. SAI [redacted] was identified 14:58
11 from review of a complaint sent by his family."
12
13 So that would appear to be an assurance provided that
14 this matter was being dealt with. The electronic
15 referral process is that a referral to e-triage at that 14:58
16 point?
17 A. MR. CAVANAGH: Electronic referral comes from a GP to
18 the Trust and then will be e-triaged then.
19 160 Q. Were you involved in dealing with any of these SAIs,
20 was this something you were -- 14:58
21 A. MR. CAVANAGH: Not directly, no.
22 161 Q. Not directly. And the electronic referral process has
23 been highlighted at that point, did that answer then
24 give you some comfort around the likelihood of that?
25 Would it give you some comfort, I realise you weren't 14:59
26 involved directly, in the likelihood of reoccurrence?
27 A. Well we spent a lot of time over the last seven or
28 eight years, not so much during the pandemic time, but
29 promoting electronic referral, working with GPs,

1 ensuring that they are actually using the system and
2 using it as appropriately in line with the guidance.
3 So we put a lot of effort into it, a lot of meetings
4 with GPs as well. So on that basis we remain keen to
5 encourage electronic referral because it also helps at 14:59
6 the point of triage because you have all the
7 information in front of you to then e-triage.
8 162 Q. Would you have anticipated, and I am asking these
9 questions knowing that you weren't personally involved
10 in these, the previous SAI around triage as well and 14:59
11 this one would you have expected the Trust to identify
12 that this was another issue around triage now if that
13 were to happen?
14 A. MR. CAVANAGH: I mean it looks like the DRO identified
15 that, more important than me. I mean the DRO clearly 15:00
16 recognised that this was an issue and I suppose the
17 Trust have come back. It doesn't look like they have
18 particularly answered that question in that response
19 but I mean it does look like there was some connection
20 there, yes. 15:00
21 163 Q. The answer is not particularly fulsome in providing
22 reassurance about systems --
23 A. MR. CAVANAGH: I appreciate that.
24 164 Q. -- would you have expected the DRO to go back and say:
25 'I'm not quite sure that's the answer that I was hoping 15:00
26 for or anticipated, can you provide reassurance given
27 this is at least a second SAI where triage has been
28 highlighted as problematic'?
29 A. I think, I mean DROs obviously are dealing with a lot

1 of cases at any one time. My experience of DROs is
2 that they tend to follow through on those kind of
3 issues. Fair enough this is an e-mail here. For all
4 I know there could have been phone conversations, and
5 so on, going on at the same time. But, yes, I would 15:01
6 have hoped that the DRO would have exhausted the issue
7 because he or she obviously had raised the issue in the
8 first instance.
9 A. MRS. GALLAGHER: Ms. McMahon, if I might add just in
10 terms of the process and improved process, so the Datix 15:01
11 system which we use to log SAIs and manage it we have
12 enhanced our coding mechanisms so that we can drill
13 down in terms of the issues. That was a challenge that
14 had come up throughout the previous hearings, our
15 ability to identify all related SAIs. So we have 15:01
16 enhanced that facility. We have also included a
17 dashboard system where we can understand when SAIs were
18 first reported and the time elapsed between each
19 period. DROs now have view access to that as have the
20 senior personnel in the safety teams and the 15:01
21 multidisciplinary professional teams. So there is much
22 more visibility in terms of tracking, in terms of time
23 frames and the ability to escalate where timescales
24 seem to be elongated, and I described the process of
25 risk management earlier. The other important point is 15:02
26 the ability for us to triangulate linked or potentially
27 linked issues and not rely totally on the Trusts,
28 albeit it is primarily their responsibility to do that.
29 165 Q. PHA in their evidence on Tuesday had mentioned about

1 the difficulty with Datix searches?
2 A. MRS. GALLAGHER: Yes.
3 166 Q. Is that remedied?
4 A. MRS. GALLAGHER: That's exactly it. About a year and a
5 half or two years ago in response to, you know, what we 15:02
6 were hearing around this we have put our own coding
7 systems which complement the Datix coding systems but
8 allow us to provide, to better interrogate the system,
9 to better make linkages and to cross refer.
10 167 Q. Thank you for that. Just to complete the loop on that 15:03
11 particular journey of that SAI, that was listed for
12 discussion at the acute SAI professional group on
13 20th November 2017 to consider the Trust's responses
14 and there was no indication of trends or requirement
15 for the dissemination of regional learning. The SAI 15:03
16 would be referred to the Regional Scheduled Care Group
17 in respect of its views on timely triage and
18 categorisation. Then on 10th April 2018 the Trust
19 provided an update on the two local recommendations
20 regarding clinical triaging and the escalation of 15:03
21 triage non-compliance:
22
23 "Advised that actions had been completed which was
24 forwarded to the DRO, who responded on 18th April 2018
25 to say she was content." 15:03
26
27 And the SAI was closed. So there was that further
28 follow-up and engagement with the DRO providing
29 information about that.

1
2 The SAI [redacted], this was notified to the:
3
4 "This was notified to the HSCB via the mailbox on 22nd
5 September 2017, marked as a Level 1 review. The 15:04
6 notification indicated that the incident had occurred
7 on 10th July 2016." So there was a 62 week delay from
8 the date of the incident until it was reported to the
9 HSCB. There was a further delay of 115 weeks before
10 the final review was submitted." 15:05
11
12 There's evidence in the bundles of the
13 Chief Executive's correspondence from the HSCB which
14 seemed to be fairly pro forma template letters saying:
15 Get your SAIs in on time effectively. But there 15:05
16 doesn't seem to have been any further follow-up and
17 correspondence in that regard, is the position still
18 the same, that a pro forma -- you're shaking your head,
19 you know your answer before I say the question so I'll
20 let you give us the information. 15:05
21 A. MRS. GALLAGHER: I apologise, Ms. McMahon.
22 168 Q. No. Go ahead?
23 A. MRS. GALLAGHER: I suppose there is still, and I think
24 I referred to writing to Trust Chief Executives quite
25 recently in a relatively formulaic approach basically 15:05
26 to outline concern about SAIs, which is a shared
27 concern, and to invite them to comment on that. So
28 that is part of a routine process. But, importantly,
29 the improvements that I have described allow for

1 identification where there is potential issues in terms
2 of the management of SAIs at local level, the
3 notifications, the actioning and the completion of
4 SAIs. So the regular performance meetings, and I'll
5 call them that because that's what they are, an 15:06
6 engagement between my team, PHA, and the Trusts now
7 have the opportunity to discuss any emerging or
8 potential issues and that could include if a pattern
9 emerged in terms of late notifications.
10 169 Q. Thank you for that. Chair, I just want to go back, 15:06
11 I think I in error gave you a chronology for the wrong
12 SAI and I just want to correct it on transcript. The
13 sentences I read out were:
14
15 "Following consideration of the RCA report by the SAI 15:07
16 Acute Professional Group on 6th June 2017." I then
17 gave you a date of 20th November and then 10th April,
18 when I said: "The DRO was content and the SAI was
19 closed." Those actions refer to SAI [redacted], the very
20 first one I spoke about. Apologies for that. I didn't 15:07
21 ask you any questions arising out of that because you
22 weren't involved so I didn't take you out of sequence.
23 I just want that corrected for the transcript.
24
25 Just the last SAI I was speaking about, [redacted], the one 15:07
26 that you have explained, the new, well the approach,
27 hopefully, that may well trigger better compliance with
28 the timescales, which I presume are still the same, the
29 72 hours? I don't see anything to suggest ourselves.

1 The last SAI that I spoke about:
2 "Following a review of this SAI by the acute services
3 SAI Review Team on 30th June 2020 it was agreed that a
4 newsletter article reiterating the importance of
5 communication between all teams' specialties involved 15:08
6 in the care and treatment of a patient would be issued.
7 Also importance of communicating with the patient.
8 Regional distribution of this learning was initially
9 delayed due to the fact that PHA colleagues who were
10 responsible for the drafting of articles and 15:08
11 disseminating the newsletter were redeployed during the
12 COVID-19 pandemic."
13
14 Then:
15 15:08
16 "An administrative error was noted in the HSCB system
17 in August 2021 when the HSCB Governance Team realised
18 that the Trust had not been advised the SAI was closed
19 in June 2020 and that learning was to be distributed
20 via a newspaper article. Agreed that learning would 15:09
21 not be issued as there was a potential for much wider
22 learning as at that point nine further SAIs regarding
23 Mr. O'Brien's practice."
24
25 The administrative error I'm not going to speak to but 15:09
26 in relation to the way in which learning is
27 disseminated via newsletters does that happen
28 frequently or after particular SAIs or what is the
29 format for that method?

1 A. MRS. GALLAGHER: So maybe I'll speak to that,
2 Ms. McMahon. I mean there is quite a range of ways in
3 which we disseminate learning. Forgive me, I was
4 looking at my notes here in terms of my evidence and it
5 brought that up to date. I think I referred to the 15:09
6 22/23 Quality Report and that that evidenced that
7 throughout that period there were 48 areas of learning
8 that was disseminated to the relevant networks,
9 clinical networks and groups for dissemination across
10 specialties. There were 22 newsletter articles issued. 15:10
11 There was one learning letter, so a learning letter is
12 new learning, everything else is a reminder of learning
13 that's already there or guidance that's there. There
14 were three professional letters, sorry, two
15 professional letters and five reminders of best 15:10
16 practice guidance letters. We also used, I think
17 Mr. Dawson referred to Echo, which is essentially
18 pretty much like any other, like a Zoom platform or a
19 Teams platform and it is used within Health and Social
20 Care to share learning, to bring people together 15:10
21 virtually, it is used to augment and wrap around the
22 other communications that are targeted to specific
23 areas or specific Clinicians or professional groups
24 based on the nature of the learning. So there's a
25 quite significant volume of learning that's issued as 15:11
26 quickly as possible post the event. But I think you're
27 absolutely right and it is fair to say that throughout
28 Covid there was a hiatus in terms of our ability to
29 issue learning and to undertake reviews and the process

1 in the way that we would have wanted.
2 170 Q. And the exceptionality of that time then is reflected
3 in where you had to prioritise I presume?
4 A. MRS. GALLAGHER: Indeed.
5 171 Q. When you look at some of this now and you look at the 15:11
6 SAIs and the potential drip feeding of red flags of
7 what were happening and the issues that were arising do
8 you think that the issues could have been identified
9 earlier by HSCB even if they couldn't have acted on
10 them immediately given your demarcation of governance 15:12
11 accountability? Do you think when you look at this and
12 you look at the timeframe and the information now as a
13 whole, and I realise we're looking back, but when you
14 look at that as a whole do you think there was a
15 potential for concerns to be raised? 15:12
16 A. MRS. GALLAGHER: I think the nature of the processes
17 that we oversee and manage in terms of complaints, and
18 there was no evidence in relation to complaints of it
19 being in this regard, the SAIs in terms of our process
20 now and our ability to drill down more in relation to 15:12
21 the nature of the issue could potentially have flagged
22 up over a period of time that urology, there may have
23 been issues in urology. What it would not still
24 probably have flagged up, and I do accept that we have
25 just referred to the reference of the single Consultant 15:13
26 there, but what it wouldn't flag up is issues in
27 relation to an individual Consultant necessarily but it
28 would certainly start to create a picture about issues
29 in certain specialties. Now that could be for many,

1 many reasons, including the delays that we have and the
2 challenging working environment that we have. But
3 certainly -- you can never say that enhancements to a
4 system or a process is going to necessarily lead to a
5 better outcome, that's never possible, but certainly we 15:13
6 have put more robust arrangements in place to be able
7 to understand the areas where issues are arising in a
8 more robust way.
9 172 Q. And to be fair to you by the time the information gets
10 to the HSCB it's been seen by perhaps quite a few 15:13
11 people already?
12 A. Indeed.
13 173 Q. I'm not saying that you of all people should have
14 identified this but if all of the organisational
15 structures allow for oversight of governance 15:14
16 collectively then the possibility exists that there
17 maybe was a nudge in the right direction to be more
18 curious?
19 A. I agree, and it's an important point you make,
20 Ms. McMahon, because the premise on which we're all 15:14
21 operating is to prevent it getting to SAI, prevent it
22 getting to AI. So it's about making provision for safe
23 services, for quality services in advance so that we
24 minimise the amount of instances where SAIs occur, and
25 that's really important. That's remains our priority, 15:14
26 that we need to put our energies in to putting the
27 systems, the environment in place, including the
28 safeguards around clinical practice to ensure and
29 mitigate against SAIs happening, albeit, you know, you

1 can't prevent things going wrong.
2 A. MR. CAVANAGH: Now I think increasingly DROs now
3 talking together is an important feature of
4 recent years as well. I think DROs in the past would
5 have been working on individual SAIs and working 15:15
6 through them but I think as the years have gone by
7 those opportunities to talk together. Different DROs
8 may have looked at different SAIs in relation to this
9 but now they actually are having the opportunity to
10 discuss those, and that may lead to, I suppose, themes, 15:15
11 and so on, emerging much more readily off the back of
12 that too.
13 A. MRS. GALLAGHER: Just to --
14 174 Q. Sorry.
15 A. MRS. GALLAGHER: Sorry, Ms. McMahon, just to emphasise 15:15
16 that, that is a deliberate strategy that we have
17 deployed based on the learning here. So I think
18 I referred earlier to the DRO and a wraparound
19 multi-professional team and that's to make sure that
20 the learning and there's a broader line of sight so we 15:15
21 engage and talk about the range of information and
22 intelligence, not just from SAIs but from Early Alerts,
23 from complaints, from whatever evidence we have from
24 PCC and there's a Multidisciplinary Team approach and
25 they meet regularly to discuss these matters. 15:16
26 175 Q. And without rehearsing the point about anonymity, but
27 it's probably more fairly put in relation to SAIs given
28 the frequency or the number of them that ultimately
29 came through, and I know what you say about there being

1 learning, again is that another opportunity if you were
2 to have known that there was an individual perhaps
3 involved in certain aspects that a deeper review of
4 practice or a wider look at issues may have been
5 triggered at an earlier date? 15:16
6 A. MRS. GALLAGHER: I can understand why you would say
7 that. I think the practice of a clinician is
8 absolutely within the purview of the employer, of the
9 Trust and of the Trust Board in terms of oversight.
10 I would expect today as we sit if there are individuals 15:17
11 where there are practices that are not in line with
12 what is expected that colleagues, the management team,
13 others would identify that, that that would be picked
14 up as part of their appraisals, their feedback, their
15 revalidation and the processes that's in place to do 15:17
16 that.
17 A. MR. CAVANAGH: And remain strongly of the view that
18 this is a learning system, that we are trying to draw
19 out the learning and we're trying to encourage people
20 to come forward with some of the challenges that they 15:17
21 face which are, I suppose, showing up in adverse
22 incidents, serious adverse incidents. So we are keen
23 that the report comes forward so that the learning then
24 can be drawn out.
25 176 Q. Now in relation to your SPPG awareness of the issues 15:17
26 around Mr. O'Brien, you first became aware of those in
27 the Early Alert process and were you involved directly
28 in that, Mr. Cavanagh?
29 A. MR. CAVANAGH: I was involved in that, although it's

1 probably later in August 2020 before I actually become
2 directly involved.
3 177 Q. Was that the point at which HSCB became aware that MHPS
4 had been used?
5 A. MR. CAVANAGH: We had no previous knowledge of that. 15:18
6 That was really in the initial conversations we had
7 with Trust colleagues.
8 178 Q. Would you expect to know that? Would that be
9 something or that's another operational issue --
10 A. MRS. GALLAGHER: It is. 15:18
11 179 Q. -- that doesn't need to come to you unless it needs to
12 come to you. Would that be fair?
13 A. MR. CAVANAGH: That's right.
14 180 Q. This was another potential delay, the Trust didn't
15 notify you within the required time, you have put this 15:18
16 out at your statement at WIT-104327 at 313. We'll just
17 read from 311 because it gives us the context of your
18 knowledge. I think it became incremental as time went
19 on, and you say at 311:
20 15:19
21 "On 21st August 2020 I received an e-mail from
22 Jackie Johnston, Deputy Secretary, in the Department
23 about an Early Alert, EA181190 received from the
24 Southern Trust regarding Urology Services. The e-mail
25 was also directed to Olive MacLeod Chief Executive of 15:19
26 PHA. Jackie Johnston attached the Early Alert form
27 from Dr. Maria O'Kane, Medical Director Southern Trust,
28 which outlined the Trust's concerns about delays in
29 treatment of surgery patients who were under the care

1 of a Trust employed Consultant Urologist. It also said
2 that a lookback exercise had been conducted of the
3 Consultant's work for a 17 month period (January 2019
4 to May 2020) to ascertain if there were wider service
5 impacts. The Early Alert form noted the initial 15:20
6 actions the Trust had taken."
7
8 Just moving on down:
9
10 "The Department's Early Alert system is designed to 15:20
11 ensure that the Department and the Minister receive
12 prompt and timely details of events (including
13 potential SAIs) which may require urgent attention or
14 possible action by the Department. The Early Alert
15 notification sent by the Trust on 31st July 2020 15:20
16 provided necessary details to alert the Department and
17 explained the Trust's efforts to ascertain the extent
18 of concerns regarding the practice of the Consultant in
19 question."
20 15:20
21 At paragraph 313:
22
23 "The Departmental Early Alert circular issued on
24 27th February 2019 requires organisations to notify the
25 Department of any event meeting the Early Alert 15:20
26 criteria within 48 hours and the notification pro forma
27 must be completed and forwarded to both the Department
28 and HSCB within 24 hours after notification. The Trust
29 did not meet this requirement."

1
2 Just on that, I know we've looked at time frames before
3 but I imagine there is a requirement to meet a certain
4 timeframe because of the potential need to react?
5 A. MR. CAVANAGH: Yeah, absolutely. 15:21
6 181 Q. To the extent that this was late the HSCB were denied
7 that opportunity. Do you feel that there was any
8 impact of that delay operationally for you to take a
9 view on the significance of this Early Alert and the
10 act? 15:21
11 A. MRS. GALLAGHER: I think there may be two separate
12 issues, Ms. McMahon, the Early Alert is as it is
13 described, alerting the Department and the Minister in
14 case there is potentially a fallout in terms of media
15 or something that the Minister has to be alerted to. 15:22
16 The SAI, as we have just described, should be issued
17 and that should trigger the work to address the issue.
18 So the Early Alert process doesn't replicate or doesn't
19 seek to supplement for a failure to issue an SAI.
20 182 Q. No, and I am sorry if I presented it in that way but 15:22
21 the point, I suppose, was the time frames are there to
22 allow you to react appropriately at the right time?
23 A. MRS. GALLAGHER: That is exactly right.
24 A. MR. CAVANAGH: Yes, that is right.
25 183 Q. There certainly seems to have been a pattern in some 15:22
26 respects of delay?
27 A. MRS. GALLAGHER: There would appear to be.
28 184 Q. Just move down to 315 please. You say at 315:
29 "The HSCB was not notified of the issue prior to

1 receiving the Early Alert. The Trust could have raised
2 the issue with the HSCB earlier through established
3 channels given that there would be an impact on service
4 delivery due to any lookback activities."
5 15:23
6 And you go on to mention again about the pandemic and
7 impact on that. But is it fair to say that you would
8 have expected to know about this before the
9 Early Alert? Would it have been appropriate for HSCB
10 to be involved in advance of that step? 15:23
11 A. MR. CAVANAGH: There was a lot of staff changes in HSCB
12 in this period. I came into post in the middle of July
13 so in that way my predecessor had left at the end of
14 May. Maybe some of those key contacts weren't
15 available but others were available. And I think the 15:23
16 point that I am trying to make there is, you know, the
17 Trust is talking to us in various forums in various
18 ways, including lifting the phone and asking us
19 questions and taking advice on various issues. Had
20 they mentioned to someone in the Board at that time 15:24
21 that this was happening it is likely we would have
22 said: Have you raised an Early Alert? But, as I say,
23 the weeks went past and there was no contact
24 whatsoever. So the informal channels were there, I'm
25 not saying they should replace in any way the formal 15:24
26 channel, but I did find it unusual that there wasn't
27 any contact whatsoever until the Early Alert actually
28 arrives given the amount that was actually happening
29 from early June right through to the end of July.

1 MRS. GALLAGHER: I think perhaps, Ms. McMahon, to
2 augment Paul's evidence, we can't speak for what
3 happened at that time in terms of any discussions or
4 staff issues but what is absolutely paramount is where
5 there is even the potential for harm that an SAI is 15:24
6 sent so that we can act appropriately. We try to
7 operate within, we do operate within that framework
8 because if you work on informal mechanisms then, you
9 know, that does not point to good governance. SAI is
10 the accepted process. 15:25
11 A. MR. CAVANAGH: Yes.
12 MS. MCMAHON: Is it ever the case if there had have
13 been conversations in advance of the Early Alert, if in
14 the informal channels somebody said that's where we're
15 heading, is there room for intervention or potential 15:25
16 action from HSCB to try and mitigate either the
17 Early Alert having to be issued or to identify the
18 immediacy of the risk?
19 A. MRS. GALLAGHER: So if it's appropriate for an alert
20 to be issued it's appropriate for an alert to be 15:25
21 issued, we wouldn't be trying to talk people out of
22 that or put in place any kind of mitigation or plans.
23 That's the process and we work then to support and
24 enable that process.
25 A. MR. CAVANAGH: The Early Alert has a certain function, 15:25
26 and that function is to alert the Minister in the
27 Department at the earliest opportunity that this is
28 taking place. I think all that I am suggesting is that
29 we might have encouraged the Trust to raise that

1 Early Alert much earlier but, as I say, the opportunity
2 wasn't there.
3 MS. MCMAHON: I know we've talked about what the
4 position is now, and I know the SCRR are processing a
5 Lookback Review and the Panel has heard a lot of 15:26
6 evidence around that, but from the SPPG - I'm getting
7 used to the new language - from your perspective in
8 relation to the oversight mechanisms that we've touched
9 upon and you have explained very helpfully for the
10 Panel are there any further updates or any further 15:26
11 advancements or plans that you would like to share with
12 us that the Panel can take into consideration when
13 looking at governance structures currently in the Trust
14 and within other bodies? I know you have talked about a
15 lot of different... 15:26
16 A. MRS. GALLAGHER: I think it's fair to say, and
17 I described some of this earlier, we are certainly on a
18 journey, continue to be on a journey of learning. The
19 work being led in the Department in relation to the
20 Inquiry's Implementation Programme Management Oversight 15:27
21 Board with the learning of previous Inquiries will of
22 course continue to support and advise our actions, our
23 governance and our system response. One of the strands
24 of that work is governance. Workforce is another
25 strand and safety and quality another strand. So there 15:27
26 will be aspects of that that we will adopt and
27 implement as a matter of course.
28
29 In relation to the lookback and the SCRR you'll know

1 that we are part of the oversight arrangements and we
2 will continue to keep a watching brief on that to make
3 sure that the appropriate actions are taken in the way
4 they should, that families and patients are engaged
5 appropriately so we continue to be part of that 15:28
6 oversight arrangements and take the learning from that.
7 I think it's fair to say, Ms. McMahon, if I have
8 understood your question correctly, and I may not have,
9 that we remain in a process and open to learning.
10 185 Q. The process seems to involve individuals at a very high 15:28
11 level, the Permanent Secretary is involved in the
12 groups and you are involved in the groups?
13 A. MRS. GALLAGHER: Absolutely. Our attention to this is
14 at the very highest level of not just the Department,
15 of system readers right across. 15:28
16 186 Q. Just to go back further, I know we have moved forward
17 to learning but there was a question I had forgotten to
18 ask in relation to the funding of an administrative
19 exercise by the Board at one point to look at waiting
20 lists and to shortcut it I think. The plan was that 15:28
21 individuals on the waiting list would be phoned to see
22 if they still needed treatment for whatever reason and
23 that would allow the waiting list then to be properly
24 identified who was waiting for clinical care and who no
25 longer needed it for whatever reason. Now that was a 15:29
26 process that was funded by HSCB, did the idea for that,
27 you may not know that, did the idea for that come from
28 HSCB or did the Trust ask for that in order to get a
29 more realistic feel for waiting list numbers?

1 A. MRS. GALLAGHER: I think it would be a combination of
2 both. That was part of our elective care strategy
3 where we would cleanse the waiting list, but that's to
4 ensure that there was no duplication and that there was
5 follow-up of patients because some patients might have 15:29
6 chosen to go privately or change in some circumstances.
7 So it's routine practice to make sure that the waiting
8 lists are up to date and we are recording and
9 prioritising patients and following up in the right
10 way. So the funding was allocated to the trusts and 15:30
11 then they used that money in order to make contact with
12 patients and assess whether or not they still needed to
13 be on a waiting list.
14 187 Q. So that was always anticipated to be an administrative
15 process? 15:30
16 A. MRS. GALLAGHER: There is clinical involvement
17 absolutely.
18 A. MR. CAVANAGH: There is.
19 188 Q. The clinical involvement is done by a clinician at that
20 point, the point of contact? 15:30
21 A. MRS. GALLAGHER: So the mechanisms of how that happens
22 I am afraid I can't say but it's not simply an
23 administrative process because clearly there's a risk
24 that people might say they don't need the treatment
25 anymore and that wouldn't be appropriate that, you 15:30
26 know, you could take it at face value.
27 A. MR. CAVANAGH: I know similar exercises, I can't speak
28 directly to this one, in similar exercises we have
29 actually engaged GPs to be involved in some of that as

1 well, so that they bring some of their clinical
2 expertise. In other instances we have drawn nurses
3 into it. I suppose it also depends upon the particular
4 issues. As Sharon says it's not purely an
5 administrative exercise even though obviously 15:31
6 administrators do the calls, sort of take the
7 information, and so on, there is still a clinical
8 requirement to actually ensure we're doing things
9 correctly.
10 189 Q. That the appropriate decision is reached? 15:31
11 A. MR. CAVANAGH: Yes.
12 190 Q. Just the context for the Panel in asking that, if we
13 could go to AOB-09344, (administrators) the background
14 to this is Mr. O'Brien on review of one of his patients
15 discovered that he had been removed or removed himself 15:31
16 from the waiting list following a validation call and
17 Mr. O'Brien takes issue with that because of the
18 clinical presentation of the patient. We'll see in
19 this e-mail from Mr. O'Brien, 22nd September 2019 to
20 Martina Corrigan and Mark Haynes. I'll read this in to 15:32
21 the record:
22
23 "Martina, I write to you regarding this 69-year-old
24 diabetic man who had a stone obstructing his upper
25 right ureter in 2015. He was managed by ureteroscopic 15:32
26 laser --"
27
28 I'll have to get a hand with that.
29

1 " -- lithotripsy."
2
3 Thank you. You would think I would know this by now.
4
5 "He was noted to have a grossly enlarged prostate gland 15:32
6 on endoscopic assessment. I advised him that he would
7 be better served by having his prostate resected. He
8 was placed on the waiting list on 8th October 2015. On
9 reviewing my waiting list during August I noted that he
10 had been removed from the waiting list in July 2019. 15:33
11 When I contacted him by telephone he advised that he
12 had received a letter enquiring whether he wished to
13 remain on the waiting list, or words to that effect.
14 As his only systems were that of nocturia he replied
15 that he did not wish to proceed with surgery. I 15:33
16 requested an ultrasound scan, which has since indicated
17 that he may not recurrence of stone in his right
18 kidney, that he has inadequate bladder voiding with a
19 residual volume of 190mls and would appear to have
20 formed a stone in his bladder. I have again spoken to 15:33
21 the patient by telephone advising him of the above
22 findings. I have requested a CT urinary tract to more
23 clarify his stone status. He has agreed to being
24 returned to the waiting list for admission for TURP.
25 I have dictated a letter to the GP requesting that he 15:33
26 be prescribed Tams ulosin until admission for TURP in
27 addition to requesting optimisation of diabetic control
28 prior to admission. I hope that you will agree that it
29 is appropriate that I bring such a case to your

1 attention. I believe it is entirely inappropriate that
2 non-clinical staff should correspond with patient to
3 enquire whether they wish to remain on a waiting list
4 and entirely for the purpose of reducing the numbers of
5 patients on waiting lists. Patients have the right to 15:34
6 decline proposed management but should be empowered to
7 make decisions informed by clinical advice. I would be
8 very reassured if this practice has been discontinued
9 as you had already indicated. I would also be grateful
10 if I could be furnished with a list of those patients
11 of mine who have been so communicated with. Thank you,
12 Aidan."
13
14 Just go down please. Mr. Haynes replies on
15 22nd September 2019 at 21:05 to Mr. O'Brien and Martina 15:34
16 Corrigan:
17
18 "Thanks Aidan. As I have stated before I was not aware
19 of the process until it had started and when I became
20 aware had requested it cease. Where the process is 15:34
21 administrative only, i.e. checking patients not
22 deceased and checking they haven't had it done
23 elsewhere then it is fine. This process went beyond
24 that and asked that if patients wanted the operation
25 (no one wants an operation) and then I believed offered 15:35
26 them an opportunity of an OP review to discuss. Not
27 only does this mean informed decisions are not possible
28 by the patient (as no one is discussing the pros and
29 cons of surgery) but it is also offering something that

1 we cannot deliver, i.e. a timely review appointment.
2 I believe the process also raises false hope in
3 patients that they may get a date for their surgery in
4 the near future. Martina, do you know who led this
5 work and are they able to provide the urologists with 15:35
6 the details of all the patients who have either asked
7 to be removed from the WL or requested a review OPA."
8
9 That's from Mr. Haynes. I read that into the record,
10 Mr. O'Brien raised that issue of the potential that the 15:35
11 process was carried out administratively only but with
12 clinical implications, if I can put it like that. But
13 from SPPG's point of view this was a post that was
14 funded for the Trust to work out the best way they
15 could employ that person to identify that but there was 15:36
16 an expectation that there would be clinical input if a
17 clinical input was needed in the decision making, would
18 that be a fair summary?
19 A. MR. CAVANAGH: If it was done today that would be our
20 exception and I would have thought in those days it 15:36
21 would have then been our expectation. It seems strange
22 that the Clinicians didn't feel sort of fully involved
23 in the process.
24 191 Q. Thank you for that. Just in relation to the final
25 issue about the operational Trust issues around 15:36
26 grievance, formal grievance, were you informed or aware
27 of advised of formal grievances submitted by
28 Mr. O'Brien in relation to the Trust?
29 A. No.

1 192 Q. Would that be something that you would expect to know
2 about?
3 A. No.
4 MS. McMAHON: Chair, I think I have covered the areas
5 that I hoped to today. It may be the case, 15:37
6 Ms. Gallagher, that you wish to say anything else in
7 relation to your evidence or you, Mr. Cavanagh, if you
8 think I need to cover anything else. If you wish to
9 say anything at this point please feel free to do that.
10 MR. CAVANAGH: No, I am content. Thank you. 15:37
11 MRS. GALLAGHER: No, I am certainly content to answer
12 any further questions or clarifications.
13 CHAIR: I think we will have some further questions, so
14 I will start with Mr. Hanbury, first of all.
15
16 THE WITNESS WAS THEN QUESTIONED BY THE PANEL,
17 AS FOLLOWS:
18
19 193 Q. MR. HANBURY: Thank you very much for your evidence.
20 I have just got a few somewhat disparate questions, 15:37
21 I don't really mind who answers them, so maybe you'll
22 tell me. First just a small thing on regional learning
23 following SAIs and we have spoken about DRO, is the DRO
24 for a particular SAI, Serious Adverse Incident, someone
25 from that specialty? 15:37
26 A. MRS. GALLAGHER: That is correct.
27 194 Q. They are.
28 A. MR. CAVANAGH: Not necessarily. Apologies. Apologies
29 for disagreeing as well, Sharon. The DROs are Health

1 and Social Care professionals so in the case of
2 healthcare it's often a Public Health Doctor, so
3 somebody with public health medicine qualifications,
4 although increasingly they don't necessarily have to be
5 a doctor but in general they have been a doctor and 15:38
6 they may have had some experience of the specialty. As
7 you know doctors' training takes them through quite a
8 number of specialties but they won't as such be a
9 specialist in Urology, they will be a Public Health
10 Specialist but they may have spent some time in 15:38
11 relation to a particular specialty and they tend then
12 with that to maybe look at the sort of Urology SAIs,
13 and so on, but again not exclusively.
14 195 Q. It just struck me reading through the early SAIs that
15 it was a slight shame that the three issues, which are 15:39
16 principally triage, or the lack of it, not reading a
17 report, or acting on that, and this old chestnut of
18 changing JJ stents, which is a method of draining the
19 kidney, which every Urology Department struggles with,
20 and just literally a simple letter would have prompted 15:39
21 other departments around the region to perhaps look at
22 their systems. It's sort of more of a comment than a
23 question.
24 A. MR. CAVANAGH: Yes.
25 A. MRS. GALLAGHER: Mr. Hanbury, apologies, I didn't mean 15:39
26 to mislead you in any way, I guess the point that was
27 making very crudely, and clearly incorrectly, was that
28 we tried to appoint the most appropriate DRO from the
29 basis of knowledge. So my apologies.

1 196 Q. Yes, absolutely. Thank you. This is probably one more
2 for Mr. Cavanagh, with respect to some tertiary
3 opinions outside the region for various things, and
4 I know you were involved in that from your witness
5 statement, the Inquiry is aware of two particular 15:40
6 cases, one a cancerous case, I don't have to go into it
7 in detail, and the other a very large prostate, for the
8 cancer case the NICE guidance, which was accepted by
9 NICaN, was that it should go to a superspecialist
10 centre which at that time did not exist in 15:40
11 Northern Ireland, that was one case. The other was a
12 very, very large prostate which, you've heard of the
13 operation TURP, but this was really just too big to
14 manage that way and there is a laser version called a
15 HoLEP which at that time wasn't available in 15:40
16 Northern Ireland but actually now is so it is not the
17 same now. My question is, and in fact in both cases
18 there were unsatisfactory outcomes for various reasons,
19 and I just wondered if there was any disincentive from
20 your point of view that patients shouldn't travel to 15:40
21 either Dublin or England or a specialist centre
22 appropriately?
23 A. MR. CAVANAGH: We can provide services to patients
24 outside Northern Ireland through our Extra Contractual
25 Referral route - our ECR route, as it's called - and, 15:41
26 on that basis, we can support patients to travel and to
27 get the care necessary and also ensure that, within
28 their care pathway, they continue to get aftercare back
29 home as much as possible. Their Consultant here in

1 Northern Ireland will advocate for that, so they will
2 seek -- if they feel that they need to go to a
3 specialist centre for services not available here,
4 their Consultant can apply to us and we will agree on
5 the funding for that. So it's not as such -- we're not 15:41
6 questioning the Consultant's sort of decision to treat,
7 but, rather, we have to actually review kind of the
8 funding, and generally we will approve those and the
9 patient can go and get the treatment in the appropriate
10 centre, so there's no real impediment to that, and 15:41
11 Clinicians generally will seek to do that as well in
12 the interests of their patients.
13 197 Q. But you need to Clinician to advocate that cause of
14 action?
15 A. MR. CAVANAGH: It can only be a Clinician. As such, 15:42
16 they are proposing that their patient go forward, and
17 our expectation is, in the going forward to the
18 specialist centre, that the Clinician will then receive
19 them back to do the kind of ongoing care.
20 198 Q. Thank you. A commissioning question: Urology has, 15:42
21 interestingly, got the sort of cancer and the urgent
22 stones and the bleeds at one end, but, actually, at the
23 other end, there's lots of not very urgent stuff -
24 people requesting a vasectomy, maybe some fertility,
25 erectile dysfunction, you can debate the relative 15:42
26 merits. But in a situation where there's massive
27 waiting times, was there ever a conversation about what
28 we should and could offer that came between you and the
29 Clinicians, the Urologists, for example?

1 A. MRS. GALLAGHER: I think in terms of the context within
2 which we are operating, that's a very live question,
3 particularly in relation to, say, for example,
4 vasectomies, versus the investment in the more serious
5 treatments. So those discussions and decisions are 15:43
6 very live in terms of how we use the scarce resource
7 within Health and Social Care to best patient outcomes.
8 199 Q. So that is an active discussion now?
9 A. MRS. GALLAGHER: Yes.
10 200 Q. Thank you. 15:43
11 A. MR. CAVANAGH: And we do have some GPs, for example,
12 who can provide vasectomies, but the actual resourcing
13 of that is proving a challenge for us. So we have
14 looked at a number of ways that we can develop Primary
15 Care Services, which would deal with some of those 15:43
16 routine patients, and also looking at skill-mix within
17 Secondary Care as well so that Specialist Nurses, and
18 so on, could be doing some of the things that
19 Consultants would have done in the past.
20 201 Q. Just two short questions on NICaN. On the subject of 15:43
21 hormone treatment in prostate cancer, there was an
22 observation by one of the Clinical Oncologists in
23 Belfast, Dr. Mitchell, and we have heard from him,
24 about the use of Bicalutamide. I don't have to go into
25 it in detail, but he was moved to write an updated 15:44
26 article for NICaN, which was circulated, but it didn't
27 seem to be implemented, and I was a little confused
28 about the process, really. I mean, from your point of
29 view, if someone is engaged -- a senior Clinician is

1 engaged to update guidelines, and does that, would it
2 be your expectation that that should be respected by
3 the Urologist in the region?
4 A. MR. CAVANAGH: Yes, and I am a little bit surprised
5 that it didn't follow through in that way, but don't 15:44
6 know, obviously, the particular details. I mean, how
7 it works, straightforwardly, is that the Clinicians
8 talk together in the Clinical Reference Groups, and
9 those Reference Groups relate to tumour sites and also
10 to treatment modalities, and they are then bringing 15:44
11 together sort of evidence issues, questions, and, from
12 that, are developing guidelines, and those guidelines
13 are being shared through -- agreed through the formal
14 processes, but then shared out with the service and
15 then the service then is taking those forward through 15:45
16 MDTs. So, I mean, the complexity of a lot of the
17 cancer issues, I also appreciate; there is a lot. I
18 mean, having looked through, recently, all of the --
19 kind of the Cancer Network Guidelines, they are
20 voluminous and they need to be voluminous, but I think 15:45
21 that's not really an excuse for not carrying that
22 through, so it is certainly something I will take back
23 and consider further as well.
24 202 Q. Thank you. Just one thing on the NICaN. There was
25 talk about the implementation of the red flag suspected 15:45
26 cancer diagnosis and there was a comment back in 2019
27 that the NICaN Group would be happy to go forward with
28 this, provided they had the capacity diagnostics, but,
29 until then, they were not happy, they wouldn't agree to

1 implement; did that come to your --
2 A. MR. CAVANAGH: I mean, I certainly haven't heard it
3 recently, but diagnostics is a challenge. Probably our
4 biggest challenge in our cancer pathways is actually
5 having diagnostic capacity, given the variety of 15:46
6 diagnostics as well that's required, so it is a
7 challenge, an issue, but again don't know the
8 particulars in relation to it.
9 203 Q. But at the moment, are you satisfied that the red flag
10 criteria are being responded to appropriately by -- 15:46
11 A. MR. CAVANAGH: I believe there are, and having been in
12 Cancer Performance Meetings with Trusts, they haven't
13 been raised in that way with me.
14 204 Q. Thank you. Just moving slightly away, this thing about
15 the waiting list initiatives, independent sector for 15:46
16 long waiters, who decided what category of patients
17 would be treated? Was it the long waiters, the very
18 urgent, the red-flag type? Did that come from the
19 Clinicians or yourselves talking to Urologists?
20 A. MRS. GALLAGHER: A combination of both. So, I mean, 15:46
21 clearly we need to prioritise those with clinical need,
22 but there was also some investment in terms of the long
23 waiters and it was a balance in that regard, it's a
24 constant balance being kept under review, depending on
25 the amount of additional money that's received and 15:47
26 depending on sometimes the workforce available at that
27 point in time. So, for some specialties, we're able to
28 secure IS provision to allow us to, for example, in
29 terms of cataracts, for example, very recently, we've

1 been very successful in dealing with cataracts through
2 IS. They would not necessarily be of the highest order
3 clinically, but, nonetheless, important to those people
4 that need their cataracts removed. So, in general
5 speaking, our prioritisation is based on clinical need, 15:47
6 but there is the balance always to be had.
7 205 Q. Okay. A couple more, if I may. One, the Royal College
8 of Surgeons of England did a document in about 2021
9 about the ten easy steps to surgical recovery - I mean,
10 things like the surgical hubs we have heard about, the 15:48
11 recruitment we've heard about, the difficulties.
12 What's your comment about how you feel you're doing?
13 A. MRS. GALLAGHER: So I think -- I mean, we engage
14 routinely with the Royal Colleges, we've worked with
15 Mark Taylor, who is working with the Department very 15:48
16 closely in terms of the Elective Care Plan and to our
17 waiting list initiatives and also in relation to,
18 I referenced earlier the Regional Prioritisation
19 Oversight Group. Waiting lists are getting longer, it
20 is a perennial problem, and it is something which our 15:48
21 new Minister has already started to take very, very
22 seriously. And with the limited resource we have, we
23 need to think very carefully about how we use that
24 resource in order to provide the best outcomes for all
25 of those people. 15:49
26 206 Q. And, in particular, I'd advocate for surgical training,
27 and it is the young surgeons, the young registrars sort
28 of go on to put their tap routes down in Northern
29 Ireland, and they should be looked after. That's a

1 comment, sorry. I shouldn't...
2 Final comment about GIRFT, or the Getting It Right
3 First Time organisation, who visited the region last
4 year, and obviously this is sort of a high-level report
5 with similar suggestions, I guess. Do you -- how do 15:49
6 you feel that that's going? Is that going to be a good
7 influence to change and improve? Are they going to
8 come back for deeper dives? What's the situation
9 there?
10 A. MRS. GALLAGHER: So our relationship with GIRFT, and 15:49
11 we've used GIRFT now for four occasions, if not five,
12 in the last year to year-and-a-half, our relationship
13 is very positive in terms of the learning and the plans
14 that we can put in place in order to improve services.
15 So we have looked to GIRFT to give us that external 15:50
16 perspective and be able to benchmark across other
17 jurisdictions to understand how we compare in that
18 regard. So it is very positive relationship, and
19 again, helps us to understand how we address the issues
20 that we have with the broader resource, not just the 15:50
21 financial resource, but the human resource, the
22 personnel that we have available to us.
23 A. MR. CAVANAGH: And some of the issues are familiar to
24 us, so, on that basis, we're building on issues that
25 we're already in the process of addressing. Some of 15:50
26 the issues are new to us and it's always good to get
27 some new ideas as well, so I think bringing an
28 organisation like GIRFT in does give us a chance to, I
29 suppose, lift our head up a bit and actually see if

1 there is other ways of thinking about these things.
2 So, certainly, I think we'll be doing a lot work on
3 that in the coming months once the final report is
4 published.
5 207 Q. Yes. And certainly subspecialising, for example, 15:50
6 stones in Southern Trust --
7 A. MR. CAVANAGH: Yeah, absolutely.
8 208 Q. -- and other Trusts with other things? Okay, thank you
9 very much. I've no further questions.
10 CHAIR: Thank you, Mr. Hanbury. Dr. Swart? 15:51
11
12 209 Q. DR. SWART: Thank you for your various explanations
13 about how things work, it's slightly clearer to me, I
14 think. It's still quite hard to understand because it
15 is quite complicated. I just want to start with a 15:51
16 really sort of basic thing, really. A lot of emphasis
17 on ministerial targets, people in the Trust saying,
18 'Well, if you say, "well, why didn't you look at this
19 issue over there?" And they will say, "Well, you've
20 got to understand, we're trying to do the ministerial 15:51
21 targets and, basically, we haven't really got time for
22 other things",' is the kind of atmosphere that you
23 feel. And I think that leads to the statement they
24 only care about targets, which you would absolutely
25 refute, and I think the reason for that is that what 15:51
26 you measure is what people think you care about. So
27 accepting that it is the Trust's responsibility to
28 measure quality and safety and to act on concerns and
29 to have a system that supports that, I think there is

1 also merit, probably, in having an agreed set of
2 quality and safety metrics more widely for Northern
3 Ireland, not to beat people up with but to allow
4 measurement for improvement. In the specialties, there
5 is a lot of indicators that can be used, and 15:52
6 I certainly have experience of that being used in a
7 positive way. Would you agree with that as a premise,
8 that there is room to do something like that?
9 A. MRS. GALLAGHER: I think that's a very fair comment,
10 Dr. Swart, in terms of, I described earlier a process 15:52
11 in terms of the new commissioning model and broader
12 higher level outcomes and part of the document as it is
13 being developed at the minute includes a section on
14 safety and quality and what we would expect to see in
15 that regard to provide assurance, so that's certainly 15:52
16 within our thinking, very firmly in our thinking.
17 210 Q. So that sounds very positive. I am just interested in
18 what the role of the Chief Medical Officer in the
19 office under that is with respect to all of this and
20 with respect to the PHA input that you have described, 15:53
21 because it's not entirely clear to me how that guides
22 some of the development of this work, if at all, or
23 whether that's been specified or clarified anywhere
24 that I have missed?
25 A. MRS. GALLAGHER: So the Chief Medical Officer's role is 15:53
26 paramount in terms of issuing the guidance, the
27 clinical standards across. They are disseminated
28 through SPPG, and we monitor same. But ultimately, you
29 know, the priority with the Chief Medical Officer is to

1 make sure that Northern Ireland is aligned in terms of
2 NICE guidance and any other learning that is in place.
3 It is for us, and then through to the Trusts and the
4 providers, to implement that guidance, and we then
5 provide assurances where it is appropriate. 15:53
6
7 I talked earlier about the business plan and the fact
8 that we now develop a yearly or an annual Safety and
9 Quality Report and that sits in the Department's
10 Business Plan. That's co-owned by myself and the Chief 15:54
11 Medical Officer, and that demonstrates our joint
12 ambition to provide a clear leadership across the
13 system about the importance of safety and quality
14 within the provision of Commission services.
15 211 Q. And one of the ways of doing this is measuring things. 15:54
16 I noticed in the Quality Strategy 2020 that was
17 specifically mentioned, a set of indicators for each
18 service was how it is referred to, and it didn't come
19 to pass, it's not that easy to do, actually. But is
20 there still a desire to improve that kind of system 15:54
21 because it's much broader than NICE, and so on?
22 A. MRS. GALLAGHER: It absolutely is. The 2020 issue, as
23 you can imagine, was in the middle of Covid. We're
24 still getting back to normal business. But I should
25 say, and I think I have referred to this throughout our 15:54
26 evidence this afternoon, safety and quality is
27 paramount in our thinking in the Department and in
28 terms of what we do and how we do it. And our approach
29 in relation to that, particularly in terms of the

1 learning, is starting now to, I guess, get back to
2 where it should be post-Covid and we're trying to work
3 through Covid and the recovery of Covid, but it's very
4 important in terms of our priorities.
5 212 Q. And I am just interested in your views on RQIA and 15:55
6 potential roles. So, obviously, in England, the
7 equivalent would be the CQC and they go go into
8 hospitals and do unannounced inspections and people
9 have different views on the efficacy of that, but they
10 do go in and look at everything in terms of governance 15:55
11 and services, governance in the Trust, leadership and
12 so on. Not everybody thinks it is valuable and there
13 is a big conversation going on about, should you put in
14 more regulation for individual Trusts, for example, or
15 should you move towards setting standards and measure 15:56
16 for improvement and only try and regulate when there is
17 a real problem; what's your view on that balance?
18 A. MRS. GALLAGHER: I'm not sure I have a very informed
19 view, to be absolutely honest. I think there is the
20 need for both. The extent to which you can heavily 15:56
21 regulate an organisation, but -- or a system, but this
22 does come down to behaviour, it comes down to focus, it
23 comes down to attention. And, you know, the culture
24 around providing safe services, around speaking up,
25 around being open, is, arguably, as important as the 15:56
26 regulation of that, so I wouldn't profess to have a
27 very informed view, but I think this is a matter for
28 others to think through as we --
29 213 Q. But do you agree it needs, you know, proper thought in

1 terms of --
2 A. MRS. GALLAGHER: I, absolutely --
3 214 Q. -- investment, because you could spend a lot of time
4 and resource doing something that might not be the most
5 important thing? 15:57
6 A. MRS. GALLAGHER: Indeed, indeed.
7 215 Q. On the safety agenda, something I'm quite interested
8 in, there's been a huge amount of work done on this
9 internationally. My own experience is mainly from
10 England, and it is my view that if you want to align 15:57
11 people culturally, patient safety is the route in
12 because everybody really can't disagree with it and
13 it's a way of bringing people together. What is your
14 view on the current work that's going on in England to
15 reframe the safety agenda by changing the 15:57
16 classification of incidents, putting a lot more
17 influence on the just culture, all of that sort of
18 thing, is that something that it would be useful to
19 piggyback on? Because it's been based on learning that
20 says, actually, we're all struggling with the SAIs, the 15:57
21 time frames are being missed, maybe it wasn't the best
22 way of doing it, after all, you know, this is all about
23 involving people on the ground, staff and patients, in
24 working out what went wrong and getting there a bit
25 quicker, etc., there's a massive amount of work, but 15:58
26 you wouldn't want to reinvent the whole wheel on that,
27 I would imagine. What conversations have been had in
28 that regard since this was mandatorily introduced last
29 year, the new Safety Framework Plan?

1 A. MRS. GALLAGHER: So I think I described earlier the
2 work that sits under the purview of the oversight of
3 the Inquiry's Implementation Programme Management
4 Board, and part of their considerations in terms of SAI
5 and the broader safety and quality piece is exactly 15:58
6 what you have described what's happening in England and
7 in other jurisdictions, and I think I described the
8 process or the area of work that we're calling being
9 open.
10 216 Q. Yes. 15:58
11 A. MRS. GALLAGHER: And that is our exploration in terms
12 of what's happening elsewhere and how we adapt,
13 incorporate and create a culture within Northern
14 Ireland that promotes that as the way we do things.
15 217 Q. That sounds very positive. That group that you have 15:59
16 set up, which also sounds -- it's absolutely the right
17 thing to do. I mean, there are Inquiries all over the
18 place, in England as well, and it is very difficult to
19 implement all the recommendations and there is a lot of
20 overlap. Safety comes through and culture comes 15:59
21 through and I don't think people are really aligned as
22 to what they mean by that exactly. How long is that
23 Inquiries Group been set up now?
24 A. MRS. GALLAGHER: So we ran separate oversight groups
25 for the Inquiries and it has conjoined around the last 15:59
26 year, I can't be very clear in terms of when we moved
27 to that position, but in and around the last year, and
28 that was, as you say, to bring both together.
29 218 Q. And how do you think that's working? What's your

1 personal view of that?
2 A. MRS. GALLAGHER: I think it's working very effectively.
3 We have patient representatives, we're engaging very
4 closely through the subgroups that feed into that
5 oversight process, so we have our reference group and, 16:00
6 importantly, and I described this earlier, this is not
7 just about an action plan and clearing actions, this is
8 about an assurance framework that has been
9 independently developed, co-produced with patients and
10 stakeholders in order to give a really strong 16:00
11 assessment in terms of, did this achieve what it was
12 meant to do? Because, too often in the past, you will
13 appreciate that boxes have been ticked and actions have
14 been taken, but it didn't resolve the core issue, so
15 that's been paramount in our thinking. 16:00
16 219 Q. Sort of, one of the things you have described, which
17 sounds very positive, is your new process, if you like,
18 for the SAIs and multidisciplinary, bringing all the
19 leads for the SAIs together. I'm familiar with that
20 way of doing things, and I think it helps a lot? 16:01
21 A. MRS. GALLAGHER: Yes, indeed.
22 220 Q. It also helps a lot to make sure that you get the
23 patient input at the right place, which is not that
24 easy to do, but it's a great thing. But in that
25 spirit, you bring everybody together, you're getting 16:01
26 the patients in there. It's not mandatory for patients
27 in Northern Ireland to receive copies of all their
28 letters from clinics and procedures, which it is in
29 England, and I can remember when that was introduced

1 and there was a certain amount of discussion at the
2 time, but, overall, I think it's been very helpful.
3 The patient is a great fail-safe for, did things happen
4 when they should have happened? And all of that. Have
5 you any observations on why that's not mandatory and 16:01
6 what the blocks to that are?
7 A. MRS. GALLAGHER: It's an area that is currently under
8 our line of sight, actually, in relation to the
9 guidance and, you know, the communication with
10 patients. We're currently working with Trusts to 16:01
11 understand where they are in that journey and to work
12 with them and support them in terms of moving to that
13 position as soon as possible.
14 221 Q. And another thing you have talked about is the model of
15 setting up an Integrated Care System way of looking at 16:02
16 this, so, clearly, you have got integrated Trusts
17 already, which should give you the right basis for
18 that. A huge amount of work in Integrated Care Systems
19 in England, not all of it has achieved what it was
20 meant to achieve, and I understand you are having some 16:02
21 advisors in, helping you with all of this. How do you
22 see that working going forward in terms of bringing
23 more partners in at the right time without creating
24 another layer of governance and having a million more
25 meetings and all of that, what's your strategy for 16:02
26 that?
27 A. MRS. GALLAGHER: That's always the risk isn't it?
28 I think Mr. Dawson described some of the work that
29 we're doing, including independent advisors. It is

1 important to say that the ICS in Northern Ireland is
2 not at all the same as the ICS anywhere else, so where
3 we have landed this, and we have had quite considerable
4 time to consider it, given the journey lapse since the
5 decision to close the Board and change the 16:03
6 commissioning system, so we have quite a bit of time to
7 consult, engage, look at models, not just within Great
8 Britain, but right across the world. Our approach is,
9 I guess, in terms of a Framework rather than -- so the
10 Framework is -- puts collaboration and integration at 16:03
11 the heart of everything we do. So, you're absolutely
12 right, we did have Integrated Care and the Trust
13 provided Integrated -- and I commission all services on
14 an integrated basis, so I commission Primary Care
15 Services, Community Care Services and Acute Services. 16:03
16 Many would imagine that that, in itself, would be an
17 enabler for an integrated system, but, of course, it
18 has limitations. So our focus has been as much on
19 going back to people's behaviour and the culture of
20 integration. So the new model that we've put in place 16:04
21 sees three strands, and I know Aidan described a little
22 bit of this. So, in the main, the core commissioning
23 service continues to flow through SPPG, supported by
24 PHA. So the money will continue, 97% rollover of
25 services day to day. The Area Integrated Partnership 16:04
26 Boards bring together the stakeholders at a local
27 level. Importantly, they have no budget, but what they
28 look at is their shared resource and assets the
29 population health needs within their area, to

1 understand how they work together and how they shape
2 the commissioning agenda.
3 Then, the third level is an oversight arrangement,
4 which will have stakeholders from Health but also from
5 councils and from those stakeholders that have a stake 16:05
6 holding in the determinants of Health and Social Care
7 and they will provide guidance to the Area Integrated
8 Partnership Boards, which will ultimately influence our
9 commissioning.
10 16:05
11 So, what we have tried to do is, previously we
12 allocated money to groups and departments and then
13 there was a lack of line of sight up and down between
14 Minister right through to local level and back up
15 again, so the approach that we have developed is to 16:05
16 reduce the potential for duplication and to have a
17 clear alignment and understanding and a joined-upness
18 that sits within SPPG in terms of all of the inputs, in
19 order to inform how we commission services and what
20 services we commission. 16:05
21 222 Q. So that's really interesting. What's been your -- you
22 know, looking at the international systems, there are a
23 few examples where they seem to have cracked this much
24 better than we have in England, but just to use that as
25 a benchmark. What's been your biggest learning from 16:06
26 that, other than the communication, at a local level,
27 that you've talked about? Is there anything else, as
28 an enabler, that you have found internationally that is
29 required to make that all work, do you think? A

1 completely open question. I don't actually know the
2 answer. I just --
3 A. MRS. GALLAGHER: So I heard a comment quite recently,
4 and it stuck with me: when you see one Integrated Care
5 System, you see one Integrated Care System, and all of 16:06
6 them are very different. I guess my reflections is
7 that there needs to be clarity of purpose, so everyone
8 needs to be looking in the same direction, everyone
9 needs to understand what the priorities are, everyone
10 needs to understand what the desired outcomes are and 16:06
11 there needs to be that clear line between the
12 decision-makers -- the Minister, the decision-makers,
13 the Commissioners and the providers. Where things then
14 start to -- where there isn't that clarity of approach
15 then people start to do different things. So that 16:07
16 clear focus that we're all in the same space we're
17 pointing ahead.
18 223 Q. Yes. There's been a lot of learning from this Inquiry,
19 I am sure, and how that's all pulled together is
20 another matter. But what's your personal learning from 16:07
21 having kind of been involved at various stages and
22 thinking about it now in your current role, in terms of
23 this is something that happened in urology, centred
24 around one Clinician, but it's not really just about
25 that at all, it's about a whole range of things, what's 16:07
26 your personal learning?
27 A. MRS. GALLAGHER: You clearly kept the easy questions to
28 the end, Dr. Swart! I guess as system leaders it is
29 important that we are clear about our role within

1 health and social care. I think I described earlier in
2 any leadership role, in any senior management role
3 you're interested, obviously, in money and productivity
4 and in governance. It's just as important that we are
5 inquisitive and are asking questions and providing the 16:08
6 leadership in all of those aspects. So I think
7 creating the atmosphere within our own areas of
8 responsibility and our own sphere of responsibility so
9 that people understand what our priorities are and feel
10 enabled and empowered to discharge their 16:08
11 responsibilities in line with what we're required to
12 do. So the whole issue of leadership and really
13 understanding what it is you are there to do and how
14 you contribute to a broader system, because none of us
15 act alone, has come out as a reminder, if you like, to 16:08
16 me throughout this process.
17 224 Q. If you had to do - your next step in terms of the
18 changes you have been involved in and are still making
19 - what would that be?
20 A. MRS. GALLAGHER: So we're in a really fortunate 16:09
21 position because we're starting now to develop and put
22 in place our arrangements for commissioning moving
23 forward. There is already learning throughout this and
24 that will continue to inform what we do. I mean, we
25 have heard, and it has given us the opportunity, me the 16:09
26 opportunity to reflect in terms of some of the
27 propositions that's been put forward; you're only
28 interested in performance and not interested in the
29 entirety of work. Sometimes perhaps how we describe

1 things and, as you say, what we say matters as much.
2 So it's important that we have absolute clarity and we
3 are clear about our priorities and how we support
4 people to do the jobs that they are there to do.
5 16:09
6 I mean, with any organisation across any sector there's
7 too much to do and too little time to do it, and it is
8 a matter of prioritisation and giving people the
9 permission to say 'I can't do this because I need to
10 focus on that'. Again that's a cultural piece in terms 16:10
11 of enabling people to do the right thing.
12 225 Q. Do you think there is any kind if opportunity at the
13 moment, I mean there's this huge recruitment in
14 Northern Ireland with clinical staff and others but
15 I am particularly thinking about some of the things we 16:10
16 have heard about, there is a lot of change going to
17 happen, this is a time for new things, is there a
18 strategic group looking at how to maximise the
19 opportunities for different kinds of recruitment in
20 this atmosphere, is that going on, who is leading that? 16:10
21 A. MRS. GALLAGHER: So it's led by the Department. We
22 have a workforce strategy, it sits under - I referred
23 earlier to the Performance Transformation Executive
24 Board which compromises of system leaders, Trusts and
25 Department. The work of that group sits under the 16:10
26 purview of that. That is again a live debate in terms
27 of what we do to attract, retain and keep our staff
28 motivated in the broader sense.
29 DR. SWART: Okay, thank you very much. That's all from

1 me.
2 CHAIR: I think maybe -- did you want to say something
3 in response to the last question?
4 A. MR. CAVANAGH: I was just thinking of the learning,
5 I think it's an important question. I mean, I think 16:11
6 certainly the importance of MDTs and MDMs, I think, is
7 something that we are now reflecting on considerably.
8 The overarching report of the SAIs really did focus in
9 on the importance of that. We have already done some
10 work on it, around developing a self-assessment tool, 16:11
11 I think we need to do further work. I think there is
12 something as well - unfortunately we can no longer
13 participate in the NHS England peer review piece - but
14 I think we now need to think about how can we develop
15 our own peer review type programme. It might not be 16:11
16 quite in the way that the NHS England has done it. So
17 I think it is important that, yes, clinicians will lead
18 all of that, of course, but I think it's also important
19 as commissioners that we're also setting a framework
20 for that in the future. But MDTs are key. 16:12
21 DR. SWART: Thank you for raising that. I strongly
22 agree with that. I think if you encourage trusts to
23 self-assess themselves more frequently and make sure
24 that the oversight at Trust level is led by an
25 Executive and that is reported up through the Board, 16:12
26 there is a transformation in the focus on cancer. That
27 is a mixture of quality and performance standards
28 really when you think about it. There's no good
29 getting everybody seen if you haven't got your MDT

1 working properly, and it should be possible to do that
2 across Northern Ireland in the kind of way that you
3 suggest.
4 226 Q. CHAIR: I have just a couple of things in terms of the
5 SAIs. We know that the RQIA is going to report later 16:12
6 this year on their review of the SAI process. But I am
7 just wondering, we have thought and have discussed
8 amongst ourselves, one of the reasons for the delay,
9 both in all of these procedures, SAIs, the MHPS
10 process, is getting people to do the job, you're asking 16:13
11 busy Clinicians to carry out the work that's necessary.
12 We have been looking at has consideration been given to
13 a pool of people whom you can call upon and draft in to
14 a Trust, for example, to carry out the work that is
15 necessary in those fields, SAIs, MHPS? I mean, I spoke 16:13
16 to Mr. Pengelly about this, the former Permanent
17 Secretary, and he felt that having a body of people
18 sitting within the Department just really wasn't
19 feasible. But has any consideration been given to
20 having a body of people who are willing to go in 16:13
21 externally to the Trusts and do the work that's
22 necessary to free up the Clinicians to get on to do
23 their day to day work?
24 A. MRS. GALLAGHER: So there's two parts of that, if
25 I might, Chair. First of all is in terms of the 16:13
26 appraisal and the management of the individual.
27 I suppose my background, I have been an HR RD, Human
28 Resources Director. My personal view is the importance
29 of understanding the individual and the appraisal, not

1 just every six months or a year, but that constant
2 feedback, the observation and the engagement is best
3 done by those that work with an individual. It is a
4 requirement for all of us within our own organisation
5 that we discharge ourselves in a professional way and 16:14
6 from an evidence-based perspective.
7
8 So I would be open to all suggestions, but I think it
9 would be challenging to bring others into an
10 organisation to conduct appraisals and feedback in 16:14
11 terms of individuals.
12 227 Q. I'm not talking about appraisals now, they would
13 necessarily have to be done in-house. I'm thinking
14 more of people coming in to carry out an SAI
15 investigation or an MHPS investigation? 16:15
16 A. MRS. GALLAGHER: Indeed.
17 228 Q. Rather than -- I mean, for example, the MHPS
18 investigation into Mr. O'Brien took an inordinate
19 amount of time because trying to coordinate the times
20 when Clinicians could meet, trying to coordinate the 16:15
21 diaries is a big issue; and the same with the SAIs,
22 trying to get people all together before that report
23 can be finalised. I mean, certainly in terms of the
24 SAI and learning, that is not ideal if you're trying to
25 learn quickly? 16:15
26 A. MRS. GALLAGHER: Sorry, Paul, if I may. I think if you
27 bring people in you're bringing experienced Clinicians,
28 so they will be displaced from elsewhere which could be
29 a potential problem. The reason why I referred to the

1 appraisals was, clearly the appraisals contribute to
2 the MHPS process, so there's a graduation there. The
3 SAIs, the RQIA has published its review and we're
4 working on that basis in terms of its implementation.
5 But again it talks about the training and the support 16:16
6 of managers so that everything doesn't end up in an
7 escalated way and that people are supported in order to
8 make assessments on what needs to be escalated and how
9 things should be managed in-house.
10 16:16
11 Again, I mean it would be for the Panel to consider the
12 recommendations that comes from this. But sometimes it
13 feels that, if you outsource to others, organisations
14 lose a bit of that accountability and responsibility
15 and it is someone else's responsibility. In my 16:16
16 experiences, particularly in the public sector, the
17 outsourcing of that doesn't necessarily mean a better
18 outcome. But I'm open to being convinced on any level.
19 229 Q. One of the reasons that I am asking is that certainly
20 we have heard evidence that the Trust would welcome 16:17
21 having somebody come in, that it takes some of the
22 difficulties with challenging people in-house away from
23 them?
24 A. MRS. GALLAGHER: And I think on a very human nature all
25 of us want to come in and do our jobs and the most 16:17
26 difficult part of all of our jobs is challenging poor
27 behaviour and all of us do that, particularly in senior
28 management roles, it is part of how we make
29 organisations work. So I think it's probably

1 reasonable for someone to say I would like that someone
2 else to do that, but in reality it is for us as senior
3 leaders to discharge our responsibilities in that
4 regard would be my view. And that's a personal view.
5 230 Q. That's what you are here to give us. Just in terms of 16:17
6 - well we will be making recommendations ultimately,
7 obviously, based on the evidence that we have heard -
8 but if you had all the funding that you wanted, what
9 would you like to see happen, what one thing would you
10 like to change to make things better in terms of 16:18
11 patient safety and patient experience, what one thing
12 do you think would make a difference?
13 A. MRS. GALLAGHER: So if we had all the money tomorrow we
14 couldn't change this tomorrow. It's not one single
15 thing that's going to make a difference. This is where 16:18
16 I referred back to the work nearly ten years ago in
17 terms of the Delivering Together strategy. This is
18 about future proofing. We could recruit, if we had the
19 staff to recruit we could use all of that money and
20 bring more people online. But this is about systems 16:18
21 and not structures, that was what Bengoa said. We need
22 to transform the way we deliver services. We need to
23 work with the public to understand what the future
24 proposition for health and social care is. We need to
25 move from an acute service to a prevention service, 16:19
26 enabling and supporting people to keep well for longer.
27
28 So I think what I would -- my wish on that is that we
29 would have the time and energy to put long-term plans

1 in place that help us effect that system change.
2 Because we called it transformation for a reason, this
3 is not about moving the deck chairs, it's not about
4 reconfiguration, this is about significant change.
5 231 Q. It's not a quick fix? 16:19
6 A. MRS. GALLAGHER: It is absolutely not a quick fix.
7 CHAIR: Okay. Well thank you both very much, it's been
8 very useful to have you both here together, so thank
9 you for that. Is there anything else, Ms. McMahon?
10 MS. MCMAHON: No. 16:19
11 CHAIR: Well then, Ladies and Gentlemen, that is us.
12 We are not sitting next week, for those of you who have
13 children and have half term commitments enjoy and we
14 will see you back again on the 20th, I think it is,
15 Tuesday the 20th, whatever the Tuesday of the week 16:20
16 after next is. Thank you.
17
18 THE HEARING STANDS ADJOURNED TO TUESDAY, 20TH FEBRUARY
19 2024
20 16:20
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