Urology Services Inquiry

Oral Hearing

Day 91 – Thursday, 14th March 2024

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON THURSDAY, 14TH MARCH 2024 AS FOLLOWS:

CHAIR: Good morning everyone. Mr. Wolfe.

10:01

CONTINUATION OF QUESTIONING BY MR. WOLFE

MR. WOLFE: Good morning. Good morning, Dr. O'Kane. Just going back to something I was asking you about yesterday. We were looking at the outworking of the 10:01
recommendations following the Serious Adverse Incidents Reviews, and we were looking at the audits that were and have been carried out in respect of, for example, quoracy, in respect of cross-referencing from pathology, and then we came to nursing and we 10:02
identified something of a gremlin in the works in the sense that CaaPS requires further work so that we can have an electronic record of the allocation of key workers to patients, and I was raising that with you as a concern because it's essentially a concern within the 10:02
recommendation report that you have helpfully brought to our attention. You did say that there is nevertheless a paper check or a manual check that key workers are being allocated, and I just wanted, after that long introduction, to bring you and bring the 10:02
Panel to some references for that.

If we go to TRU-304474. And we can see this dates back to November 2022. And Kate O'Neill, one of the nurse

specialists, is writing to Wendy Clayton in response to a request for data outcomes, or audit outcomes I should say, and she sets out some information which helps to clarify that in the vast majority of cases key workers had been allocated, and gives explanations for the cases where allocation had not yet taken place. Any further comment you'd like to make on that?

A. I have seen more up-to-date information in the last few weeks that suggests that that has moved on but that it is still being, the information is still being collected in the same way, so we can provide the Inquiry with that.

10:03

10:04

1 Q. Very well, that would be helpful. There's another reference I was going to bring the Inquiry to, but we needn't bring it up, it's five pages further on at 304479, but I think it was necessary to make the point that the information is being gathered, albeit not being gathered quite in the way that you would like, you'd like it to come through CaaPS?

10:04

A. Yes, that would be more automatic, yeah.

10:04

2 Q. Yes. I want to move on to look briefly at the measurement of quality and safety through the use of metrics. I think it was Simon Watson who said to the Trust "In God we trust, all others bring data." You have set out in one of your early witness statements that in your role as Medical Director you were responsible for leading on the development of mechanisms to improve patient safety data, and we can see some examples of how that has progressed, in

10:05

particular the annual quality report shows out, sets out some examples that I'll bring you to. But I want to start by I suppose asking you, how important do you consider the use of metrics for the purposes of superintending or giving a better insight into the quality of care and the safety of the services provided by the Trust? How important is it, and how much of a journey has the Trust still to complete in order to get it to where you might want it to be? 10:06

A. I think it's fundamental to the functioning of the organisation, and I think traditionally people have thought about data as being quantitative in terms of numbers, but actually what adds the narrative to all of that, and I think deepens and broadens the understanding, is the qualitative data. So what we have striven to do over the last period of time through the governance mechanisms and the strengthening projects that have taken place in each of those various domains that are in my submissions, is to increase not just the quantitative data but also the qualitative data in terms of the understanding of all of that. So we can measure mortality through the standardised hospital mortality indices. We can - now what we do is we further delve into that using VLAD which basically breaks that into, you know, numbers of scores looking at the various aspects of that so that we can see changes and trends. And then - so, for example, the SHMI, as it's referred to, the Standardised Hospital Mortality Index, gives us an indication, compared with 10:06 10:07 10:07

our peers and compared with our peer locally and nationally what our mortality is like, we can follow the pattern of all of that, but actually the devil is in the detail. So then we automatically go to the VLAD which, as I say, highlights aspects of that to show us 10:08
where we are improving or not performing as well as we did before so that we can actively work on those areas. And then we use the RAMI data, which is the standardised measure for in-patient deaths to cross-reference all of that. Plus, the information 10:08
that then comes through in relation to our mortality meetings, any of the patient safety meetings, to understand, you know, from a basic premise of data how do we work forward to understand actually what is bringing harm to patients and what potentially we can 10:08
work on then to improve?

So, I think as time has gone on we have become much clearer about the functioning of those, of that data, to help us understand. And then in the same way we use 10:08
other data as proxies. So we have very robust reporting now on the nursing quality indicators. So for each area for nursing. For example, there's a plethora of data produced in relation to pressure sores, falls, you know, various other measures and, 10:09
again, in the same way we watch the trends in all of that, collect the narrative, measure that against, for example, you know the level of agency and locum cover in a particular area, the level of one-to-ones with the

patients, and the level of confusion that they might be suffering, you know, the environment around all of that, to try and get a clearer picture as we go along of all of those areas.

10:09

So, increasingly we have moved away from just looking at lines on a graph to putting a narrative around it through various other direct measures and proxy measures to help us understand how the organisation works. And, again, we have seen it with Urology, in that whenever we have looked at, for example, some of our waiting time data, we know that we run regional Lithotripsy now and, again, when we looked at that in some detail we were able to show the trends across Northern Ireland and how an understanding of that could then help us build up the clinical provisions so that we could reduce our waiting times markedly. So it's used in various domains.

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10:10

3 Q. Yes. I'm just going to invite you to slow it down a little.

10:10

A. Sorry. Sorry.

4 Q. Thank you for that. So it's much more than mortality?

A. Yeah.

5 Q. It's going into other aspects of the patient experience, and it's - I suppose the base data you're suggesting is being intelligently interrogated to see, by cross-reference, what are the underlying causes of any outcome to see where improvement can be met?

10:10

A. Yes. And that's why clinical audit is so fundamentally

important to all of this, in terms of getting baseline data, being able to then benchmark it or look at the improvements that can be made through change, and then in addition to that, you know, the weekly governance report is helpful to us in giving us indicators of where, you know, in relation to areas we should be concerned about. And then we take feedback from service users and carers, you know, through care opinion or through service user feedback. We have 92 service users involved in various projects across the Southern Trust in terms of giving us their feedback. And in addition to that, I get a thousand complaints every year, I get twice as many compliments and, again, each directorate draws from that in terms of drawing out patterns of activity and behaviour to try and inform that overall picture. 10:11 10:11 10:12

Now, it's very messy and it's very broad, and I think when you asked earlier about where we would like to get with all of this, certainly the learning that we're taking from the Scottish improvement experience has been that as we develop dashboards in relation to bringing some of these key areas together, as we enable Encompass next year, and as we really become a lot more intelligent around data analytics, increasingly this data should be of more use to us. 10:12 10:12

6 Q. The conversations that were taking place as part of the External Reference Group initiative have trespassed into this area. We can see, if we pull up TRU-303736 -

scrolling down. So this subgroup within the External Reference Group was led by your Medical Director, Dr. Austin?

A. Yes.

7 Q. Accompanied by, I couldn't see his, whether he is - I assume he's a medical doctor? 10:13

A. Yes. He is, yes.

8 Q. Dr. Simon Watson, who is Medical Director at Health Care Improvement Scotland, is that correct?

A. That's correct, yes. 10:14

9 Q. And they reported into, I think it was the November last year meeting of the External Reference Group, the following:

"The group explained that their approach..." 10:14

- I'm reading from the minute here:

"...was routed in themes that emerged from the clinical issues that were being identified in the Urology Review. The meeting was also advised that themes emerging from the wider analysis of the External Reference Group had also been considered in the approach taken." 10:14

And they go on to say:

"The final recommendations in the paper shared at today's meeting reflect all these considerations and

the wider landscape."

And then they go on over the page to say that:

"It is recommended that the Trust commissions a formal strategic plan for data and intelligence that should include consideration of 5 key areas." 10:15

And they are set out there. And they include supporting continuous improvement in clinical and care processes, the creation of a warning system to identify emerging clinical care or clinical governance concerns, to name but two of the suggestions. 10:15

And then just to go into their conclusions, they reflected there's never an ideal time to commence the creation of a new data and intelligence strategy, but they say: 10:15

"The lessons emerging from this Public Inquiry and the need to develop a culture built on team working, leadership and governance, all require intelligence, insight and knowledge to inform action and importantly to evaluate progress." 10:16

10:16

And then he uses the phrase that I quoted from him this morning "In God we trust, all others bring data." And then there's I think a link, if we just go down the page and move away from that subgroup. If we go over -

just scroll down. Yes. Robbie Pearson, on behalf of the governance and accountability subgroup, highlights, I suppose, a concern that the Trust should consider better ways to facilitate the triangulation of systems - sorry to facilitate the analysis of data and perhaps a call for greater use of soft intelligence. And then something I think you were touching upon yesterday, an integration of learning systems to be put in place going forward. 10:17

So you've explained the context in which the External Reference Group is working. But the picture emerging from the thinking is that there's still perhaps a substantial part of the journey still to go in terms of better exploiting the opportunities which data might provide the Trust in terms of it's quality agenda and safety agenda? 10:17

A. I think that's absolutely right. But we need to have the rudiments in place, and I think that again is why a lot of this work needed to be done in terms of strengthening our governance processes and, in particular, some of the measurement and audit processes, so that we could put ourselves in this position. 10:18

10 Q. Mmm. 10:18

A. I'm not sure if you have a copy of it, I think we submitted it, but again through this work, what Mr. Pearson and Dr. Watson introduced us to, and I alluded to it yesterday, was what we refer to, as I

said, the Scottish heat map, but essentially is a lead into the framework for measuring and monitoring safety, the assurance map. And, again, we have started to use that, we've started to test that within the organisation in relation to identifying areas where we feel that there are hotspots and then starting to triangulate the data from other areas to build up a picture of how much concern and attention then we should give those different areas. So we're using it in a practical way, but we are not - and I'm hoping that - well Encompass next year should help us with this, but I would really like to get to the position where we had really good business intelligence and analytics around all of the information that we have to give us a clear vision of where we actually are, you know, in real-time, so that on day-to-day basis we have a clear pattern of, you know, are we safe today and is there something that we should be concerned about in relation to tomorrow? 10:19 10:19 10:19

11 Q. Mm-hmm. As I said earlier, we can observe some of the work that is being done in terms of the metrics and I suppose the intelligent use of data. I'll not bring it up on the screen, but the Inquiry has the references set out in the annual quality report, to cite one publication, where we can see how improvement is being measured, and some examples are given in there in terms of the data that's gathered to reduce, in the area of reducing health care associated infection, in terms of safer use of - safer surgery; falls, as you mentioned 10:20 10:20

earlier; VTE, as well as medicines management, there's a body of work done in relation to pharmacy and the reconciliation process. The identification of error and how that might be avoided. So rest assured the Inquiry has the references in that respect. 10:21

Is the concept of quality score cards familiar to you and is it an area that the Trust is thinking about?

A. We might know it under a different name. Can you describe it to me? 10:21

Q. So you've talked about the key performance indicators associated with nursing, and there seems to be a bias in the sense of, that's been a longstanding area of activity in terms of measuring on the nursing side of the ledger their performance against quality marks 10:22 associated with different realms of their practice. Quality score cards, and I'm sure Dr. Swart will be interested to ask you about this, in terms of clinicians and in terms of the delivery of what might be expected by standard health care matrixes, has there 10:22 been any attempt to, if you like, set them out: This is what we expect in the delivery say of stone management, this is what we would like to measure in terms of, say, the promptness of treatment, the follow-up, whether infection has arisen, that kind of thing, and then 10:23 seeking to learn from that?

A. There, there are - there's information across the system, but again the coordination of it I think is where the dashboards and the bringing together of, you

know, the overlaps in information and the business intelligence, and as I said the analytics around all of that will become important, and we're not there yet with that. I think there are different ways in to supporting quality in a very practical way. So each of 10:24
the directors will have a scorecard looking at the different domains of functioning within the corporate strategy, and then within the layers as they go down through the directorates, the divisions and the individual teams, there will be objectives set in 10:24
relation to activity and safety, and other measures such as culture, and sick leave and, you know, some of those things - violence and aggression, those things that we would be interested in. So that's one aspect of it. 10:24

And then one of the areas that we're considering in relation to this is having accreditation scores for different wards, so that in relation to the nursing quality indicators, some of the other information 10:24
that's coming through our governance streams, and then the expectation in terms of the services, I know the Director of Nursing is working hard on that in terms of trying to bring all of that together and to develop dashboards around that, but we haven't got that done 10:25
yet.

And then, I think, in relation to clinical audit, what it picks up on then is our compliance with some of the

national standards. So, you know, if we're audited against NICE guidance, for example, you know, whether it's Lithotripsy or other things, then, you know, we come with the expectation that we meet the NICE standard because it has been, that particular one has been adopted for Northern Ireland, and we measure ourselves against that and again that's fed into the information. 10:25

But ideally I think where we would really want to get to is system by system, and maybe even down to the individual having a clear understanding of how we're applying all of that. 10:25

Now, one of the things I mentioned yesterday that Dr. Austin is involved in developing, which is this Profession - the PGIS - the Professional Governance Information System, the aspiration behind that certainly for medical staff is to bring the relevant governance information under one roof, if you like, so that we can eventually look at that in terms of not just people's activity, but also their quality performance in terms of understanding that. But, again, it's very early days in relation to that. 10:26 10:26

13 Q. Yes. And it's perhaps of interest to the Inquiry, and perhaps it's important to reflect that bringing it down to the individual and measuring that individual performance no doubt, sensitive no doubt, perhaps controversial, and a lot to work through with that, but 10:26

it is undoubtedly invaluable where you perhaps have a doctor working in a way which is placing patients at risk. If that's hiding below the parapet it's clearly not healthy. If the situation can be understood by reference to data, objective data set against the standard, that gives everybody clarity around the issue and the baseline from which to design improvement?

A. I think it depends on the approach that you take to all of this. Now, you know, the vast majority of doctors love data, you know, it's the way medicine uses in training and, you know, the vast majority of people in the system are working above and beyond in terms of, you know, delivering on good quality care, and I think, you know, whether it's through the appraisal system or other ways, I think are very proud of what they do, and this can offer an opportunity in terms of, you know, demonstrating that. Right. So I do think it will be down to the approach that we take with this. But at the same time, if there are areas where people are struggling, it does, you know - and, again, against a backdrop of a just and open culture, it would be really important that we would not be, you know, pursuing this to be - to punish, but actually to try and understand and to support people. And, again, that's the - that is the approach that we're trying to take to this rather than actually making people frightened of it.

14 Q. Yes. Let me move on to a not unrelated area, which is mortality and morbidity, or the patient safety meeting, to give it's, I suppose it's more modern title.

A. Mmm.

15 Q. Clearly a relationship there in terms of how the patient safety meeting does its work, is its ability to access quality data. I think the Inquiry will remember that we had the evidence of Mr. Glackin, who in his time as the Chair or the lead of the patient safety meeting was rather scathing in his evidence, or perhaps despondent as to the support given to that meeting, and brought within his area of criticism was the lack of support for audit, whereas Mr. O'Donoghue giving evidence from his perspective as the now Chair, or lead of the patient safety meeting, thinks that we're in a much better area, that the patient safety meeting has developed. And I forget who it was, but I think we've other evidence that it's a more constructive arena for learning. 10:29 10:29 10:30

Have you any observations to make from where you sit as Chief Executive, whether in urology or more broadly across the services, how the patient safety meetings are fairing, and whether they are delivering for the corporate level the kinds of information that you need to make correction or drive improvement as appropriate? 10:30

A. I think that we have improved in relation to what we had originally, in that we have put, you know, more support around the teams in terms of facilitation and the administration of it. But I still think there's a way to go with it. Because it tends - the meetings tend - it's a while since I have sat in on one of the 10:31

meetings, but my sense is that it tends to focus on - because M&M stands for mortality and morbidity, and it tends to focus on mortality rather than morbidity because of the timeframes, and I...

16 Q. I think - sorry just to... 10:31

A. Yeah.

17 Q. Sorry to cut across you. I think that was, I hesitate to say it was Mr. O'Donoghue's point, but it was somebody's point who attends the Urology, who said that has now been flipped. It used to be you had to sit 10:31 through endless material on the mortality side of it, but I think the meeting is now organised in a way that you get to the more interesting stuff, the learning stuff first.

A. And I think that it's not yet as consistent as it needs 10:32 to be across all of the different disciplines. So I think, you know, in the case of Urology I think they have really grasped this. They have, you know, individual consultants who are responsible for the different areas and will bring that forward. They'll 10:32 use, you know, any information that comes out of the weekly governance report and any other data that they have themselves.

In other areas, like big volumes areas like medicine 10:32 where they're dealing with a lot of in-patients, a very high turnover, a lot of the time I know that it is more challenging in there and, again, there tends to be a greater focus on mortality there rather than morbidity.

So I think Urology has demonstrated that this can be done really well, but as we get, you know, as I get funding resource, certainly it is one of the areas that we would aim to try and improve, but it's not there yet. 10:32

18 Q. Yes. Some of the things that have been done include the attendance of the audit manager at patient safety meetings, the relaunch I think during your time as Medical Director of the Morbidity and Mortality Strategic Oversight Group - the purpose of that group we'll just look at briefly. It's to be found at WIT-45406, and just at the bottom of the page, sorry the top of the page. So it's responsibility is to provide a high level of oversight and assurance that effective systems and processes are in place for review of mortality and morbidity, ensuring that the capturing, sharing and implementation of learning and good practice arising from M&M meetings, and to consider reports of the type you mentioned earlier. 10:33 10:33 10:34

What kind of initiatives are in place or are you thinking about in terms of driving improvement more consistently, or more across the board in the Trust, in the area of patient safety meetings? 10:34

A. Well, I think there's a whole landscape of things that can be developed. So on a daily basis, you know, each clinical team will have a daily huddle. So in terms of identifying anything that's live and has to be

escalated, or indeed anything that is working well, that information will be very quickly shared, and that's done verbally, but there can be records kept of that. And in addition to that they have, you know, handover meetings at the various points, particularly when nurses and doctors change shift, to make sure that the information flows in the system. 10:35

In addition to that then, you know, behind all of that day-to-day management of risk and improvement we obviously have this machine of governance that collects as much data as we reasonably can to feed into the system. 10:35

Eventually what I'd like to get to is a process whereby, you know, we have clinical teams in their 15 minute huddle being able to pull up their daily dashboard with the governance information readily available and on it, so they can say, you know, "Yesterday it looked like we had a problem with insulin, we had a problem with falls, can we think today about how we do that better", and it gets into the business of live reporting so that all of that information that we have gets immediately to the frontline and the clinicians can use it in terms of how they run their services. 10:35 10:36

And, again, in relation to M&M, some of the information that comes to them, you know, is electronic, but it

tends to be historic rather than in real-time. So again, you know, when, for example, Urology goes in to speak about mortality and morbidity, what I'd really like to get to the point of being is that their morbidity is live, that they would automatically know that "Actually in the last week we had a problem with a surgical instrument", for arguments sake, "we have seen that, we have corrected it and we've moved on". 10:36

19 Q. Mmm.

A. We brought in Niall Downey, who is an airline pilot, who also trained as a doctor, to talk to us about the safety systems in the airline industry. Now, obviously they work in an incredibly controlled environment but, you know, what really stimulated us, I think as well, is how much they do in real-time. If you have a problem in the airline industry they will know within two to three days what that was, what the patterns were, and how they're going to fix it. It takes us much longer in the Health Service to be able to do things like that. 10:36 10:37 10:37

20 Q. Yes. One of the issues we observed when considering the agendas of the patient safety meeting, and maybe this is a rogue example, but the example I'm choosing is the management of stent patients.

A. Mm-hmm. 10:37

21 Q. And clearly a significant morbidity issue in Urology. But what was being discussed at regular intervals at the patient safety meeting was, here's another number of patients who should have had their stent removed or

replaced, dates were missed, and there didn't seem to be planning or programming around getting the patients into place for theatre at the right time. Now, part of that was undoubtedly resources, and we've heard about the Lagan Valley Initiative, which is a regional initiative to tackle stent in particular. But moving more to the general, I suppose, from that example. When clinicians are identifying clinical concerns that impact morbidity, has there been any improvement in connecting the problem to a solution? In other words, if things are coming back to patient safety meeting on a repeat regular basis, who listens and who is responsible for driving improvement? 10:38 10:39

A. Well, I think there are couple of things in what you say. Right. I think one of the confusions at an early stage in relation to, and I'll use Urology as an example, is that activity and waiting lists was getting conflated with quality of care. Now, there is an overlap, because it's not reasonable that people have to wait long periods of time to actually be treated, but the focus at times was on the narrative around these - the huge demand and the huge waiting lists, but not actually in terms of what is the quality of the care we're actually delivering to the patient in front of us today? Right. So I think one of our early learnings in all of that was to try and separate all of that out. So we have, you know, regional processes and local processes in terms of managing waiting times, some of the work that we're involved in is thinking 10:39 10:39 10:40

about how we regionally provide, but also how we share the work that is outwith the rest of the region with the region to try and level that up in terms of waiting times and make sure that those patients who are on those waiting lists, you know, receive appropriate support and care and keep in contact with them and do all of those kind of things. So that's one aspect of it. 10:40

And then the other part of it is in relation to the patient who is in front of us today, how are we making sure that they get the best possible care and attention within all of that? 10:40

So, separating those two things out has been important. And then again through the huddles, through the weekly governance reports, through the M&M/patient safety meetings, through clinical audit, through what's reported up to us, you know, in terms of the region and their feedback on our performance, you know, and the different lines of assurance in relation to particularly second and third line assurance, we get that fed back to us, and that will then get discussed either in relation to the weekly governance discussions at the Senior Leadership Team, and then how all of that information then is brought through all of the various subgroups into the overarching governance system. So, it's complex, but I think we have a better knowledge of what our concerns should be in the organisation these 10:41 10:41 10:41

days in relation to the patients in front of us, rather than confusing it with waiting times, which is a slightly different thing.

22 Q. Yes. Thank you. Another domain, or another tool in the Clinical and Social Care Governance Manual, if you like, is the ability for yourself and others in your leadership team and the Non-Executive Directors to go into the services to meet frontline staff. I think the concept has now moved from being one of leadership walks to director visits? 10:42

A. Mm-hmm.

23 Q. And we can see from the material provided by the Trust that there's a relatively consistent approach to this in that they regularly happen, albeit they do, as I'll perhaps highlight in a moment, seem to be - seem to be a fairly high attritional rate in terms of cancellations or postponements. 10:43

A. Mmm.

24 Q. But these are preplanned visits, everybody knows why they're happening and when they're happening. Is there - you're familiar with the concept of the secret shopper? 10:43

A. Yes.

25 Q. Is that concept anywhere to be found in how you approach these matters? So as opposed to everybody is on their best behaviour because the directors are coming today and the ward will be immaculate and all the patients will be sitting up in bed with a smile on their face, is perhaps a fear that you're not getting 10:43

the information you need if it's preplanned?

A. The information - so I agree with you. I think - I'm always a bit concerned about the artificiality of some of the preplanned visits. Right. And I think, I think they're very useful in that they focus everyone's minds, it gives the teams that we visit the opportunity to step out and say, you know, "This is what we're proud of. This is what we're worried about." It also gives us - we use different proforma for actually measuring, you know, the impact of all of that, and one of them is 15 steps. So, you know, trying to gauge the temperature of the area, you know, and lots of - using lots of visual signals essentially, you know as you step into any ward or community area, to try and get a sense of what that place might be like. Right. So, you know, they're not - they are organised, they do have their place, but they're not the whole story. 10:44 10:44 10:45

So, my view always in relation to this is that particularly the Executive Directors, and that includes me, it's access all areas and that, you know, if the Medical Director wants to go to any particular team, they go. Right. They don't have to ask permission, they can just turn up. The same with nursing, finance, social work, they do appear. And I do as well, I randomly go off and have conversations with people and be in and out of units to find out what it's like. I find those visits really really helpful. 10:45 10:45

I also know that we have taken a concerted effort across the Senior Leadership Team to think about how we organise ourselves in relation to that. So the middle three days of the week - because we're a fairly dispersed health and social care hospital and community 10:46
Trust, we have I think 226 facilities across the Southern Trust, because there's lots of places to visit. So what we tend to do is the Senior Leadership Team comes together in Trust Headquarters Tuesday to Thursday, but Mondays and Fridays they're out with 10:46
their own teams basically, you know, testing the temperature of what goes on there, and that's enormously important I think. There's a fairly - I hope there's, and my sense is there's a fairly flattened hierarchy in terms of, you know, getting to 10:46
hear information, which I think is really important. You know, there are some areas that definitely get visited more than others, but we do try and encourage visibility as much as possible across the Senior Leadership Team but also with the Non-Executive 10:46
Directors.

The other areas that we try - and actually technology has been helpful in relation to this and, again, I mentioned it briefly yesterday - I do a weekly chat 10:47
with the chief, so 15 minutes, 20 minutes every Tuesday I go on-line to the organisation and talk to them about what's going on, but also ask them to give me feedback, and actually that's quite useful because either myself

or the Comms teams will get emails from people saying "Did you know there's a car parking problem at Bluestone?", or "Do you know that actually there's concerns because there is, you know, a team under pressure over there? You know, could we do a thank you Thursday for them in terms of support?", because we've a system of, you know, recognising teams on a Thursday. So things like that.

26 Q. I think the car park problem is at Daisy Hill, according to one of the visits! But, sorry... 10:47

A. I have to say it's a challenge on both - all four hospital sites, it is a huge problem. But for people in a hurry I think particularly, there's not a lot of space. And the public transport doesn't always work as well as we'd like it to in terms of just the availability. But that's a whole - sorry, that's a whole other soapbox! 10:48

So in relation to all of that, I would like to think that we are accessible, you know, if concerns have to be raised that people can raise them informally with us through whistleblowing, whatever way they want to, and I think you achieve that by building confidence within, you know, all of us as a system, and being available. But I also know that it's not perfect and there will still be things that we miss. 10:48 10:48

But I would hope that, you know, people have the confidence to go in and out of the different areas and

then be able to feed back to directors or to other people, and that that would be received in the spirit that it's intended to be helpful, rather than being seen, you know, as a criticism, and that's really important in relation to all of this. 10:49

27 Q. Yes. Well let's just go to some of the documents that pick up on some of the themes you've just taken us through. So if we go to TRU-305048. And this is the leadership walk or Director Visit Schedule for the year just behind us. It appears, certainly on my reading of 10:49 the papers, Dr. O'Kane, that there's various different ways that these visits take place. You've mentioned already that it doesn't depend on - it isn't process driven, so at any point in time you can decide open access for any area, you and your directors can simply 10:50 go and drop in.

A. Mm-hmm.

28 Q. But on a more formal level it does appear that there's Non-Executive Director visits, there's solo Non-Executive Director visits, and then there's visits 10:50 that bring both the Executive Directors, or Operational Directors, and the Non-Executive Directors together for a visit. So there seems to be a variety of species at play here. Is there any reason for that diverse approach to it? 10:50

A. I think it's to try and provide as much opportunity as possible to get feedback, and also for people to, you know, gain perceptions of different areas. As I say, there are the formal visits but then, you know, as

important are all of these drop-in visits, and I know that, you know, across the Senior Leadership Team and, you know, including the Chair of the Trust, she will drop into various areas, we all will at various stages, and then what we will do is feed back to each other at SLT and then the formal reports also come back. I mean one of the areas where there is a requirement for visits is our childrens' homes. So the Non-Executive Directors will visit the childrens' homes on a regular basis and, you know, we'll follow that up as well, and those are enormously helpful in terms of getting the feedback from those areas. 10:51 10:51

29 Q. If we just scroll down through this, the Panel will no doubt pick up that multiple sites are visited, multiple disciplines or services are visited, usually led by a member of the Senior Management Team, and usually, but not always, accompanied by a Non-Executive Director. As I say, the red highlights where a visit has been cancelled or postponed, and just scrolling on down one can see that they're perhaps particularly vulnerable to being postponed, whether because in some cases, for example, there has been an infection breakout or just basic availability issues. So, just looking at this record, you don't feature heavily in terms of your involvement in these formal visits. I think I picked up on one visit in June to, I think it was to Bluestone. Should you, as Chief Executive, not be more involved in these formal visits? 10:52 10:52 10:53

A. I was heavily involved in them when I was Medical

Director, right.

30 Q. We can see that Dr. Austin is regularly attending.

A. Yeah, yeah. Yes. Yeah, yeah. And in relation to Bluestone, I go to Bluestone two Fridays a month to take a Balint Group with the psychiatric trainees, because I co-Chair that for the trainees. So I, you know, I have a lot of familiarity with that area. The rest of it, my drop-ins are informal. You know, I will regularly be in different areas, particularly on the Craigavon site. If there are concerns about the mental health or disability community sites, I visit, and visit at all hours of the day and night, basically to find out what's going on, and then I'll give feedback into the Senior Leadership Team. 10:53 10:53

But you're right, I don't tend to pair with a Non-Executive Director. Sometimes I pair with the Chair, and she and I go and do specific visits, and we'll organise some of them in fairly short notice. So, you know, some of the more recent ones in recent months have been Urology, and Dermatology, and if the directors are drawing attention to something I'll go and see the unit. 10:54 10:54

31 Q. Yes.

A. But I think it's a good point that it's not formally recorded in that way, but, yeah, probably needs to be. 10:54

32 Q. Certainly picking up on Urology, I wonder - looking through these formal visits, I wonder why there isn't a Urology visit almost as a standing item, given our

recent history with Urology. Does that suggest a sense of complacency perhaps? Why isn't Urology visited very regularly just at the moment until things are behind you?

A. So in terms of my, in terms of my contact with Urology, you know, for very sad reasons I know that I was, you know, in the units a few times before Christmas. 10:55

33 Q. Mmm.

A. So I certainly had contact then. And then the other contact I have with the Urology team is, I mean I am in regular contact with Mr. Haynes. I would be in contact with some of the other staff in terms of the managerial staff. But on a Friday morning at 8:30, after we have the Inquiry, I will meet the Director for Urology, which includes surgery and cancer services, and Jane McKimm and myself, we will meet with the Urology team on-line, basically to give them an update in terms of the Inquiry that week, an update in terms of progress, but also to hear back from them in relation to their concerns. So it may not be done in person, but I would have reasonably regular contact with the Urology team as a result of all of that. 10:55 10:56 10:56

34 Q. Could I bring you to TRU-305033? And if you just scroll back so that I can better orientate ourselves to the - is there a cover page? No? Yeah. So it's a summary report of the director visits that took place in the early months of last year. Over the page it sets out the purpose of the visits, they're an informal method to meet with frontline staff from across the 10:56

organisation. They allow teams to share the work they do, the achievements and the challenges. So it was in that context I was asking you about the absence of a visit to Urology. No doubt it is important to meet them as regularly as you do to discuss progress or issues arising out of the Inquiry, but these director level visits are for a defined purpose, and it would appear on my reading of it that they didn't take place in Urology throughout last year, and I wonder is that, as I say, a little complacent, given the issues that have troubled that service and which we're discussing through the Inquiry? 10:57 10:57

A. I mean I think it's a fair enough reflection. I imagine the reason that we - that whenever - so Corporate Comms designs the programme along with the Senior Leadership Team members and the Non-Executives, and they know that these discussions take place a couple of times a month, or three times a month at times, with the Urology team and with me. So, I couldn't definitively say, because I haven't had the conversation with them, but they will know that, you know, I do have those conversations with them. And certainly in terms of some of the developmental work that's being done in relation to, for example, you know, bolstering secretarial support, admin support, thinking about waiting times, you know, discussing some of the issues around the Lithotripsy Unit, and the MDMs, we would have those discussions on a Friday morning and I would hear it from the teams. 10:58 10:58 10:58

35 Q. Yes.
A. So I imagine - it certainly wasn't intended to be complacent, but I imagine that might have affected the thinking on this. But I mean that can be easily rectified, because you're right, I mean it doesn't look like we've paid it any attention, where in fact I think - I hope we have. 10:59
36 Q. It explains in this introduction that in relation to Non-Executive Director visits a report is completed within 14 days. Issues identified are escalated to your office and the relevant director, and then the relevant director addresses any issues raised, and assurance is then provided back to the Chair in relation to any issues. 10:59

So we can see that in action, if we just scroll down a couple of pages you can see, that's the Non-Exec visits last year highlighted for the earlier months of the year, and then at page 36 in the series is a typical report. 10:59 11:00

So we reflected earlier on whether these kinds of formal prearranged visits have their place and whether it would be better to do it as a secret shopper kind of approach, but they clearly have their place if some meaningful outcome can be drawn from it. 11:00
A. Mm-hmm.
37 Q. Whether, if you like on a softer level, which is the leadership have come to visit us and even the fact of a

visit no doubt can be helpful in communicating that staff are valued and appreciated, and you've talked about the diverse geography of the Trust, and no doubt there are pockets of the Trust estate that do value such visits. I suppose in terms of any service issues that are highlighted through these reports, do you tend to rely on your director to follow up on that? 11:01

A. Well, I get the report sent to me. The other reports that I get sent from visits are from RQIA from the Regulator. Right. So they will also visit the childrens' homes, they will also then have organised visits to different areas, particularly in acute medicine and the nursing homes. So if we get feedback in relation to that, that comes on as an item onto the Senior Leadership Team and those are discussed every week in terms of the outworkings of that, and then there should be action plans on the back of all of that, and then I asked for updates usually in the one-to-ones with the directors in terms of how that's progressing. So I think that again we take these visits really seriously, they're a huge source of information for us in terms of driving improvement, and also recognising what works well. So they are followed up, yep. 11:01 11:02 11:02

38 Q. Okay. Thank you for that. I want to move on to briefly talk about Risk Registers and the work that has been done around thinking about risk, and the Trust appreciation of risk and what it means for it's activities. The most up-to-date Corporate Risk 11:02

Register that we have access to I think is WIT-62044, and it's from September 2022. Is that a living document that will have been revisited regularly, or is this something that has to await further developments through the Board Assurance Framework and that line of work, which is ongoing as I understand it? 11:03

A. So the Corporate Risk Register is updated every month, at the risk and assurance part now of the Senior Leadership Team. So I see that one says September 2022. 11:04

39 Q. Yes.

A. There should be a February 2024.

40 Q. Okay.

A. Yes.

41 Q. Maybe we just haven't looked hard enough. 11:04

A. Yes. Yes. Yeah.

42 Q. But it's - I'm not terribly interested in the substance of it for the purposes of our questioning. Do you think that the Risk Register and the approach to defining risk is well understood, whether at corporate level or within the directorates or divisions? 11:04

A. I think it has got better over time, and as we have moved it away from being in the past I think it would have come up through the Governance Committee and there would have been some discussion at Trust Board, but it wasn't a live part of the Senior Leadership Team's discussion on a regular basis. We've moved on from that, and with the whole reorganisation and development of corporate document this is very much a live 11:04

document. So this will be talked about and there will be reflection in relation to understanding whether the risks we have on it are appropriate or not, and particularly, you know, the extreme risks, if there are any of those, you know, how they're being dealt with, those will definitely be given attention. 11:05

Now, I think that our sense is that in terms of the categorisation of these, you know whether they're moderate, they're mild, moderate or severe, some of that, in terms of how that's constructed and how it's used regionally, I think doesn't always make complete sense to us, but, you know, we'll use the narrative then to try and make that better understood. And I think what I do see now is that the risks move up and down as we deal with them, you know. So we do close off the risks that we've addressed and we do escalate others. And I will also hear, you know, in the weekly governance discussions, and in some of the discussions that come out of the Directorate Governance meetings that they have revised their Directorate and their Divisional Risk Registers and they're working accordingly and making sure that all of that aligns. 11:05 11:06

So I think, it's not perfect, but it feels to me certainly a lot - we're engaging with it much better I think than we did before, and I think we're using it better, but I think there are certain flaws in the document itself, but that has moved on a bit. 11:06

The other part that we've done over the last year as well is to have discussions around risk appetite.

43 Q. Yes.

A. In terms of what we can tolerate, and a variation on that... 11:06

44 Q. We can see that. Just to assist your answer, we could bring up the document at TRU-305589. And there it is. It's prepared through the Medical Director's office. If we can just scroll down over the page we can see in the summary section why such a statement is prepared. It explains: 11:07

"As part of improving risk management maturity of the Trust, which will include a revised Board Assurance Framework, Corporate Risk Register and Risk Management Strategy, the Trust is required to have a Risk Appetite Statement. This is required as part of the annual governance statement." 11:07

And just going through to the Risk Appetite Statement itself, this is obviously the summary of it, if you go to TRU-305591 at paragraph 2, the risk appetite is defined as being: 11:07

"The amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives. It represents risk optimisation, a balance between the potential benefits of innovations 11:08

and the threats that change inevitably brings."

And then just finally by way of introduction, if we scroll down to I think the next page, please? Just on to the next page. No, one more. Sorry. Yes, there's 11:09
this Draft Risk Management Statement which recognises that:

"The Trust has a duty of care, that health and safety is not compromised and therefore taking into 11:09
consideration that most risks cannot be completely eliminated, the Trust will have a low tolerance to those kinds of risks that could result in a negative impact on the health and safety of service users. However, within the boundaries of regulatory 11:09
constraints the Trust has an open appetite to take well-considered and balanced risks to pursue innovation and opportunities where outcomes can be improved for the population we serve."

11:10

So I suppose it's important from an organisational perspective to be having these conversations and to be thinking out loud about how risks are to be regarded. A zero tolerance perhaps for risks that might damage or harm your key constituent, your patients, and your 11:10
staff, but a preparedness to be more flexible within parameters where I suppose a benefit analysis suggests that you should pursue innovation?

A. Yes, and I think it's - those are really important

discussions I think in terms of understanding our way through this, particularly in the current environment where, you know, finance is extremely pressurised and the waiting times are growing. I mean these are the kind of considerations that have to be in this all of the time.

45 Q. Does that - we'll come on in our conclusion today just to look at some aspects of innovation, how, through the GIRFT analysis, how waiting lists and delay has to be tackled by innovation, by different kinds of thinking, by developing services and bringing resources and problems in a different way. Is that all looked at through a risk lens?

A. Yes. In relation to - because I think and, again, this is always the balancing act with this. We want, I mean we want to provide, like any health care provider does, you know, up-to-date modern treatments that deliver good outcomes for patients. But, again, it's about how you make the transition with all of that. So some of that is, you know, I think we're starting to realise that regionally through increasing the amalgamation of regional waiting lists, and I think Urology is a good example in relation to that in terms of sharing the waiting lists around the five hospital and community Trusts, to bring that together. But then, alongside that, there are obviously other innovations that we make ourselves. So, you know, two of the more recent ones have been a Steps to Wellness programme that was developed within mental health services where, you

know, outwith the region we took the view that we had far too many people waiting for mental health services. We designed a very comprehensive on-line programme with East London Mental Health Foundation Trust, and that is now running in its own right, you know, the outcomes are great from it, and it certainly has greatly improved our waiting times and the quality of care given to the patients. 11:13

In the same way, you know, when we look at huge overcrowding these days in emergency departments, you know, some of what we have to consider in relation to all of that is, we know that people can access really good quality care with good outcomes through our hospital at home service and, again, how do we manage the risk of developing that while mitigating against the risk of managing overcrowding in emergency departments? So these are constant conversations within the organisation in relation to all of these things. And then, I suppose, you know, the one that was very high profile, particularly in relation to surgery in recent times, was the decision and then the consultation around moving emergency general surgery out of the Daisy Hill site and increasingly changing it to an elective care centre for surgery, but at the same time having to mitigate the risks around the emergency department for people who arrive and how we, you know, save and send those people quickly, you know, to get to the right speciality, either on the Daisy Hill site or 11:13 11:14 11:14

regionally to Belfast or locally to us.

So all of - it's - I'm sure, as you appreciate, you know, the risk sometimes can appear in one bit of the system, but actually what you have to continually consider is what are the ramifications across the rest of the system and what is the risk balance in all of that? 11:15

46 Q. Yes. Thank you for that. Can I just ask you, again briefly, about the whole area of complaints and service user feedback? As has been the tendency over three days of evidence, we've touched in and out of that subject at various times, but I want to get a sense from you in terms of where you think you're at as an organisation in terms of listening to your patients and their carers. Clearly from a clinic social care governance perspective it is important to have a robust complaints system. It is important, as I think you've reflected this morning, to draw out of your engagement with your patient body information about their experiences, whether good or for ill. So, tell us a little bit about the developments that have taken place in the area of complaints and patient liaison, and the kinds of infrastructure you have in place to ensure that that is perhaps in a better standing than it was when you took up the Medical Director's role? 11:15 11:16 11:16

A. So I think as I said earlier, I receive approximately 1,000 complaints per year, and in an organisation where we do hundreds of thousands of pieces of business every

year that, you know, I think reflects the broad spread of all of that. And, so, very often people will write, the public will write to me directly, they'll write to the Complaints Department, or the different directors or doctors or other people, to raise the complaint. We have a Complaints Management System within the Trust that collects that, and then the standards that we work to - and, again, there's a regional revision in all of this - is that we respond within five days in relation to acknowledging the complaint and we should try to have that resolved within about 20 days. 11:17 11:17

There's a proportion, a small proportion of those complaints we don't respond to, I think well, in relation to people's satisfaction with how we have responded. And, again, if, you know, the local measures around that aren't sufficient, then very often that will get escalated to the Ombudsman. So, at any given time I think I have 29 complaints out of 1,000 that currently sit with the Ombudsman. And, again, then they will, you know, come back to us in terms of working with us to try and resolve all of that. 11:17 11:17

I think to try and - so that's the formal mechanism for it. And I think as I've said before, just to keep the balance in all of this, you know, we will get two to three times the number of compliments sent to the system as we get complaints. Right. So we learn as much from the compliments as we do from the complaints, 11:18

and we acknowledge the compliments in the same way as we do the complaints, in terms of taking them really seriously.

The other measures that we have in there are obviously the approach then to - as I say, across the organisation I think at the last count we have 92 service users who are involved in various shapes and forms in helping us shape service and giving us feedback in relation to that. We are, you know, we have contact with the Patient Client Council, which is obviously the formal body that provides feedback into all of that, and we'll also then take, you know, feedback from, you know, anything we pick up in the local media, but also from the local politicians. So there's a fairly broad breadth. 11:18 11:18 11:19

And back to what you said earlier in relation to secret shoppers. We will have usually ex-members of staff and other people who have been around the system and are picking things up and will lift the phone or contact us to say "Right, we're concerned about this". 11:19

During the pandemic, and in terms of being supportive to people, one of the things that we developed was a live time, sorry, real-time reporting function to the wards in relation to - what we did within Southern Trust was we developed the concept of medical student technician. So during the pandemic we were really 11:19

struggling to understand how we would get our medical students in the system and keep them there, because we were worried about the impact that that was going to have on their clinical ability, you know, if they were delayed. So with the agreement of Queens we introduced this concept, and at that time we brought - because then they were formal employees, we could bring them in during Covid to actually visit the words, speak to the patients and, again, that was supervised in terms of them developing good communication skills and understanding how the system worked, but also allowing them the opportunity then to hear the patient's feedback in terms of what was happening, and bring that back to the ward sister or the ward consultant, so that actually in live time that could be dealt with. That was enormously important to us. 11:20 11:20 11:20

As time has gone on and we have developed Care Opinion, which is the on-line feedback in relation to that, and we are the single biggest user of Care Opinion in Northern Ireland, what we've realised is that the usefulness of that as a system in terms of immediate feedback is increasingly less useful, so we're now moving all of that to Care Opinion, and we have hundreds of responses in that every month in relation to, you know, good and poor experiences. And, again, you know, we respond to that and take the themes. 11:20 11:21

47 Q. Mm-hmm.

A. In order then to understand...

48 Q. Sorry, just on that.
A. Oh, sorry.
49 Q. And the intelligence that comes through and the information that comes through these various systems, how does that connect with the mechanisms for improving, for correcting what might be poor practice, or perceived to be poor practice, in driving improvement? 11:21
A. So, where there's a complaint about an individual, that will be fed to the manager and the professional lead for that area, basically to consider and then investigate as appropriate. And then either, you know, to get a full understanding of what goes on, or to - and then to put in place any remedial action that's needed. Okay. So that certainly goes on on a regular basis when I or anybody else picks those up, that's where it is sent. I have to say those complaints about individuals are really really tiny. You know, it tends to be about services and waiting times, much much less about individuals. 11:21 11:22 11:22

And the other way then that we interrogate our data in relation to complaints is through HCAT, and I cannot remember - there are so many acronyms, I can't remember what HCAT stands for. It was a tool that we developed with the London School of Economics. We've started to use it in earnest since 2022 and, again, what it does is it interrogates these lines of feedback and gives us themes in relation to things that we should be 11:22

considering. And where I've found it particularly useful - I mean I can think in recent times there was one of the in-patient wards where we knew there was, you know, concerns about staffing levels and interaction and various other parts. What we can then do is narrow down any complaints that we get, for example, in relation to specific clinical areas, use the HCAT process in relation to that and start to drill out through the themes of what emerges. 11:23

So, increasingly it's not just about the big data in terms of the volume, but also then using parts of that to again intelligently scrutinise what we've got, to see where we, you know, really drive in relation to the themes coming out of that. So it won't be a surprise to you that violence and aggression particularly in our emergency departments is a significant problem at various points in time. And, you know, the learning that came out of that, plus came out of other areas, you know, we embarked on a programme of improvement around that, you know, involved colleagues from the PSNI in terms of trying to think about how they respond, you know, how do you manage escalation, what's the learning, where can we call from, how do we educate the public in relation to all of this and then watch the trends with that? And, again, some of that came out of the complaints that we were getting from the public in relation to being treated in that kind of an environment. 11:23 11:23 11:24

So we are - we do use all of that information and we do take it really seriously, and we use it, you know, as areas of improvement in some of the areas particularly where we're concerned. 11:24

50 Q. Yes. Again some of the specific infrastructure that has been invested in an appointment of a patient liaison officer in 2021?

A. Yes.

51 Q. That remains a feature of the environment? 11:24

A. Yes. Very much so. Yes, yeah.

52 Q. We know that in terms of the material that's gathered for governance complaints features in those reports and is also the subject of the one-to-one discussions at service level with the Medical Director team. 11:25

A. Mmm.

53 Q. I want to bring you to the update document that you supplied us with and which we looked at briefly yesterday in the context of adverse incidents, but you've also set out some update information in relation 11:25 to service user feedback. So if we go to TRU-306448. You catalogue for us - just scrolling down. Yeah. So you catalogue improvements to date in terms of service user feedback and - so you have quarterly meetings with the Ombudsman's office as well as with PCC, the Patient 11:26 Client Council.

A. Mmm.

54 Q. So tell me about that, those interfaces? Who attends on The Trust's behalf?

A. So those I don't attend, but those will take place between directors and assistant directors, and the various organisations.

55 Q. And why has - why have those interfaces been opened? Why do those meetings take place, the purpose? 11:26

A. I think for learning, because I think our experience is - obviously these are, these are very well established organisations that represent the public and, again, it's a very rich source of information for us in terms of driving improvement and what they're concerned 11:26 about. And, again, you know, if there are things that we haven't communicated particularly clearly, it gives an opportunity for us to, you know, improve on that, you know, in relation to our explanation. So, you know, the feedback I get in relation to these meetings 11:27 is very, very helpful.

56 Q. Yes. And then under a related heading, there's a liaison service?

A. Yes.

57 Q. It has been used in association with Urology Lookback 11:27 Review as well as in the Cytology Review. Again, what is the purpose of the liaison service and how does it assist your work and your Senior Leadership Team's work in relation to improvement issues?

A. So this team is affectionally known as FLO, which is 11:27 Family Liaison Officer, and we have approximately five people in the system, and they come from a background of working with individual service users and families, and we, we grew this service again in the course of the

pandemic in supporting people who were coming through with Covid. And, again, based on our experience in relation to all of that, extended that then to Urology and more recently to Cytology. But also, we also use these individuals in supporting families and 11:28
individuals through serious adverse incidents. So it's heavily used. As you saw yesterday, approximately half of our serious adverse incidents are located in mental health and disability, so they do spend a significant amount of time supporting families and service users in 11:28
mental health services and that - again the feedback we get from that is enormously helpful in terms of, you know, bringing education both ways and clearing up inconsistencies that, you know, are adding distress, and also, you know, providing a rich source of 11:29
information, I hope, to the service users and families in terms of how we're doing our business. Because, you know, I think we're very aware that we use one language that's common to all of us within health and social care, but it's not easily understood by anybody outside 11:29
of all of that. So, again, these individuals provide a really important bridge between ourselves and the public in terms of making sure that we're being clear and we're communicating clearly.

58 Q. And as you know improvement never stops. 11:29

A. Yeah.

59 Q. If we go on to - if we scroll down two pages I think to 50 in this sequence. So further initiatives in respect of service users set out here. You're looking to

develop a service user feedback awareness training package, and you're planning to pilot service user feedback process in the coming months. Going over the page to 51, we can see there implementation of the public service Ombudsman's model complaints handling procedure is on the agenda for discussion. Development and implementation of a complaints reviewer training package, and the development of a pathway for liaison service involvement in complaints. So how confident are you, Dr. O'Kane, that you've got the building blocks in place to better engage with your patient body for the purposes of learning? 11:30 11:31

A. I think we interface with thousands of patients and I think it's really difficult capturing all of this. This was one of the things I know that I have, you know, wondered how we can do this much better. I went in the past to visit - when Navina Evans was Chief Executive of the East London Mental Health Foundation Trust, I went to visit her, because they do this particularly well, and she described to me their system of actually involving service users in the compilation of the complaint response in terms of sending that back to the service user, right, or their family. We haven't got to that point yet, and there's all kinds of machinations around from a confidentiality point of view and all of that, how you would manage this. But ideally I would like us to be doing this at that level so that we - because I think - we tend I think as a system, and this is germane I think to all of health 11:31 11:31 11:32

and social care, the language that we use in terms of communicating with the public I think a lot of the time is really complicated and it needs to be said in a different way. So I think that's where some of our learning has to go to in relation to this. 11:32

60 Q. Okay. Thank you for that. I don't have very much more to go, maybe half an hour or so, would it be convenient to...

CHAIR: Okay. Well, we'll take a 20 minute break now and then that is a good indication for Dr. O'Kane for how much longer she's going to have to stay here. 11:32

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS:

11:54

CHAIR: Thank you everyone. Mr. Wolfe.

MR. WOLFE: Dr. O'Kane, we spent large parts of the last three days charting the progress you say you've made through clinical social care governance, different systems, you've developed infrastructure that has been built, and we've looked at that through the, I suppose, the lens of what it means for patient safety and improvement of services. It's also at the heart of it a project, I suppose, designed to give yourself in the Senior Leadership Team, and the Board, a way to be assured about the quality and safety of your services. Is that the way you view it? 11:55 11:55

A. Yes, you know, and it has to be assurance rather than reassurance, yes.

61 Q. Yes. I mean is it your sense that the Trust was built around a reassurance model? In other words, things were placed on trust, placed on perhaps professional opinion, expert opinion, rather than the triangulation of information which tends to be at the heart of a good assurance model? 11:56

A. Yes, that's right. And I think, you know, some of that came through in the Maintaining High Professional Standards Investigation that some of the information that was offered was reassurance rather than assurance, yes. 11:56

62 Q. Obviously there's a place for both, and the balance has to be right. It is important to seek the opinion and to be able to place trust in those you employ and those who speak to you and your Senior Leadership Team about their experience, but your project seems to have been to better develop the assurance tools that are available? 11:57

A. Yes. That's right.

63 Q. Where do you think you stand now on all of that? We've looked through each of those, at least as many of the systems and the tools that perhaps time allows us at the Inquiry over the last couple of days, in terms of a temperature check and bringing it all together, where do you think you are now as a Trust in that respect? 11:57 11:57

A. I think my sense is that we're better, but we're still not fully there. Right. So I - rather than, you know - and I think I made mention of this before, one of the things that I found difficult when I arrived in the

Southern Trust was, when you asked a question, I think it was experienced as an attack almost, that, you know, it was almost around people I think feeling that if I asked them a question I didn't believe them, when in fact what I was looking for was assurance rather than reassurance, although that's not the way I probably would have described it at that point in time. But I think as time has gone on, as a system, increasingly if statements are made or we're presented with information, we look for the assurance behind it. So we will look for the data. We rarely take anything at face value unless, you know, we've - it's already been known to us and we feel confident in what's being offered. So I do think that that has moved on. And, you know, we're able to tolerate the questions much better than we did at the outset, rather than feeling that there is somehow a judgment call rather than actually a genuine, a genuinely curious question around what's going on.

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64 Q. I hope it's not an unfair question to say this, where does your - where is your confidence weakest, or where do you think you remain most vulnerable in terms of governance, particularly social and clinical care governance?

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A. I think probably among some relatively junior staff across the organisation, right, and I think, you know, I can see vulnerabilities where people - and, again, we've tried to address this in terms of giving different groups professional line management. I'm

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always worried about the confidence, for example, of social care workers, and some of the administrative, you know, the Band 2/3 administrative staff within the organisation, because I feel that they don't always have the confidence to speak up and say to us what sometimes needs to be heard, and I think they are still concerned just about the hierarchies and just how that impacts on them. So if I were to think about - and those staff tend to be across a multiplicity of areas, so they are the staff that I would worry most about in relation to all of this. And I think certainly the higher banded staff, you know, within the organisation, I think are a bit further on in relation to this, but certainly the lower banded staff probably not so much. 12:00 12:00

65 Q. Could urology happen again? In other words, notwithstanding the assurance framework that you and your team have built, do you remain vulnerable as an organisation to circumstances where a clinician can behave, in the eyes of the Trust, in the way that he did? And could you also, sitting beside that, have a situation where the governance frameworks are not either sensitive enough or receptive enough to challenge in addressing? 12:01 12:01

A. Well I think as I've said over the last couple of days, one of the things that has beleaguered me throughout all of this is, you know, potential for blind spots, and I have no doubt that, you know, whether it's, whether it's in the Southern Trust or whether in other organisations, there will be similar situations again. 12:01

And I mean we have seen that in the history of the NHS. You know when I looked back to, you know, previous Morecambe Bay, and Patterson, and all of those other inquiries that went on, or investigations that went on in the past, you know, this has been the history of the 12:02
NHS, that, you know, every so often a situation emerges where, you know, if you're looking in your rearview mirror you think "We should have seen that coming but we didn't." But, you know, some of the challenge in all of this is about how do you make the system robust 12:02
enough to be able to be sensitive to it's own operations to spot these things at an early stage and actually intervene before anybody comes to harm? And also then, how do you maintain institutional - well, develop institutional learning, but also then maintain 12:03
institutional memory? Because, again, regardless of the fact that, you know, as I say, this has been the history of the NHS, where sometimes it almost feels like we're back to, you know, there's a groundhog day sense to it. I mean certainly when I read those other 12:03
inquiries I can see similarities.

So I think those are some of the bigger challenges for us in relation to all this. And I think, you know, the complexity of health these days is such that it moves 12:03
on such at such a pace that, you know, systems and processes that might have worked 10, 20 years ago don't work today because they're not sensitive enough to pick up the nuances of, you know, clinical activity,

people's behaviour, all of that. So you have to constantly, you know, keep up with it in terms of understanding the system that you're working with and thinking about how do you make it fail-safe so that actually these things, you know, whether on purpose or inadvertently can't happen, and that's a huge task. 12:03

So, no, I can't guarantee that this won't happen again. I would hope it'll not be in the Southern Trust, but I would be surprised if it didn't happen again somewhere. 12:04

66 Q. Yes. Of course all of the change which has been brought, obviously it's a matter for the Panel whether it does constitute improvement, and if it's improvement, is it sufficient? But it's all taking place in an environment or a context which remains very challenging in terms of resource, and we've oft reflected, or witnesses have oft reflected on the demand, capacity, shortfall, or mismatch. Now we can see from the material recently supplied to us that waiting lists remain stubbornly high, although there does appear, and I'll bring you to the statistics, to be pockets of improvement. 12:04 12:04

Before we look at that, do you consider, upon reflection, that the Trust has been institutionally blind to meeting unmeetable expectation? I ask that question because it derives, the source of it derives from some of the work which Ms. Veryan Richards has done, and that's set out as a question within it, the 12:05

suggestion in the question being that there is this unmeetable expectation in terms of your services, but you, as a Trust, haven't behaved appropriately towards that, that you've been blind to it and haven't responded with solutions.

A. Specifically in relation to waiting times?

67 Q. Yes.

A. I think that, I think we have been cognisant of it. I think that - but in terms of solutions, I think there are definitely periods of time where, you know, the demand can feel completely overwhelming, and I think can have the impact of paralysing people. Okay. So I mean this is why I think it has been important that, you know, we have tried to take a solutions based approach to these things and narrow them down as much as we possibly can and think about potentially what some of those solutions might look like.

So, when I think about Urology, for example, and think about, you know, the Lithotripsy service - it's referred to in there I think as ESWL - you know, that all seemed impossible in terms of the resource that was there and how that could be expanded. But what the team were able to do was to again use the data rather than just think about the demand, and systematically step their way through that in terms of what a solution might look like and how that could be beneficial, not just to patients locally but regionally, so then on the basis of that, have gone out, you know, put together

the business case in terms of developing all of that and bringing more sessions into the Trust so that they can deliver out on, and use the machinery that's available, you know, five days a week, but also support the region. And I think, you know - I suppose, you know, we have - we've tried to push forward in relation to some of the theory behind quality improvement, and very often that's about narrowing, you know, taking big problems but narrowing them down into actually what's the doable here. And, again, it was the same with, you know, when we were faced with this situation in relation to some of the flexible cystoscopes, for example, that the urologists were doing, you know, they realised that actually the clinical nurse specialist could take that on, we moved that work across to them to free up the urologists, and in order then to support the CNSs brought in more administrative time. So it is always about stepping - taking it problem by problem and stepping your way through it, and thinking about, you know, are there not just local solutions but regional solutions? 12:08 12:08 12:08

So, you know, there are plenty of examples like that. Some of them are easier to deal with than others. But I think part of the approach in all of that is not to feel overwhelmed by demand, to try and do the best that you can and think about how you improve on that. 12:09

68 Q. Yes. Thank you for supplying the most up-to-date performance report just so that we can put this in

context. I think I did remark on pockets of improvement, and you can help us with this. If we just go to TRU-306123. So I think this material is up to date as the start of this quarter, 1st January 2024, and to summarise, this is the numbers for patients 12:09
waiting consultant led out-patients appointments, first appointments, and we can see in bold at the top of the page that the longest waiter is 414 weeks. Just in the table below that we can see that the total waits is 3857, and that can be broken down into urgent waits and 12:10
routine. So the urgent waits sit below that, a total of 874, and then the routine waits is obviously the bigger number.

Again, it's probably - the reasons for this are 12:10
probably well explored. There's not enough capacity in the region, let alone Southern Trust, and that capacity is broken down into both human resource and quite often the attention that needs to be given to red flag patients, and that the casualty of that is those 12:11
patients with benign disease.

Is there any sense, in terms of your dealing with commissioners, that these problems are - of extensive waiting lists such as this are going to be grappled 12:11
with, or is it just a shake of the shoulders approach?

A. No, I think there is a real appetite for improving on this situation, you know, through the - you know, certainly through the Department of Health and, you

know, with the reinstatement of the Minister, I'm not picking up that that isn't something that's a priority for them. But I think at one point the Minister did mention that in order to address the serious problems we have with waiting times and other aspects of health and social care in Northern Ireland, it would take £1 billion. You know, Northern Ireland already takes over 50% of the block grant. That would leave less and less for other departments. So this is a fairly intractable problem, and the solution to it is not just money. 12:12 12:12

There is something about the way services are organised, and increasingly what we're attempting to do, certainly through the Chief Executives, with the support of the Department, is regionalise what we can, to try and, you know, bring together some of the aspects that work well in certain Trusts to make them available to other Trusts. 12:13

So, you know, we should have seven consultant urologists. At this point in time we have four in substantive posts. We have internationally recruited three, who will arrive over and be trained, you know, over the next six to nine months. That should help in terms of the levels of activity. But at the same time, you know, what we encourage is two of our - all of those consultants work as well in different Trust areas, you know whether it's through Lagan Valley in 12:13

the South Eastern Trust, or two of the surgeons operate in Belfast on their cancer lists, that are a shared regional resource. So there's something about pooling our resources to try and get the best results. But there's also something then about thinking about it not just being in terms of doctors but in relation to other people in the team, and how do we really build that up through CNSs, physician associates, you know, better use of admin and, again, developing that approach across the region rather than service by service. 12:14

But I mean this is a very depressing situation and, you know, I think what we know from history is that where, you know, there are financial pressures, that that manifests itself in a kind of pseudo rationing, and particularly manifests itself in terms of increased waits, particularly for non-cancerous conditions and, you know, these are already the worst across the UK, you know, in comparison with, you know, some of the other OECD countries across the world, and with the current financial situation that's likely to deteriorate. So I mean this is a really worrying picture. 12:14

69 Q. As I said, and I hope I interpreted the table correctly, but if we move through to 126 in this series, just a few pages down, we can see a Review Outpatient Backlog Update. We had the clinicians listed along the left-hand margin, and we can see if we move from January 2023 on the left, that the total is 12:15

1579 on the review backlog, reducing gradually through '23, and then as of January '24 it's reduced by a significant percentage - I haven't worked out what the percentage is, but it looks to be in the order of about 30% or so.

A. Mmm.

70 Q. Is there an explanation for that, that you're aware of in terms of how you've been able to grapple with - it's not perfect, but being able to reduce the review backlog?

A. I think principally for two reasons. One is that certainly in January 2023 Mr. Haynes, in particular, was heavily involved with reviewing the patients who were coming through in relation to the Lookback Review that was attached to the work that we had done with the Department in terms of the Urology Assurance Group, just in making and reviewing a lot of the, you know, over 2,000 patients that were historically attached to Mr. O'Brien, in reviewing their care and then seeing individuals. So that took up some of his clinical time.

In relation to the rest, I think Mr. Tyson has now left - he has gone to the Republic of Ireland to work. So - and, again, he did a lot of clinical outpatient work. We will - so - and he left just in and around Christmas time. And certainly in terms of his contribution, he returned from fellowship in New Zealand at a point in time and that certainly increased the capacity, and

then passing the work as well that can be done by the CNSs to the CNSs, just in the way I described, certainly has helped in relation to some of this as well.

But, again, I know that this waiting list really troubles the urologists because they are very cognisant of the fact that, you know, the longer some people wait for procedures the increased risk there is to the patient. And, you know, just to be mindful of the population. This is not usually a young fit healthy population, this tends to be middle to older aged males, very often with other complex medical conditions. So they are a vulnerable population. 12:17 12:17

71 Q. Yes. As I say, while that may be a pocket of improvement, to use your language, it's a fairly depressing picture overall. We now have the Getting It Right First Time Report. They reflect in the report some, if you like, Northern Ireland centric difficulties. They paint a picture of what they describe as a "decade long deterioration in Urology Services throughout the region". They suggest, amongst their various findings, that the current models do not serve the speciality well as most units nationally have or are in the process of transitioning to what's described as a Urology Investigation Unit type model, whereas Northern Ireland seems to be behind in that development. 12:18 12:18 12:19

A. Mmm.

72 Q. Our current diagnostic methods are not optimal, and there's a tendency to try to do too much in regional centres as opposed to develop specialisms, an issue that seems to have dogged the service for some time, despite the regional review that took place more than a decade ago.

Do you as a Chief Executive have a sense of that level of detail, or is that something that you leave to the service to sort out? Where are you in that conversation? 12:20

A. So, I don't disagree with that reflection, and I think that, you know, across the five health and social - we've six Trusts in Northern Ireland, one of them is the Ambulance Trust, but of the five Hospital and Community Trusts most of us do similar work in similar sized areas, right, with the exception of Belfast, which also provides quite a lot of the regional specialties. So, you know, we - and this has been part of the drive within Urology to think about how do we provide all of the different functions but not necessarily all in the same place? So, penile work, for example, the drive at this point in time is to push that towards Altnagelvin and Derry to try and support that work. The Lithotripsy, which is basically this business of breaking down stones in kidneys, you know, the move is to try and centralise that on the Craigavon site. The vast majority of cancer surgery is obviously done on Belfast site, and so it goes on in terms of

breaking the different parts of Urology into different parts on to different sites to try and improve on that. And I suppose, you know, our other contribution to that from a surgical point of view was in thinking about how we use Daisy Hill Hospital and reorganising emergency surgery on to the Craigavon site so then we could really increase our capacity for surgery on the Daisy Hill site. So, you know, since last April we have carried out more than 6,000 procedures on the Daisy Hill site because we have been able to move that activity around, which has been really successful. 12:22 12:22

And, again, some of us as Chief Executives before the assembly reconstituted became involved in what's called the Regional Hospital Blueprint and, again, it was in terms of trying to think about how, you know, taking on board, you know, the views of the clinicians, and they are - the clinicians are very clear about this, that we cannot keep doing everything everywhere - that we needed to really try and centralise and build up the expertise in different areas. So we have been working on that as a group of Chief Executives with the Department in terms of thinking about how that might be done. 12:22 12:22

And I think that, you know, that drives all kinds of prerogatives in terms of, you know, how do we provide then a regional workforce rather than a workforce that's just tied to certain areas? You know, how do we

forward plan in terms of education and development? A lot of what hijacks progress at the minute is the huge demands in relation to unscheduled care. Because there hasn't been the historic investment in the community in terms - I mean we - it has been no secret that we've been waiting for a huge increase in - you know, because as a system we've been really successful in terms of supporting people well to have longer and more fulfilling lives, but the corollary of that, or the outworkings of that now is that, you know, increasingly we have a frail and elderly population and we haven't got the community infrastructure to support all of that. So part of the challenge in relation to any of the elective sites in terms of surgery and those other areas, is that there's a huge demand coming from unscheduled care, and we know that if you're over the age of 65 it takes - and you become unwell - it takes seven times the level of investigation and care than it does for people under the age of 55, for example. And if you're over the age of 85, it takes 14 times that level of care. So once you start to multiply that up and think that on any given day, you know, or if I'm forward planning during the winter time, you know, I know that previously 45% of the investigation capacity, you know, whether its radiology or bloods, would have been taken up by unscheduled care. Today, in the Southern Trust, 70% of that capacity is taken up by unscheduled care. So, you know, not only are the numbers of referrals incrementally increasing at the

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front door, our capacity to deal with them as a system - and it's the same across Northern Ireland - gets increasingly squeezed, because we're constantly balancing this demand between unscheduled and elective care, and that impacts on these waiting lists then too.

And, as I say, the outworkings of all of that is, cancer patients by and large tend to get seen in a timely fashion, but other urgent patients then, or routine patients, then tend to get pushed back because actually everything is done on clinical imperative rather than just time on a waiting list.

73 Q. Yes. Well, the purpose, I suppose, of the GIRFT Report was to identify new ways of approaching old problems. How to better tackle waiting lists, improve structures, and ways of working and improve the quality of care, and a number of recommendations set out for the region as well as the individual Trusts, and you have provided us with the update from the Southern Trust in relation to the 18 or so recommendations, two of which have a very specific regional aspect to them, but a total of 18 recommendations directed to the Southern Trust.

The up to date position in terms of your action plan to address them is set out at TRU-306468. And one can see from working through that document, this is up to date as of last week or so, that seven are completed, nine are amber rated, and two largely depend on decisions being made at a regional level. You've already, I

suppose, unpacked in your evidence some of what has been done to meet some of the recommendations in terms of human resource, the recruitment of some overseas consultants, one can see recent recruitment of a nurse specialism, and we can see over a period of several years perhaps, efforts, as you've described, to move services, or move particular types of care across to nurse specialists, and freeing up time, and thereby freeing up an ability to attack some waiting list problems through the consultant personnel that you retain. Some of the work in progress that you're undertaking, and maybe we'll pick up on some of the examples if we go through to TRU-306472 and, sorry, scroll down another page. Another page, sorry. Yeah. So this is an example of where progress is being made, but it's not going to be delivered until later this year, so that the concern set out in the recommendation is that it would be more efficient for the service and beneficial for the patient if a straight to test model was adopted, and the detail is further explained there, and this requires the streamlining of cancer pathways to be able to deliver on this, and the actions required are set out there, including the need for commission assistance.

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But is, is a report like this eagerly received and welcomed by your Urology Service as well as the Trust as a whole?

A. Yeah. No, I mean I think it is, because they see this

as an opportunity for improvement, you know. And again, you know, the clinicians that we have working in that service, and I mean it's my sense of, you know, all of our services, they're really keen to do a good job on a daily basis. So anything like this at all that gives opportunity to actually, you know, improve the quality and amount of clinical care is particularly welcome. So, I mean, I haven't heard, certainly clinically, and nor managerially, have I heard anybody say they don't think this is right thing do. They're very enthusiastic about it. 12:30 12:30

74 Q. Yes. I get a sense from your evidence that there's some positivity around all of this, that there is at least a sense that we do need to improve.

A. Yes. 12:31

75 Q. That is in the area of Urology Services. That it has been and remains in a bad place for too long. But is there any concrete evidence that this is a watershed moment, or we're getting towards a watershed moment that somebody is going to take this Cinderella service on and actually tackle it in a meaningful way? Is there a strategy in place, whether locally within your Trust, or regionally, to try to get to grips with these massive and depressingly stubborn waiting list issues? 12:31

A. Well, in relation to the first part about how enthusiastically the team have embraced this and, again, it was said by one person on one of the calls one morning, one of the Friday morning calls, and it was reflected to me that even in the midst of having to 12:32

deal with the worry and concern around this Urology Services Inquiry, that, you know, they could see - I mean the way it was put to me, they could see light at the end of the tunnel and it wasn't a train coming, it actually felt quite hopeful - because they had full complement of junior doctors, they had, you know, more activity coming through because they had expanded the CNSs, they had more administrative support, they were really welcoming of the fact that, you know, we were able to internationally recruit in terms of consultants. So I do think they see this as an opportunity - they have seen this as an opportunity for improvement, and I think, you know, and I have the greatest respect for them because, you know, some of this has been extremely difficult to work through in many ways and could have destroyed the team, but, actually, you know, my sense is that they've really grasped it and worked really hard with it and take it in the spirit that we hoped it was intended. So that has been helpful. 12:32 12:32 12:33 12:33

On a regional level, yes, I do think, you know, in terms of the conversations that I know happen between particularly Mr. Haynes, who is the Urology lead, and Catherine Reid, the Director, and the Department, and what the Department feeds back to me through SPPG, I do think this has been taken seriously. The solutions are not going to be quick. This is going to take a bit of time to build up. And, again, some of the solution in 12:33

all of that is around regionally how we organise ourselves.

76 Q. You mention SPPG and the new, or the adjustment to the commissioning model that has recently taken place. Do you get an opportunity to engage with SPPG, and beyond that the Department, about these specific issues, or is that conversation yet to take place? 12:34

A. So, it's dealt with - I mean there are some specific conversations at times in relation with SPPG, but by and large the activity of the Trusts is dealt with through the performance meeting that we have with the Department of Health and SPPG every month. But they have certain parameters that they measure all of us against and, again, it's very - it's all activity driven and then we produce our data in relation to all of that. So, I have to say across the region, given how we are with waiting times, that there are a lot of reds on everybody's diagrams, but I think what we have all shown is that incrementally we have improved, you know, throughout the course of the financial year and, you know, we have plans in place to try and continue to improve on that. But it is a very red diagram in terms of those waiting times. But those conversations are had certainly with the Permanent Secretary and the Director of SPPG, and others, on the monthly basis, but may not always target Urology but maybe other specialties as well. 12:34 12:34 12:35 12:35

77 Q. In terms of the services that you provide, and the red on the diagrams, is Urology the one that's flashing

red? In other words, is it one of the services that is in greatest difficulty in terms of its ability to provide for the demand amongst the local population?

A. It features in there. So it's represented on that report as elective waiting times, and then there are other measures that's collected under in relation to the 31 and 62 day waits for cancer. So it's kind of put together with parameters from other services so it's an overall picture. But, yes, it's one of the areas that's contributing to this. 12:36

78 Q. But if you were to extract that from the global directorate or area in which it resides for accounting purposes, it would stand out, wouldn't it, as one of the most frail?

A. Yes. 12:36

79 Q. And vulnerable services.

A. Yes. So urology, gastroenterology, and dermatology, off the top of my list, and orthopaedics are definitely right up the top of the list. Mental health isn't as readily counted in there, but that also has challenges. 12:37

80 Q. And in terms of the relationship with the SPPG and the changes to the commissioning process, which in essence in terms of the evidence that we've heard, has taken the PHA out of the equation, or at least sidelined them - clearly a political policy or a political decision. 12:37 In terms of The Trust's and your experience as Chief Executive of the commissioning process, has that adjustment or that change made any difference to life for you in terms of the commissioning conversations?

A. So there is a review of commissioning arrangements in Northern Ireland taking place at the minute and, again, that involves the Department, the Chief Executives, and the PHA. I think that as we've, you know, as we've come in to the latest executive, Stormont Executive, I 12:38
think there is a realisation of the importance that, you know, community planning and public health plays in all of that, because, you know, we have poor outcomes on many fronts in relation to population health. And, again, you know, the PHA I think is, my sense, is 12:38
playing an increasingly strong role in all of that in describing the public health need and some of the interventions that would make a difference with that. Now, it will not automatically affect waiting times, because by the time, you know, people get on to urgent, 12:39
particularly urgent red flag, you know, cancer processes, you know, some of what they're suggesting will be helpful. But in terms of taking it further downstream in terms of some of the preventative work around, you know, hypertension, obesity, smoking, those 12:39
kind of - alcohol - all of those kind of discussions certainly PHA is very engaged in relation to all of that, but also in terms of thinking about the health inequalities, because we know that health inequality is largely what drives poor health. So, again, there is - 12:39
there is a very active discussion in relation to all of that and, again, that should impact on the commissioning process in terms of how we deliver services.

81 Q. In conclusion in terms of my questioning, Dr. O'Kane, the Inquiry is reaching the final stages of its evidence gathering process in terms of hearing from witnesses. The Trust, and it's personnel, have contributed significantly to that evidence gathering 12:40
phase, and one can readily appreciate the impacts that that will have in terms of time, and distraction, and pressure, and that deserves to be acknowledged. But, beyond that, and I'm not dismissing that of course, but beyond that, having regard to the stage we've reached 12:40
and the journey that the Trust has taken to where we are now, how do you assess the impact of the urology problem and the participation in an Inquiry and the holding of the Trust up to public scrutiny, how has that impacted, whether positively or negatively, or 12:41
perhaps both, on the organisation?

A. I think it has been a really interesting journey for us and, I mean I came from the Belfast Trust before I came into the Southern Trust, so I would have been on the periphery of other Inquiries and been aware of the 12:41
stress that that took on the organisation at a point in time. And then when I came into the Southern Trust and then we were faced with this, I think none of us had ever dealt directly with an Inquiry process before, so I think it was a very sharp learning curve for us at 12:41
the outset. And I think, you know, none of these inquiries is run in exactly the same way and, I mean that's the history of it whenever you compare even with some of the English Inquiries, that's exactly the same

and, you know, when I've enquired about Scotland, it's the same. There's, you know, different ways to interpret the process depending on the circumstances. So it was never going to be exactly the same anywhere else. 12:42

I think it has - I mean I think on the last count we reckoned we provided probably more than 500,000 pieces of documentation. Right. So I mean it's hugely - generated a huge amount of information from us I think. 12:42 And some of that obviously was duplicated. So that was interesting.

I think, you know, how we had to think our way into all of that in terms of getting ourselves organised around 12:42 it, understanding what the demands was of us as an organisation at the same time as we continued to have to function and deliver services and improve other services, I think has been interesting. And I know certainly at the outset it was quite a frightening 12:43 process because, you know, again while we were dealing in the early days of this there were reports coming out in relation to hyponatraemia, and to neurology and, you know, doctors being referred to the GMC, all of those things that, you know, just really terrify people 12:43 whenever they hear it. So, you know, all of that had to be thought about.

But I honestly have to say that it has been helpful to

us in that even though it has generated a huge amount of work, I think it has made us think really carefully about our business, about the work, you know, the work that we do and how we deliver it. I think it has helped us focus on the importance of, you know, 12:44
governance, and what's located within all of that. It has certainly given us the opportunity I think to reach outside the organisation in terms of really thinking about how things can be done well and certainly, you know, the colleagues from across the rest of the UK 12:44
have been hugely helpful in relation to that. And I think it probably has helped the relationships within the Trust, because we've had to depend very heavily on each other, and to really support and understand the pressures that the clinical teams have been under, 12:44
particularly the Urology team, in order to sustain this whole process.

So, even though it has, you know, taken effort and time, and all of the usual things, I do think overall 12:44
as a process it has been enormously helpful to us.

82 Q. Is there any adverse experience to report? Has it, not necessarily the Inquiry directly, but perhaps the circumstances of the problems that were identified, has that led, for example, to excessively defensive 12:45
practice on the part of clinicians and managers?

A. I honestly can't see that that directly reads across to that. I think - in all honesty I think some of the defensive practice has come out of the anxiety that was

generated in relation to the rumoured speculation around other Inquiries. Okay. So I do think that was always going to be there at an early stage. And certainly - I mean I've worked in the Health Service a very long time and I can see the - you know, for nearly half of its existence - and I can see the changes in it over that period of time. Medicine has become more defensive over time I think as it has felt under attack and scrutiny, and there is something about how, you know, that in itself is managed, and I think does lead to very defensive practice at times in order for people to feel that they're keeping themselves and their patients safe. But I am not picking up specifically areas of concern certainly I have within the organisation in relation to this. I think we have tried to approach this as an opportunity for learning rather than defensiveness and, hopefully, that is borne out. But I mean there will always be times that you have to take, you know, take a step back and think about all of that. But, yeah, I do think I'm not picking up that it has felt particularly punishing in relation to people's own practice. But certainly in terms of workload and demand and everything else, it has certainly produced different stresses. Yeah.

12:45 12:46 12:46 12:46

83 Q. And just finally, finally, at the heart of the Terms of Reference of the Inquiry is patient safety and, obviously, there have been issues for patients as a result of the shortcomings that the Trust has identified. Have you been able to gauge, and if you

12:46

haven't been able to gauge simply say so, whether you have been able to maintain the confidence of your patient body and their carers through all of this, whether in urology or more generally?

A. I think that that has been tricky at times. I think, you know, particularly as we worked our way through some of the Serious Adverse Incident Reviews, and then as we worked our way through the Lookback Review and, you know, there had to be the communication with people around the fact that we felt that they had come to harm, I think that has been very distressing certainly for patients and carers, and I think at times our communication has not been as good as it could have been and I think that has caused distress. So I think we have learned from that maybe, and I'm sure we have further learning to do. So, you know, certainly at the beginning of all of that, that was challenging. And I know, you know, we were disappointed in terms of how we were doing things ourselves. I honestly have to say that once we had Margaret O'Hagan seconded in there to look after the lookback process per se, rather than it being shared as different people's roles, and then with the support alongside Jane McKimm in relation to the running of the Urology Inquiry process, I think that has definitely improved quite a bit now. But, you know, we have another piece of work yet to finish out on in terms of reviewing deceased's patients, so we're not completely out of the woods with this yet. But certainly I would hope that in relation to that we're

12:47 12:48 12:48 12:48 12:49

better, and I think it has taught us something then whenever we had to think about, you know, reviewing cytology patients recently and some of the other work that has been done around that in terms of how we approach that. So it has been helpful from that point of view, but it has not been easy, particularly I think for some of the patients and carers at the outset of all of this. 12:49

MR. WOLFE: Okay. Thank you. Thank you for answering my questions. I have nothing further. 12:49

CHAIR: Thank you, Mr. Wolfe. Thank you very much, Dr. O'Kane. And given the workload that you have, that you've been here two and a half days, and I'm afraid I can't release you just yet, we have a few questions, but if you're happy to sit on rather than take a lunch break we'd hopefully do that in short order? So Mr. Hanbury, first of all. 12:49

DR. O'KANE WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS 12:50

MR. HANBURY: Thank you very much for your evidence, Dr. O'Kane. I've just got a few clinical and urological questions, which hopefully shouldn't take too long. 12:50

In the Royal of College of Surgeons Invited Review Report, we obviously - shared their frustration that in Mr. O'Brien's practice there was a lack of clarity

about plans as a result of letters not dictated, and in one of their recommendations they asked for a review of that, obviously a comparison to the paper charts with letters which are now available electronically, but there has been some difficulty doing that. That's one of the audits not started. I didn't know if there was a particular problem there?

A. I think that there has been some difficulty in terms of collecting the information, but I know that we have increased the secretarial support in there to try and allow this to happen. So I will, I will investigate the specifics of that and come back to the Inquiry, but certainly we can look into that. But I know we have increased the secretarial support in relation to that to get that sorted out. 12:50 12:50 12:51

84 Q. MR. HANBURY: Thank you. That's just Recommendation 16 on the thing.

A. Yes. Yes.

85 Q. MR. HANBURY: Just another thing on the audits of the multi-disciplinary team working after Dr. Hughes's review of the nine SAIs - you've already answered one of them. In Recommendation 5, about the extended tracking, which you remember, the problem for a few patients, especially with prostate cancer, is that they were started on hormones and subsequently not referred for radiotherapy. Are you confident that that has been picked up with the new system of extended tracking? 12:51 12:51

A. Yes. And certainly in terms of the audits that are being done, you know the 5 out of 38 every week in

relation to the patients described, it would suggest that they are being done. And that - again the trackers were specifically employed to undertake that function and to make sure all aspects of the treatment was actually happening, yes. 12:52

MR. HANBURY: Yes. That sort of leads on to my second question. The 5 out of 38 is roundabout 20%, I think one of the slides said, obviously it's a variable number week to week, but that obviously means that 80% aren't looked at. Is that - I mean whose decision was 12:52 that to just do a sampling rather than looking at every one?

A. I think because it's done on such a regular basis I think the team decided that that was a large enough figure to take, and I think within the capacity of what 12:52 the tracker can do, or the person who undertakes that piece of work, I think in order to do it thoroughly that's what they did. The cases are selected at random. So they're not, you know, they're not chosen as such. So we would hope that, you know, given the 12:53 volume of patients that are audited on an ongoing basis that that should capture it. But I mean what we could always do is occasionally do a check on 100% and see if that's borne out. Yeah. Yeah.

86 Q. MR. HANBURY: Okay. Thank you. One question as to 12:53 with MDMs are peer, and this was before your time back in I think 2015, just plucking that out of the air, and an external peer review marked the MDT process rather low at 35%, and I suppose my question is: What,

looking back, should have happened then? Should there have been intervention? Should that had been flagged up to the Trust Board, for example? Or the cancer services should respond in more robust way, it just seemed to drift? 12:53

A. Well, I would - well, I would say that what should have happened then is what I hope and think does happen now, which is it would be escalated. So, it would, you know, be escalated up through the directorate to SLT and then potentially to Trust Board. But, yes, it should have been escalated. And I think - again, I mean my sense of that at that time was that there were so many problems in terms of waiting times and in terms of this, that and the other, that just, you know, there was kind of an apathetic collapse almost. Yes. 12:54

87 Q. MR. HANBURY: Yes. Thank you. Okay. Thank you. Just on - changing the subject slightly to sort of pre-assessment and patient safety, the Inquiry are aware of a couple of patients, two patients, who sadly died fairly shortly after surgical procedures, and there are various things about that, but part of it was pre-assessment, which I think has been looked at in detail. But I haven't seen any evidence of - those cases still might have been picked up in the surgical huddle, or the WHO checklist, but there seemed to be not so robust processes among the surgeons and, therefore, surgery went ahead when it perhaps should not have done. I mean are you - can you assure the Inquiry those - as far as you know those processes are 12:54 12:54

now more robust?

A. My sense is that they are better than they were before, but I haven't got all of the data yet to suggest that they're 100%. Okay.

88 Q. MR. HANBURY: Yes. Okay. 12:55

A. So one of the pieces of work that's due to start now, and I think it was referred to yesterday in Fiona Davidson's work in relation to the plan for future audit and preoperative assessment, is to actually look at all of this in a bit more detail, and this is going 12:55 to require more resource to sort out we think.

One of the anaesthetic leads is about to start a quality - and we've freed up his time do it - a quality improvement project around all of this to look at the 12:56 baseline data and then think about how all of that can be reviewed and changed, because I think one of the frustrations that the surgeons have currently is that people come along in chronological order, have their preoperative assessment, but at that point in time if 12:56 they're not fit for surgery, or there are other interventions or investigations that need to take place, there's not enough time between that and the actual surgical procedure for that to be sorted out, so they get lost off the waiting list, or off that point 12:56 on the waiting list, need that done before they can come back on again, and there's always the potential for capacity to be lost. So where they're aiming to get to is to make sure that all of that is done in an

organised and planned fashion so that actually what they have is a running score on the patients who are due for theatre that they can then automatically approach those who are already fit and passed for surgery and pull off that list immediately. Right.

89 Q. MR. HANBURY: Okay.

A. So that is part of the work that's being done in relation to all of this to try and reduce the likelihood of people approaching theatre and not actually being ready for theatre. 12:57

90 Q. MR. HANBURY: Yes. Okay. Thank you. Just one question on Bicalutamide 50 and prescribing drugs, and we heard from Tracey Boyce about the difficulties of monitoring drug prescriptions which were given by the clinicians in outpatients which then went to community pharmacists and, therefore, there wasn't oversight, at least in the hospital. 12:57

A. Mmm.

91 Q. MR. HANBURY: So what's to prevent that happening now? What's to prevent that happening now? 12:57

A. Well, all of those prescriptions should originate within the Urology Department. So they have a good programme in terms of, I think, being aware of all of this and making sure that everybody - I mean this is talked about a lot in terms of being compliant with all of this. Right. Our pharmacy processes at this point in time aren't robust enough to pick up, you know, if it's still being prescribed for the wrong reason, in terms of whether it's 150 or 50 milligrams of 12:58

Bicalutamide. But certainly pharmacy is very aware of this and, you know, will appropriately challenge if they're concerned. But I think the ultimate solution to this will again be the implementation of Encompass next year. Now, I appreciate that's a year away. 12:58
Because the Northern Ireland version of Encompass should bring together the different aspects of the clinical pathway, and the artificial intelligence that's built into the Encompass programme should try totally the prescription of Bicalutamide to the 12:58
diagnosis and should be able to pick up that actually this is outwith what it should be in terms of, you know, the cancer disease process and metastasis.
So that artificial intelligence that kind of guides the system and it should be helpful with that. 12:59

92 Q. MR. HANBURY: And that's available within that new system?

A. Yes. Yes, it should be.

93 Q. MR. HANBURY: Thank you. The Getting It Right First Time, Mr. Wolfe sort of asked you quite a lot about 12:59
that. In England, one of the real benefits we've found in departments is when GIRFT can do sort of more of a deep dive to compare or show where you as a department, or we as a department could get better compared to better performing departments in particular situations. 12:59
Is there any barrier to doing that in the future? That is a sort of deeper dive from a GIRFT point of view. You mentioned hospital episodes, statistics, and data difficulties. Is that one of your plans for the

future?

A. There shouldn't be - the only barrier to that will be finance. But certainly there wouldn't - certainly the Trust wouldn't resist that in any shape or form, but we would really welcome that, because the more information 13:00
we have like that the more useful it is. And I know that regionally the Department has engaged with GIRFT in terms of looking at, you know, not necessarily Urology but, you know, the wider spend in relation to value for money. So I think there will be 13:00
opportunities like that in the future, but I think it's a really good idea actually.

94 Q. MR. HANBURY: Thank you. Just another thing on GIRFT and surgical hubs, which are being pushed certainly by Royal College of Surgeons of England a lot, and it is 13:00
great to hear you say the success of Lagan Valley and now Daisy Hill Hospital. Just on that, just thinking forward, is that still just day cases or do you see an availability in the future for short stays and being able, therefore, to do the more intermediate and major 13:01
cases, thereby potentially taking elective surgery away from the main Craigavon site?

A. Yes. No, the plan would be to increase the complexity of those cases on the site. Now, some of the limitation on that, as you know, or you probably know, 13:01
was around the intensive nursing support post-operatively, how that was being managed. So now has been - there has been quite a lot of work done around resolving all of that in terms of, you know,

giving it an identity and purpose and understanding how that relates to post-operative surgical care. But certainly as we build up the theatre team there, build up the commissioning process there, and build up our surgical complement and, you know, continue to work with what's within the region, we would hope to be able to enhance that. Because at the minute we run two lists five days a week, and we'd really like to get to the point where we're running three lists a day, you know, lists seven days a week. So there's plenty of scope there if the commissioning arrangement was right and we had the staff available to do it. But as I say, we've appointed the three new consultant urologists, so over the next year to 18 months that becomes possible. 13:01 13:02 13:02

95 Q. MR. HANBURY: How did you achieve when many before you didn't succeed?

A. Huge amount of work on the part, I have to say, particularly of our HROD, you know, we worked with an ethically sourced company in terms of doing international recruitment, and some of our clinicians went with the HROD staff basically to India to recruit and worked really heavily on that. But we have invested a huge amount of time and thought into making sure that people who have arrived are having a good time and that we're protecting them as much as possible in terms of, you know, just giving them that support, but it has taken a huge amount of effort, but it has definitely been worth it. 13:02 13:03

96 Q. MR. HANBURY: Thank you. The last question from me is,

on the subject of medical leadership, because we've noticed that the CDs in the past for Urology have almost entirely been general surgeons and they have lots of other things on their plates, obviously.

A. Mmm. 13:03

97 Q. MR. HANBURY: So it is good to know now that there's Divisional Medical Director in the form of Mr. Haynes for responsibility. That, I believe, is an interim job, is that correct? I mean how do you see that evolving? Will it stay like that or will that become a 13:03 Clinical Director in the future and will it be a urologist.

A. Well, I think whether it's a Medical Director or a Divisional Medical Director, they need their own leader. Right. 13:03

98 Q. MR. HANBURY: Yeah.

A. I think having Mr. Haynes there as Divisional Medical Director has worked extremely well. He's networked into the entire region, he understands the business extremely well, you know, he has a lot of credibility 13:03 in terms of his clinical practice and his relationships with other people, and he's not frightened of challenge, and to speak up in relation to, you know, aspects of all of this, but at the same time, you know, I think has been a really important and impressive 13:04 clinical leader in terms of driving forward change. So - and I appreciate not everyone will have all of those skills. So, I, I would be keen to protect that for the next period of time - and I haven't had this

conversation with him yet - but certainly to protect that over the next couple of years anyway until we get this firmly embedded, but also I think it has been a really good model to think about in terms of the other services. And, again, you know, as you heard me mention yesterday, I think one of the challenges for us is developing a really strong community of medical leaders, not just in Southern Trust but regionally. You know, I was reflecting on this. I, at a point in time, worked with a charity with medical students, you know, where we basically developed medical students to be leaders in relation to education and, you know, handing back and working with school children and all of those things, and huge potential in there, and yet somehow as a system, you know, as they come through then as junior doctors and even into consultancy, we don't seem to support that terribly well as a region, and yet I see other disciplines do it really well. Like our nurses are phenomenal leaders, and increasingly our social work staff and AHPs, but I don't see exactly the same impetus in relation to medical leadership here and I think it needs to be given that.

13:04 13:05 13:05 13:05

MR. HANBURY: Okay. Thank you very much. That's all from me.

13:05

CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

99 Q. DR. SWART: Thank you very much for giving us such a clear account of your interpretation of some of the many documents that we've read. What come through

quite strongly is the spirit of improvement, and the desire to improve, and also a lack of defensiveness, I would say, which is useful, and I just want to ask you in a bit more detail about a few things which are particularly interesting in terms of the improvement journey.

So the first one is about your External Reference Group.

A. Yes. 13:06

100 Q. DR. SWART: So, from your evidence this has been a positive thing. It's clearly a very sensible thing to do. How did you go about choosing the members of that group?

A. The first person I - so I think as I suggested in the last couple of days, I approached a few trusted advisers, you know, people that I normally would speak to outside the Trust, and they suggested - there were two or three of those people suggested Dr. Tom Frawley to me. 13:07

101 Q. DR. SWART: Yes.

A. And then I had the conversation with him, but at the same time - and I mean I had this with all the support of my own leadership team because, you know, we were all grappling with the same issue, but I had the conversations. And, you know, took their sounding on all of that, spoke to Dr. Frawley. I also had a really positive experience, I have to say, when I did the Scottish patient safety fellowship training and, you

know, I had met Robbie Pearson and Simon Watson during all of that and, you know, they stuck out in my mind as people who really authentically understood the NHS but also understood about improvement and the need for use of data and everything else. So they were obvious 13:07
people I think to go and speak to. And then what came out of that as well then, or alongside that, you know, it was suggested to me I think by our own Director of Nursing within the Trust, Heather Troughton, in relation to Mary Hinds, who was previously - I mean 13:08
again very highly regarded. I had known Mary in the past, as I say, whenever she was, you know, a Director of Nursing, but I also knew that she had been involved in turnaround teams in the past in terms of giving advice. And Hugh McCaughey, obviously very long and 13:08
extensive experience working as a really highly regarded Chief Executive in the South Eastern Trust, had then, you know, worked for the last number of years in guiding NHS Improvement England and, again, very embedded in quality improvement. And then, as I say, 13:08
Veryan Richards, she and I had done a lot of work through the Royal College of Psychiatrists, and I was really very struck by, you know, the ethical approach to what she did. And like there wasn't anybody - you know, I would really have liked to have had more than 13:08
one Veryan, but locally I couldn't, you know, it wasn't easily obvious to me who else was around to do that.

102 Q. DR. SWART: Yes.

A. And I think, you know, the other thing that helped in

all of that was - and hopefully is didn't introduce bias - was through some shape or form all of us had established relationships with the people involved, whether distantly or recently, but not particularly while I was in this role but in different roles, and I think, you know, I trusted them, and I think they probably understood very well what it was we were trying to achieve, and I have to say they have been extremely generous with their time and thinking in terms of supporting us. 13:09

Now I have no doubt there are other people that we could have included, but as a manageable group they came together and they helped us think about this, and they also worked - they have worked extremely well I think with our Senior Leadership Team in terms of really challenging us and helping us think about things. So there's no science involved, it was purely based on... 13:09

103 Q. DR. SWART: Yes, yes. No, I'm just interested because, you know, there are different ways of going about it. 13:09

A. Yes.

104 Q. DR. SWART: I think you've highlighted the importance of a bit of a relationship and trust?

A. Yes. 13:10

105 Q. DR. SWART: The sense I get from the papers as well they were trying to be quite pragmatic.

A. Yes.

106 Q. DR. SWART: It wasn't meant to be too sort of detailed

and hypercritical on every occasion. What did the Trust Board - how did the Trust Board react? So you've agreed it with your Senior Leadership Team. How did you talk to the Chair and the Non-Execs about this? Was it met with any resistance? Were they supportive of it? Were they afraid of it? Was there any difficulty there? 13:10

A. No, there wasn't. I think, Eileen, you know, the first conversation in relation to that was the conversation I had with Eileen Mullan and, you know, it was explained to her in terms of having external experts to help us think our way through this. 13:10

107 Q. DR. SWART: Yes.

A. Because we knew it was a very complex problem, and we knew the history of it in terms of some of the things we had grappled with at an early stage, and she was very supportive of this. You know, I think she saw the value in it and, you know, there hasn't - she spoke to - I mean she knows some of the members on the Panel and I think has spoken to them at various stages. 13:10 13:11

108 Q. DR. SWART: Yes.

A. And she had a conversation with the Chair of NHS Improvement Scotland as well, because obviously Robbie and Simon were both coming from that organisation, which was really helpful. And when I went to Scotland I met with the Chair with NHS just to make sure she was on the page, you know, at Robbie's suggestion. So, no, that worked well. And I think, you know, Mary Hinds and Veryan have been to our Trust Board, some of the 13:11

others have listened in to Trust Board. You know, I think Tom Frawley has - I don't know, I haven't been present, but I think there have been conversations between them in terms of just the progress that we're making. But, no, I don't think the Trust Board certainly felt intimidated or threatened by it, no. 13:11

109 Q. DR. SWART: And, you know, I get a sense that it would have given you all considerable confidence.

A. Yes.

110 Q. DR. SWART: Was there anything that came up early on that you really was taken aback at and you found very challenging in terms of the questioning aspect of their input, you know, anything that really made you think "Oh, I'm finding that a bit difficult", or not? 13:12

A. I think - just to think back on all of that, I think probably some of the more difficult conversations were in relation to what Veryan presented, you know, because she listens to the Inquiry each time it's in open session and then reflects on that, and she puts some really challenging questions to us. 13:12

111 Q. DR. SWART: Was that hard to hear, or did you think it was unfair, or what was the reaction?

A. No, I don't think any of us thought it was unfair, I'm just trying to remember. But certainly I think it certainly was hard to hear sometimes, because it was very honest. 13:13

112 Q. DR. SWART: Mm-hmm.

A. But, you know, it was done always in the spirit of trying to get us to think and to challenge us. So it

definitely didn't land poorly, but it was - a few times there were kind short and sharp intakes of breath and we thought "Gosh, right, I really hear that", you know.

113 Q. DR. SWART: I understand your thinking about coalescing this now into your own - I think you call it transformation and improvement function - which will, you know, obviously be an ongoing very important committee, I would have thought. How are you going to keep the energy that you've got from this external group flowing through that in terms of having the little critical friend on your shoulder? Have you thought about that, whether you need any further touch points? Because I imagine this has brought a lot of energy into some very complex problems, which actually most Trusts have one way or another, but if you're going to really take it forward you've got to keep that going, haven't you? 13:13 13:13 13:14

A. Well I'm sure other people do it better, but I think that it's really hard to run and lead an organisation like this without having people outside to touch base with, because otherwise I think you can become extremely tram-lined in your thinking and develop blind spots really quickly. 13:14

114 Q. DR. SWART: Yes.

A. And given our experience of that, it hasn't been good, and I'm keen to avoid it. So I think we definitely see the next stage as, you know, working towards the, you know, the process that Margaret will lead in relation to transformation, and I don't think we've quite 13:14

thought our way into actually where then will we get the listening and the support from outside? But, you know, I do agree, I think we definitely need it.

115 Q. DR. SWART: I was thinking also of, you know, this is - it's a very sensible pragmatic approach, "we'll get some help with this, it's a big issue". 13:15

A. Yes.

116 Q. DR. SWART: You're working in the context of Northern Ireland, which is a relatively small place. I've struggled to understand a little bit at times where all the direction comes from in terms of Trusts, but is this not something that could be replicated in terms of learning across the other Trusts? Have there been any discussions, particularly on the quality and safety side with the Chief Medical Officer, in terms of really trying to make the most use of data, plus the cultural side? Where do you see that going, because it would be a pity if it is just the Southern Trust learning in this way? 13:15 13:15

A. Well, I know that - so Dr. Frawley is Chair of the Western Trust, and I know that he has said to me, you know, at times when I've apologised for the amount of time events might have been taking up, he will reassure me by saying that he has found this an enormously helpful process and that it helps him think about his own business. Right. 13:15 13:16

117 Q. DR. SWART: Yes.

A. I think because, you know, some of this has felt very internal and personal, and I'm not sure we've talked

about it very widely, but I think we need to change that.

118 Q. DR. SWART: Yes.

A. Certainly the Department of Health would be aware of the work that we've undertaken, but not in the detail we've described in here. So - and I haven't had a direct conversation with the Chief Medical Officer about it, but I would know that he would be aware of, you know, some of the work that has gone on through the Urology Assurance Group, because he has been involved in that, and then through some of the work that would have occurred whenever I was part of the Medical Director's Group, and Stephen Austin with him now in the Medical Directors Group with the CMO. So I definitely think that's worth pursuing further in relation to data. 13:16 13:16 13:16

The other person I think who is interested in all of this is the Chief Nurse. And, again, Maria McIlgorm came from Scotland, so she's very familiar with this kind of approach. 13:17

119 Q. DR. SWART: Yes.

A. So I think we would be pushing on an open door, but what we've got to do now is create the opportunity for that. So, yes, yes, I think that's a good thought. 13:17

120 Q. DR. SWART: Yes. I think it does represent that opportunity to make a positive experience from something that's been tough, I'm sure.

A. Yes. Yes.

121 Q. DR. SWART: Interested in your partnership with Mersey Care.

A. Yes.

122 Q. DR. SWART: Now, what does that look like, that buddying? Who actually has been able to go over there and visit and how are they helping you exactly? 13:17

A. So I have - so Joe Rafferty, the Chief Executive, has been here a few times and he has observed us.

123 Q. DR. SWART: Yes.

A. He has done some training with us, and I have been to Mersey Care basically to view different aspects of their organisation just to see how this translates on to the ground, and some of the Directors have had Teams meeting with their equivalent staff and some of the others have visited. So it's been a combination. A lot of that has been through the mental health structures, the HROD, some discussion then in relation to finance and the direction of travel around that. So mostly it's there. And then I'm due to have another visit with Joe Rafferty in April time to go back again just to, you know, talk about this work and then to think about some of the... 13:17 13:18 13:18

124 Q. DR. SWART: How are you going to get it on the ground? I mean that's the issue, isn't it? I mean it's impressive work, I've had experience of it in the past in theory, I don't know it personally, but there is quite a big transition between understanding the value of it and getting it done. 13:18

A. Yes. There is. Yes. Yes. Yes.

125 Q. DR. SWART: Is this still at the planning stage then, from your point of view? You've chosen then someone to help you with this, is that where this is?

A. Well in terms - so the main - so their - the focus of our discussions with them have been around just an open culture, and also then in relation to good governance and what that looks like. 13:19

126 Q. DR. SWART: Yes. Yes.

A. Now bearing in mind that they're a Mental Health and Community Trust. 13:19

127 Q. DR. SWART: Yes. Slightly different.

A. But they've very good working relationships, as I understand it, with the rest of Liverpool. But - so in relation to the just and open culture, I know that Vivienne, our Director of HROD, has been in contact with Amanda Oates, and I've spoken to her as well in terms of how they've rolled this out. It's not a quick process. It takes a while. 13:19

128 Q. DR. SWART: No. That's why I am asking.

A. Yeah, and it has to be lived and breathed, and you have to be authentic about it. So we just have to work our way steadily through it. So, you know, there is something about how we check each other's behaviours at time as well and, you know, the Senior Leadership Team is not behind the door in telling me "you need to wind your neck in" or, you know, "behave yourself", and vice versa. So I think that's a good start, and we will - at times we have to do that publicly. And I think then coming with that expectation at each level of the 13:19

organisation is really important, but getting it onto the ground I think is still patchy. I can see it in some areas, I can't yet see it in others, and that's going to take time.

129 Q. DR. SWART: Okay. You also talked about serious incidents, and I'm sure you know there's a lot of revision of the serious incident framework in England. The principles of it are the very things you've talked about. So it's involving learning on the ground, involving the patients and the staff, all of that kind of thing, much more openness that kind of goes along with the just and open culture a bit. What's going to happen - is it planned in Northern Ireland, do you think, to learn from that English new approach to do something different? Why would you not sort of try and encompass some of that? What do you think should happen? Because I can see all those strands in your thoughts, but what I'm not clear about is what's happening in Northern Ireland as a whole and whether that will be redefined in a way that makes it all more manageable and focuses more on learning and staff and patients on the ground, what's your view of where that's going? 13:20 13:20 13:20 13:21

A. It is led - the review of this at the minute is led by Seamus O'Reilly, who was previous Medical Director in the Northern Trust, and he presented to us late last year in relation to the progress of this work, and I think he - my sense is he would share the view that this, this has to be fit for purpose, and not go on 13:21

forever and a day to yield results, and it has to be concentrated on improvement. So I think that's very firmly fixed in his mind. Now the outworkings of it haven't come through yet. I think there is always a tendency in Northern Ireland to want to have somebody to blame. Right.

130 Q. DR. SWART: Yes.

A. And I think we need to get away from that.

131 Q. DR. SWART: Yes.

A. I think getting it - I think convincing health and social care I think should be straightforward, but then there's the wider public opinion in relation to that, I think that's the bit that has to be challenged. 13:21

132 Q. DR. SWART: Yes. I was thinking more of the new framework that's been introduced in England. 13:22

A. Yes. Yes.

133 Q. DR. SWART: Which completely moves away from the traditional serious incident, and I think the intent was to make it simpler and to avoid the blame.

A. Yes. Yes. 13:22

134 Q. DR. SWART: I don't know how well it's actually working because it's fairly new.

A. Yes. Yes.

DR. SWART: But is it your view that it would be wise to learn from Scotland as well, and England, and bring that altogether to say "Actually, what we have in Northern Ireland, it isn't working, they've acknowledged that", but it's sort of getting on with something else quickly, and I think you've done a pilot 13:22

which you found very helpful, are you going to be able to personally contribute to that, do you think, on the basis of your experience with this Inquiry and so on?

A. Yes. No, I think so, and he has taken our feedback in relation to that and in feeding back to it. But I agree with you. I think if we could get closer to what the English model is, I think that would be much more helpful. 13:22

135 Q. DR. SWART: Another thing you've talked about, which is your desire is to have a vision for the Trust and a five-year plan, and I think this is - you're right, this is actually very important, and it's easier to say than do. You put values at the centre, which again helps to align people. How do you see that translating? I think you have consulted on the values and vision so far, but how is that going to translate into a meaningful planning process on the ground where staff can contribute every year and feel they're getting somewhere, so it gives them a bit of hope, I think, if that can work well? And if you try and do that, how will that fit in with an overall strategy for Northern Ireland, do you think? I mean how are you going to marry all this up? 13:23 13:23 13:23

A. Well, in relation to the corporate vision at this point in time, you know, we're working our way through it and we have identified those key areas in relation to quality and safety, value for money, you know being intentional, and then underpinning all of that with data. So that's the key to what, you know, the 13:23

collective is coming back to tell us should be our direction of travel. And I think that marries then - in keeping with the advice from Mersey, what we have done is decide that we will have one strategy but plans to support.

136 Q. DR. SWART: Yes.

A. So the people plan, for example, which is part of the mechanism for delivering out on just and open culture, is developed. We've already just started to work our way through that and look at, you know, in terms of how we develop the organisation, deal with what previously might have been disciplinary processes, is there a different way of actually managing all of this? 13:24

137 Q. DR. SWART: Yes.

A. And, again, in relation to the safety plan that's been, the patient safety plan that's been developed, the data plan that's being developed, all of those aspects, to try and then think about how do we - how do we focus our energies obviously on those with our vision in mind, but done through the lens of a just and open culture. So everything, you know, we're getting documents re written with all of that in mind and just trying to work our way through it so it becomes part of the way we do business. 13:24 13:25

138 Q. DR. SWART: Yes.

A. Then I think, you know, how that's delivered down through the directorates piece by piece is important. So they're doing it in, you know, through work with the directorates and divisions, but also then in terms of 13:25

groups of staff. So again, you know, as I highlighted earlier, you know, a couple of the groups of staff that we're always anxious about are social care and Band 2/Band 3 administrative staff, because they tend to be the most vulnerable in the organisation. And, again, if we can work with them to demonstrate all of this and build goodwill in terms of this is authentically how we hope to do business, I think that should help, and then continue to work down through the professional lines with the rest. So, I mean we've in and around over 15,000 staff, I mean it's a lot of people. 13:25 13:26

139 Q. DR. SWART: It's a lot of people.

A. And we obviously have turnover in the organisation. But I think, you know, if that's where we set our culture, and that's the expectation, then as we recruit people, you know, we're building it into our recruitment processes and everything else, that people come into the organisation choosing to adopt that culture at an early stage, and we just need to keep building it up. 13:26 13:26

Mersey would say it took five to seven years to actually get it fully embedded. It's not quick. But...

140 Q. DR. SWART: Yes. This is long term. I'm thinking really - I've asked a few clinicians, you know, did you meet in an annual planning process to discuss where you're going, and all of that sort of thing, and it seemed historically not to have been in the right place 13:26

in terms of making people feel that they could change things, they could be involved, they knew what the aspirations were.

A. Yes.

141 Q. DR. SWART: And I can see that this will fall out of your vision, values, cultural work, but there is also the issue of what's being done on a Northern Ireland wide scale and that will influence it. 13:26

A. Yes.

142 Q. DR. SWART: I mean the first thing is, is that going to be tied up? How do you see that working? Because I can see people on the ground being quite confused as to what's happening where? 15,000 people is a lot of people to get to. What is your plan for that? 13:27

A. Mm-hmm. Mm-hmm. I think, you know, we're not - I mean you will know we're not in a position to direct the rest of Northern Ireland in terms of how it does it's... 13:27

143 Q. DR. SWART: No. That's why I'm asking. Yes.

A. Yeah. But I think the best that we can do in relation to that at this point in time is to lead by example and to keep forging forward in relation to this. 13:27

144 Q. DR. SWART: Yes.

A. So some of that I think, you know, has been through, you know, initiatives like the stabilization of our workforce, starting to think about how we take these bigger initiatives on board, you know, such as Daisy Hill, such as some of the other things, and how do we work with that to actually drive improvement, and be 13:27

fairly relentless in, your know, our mission and vision around that so that people can see that we've...

145 Q. DR. SWART: So they can see results.

A. Yes, because that is the intentionality, yes, and the persistence. 13:28

146 Q. DR. SWART: Medical management, we've talked about this a bit. Clearly winning the hearts of your medical staff is actually quite important and I'm sure you value medical leadership, you've put some effort into redesigning that. Do the medical leaders have enough 13:28 time at present?

A. I think those jobs are still very pressurised in terms of the depth and breadth of what they need to get to, and there has definitely been an improvement with it, but I think it's still not there. And particularly in, 13:28 you know, a speciality like Medicine that encompasses some of the other smaller specialties within that, I have really seen the benefit of having two Divisional Medical Directors for surgery, and I think we do need to think our way through what the medical one then 13:29 looks like because we're about to have a retirement on that.

147 Q. DR. SWART: And have you worked out the balance between, do you have a Clinical Director for every speciality or do you have a clinical lead or, you know? 13:29 Are people recognising the value of these roles? It doesn't really matter what name you give them, they need time and support to lead their colleagues. Is that better recognised now do you think by the medical

body or is it still lagging behind? Is there a funding issue for either the time or the development required?

A. I think, again I think it's patchy. I think some areas value it more than others, and where it is valued I can see it just, you know, produces a huge amount of value. 13:29

148 Q. DR. SWART: Yes.

A. But, you know, I think particularly in persuading some of the, you know, recently appointed consultants in particular to start to take on and develop these roles, I think that is a bit of a challenge, but we need to 13:30 have, you know, we need to have succession planning and thought and everything else into that. And, again, it's about, you know, how we support each Divisional Medical Director to grow their own community of leaders within each of the directives. 13:30

149 Q. DR. SWART: And have you got a fully developed development plan that's funded?

A. Not yet. No, not yes. And, again, that's part of the discussion that's been ongoing in relation to where do we get that help? So now that we, as I say, we're 13:30 about to appoint the latest recruits into that because of just turnover, I think, you know, part of the plan in relation to '24/'25 is to develop the whole medical leadership side of it.

150 Q. DR. SWART: Just taking that up to Board level. You've 13:30 got a very big Trust, you've got a lot of different disparate services. Do you have enough clinical input at Board level and/or in the senior leadership team? What's your view on the bandwidth that's covered?

A. I think that when I counted up - wait until we see - five of our out of 12 - six out of 12 of the Senior Leadership Team come from clinical backgrounds - seven of us actually. Yeah, seven, come from clinical backgrounds. So there will always be a sympathy towards that in relation to it. Now, not everybody is bang up-to-date all of the time and they don't understand everything, and I wouldn't expect them to, it's too much. But - so I do think that it is a Board that's sympathetic to clinical work. What we try to do, but I think could do better, is bring the clinical voice in, you know, in terms of presentations and in terms of other things. So, you know, in relation to surgery, for example, we brought along the Clinical Directors and Divisional Medical Director in terms of informing the Board, informing SLT in terms of the changes that are being made there. The same with Cytology. We've done it in Obstetrics and Paediatrics. So we do try to introduce it that way to make sure that, you know, all of the responsibility of that doesn't fall back on the directors and we're getting a very clear clinical picture. But there's always room, I think, to do more of that, but we do try and do it, yes. 13:31 13:31 13:31 13:32 13:32

151 Q. DR. SWART: Oversight of cancer, clearly historically that was an issue I think.

A. Yes.

152 Q. DR. SWART: And it's improved now. Is there a forum now where cancer - all the issues with cancer are

brought together and overseen? I'm thinking particularly of, yes, the 31 and 62 day target is very important, but I would be used to, on a regular basis, knowing up-to-date information about compliance with peer review, about harm reviews for long waiters, about 13:32
strategic plans for cancer that were or were not on track, where is that brought together?

A. So out of the cancer strategy, and I can't remember the formal name of it, but it's a cancer oversight steering group that's run by SPPG and the Department of Health 13:33
now. But from what I gather from its Terms of Reference it's mostly involved with activity in terms of all of that.

153 Q. DR. SWART: It is, yes.

A. Yes. And the part that the clinicians are really 13:33
worried about is that NICaN, to use their words, is allowed to wither on the vine. Because the Northern Ireland Cancer Network is the region, is the area that really held the ring in relation to that in the past in terms of bringing evidence base, the clinicians 13:33
together, all of that, to inform the quality of all of that.

154 Q. DR. SWART: Yes.

A. And I think certainly the clinicians are really worried about losing it, and they're also really worried that 13:33
as a result of that actually the takeup in terms of the clinical reference groups for each of the cancer pathways isn't as well represented because of a sense that actually the quality of cancer provision, you

know, isn't being strongly represented by NICaN at the minute, and I think that was always a useful mechanism for bringing clinicians into the system and taking leadership of these groups.

13:34

So I am concerned on two fronts. I'm concerned that their worries are realised in relation to NICaN, and I am also concerned about the fact that the perception certainly is that there is a lack of medical presence in relation to those CRGs. 13:34

155 Q. DR. SWART: But what happens within the Trust though? Is there a way that this is brought together within the Trust to say "Here's how we're doing on cancer overall", because you've got your Cancer Directorate, where does that go? Does it go to the Senior 13:34 Leadership Team? Is there a director responsible that oversees that on an annual basis at least to say "This is where we are"?

A. So the Surgery and Cancer Directorate have oversight of a lot of that, but I think - so what's managed down 13:35 through the cancer division is all - they have oversight in relation to that, and the Assistant Director and Divisional Medical Director should have oversight of that. Separately then in terms of the gynae cancers, that's dealt with in OBs and Gynae 13:35 division. But I think increasingly what they're thinking of is: How do they marry that learning across? And then the same with dermatology, for example, which tends to be - and thyroid and lung -

tend to be managed up through Medicine but, again, need to be brought in underneath that Cancer division...

156 Q. DR. SWART: So I'm used to it coming together in a performance meeting of the Board.

A. Yes. Yes. 13:36

157 Q. DR. SWART: To say "By the way, this time we're saying we're going to give you this other information." So I was struck when you did the quoracy - we had a quoracy table, and GI, I think it was Upper GI and lung had a very poor quoracy on MDTs. 13:36

A. Yes. Yes.

158 Q. DR. SWART: With lots of issues, clearly.

A. Yes.

159 Q. DR. SWART: Now that is something, I think, that people - and I think you would agree - people should be aware 13:36 of and it should be escalated up alongside performance figures. Now, that could usefully be done as a region, clearly, with the population size that's there, but also a Trust Director could usefully have oversight of it. Is there a plan to do that, to bring that in a bit 13:36 so you're not looking just uni-dimensionally at the access targets as performance with these other performance measures? Have you thought about that?

A. There is no formal plan as yet, but it certainly has stimulated conversation in terms of, you know, how we - 13:36 how - does form follow function in terms of these divisions, and are they actually doing what they were originally set up to do. So there's no formal plan, but there definitely have been internal conversations

about this, yes.

160 Q. DR. SWART: Very quick one on job planning. You mentioned there's no link with Quality, and it's a problem, and I can see that.

A. Yes. 13:37

161 Q. DR. SWART: When job planning first came in there was the opportunity to put objectives in, and it's quite simple to say tam objective for Radiology, or a general discipline would be to meet the NICE Guidance No. 1, whatever it is, and the college standards for this. 13:37 Have those discussions taken place at all? There's some simple things that can be done without specific quality metrics that look terribly complicated. But if it hasn't happened, why not? Why do you think nobody has brought quality into job planning? 13:37

A. I think it has got lost over time and, you know, a lot of the job planning tends to be focused around, as I said, activity rather than quality.

162 Q. DR. SWART: Yes.

A. But I think it needs to be given more emphasis because, 13:37 you know, the appraisal is supposed to be against those objectives in the job planning.

163 Q. DR. SWART: I know.

A. But the two things do not read across.

164 Q. DR. SWART: So that's on the radar and hopefully - 13:38 yeah.

A. Yes. Yep.

165 Q. DR. SWART: Leadership walks. Clearly you've done a lot of work. It's evolving, as you say. One never

gets this entirely right. But people on the ground would, I think, very much value the sort of informal quality conversations. What is your view on that in terms of do you think there's enough of that so that you understand what's going on in people's heads, that you are able to get a sense of that or your colleagues are? What's your view of that? Because there's the formal round, but there's also "What is it people are feeling today?", and that requires the building of a bit of a relationship, I think. 13:38

A. Well the way - because - I was just thinking about that in terms of that table that was put up, because the other piece of information we publish every month is the meetings that Eileen and I have had with external agencies and internally. 13:39

166 Q. DR. SWART: Yes.

A. And I was trying to remember do I record all of those on that, and I think I - I'm not sure it's consistent. So we do have a record of all of that. But, you know, what we tend - I think there will be - I mean last week, for example, when I was on strike day I was round virtually every department in the hospital speaking to people. 13:39

167 Q. DR. SWART: Yes.

A. And actually got a lot of information out of doing that just in terms of where people were. And there are other times, for example, if the Emergency Department is under huge pressure I will go in, and the directors, everybody will go. But they'll also - like Trudy's 13:39

office, her second, you know, her base office is just up the stairs, so she'll be there on a regular basis, or they'll be up to see her. So we do get a ready feed. I think the areas that trouble me sometimes are the areas that are quiet, that we don't have as much access to. 13:39

168 Q. DR. SWART: Yes.

A. So - and, again, we have been thinking about that. So just, you know, and trying to get some of the feedback in relation to that and asking some of the questions. 13:40 And then I know that, you know, I don't have any - because I was Medical Director, and I know a lot of the doctors involved, I don't have any hesitation in texting people or ringing them to say "Can you give me a rundown on this?". 13:40

169 Q. DR. SWART: Yes. I can see, yeah.

A. And I know the directors will do the same thing, because I hear them talking about it. But we probably could make that a bit more visible, you know, and I think sometimes in the busyness of all of this, and 13:40 also in terms of how our behaviour adapted during Covid and getting back into being in the room with people, I think...

170 Q. DR. SWART: That's a good idea. My experience is that the problems areas get lots of attention in the busy 13:40 areas.

A. Yes.

171 Q. DR. SWART: And the people in the back room can easily get lost.

A. Yes.

172 Q. DR. SWART: But you're doing your weekly Teams conversation, and that's an interactive conversation from what you say. You tell them things and people can ask you things. Your weekly Teams meeting for the Trust? 13:40

A. Yes. Now, there's variability in that. Some weeks people ask more than others and sometimes I am sitting there in silence with people for a couple of minutes.

173 Q. DR. SWART: Yes. I recognise that. 13:41

A. Yes. While I fill in the gaps. But, yes.

174 Q. DR. SWART: And what are you trying to do with that? What's your - in your head, what are you trying to convey with those conversations, do you think?

A. Well I think they serve a couple of functions. One of them is to give the organisation - well, three functions. I think one of them is to give the organisation information, you know, about the things that are troubling us or that we're celebrating. 13:41

175 Q. DR. SWART: Yes. 13:41

A. Another is to collect information, you know, from areas that people are concerned about or want to point out to us. But the third bit I think is to make, hopefully to convey the honest impression that we are approachable, you know. Because the directors very often I notice will come on, and I don't ask them too, but they come on to that call as well and they will chip in. 13:41

176 Q. DR. SWART: Mmm.

A. But I think it's about trying to flatten that hierarchy

in terms of, you know, "Just because you're A, B and C doesn't mean that I can't have a conversation with you", and I will notice when I am out and about people will stop and have a chat with me.

177 Q. DR. SWART: Because they've seen your face, yeah. 13:42

A. Yeah. Yeah. And I may not know automatically who they are, but they know who I am. Yeah. Yeah. Yeah.

178 Q. DR. SWART: I'm getting there. Safety strategy, I was interested in that.

A. Yes. 13:42

179 Q. DR. SWART: And you had a phrase, "Are we safe today?".

A. Yes.

180 Q. DR. SWART: Now that's the important question, isn't it? And it isn't just about harm. I was - I noticed in your strategy that you acknowledge that, that it's - 13:42 measuring harm is one part of it, and the other part is "are we doing it right?", measuring that, and then alongside of that is the voice of the patient, and involving them, being kind to them and all of that. So the harm is much more developed, I think, than the "are 13:42 we doing it right?", part of patient safety.

A. Mm-hmm.

181 Q. DR. SWART: What are your plans for that in terms of being able to say - and Mr. Wolfe asked you about quality score cards, and that was probably in his mind, 13:42 you know, to say, you know, "Our Stroke service is safe because we are meeting these five standards, which are all related to quality of care", or "Our Urology is safe because", or whatever, alongside obviously

real-time data. I mean I think those things are difficult to do well.

A. Mm-hmm.

182 Q. DR. SWART: And, again, should that be done Trust by Trust, or should it be done across Northern Ireland, or what's your view on all of that? 13:43

A. I mean, I think each Trust probably tries to do it in its own way. I think if we had a standardised approach to it across Northern Ireland it would be really helpful. Now SPPG I know has begun to look at the Australian framework for starting to collect some of the quality measures, but it is at a very infantile stage. And, you know, we haven't developed it yet across the Trust in terms of our understanding in relation to how that will be developed, but even to start with something like that, or to start with some of the ideas pulled out of it, I think would be really helpful, because there is a lot of emphasis on activity, but - and understandably, given our waiting times, and I don't take away from that. 13:43 13:43 13:44

183 Q. DR. SWART: Mmm.

A. But it can't be, it can't be a trade off against quality. We need both.

184 Q. DR. SWART: Yes. Yes. I think they recognise that from the conversations. 13:44

A. Yes.

185 Q. DR. SWART: So you've talked about the time commitment for this. You've talked about, you know, some positive bits. I would think that starting when you did as

Medical Director and Chief Exec, and with all the challenges you've had in the Inquiry, it has actually been quite helpful for making change, I would suggest, however difficult it might have been.

A. Yes. 13:44

186 Q. DR. SWART: What has been the biggest improvement that you've seen? You know, you've mentioned loads and loads of things, but what's the one thing you would singled out as having improved over this time that you found that you've got satisfaction from personally? 13:45

A. Well, there are a few examples, but I think probably the one that, you know, we've probably talked about most recently within the Trust, there was - I think I mentioned there was a year when I was Medical Director and Director of Mental Health? 13:45

187 Q. DR. SWART: Mm-hmm.

A. And one of the things that, whenever I came into the Trust the previous director had just arrived and had raised concerns about the quality of care in mental health services, so we had an invited review. 13:45

188 Q. DR. SWART: Yes.

A. And that was really helpful in terms of just identifying some things. And, you know, took that plan really seriously, and he and I worked our way on it, along with the Director of Nursing, and it came through 13:45 to fruition. You know in recent times, and we're now through to the director now who succeeded me who, you know, kept the momentum going and built on it with the team and really developed it. So, you know, we've now,

within all of that, they've now been acknowledged by the colleges having safer wards. So they really went from strength to strength within all of that, you know, whether in learning, disability, and mental health, you know, inpatient unit, and the dementia wards, and really went from strength to strength. Then in terms of some of the community development and the accreditations and all of that, really building on it.

So I think that has been enormously satisfying, because you could see where actually it was taken seriously and it was built on, and I think in terms of giving me the confidence, and hopefully other people the confidence, to see that actually, you know, if you identify something, are really persistent about trying to make it happen and get it through the other end, you can effect change. Now you can't do it all at once. Right. 13:46 13:46 13:46

189 Q. DR. SWART: Mm-hmm.

A. I've also seen it with - I mean we have a great acute care at home system, which is part of our hospital at home, and I can see how that's developed over time in terms of just constantly increasing the number of frail, elderly people we manage in the community. I have seen it in relation to the childrens' homes in the way we've changed the internal fabric of those, because some of them were really rundown. And then in relation to Urology and some of the work that's gone on within surgical services, I can see how they've moved on and 13:46 13:47

developed as well. And then I can see other areas where they maybe have come through problems and have settled and are starting to get their feet, like Obs and Gynae and Paediatrics. So I can see it everywhere. There are also other areas that at times feel really overwhelming, like the Emergency Departments.

190 Q. DR. SWART: Mmm.

A. But the rest of it I think holds the hope in the system in that you can see, if you're really persistent and, you know, determined to actually effect change and improvement, you can actually with time get it, you know, changed. 13:47

191 Q. DR. SWART: So going forward. There's huge challenges in the health and social care system everywhere.

A. Yeah. 13:48

192 Q. DR. SWART: Huge financial challenges, huge quality issues. How are you going to use that learning to mitigate those challenges at Southern Health Care Trust going forward, because this is going to keep going, isn't it, this pressure and problems? 13:48

A. Yes.

193 Q. DR. SWART: So what do you think you've learned from this that will allow you to mitigate it, and what will those key mitigations be? You've mentioned keeping going. What else do you think you will be personally using as a tool to keep everybody focused? 13:48

A. Well, I think the use of data is really important in all of that, you know. And, again, the emphasis at the minute, and again it is part of our key vision, is

around adding value for money and about not, you know, minimising the frustrating stuff in the system that doesn't actually add to patient care. So some of that will involve thinking, you know, for example, around our clinical teams, and we've seen it with the Urology Service, how we change some of - we don't need consultants and nurses sitting in front of a computer all day, but we do need them to do the clinical work, because actually that's what they want to do and that's what they're trained to do. 13:48 13:49

194 Q. DR. SWART: Mmm.

A. And why could we not then change that work around to allow the administrative staff to do the rest of it? So things like that I think we can get some gains with. And then in terms of, you know, how we really work with multi-disciplinary teams to get the most out of everybody's expertise, and I think again Urology is a good example of that, because we've shifted some of the work that was traditionally associated with the consultants into, you know, the nursing domains. And then again, I mean when you look at - when you look across the world and look at areas like Pakistan and India in terms of how they manage their services with actually a lot of, you know, nursing AHP input to deliver really good services, you think there must be scope in all of that in terms of how we do our business. 13:49 13:49 13:49

195 Q. DR. SWART: Mmm. Well there is belief which I think is borne out in evidence, that if you use quality

improvement well you will improve standards and reduce costs.

A. Yes.

196 Q. DR. SWART: However, getting people trained do that is not a small matter. 13:50

A. No.

197 Q. DR. SWART: Is there enough emphasis on that overall and where should that be led from in Northern Ireland?

A. Well, I think it should be led centrally. Now I completely appreciate at this point in time a lot of the energy around data and data analytics and getting the oversight of all of that at that minute has to be invested in the rollout of Encompass, because this is a huge programme. 13:50

198 Q. DR. SWART: Yes. 13:50

A. But beyond that I would hope that when we get stabilised with all of that, with all of the Trust areas involved, then the next iteration of that would be about "How do we really use this information to change the way that we do the business here?", you know, and drive that forward. 13:50

199 Q. DR. SWART: And have you got enough of a voice in these discussions and arrangements that are going on at the moment, do you think, as a CEO, and has your Medical Director got enough of a voice? 13:50

A. I hope so. I mean we do meet regularly. All of the Chief Executives, we meet together every week on Teams, and then we meet for a longer period of time once a month. So, you know, to kind of change these ideas,

and working relationships are good. And then, you know, we meet with the Department of Health, and particularly the Permanent Secretary, on a monthly business. So I do think that is taken seriously in relation to how we're responded to, yes. 13:51

DR. SWART: Thank you. That's all from me.

A. Thank you very much. Thank you.

200 Q. CHAIR: I think a lot of the questions that I would have wanted answered have been either answered in your evidence or through Mr. Hanbury or Dr. Swart's 13:51 questions, but there's a couple of questions just - one of the things that struck me, and you'll recall from me writing to you about this, was issues about communication, and even some of the documents that have been called up the past couple of days, they show an 13:51 imprecise language, if I can put it that way?

A. Mm-hmm.

201 Q. CHAIR: And I just wondered - we haven't heard too much about how that is being addressed. How are you communicating better with those people who need to hear 13:52 the message, whether it's through the staff, whether it's up to the Board, whether it is the patients, more importantly, who need to know what it is that you're doing, what it is that is affecting them - and we go right back to the fact that patients are not included 13:52 in a letter about their care that goes to the GP. When they see a consultant it's not compulsory here for a consultant to write to the patient, many do, but not everyone does. Is that not something that could be

mandated within the Trust without it having to be done generally across the region?

A. So, some of the services - and within Urology they write to the patient and copy it to the GP, and in some of the other services they do the same thing, and I think that some of those areas are more advanced in relation to this than others. And when we have tried it out in small ways in certain areas, what we found is that the language is so technical that actually it has created difficulties. So in order to get to that point, what we have realised we will have to do - and, again, this is in an early stage of thinking about it - we will have to probably, and this sounds a bit unusual, we will have to train the letter writers to be able to write letters that actually can be understood by the recipient, right, and that's going to take us a bit of time. You would think logically it should be very straightforward, but it's not as easy as you would think it could be. 13:52 13:53 13:53

202 Q. CHAIR: Can I make a suggestion? 13:53

A. Yes.

203 Q. CHAIR: You have these 92, is it, service user group.

A. Yes. Yes.

204 Q. CHAIR: Who were in the hospital, and you were worried about the confidentiality of material, but it would be quite easy, surely, to take some sample letters, to redact those in terms of the patient's details and names and dates of birth, and hand them to them and say "Do you understand what's being said here?", and you 13:53

could, in that way, get some sort of feedback at least from what is understood in terms of the communication?

A. Yes, we could certainly do that. I think that's a good thought.

205 Q. CHAIR: And, you know, that would be a simple way to address the confidentiality issue, if I can put it that way. 13:54

A. Yes.

206 Q. CHAIR: And get some feedback that then could filter down to the people who are writing the letters. 13:54

A. Yes. Yes.

207 Q. CHAIR: You know? At least it would make them stop and think "Well, I thought I had made myself clear, but I obviously haven't", if that were the case.

A. Yes. Yes. Yes. 13:54

208 Q. CHAIR: Just in terms of, yes, Datix and the use of Datix. I mean we heard universally from those people who do actually use it, and a lot of people find it very off-putting because of the system. I mean I think there is a whole issue here about IT systems, and the connectivity of them, and the user friendliness of them within the Health Service and, you know, I hate to put a dampner on the wonderful thing that is Encompass, but anecdotally I've heard maybe that isn't all it is cracked up to be either in terms of its usability. So how can that be actually, in this day and age, you know, we have such a wide range of tools at our disposal on-line and so forth, how can regionally and at a Trust level things be improved? I mean I'm just 13:54 13:55

coming back to being quite appalled by the fact that Mr. Haynes wrote his own programme to provide a dashboard for the team about who was doing what. You know, surely that isn't a good use of a consultant surgeon's time? 13:55

A. No, but unfortunately for the last 18 months practically the entire IT Department has been taken up with Encompass.

209 Q. CHAIR: Right.

A. So there are all these competing priorities in the midst of all of that. So, no, I agree with you. In an ideal situation you would have a clinician in the room describing what it is exactly they need in an IT system and being able to develop that. Yeah. No. And I think in fairness, I think that's what Encompass is aiming to try to do, and I appreciate there are difficulties. What they tell us is that we are - along with the Western Trust we will be the last Trust to adopt it, and what they tell us is every time it goes through a local iteration it actually improves. So that's part of the promises... 13:56 13:56 13:56

210 Q. CHAIR: Fingers crossed!

A. So - but, no, I agree with you, I think there's an inordinate amount of time spent on IT and, you know, it does concern me always that, you know, because we all know how to type after a fashion we end up doing things on computers that actually would be letter left to someone else and there needs to be better use of dictation and all of those kind of things. So, no, 13:56

that's definitely in our thought. And I know that, you know, one of the pieces of advice that has come through from the South Eastern Trust in relation to Encompass is about really taking the administrative system seriously at an early stage and building, you know, a plan around all of that, because otherwise you end up with clinicians actually spending a lot of time typing when they should be doing other things, and it really frustrates - it frustrates the whole system, particularly the clinician, if they see that's how they're using their time. 13:57 13:57

211 Q. CHAIR: Yes. And I think that's the problem.

A. Yes.

212 Q. CHAIR: You know things will only work, you know, if it is simple for people to use. 13:57

A. Yes. Yes.

213 Q. CHAIR: And that seems currently not to be the case with Encompass.

A. Yes.

214 Q. CHAIR: But, yes, one of the things that would concern the Inquiry is - I mean - and first of all I should say that the Inquiry recognises that the Trust is working very hard to improve things and, you know, that will be reflected ultimately in whatever we say. But one of the things that concerns us is that the impetus that has been caused by this Inquiry, for example, will be lost, and the good improvements that are being made in terms of governance require investment. For example, you have gone at risk to put in place certain bodies to 13:57 13:58

carry out tasks, and with the financial constraints there is a risk that what happened before could be repeated here, that governance is the one that's easy to cut back on because funds have to be put into the frontline. 13:58

A. Mm-hmm.

215 Q. CHAIR: So how can you assure the Inquiry, first of all, that that isn't going to happen? And if you can't do that, is it something that we need to go to the Department about to seek that assurance? 13:58

A. I think - I have been thinking about this, and I suppose there is something about, you know, governance has been done long enough across the NHS at this point in time that I would presume there's a statistic somewhere that suggests that out of an overall budget this amount of it should be spent on governance, whether it is 1% or 2% I don't know. It's not a huge amount. But even to have that as protected in the system would be really helpful, because then that means that we automatically know then when we go to Commission that there has to be cognisance given of that. 13:59 13:59

216 Q. CHAIR: That's there.

A. So I don't know whether there's a better way into it or not. But certainly from our point of view, you know, we have worked so hard to try and improve the government system it would be hard for us now to let it go. But you can see maybe two or three Chief Executives along the line when the memory of this is 13:59

lost again, and then how is that protected unless it is built into commissioning.

217 Q. CHAIR: Okay.

A. Yes. So I think discussions around that would be very welcome. Yes. 13:59

CHAIR: Okay. I think that's all that I have for you.

A. Thank you.

CHAIR: So thank you very much for your time. We know - and I should say this in respect of all of the Trust witnesses who have come to speak to us, it's been very 14:00 valuable to hear from them, not just to get the over 500,000 pages of documents that we are working our way through gradually, but it has been very helpful to hear from the Trust employees, staff, and executives and Board members. So thank you for giving us your time in 14:00 what we appreciate has been a very difficult and trying time for all of you.

A. Thank you very much.

CHAIR: So, thank you. And I think that's us, ladies and gentlemen, until actually after Easter now, 14:00 Mr. Wolfe. Yes. I think our next sitting day will be the 8th April, and I look forward to seeing you all then. In the meantime please don't eat too many Easter eggs! I think there's enough stress on the Trust without any of you getting sick. Thank you. 14:00

THE INQUIRY ADJOURNED UNTIL MONDAY, 8TH APRIL 2024 AT 10:00A.M.