Urology Services Inquiry

Oral Hearing

Day 93 – Tuesday, 9th April 2024

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

Held at: **Bradford Court, Belfast**

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1 THE INQUIRY RESUMED ON TUESDAY, 9TH APRIL 2024, AS
2 FOLLOWS:
3
4 CHAIR: Good morning everyone. Apologies for the
5 delay. I think we're back to "Technical Tuesdays". 10:13
6 And in fact we seem to have difficulties on a great
7 number of Tuesdays, but hopefully we can get on with
8 things now. So, Mr. May.
9 MS. McMAHON: Good morning, Chair, members of the
10 Panel. The witness this morning is Mr. Peter May, who 10:13
11 is the Permanent Secretary of the Department of Health,
12 and he wishes to affirm.
13
14 MR. PETER MAY, HAVING AFFIRMED, WAS QUESTIONED BY
15 MS. McMAHON KC AS FOLLOWS: 10:14
16
17 MS. McMAHON: Good morning, Mr. May. My name is Laura
18 McMahon. I'm junior counsel for the Inquiry. We met
19 before, so welcome back.
20 A. Yes, good morning. 10:14
21 1 Q. You were our first witness a while ago, and you're
22 almost our last, but today you've been called back so
23 that the Panel can get an update on where we are since
24 we started, and perhaps some further clarity on some
25 evidence that's been provided by other witnesses as 10:14
26 well. So, you have previously provided written
27 evidence in the form of a previous Section 21 notice,
28 and for the Panel's note that was dated 18th August
29 2022 and can be found at WIT-42367. You also gave

1 evidence previously on 15th November 2022, and for a
2 note, the transcript of that can be found at TRA-00707.
3 And after you gave evidence you kindly provided us with
4 further information and clarity on issues that had
5 arisen on that occasion, and the response to questions 10:15
6 that we've asked can be found at DOH-71042. And those
7 replies are dated 15th November 2022.
8
9 In order to allow an update, we sent you a Section 21
10 No. 1 of 2024 earlier this year, and you replied to 10:15
11 that on 22nd March 2024. And if we can just go to that
12 Section 21 notice at WIT-107060. And you'll see that
13 that's No. 1 of 2024. Your name is at the top of that
14 statement. And your signature can be found at
15 WIT-107122. Do you recognise that as your signature? 10:16
16 A. I do.
17 2 Q. And it's dated 22nd March 2024. Do you wish to adopt
18 that as your evidence?
19 A. Yes.
20 3 Q. Now, we will be relying substantially on that 10:16
21 statement. I'm going to pick out some of the issues
22 that you've brought to our attention, and you've
23 provided an addendum to that notice more recently, and
24 that can be found at WIT-107624. Again, your name at
25 the top of that and your signature can be found at 10:16
26 WIT-107640. And, again, do you recognise that as your
27 signature?
28 A. I do.
29 4 Q. And the date is 29th March 2024, and do you wish to

1 adopt that as your evidence?
2 A. Yes.
3 5 Q. Thank you. Now, the addendum statement provides us
4 with further information, and I'll go between the
5 statements as necessary just to draw the Panel's 10:17
6 attention to where we're at at the moment. But for the
7 purposes of today, the structure of your evidence, I
8 will take you through some of the headings that we'll
9 cover within the time allocated. Firstly, we'll look
10 at the SPPG structure and the new commissioning 10:17
11 arrangements. Secondly, we'll look at Information
12 Systems in Health and Social Care. Thirdly, Standards
13 For Quality and Patient Safety. Fourthly, we'll look
14 at reform and reviews. Then we'll look at culture and
15 driving change. No.7, we'll look at workforce issues. 10:18
16 8, we'll touch on innovations around hearing the voice
17 of the patient. And lastly we'll look at learning from
18 other inquiries and what's anticipated the learning
19 from this Inquiry and how that might be managed going
20 forward. 10:18
21
22 So, what I plan to do is just take you to various
23 sections of your Section 21 and ask for some clarity or
24 explanation as appropriate.
25 10:18
26 Now, the starting point of your further Section 21 is
27 that since your evidence on the last occasion the
28 Inquiry had the opportunity to hear from your
29 predecessor Richard Pengelly, and you reviewed

1 Mr. Pengelly's statement and evidence, and although you
2 have, don't have knowledge of all the aspects that he
3 refers to, naturally as you took over from him, you
4 were in overall agreement with the evidence provided by
5 him? 10:19
6 A. That's correct.
7 6 Q. Now, just moving on to the first heading "SPP Structure
8 and the New Commissioning Arrangements". Now, we have
9 heard from Paul Cavanagh and Sharon Gallagher, who
10 provided evidence on behalf of SPPG, and they explained 10:19
11 the new structure, just some of the nuances around
12 that, just so we're clear in our understanding of that.
13 They are no longer an arms length body. The HSCB prior
14 to that had been, but the positioning of SPPG changes
15 that somewhat. And as we understand it, the SPPG sits 10:19
16 within the Department and under your general authority,
17 is that a fair explanation of that position?
18 A. Yes, it is. I wonder just before I say more if I could
19 just make two very brief introductory comments? The
20 first of which is to reiterate the apology I made on 10:20
21 behalf of the Department to all of those who have been
22 affected, including particularly, obviously, patients
23 and families in relation to the work of the Inquiry.
24 And, secondly, just to recognise the huge amount of
25 work that this Inquiry has already done over 90 days of 10:20
26 hearings. And I realise, as you said, you're nearing
27 the end of that particular phase of the work of the
28 Inquiry, and just to signal my intention today is to
29 try to assist the Inquiry as best I can. If at any

1 point there's a question I don't know the answer to,
2 particularly if it's factual in nature, I would like to
3 offer that I would write to the Inquiry and provide
4 that information thereafter, if that's acceptable to
5 the Inquiry? 10:20
6 7 Q. That's very helpful. Thank you. And if we do come
7 across any queries that either I can't explain further
8 on the evidence or you need more information about, we
9 can follow that up in correspondence after today's
10 evidence. 10:21
11 A. So just turning then to the SPPG and it's place in
12 things. You're correct to say that SPPG is now part of
13 the Department of Health. The Health and Social Care
14 Board was it's predecessor and it ended in 2022.
15 Indeed the life of the Board ended the day before I 10:21
16 took up my role. So I wasn't party to the legislation
17 and the detail of the legislation, but I understand
18 that a succession of health ministers had taken the
19 view that the commissioning space was overly cluttered
20 and that they wished to try to create a simpler and 10:21
21 more straightforward approach, and that the removal of
22 the role of the Board was one element of that, as is a
23 more general change to the way in which commissioning
24 takes place.
25 8 Q. And one of the outworkings of this renegotiation of the 10:21
26 structures, it sounds like it was based on a desire for
27 efficiency around commissioning, but one of the
28 outworkings of that was that we've heard that the duty
29 of quality doesn't apply to SPPG and had applied to the

1 previous Health and Social Care Boards. You've
2 provided further detail on that in your addendum
3 statement in, and in summary form it would appear to be
4 that because of the functions now carried out by SPPG
5 and the way in which services are reconfigured under 10:22
6 this new structure, that the legislative requirement,
7 or the attachment to a duty of quality under the
8 legislation to the HSCB falls away under SPPG, purely
9 by drafting mechanisms it seems, but can we assume the
10 expectation is that the duty of quality in general 10:22
11 terms, although not a legislative requirement, is
12 something that is imported into the mindset and the
13 service provision of SPPG?
14 A. Well, absolutely, it's still a critical part of the
15 work that SPPG does to oversee the quality and safety 10:23
16 agenda working in partnership with the Public Health
17 Agency. The reason for the change is that in 2003 when
18 the duty of quality was first introduced, it was
19 specific in relation to -- for care for individuals.
20 At that time the predecessors to the Health and Social 10:23
21 Care Board did have some responsibilities for care to
22 individuals, particularly in the childrens and social
23 care space. Those responsibilities were transferred in
24 2009 when the Health and Social Care Board was
25 established, but in practice the Board itself didn't 10:23
26 perform those functions, it delegated them to Trusts.
27 Clearly if it's legally responsible it still had an
28 accountability for the delivery of those functions, but
29 in 2022 the decision was made that those functions

1 should sit with Trusts, they had been carrying them out
2 for many years, and it made more sense for Trusts to
3 have that role. Hence the SPPG no longer had a role in
4 relation to individuals. So, as you say, it's a
5 consequence of the way in which the legislation was 10:24
6 drafted that the duty of quality then didn't apply to
7 SPPG in that formal sense. But there are many ways,
8 and we'll come on to them no doubt in the rest of the
9 evidence, in which SPPG does play a critical role in
10 relation to the quality agenda. 10:24
11 9 Q. If we look at your statement at WIT-107063, you've made
12 reference to broad oversight arrangements in relation
13 to SPPG at paragraph 9. And when you say "the group",
14 in this context you're referring to SPPG, and you say
15 the following: 10:24
16
17 "The group is subject to the same scrutiny as the rest
18 of the department by the Departmental Board which
19 includes two Non-Executive members. The Department's
20 Audit and Risk Assurance Committee was established to 10:24
21 advise the accounting officer, through the Departmental
22 Board, on the quality of assurances they receive about
23 strategic processes for risk management, governance,
24 internal control and the integrity of financial
25 statements. The Committee membership comprises of two 10:25
26 Non-Executives of the Departmental Board and a further
27 two independent external members. The oversight of the
28 committee extends to SPPG and those former functions of
29 the Board which are now under the direction of the

1 Department."
2 There had been some evidence received from some of the
3 other arms length bodies around the oversight provided
4 to them by their own individual boards and how they
5 considered that to be significant in terms of 10:25
6 governance. Are you content that the new arrangements
7 allow for the continuity of good governance in relation
8 to the functions, the now functions of the SPPG?
9 A. Yes. I think the other thing that isn't drawn out in
10 paragraph 9, and perhaps could usefully have been, is, 10:26
11 the Department is accountable to the Northern Ireland
12 Assembly, and the Health Committee very directly, and
13 the work of that Committee will oversee the work of all
14 of the Department, including SPPG. Obviously the
15 Committee also looks at the work of arms length bodies, 10:26
16 but it tends to have a particular focus on the
17 Department.
18 10 Q. If we go to the next page at paragraph 15 and 16. When
19 the Chief Executive of the RQIA gave evidence she
20 informed the Panel that the SPPG, or the RQIA, has no 10:26
21 oversight role in relation to SPPG, where they had had
22 previously with HSCB, and you deal with that at
23 paragraph 15 and you say the following:
24
25 "The change in legislation under pins the 10:27
26 organisational and operational position that SPPG does
27 not provide care to individuals and as such the
28 Regulation and Quality Improvement Authority (RQIA) has
29 no oversight role in that regard."

1
2 And at 16:
3
4 "The new relationship with SPPG is being redefined and
5 will reflect SPPG's constitution as part of the 10:27
6 Department and its core functions as set out above."
7
8 So that explains the reason why. Again, it falls back
9 to the reconfiguration. When you say the new
10 relationship with SPPG is being redefined, what is it 10:27
11 that you're referring to in that particular paragraph?
12 A. Well, I think that the logic is that it may well be
13 that there needs to be some form of a service level
14 agreement or something that's put in place, or a
15 Memorandum of Understanding, as to how the RQIA can 10:28
16 take account of the functions of SPPG where they're
17 relevant.
18
19 I think for me it wouldn't be sensible to suggest that
20 RQIA would be the right organisation, for example, to 10:28
21 do a review of commissioning or planning within Health
22 and Social Care. But if they were doing a scrutiny, or
23 an inspection, a review, within a Trust or across our
24 Trusts in relation to a particular speciality and an
25 issue arose in relation to commissioning, then it would 10:28
26 seem perverse to me that they weren't able to follow
27 that thread back into the work that SPPG does. So,
28 it's to try and set that kind of nuance in place so
29 that there's not a barrier there to the RQIA being able

1 to conduct it's work in the way that it needs to.
2
3 I think that there's probably a wider dimension to this
4 that's worth drawing out and which I suspect you may
5 come to later, which is, the Department has a desire do 10:29
6 a review of regulation more generally. There was some
7 work done prior to the pandemic in relation to that. I
8 think that work needs to be updated, and I think it was
9 never entirely comprehensive in any case.
10 10:29
11 We are currently, and again this maybe a theme of the
12 evidence I give, in a resource constrained environment,
13 and as a result we've not been able to move ahead with
14 the review of regulation. I think there are some other
15 better reasons why we've also not yet moved on the 10:29
16 review of regulation, which again I think you will come
17 to later in the evidence that you're asking me to give.
18
19 So I do think that there's scope to look again at some
20 of these in that review of regulation and to understand 10:29
21 whether there are any lacunas as a result of the
22 changes made which the draughtsman and the people who
23 led the policy for the legislation I think were
24 accurate in redefining the roles, but we just need to
25 make sure that we've got a system that works always 10:30
26 now.
27 11 Q. And just you've mentioned the RQIA and the work done
28 prior to the pandemic. I'll perhaps just take the
29 Inquiry to the paragraph in your addendum statement

1 that deals with that at WIT-107632. Paragraph 32. And
2 just what you've said, you say at paragraph 32:
3
4 "Prior to the COVID-19 pandemic the Department had
5 developed a new draft regulatory policy framework. 10:30
6 However, further development work is required,
7 including consultation on the draft policy. The
8 Department is currently operating within a constrained
9 budget and is required to make decisions in relation to
10 the work that can be delivered within current 10:31
11 resources. In that context, work on the review of the
12 regulation is currently paused to allow for other
13 priority projects to progress."
14
15 Now, we'll look shortly at the reforms and reviews that 10:31
16 are ongoing, but from the regulatory point of view
17 that's on hold?
18 A. It is at the moment, yes, and the decision was made
19 that there were other things that we needed to advance
20 more urgently and with a view to creating the right 10:31
21 environment within which to do the review of
22 regulation. In my experience, if you look at
23 regulation, if you approach regulation at a time when
24 you don't have the system in the place that it needs to
25 be in, you can end up with an overly defensive reaction 10:31
26 and it can be very hard to bring about change.
27 Whereas, one of the things that we've been looking to
28 do is to advance those areas that will develop and
29 bring about cultural change within the organisation,

1 such as the review of SAIs, through the review of MHPS,
2 the Raising a Concern Policy that was published in
3 March, and so on. So I don't want to go over all of
4 those because I know you'll come to those, but it's
5 just to signal that by making those changes we're 10:32
6 trying to create a different environment within which
7 then to locate the review of regulation, and we think
8 that that is a better way to go about the ordering of
9 the work.
10 12 Q. And we go back to your original statement then at 10:32
11 WIT-107083. Just deal with the regulation point now.
12 A. Sure.
13 13 Q. As we've moved onto it. Paragraph 77. And just for
14 context, the question that we asked you and the answers
15 I'm going to read out relate to the following question: 10:32
16
17 "Given the current pressures affecting all parts of the
18 health and social care system, do you consider that
19 further regulation is the answer?"
20 10:33
21 And you say the following:
22
23 "As I have acknowledged in my response to Question 7,
24 the regulatory landscape is already a complex one with
25 a range of bodies discharging various roles and 10:33
26 functions which exerts some measure of regulatory
27 influence either direct or indirect. Further, research
28 and studies in the UK and beyond have acknowledged the
29 vast range of regulatory interventions in health care

systems more generally, the number of bodies involved and vast resource expended."

Paragraph 76:

"Further regulation should not be a default option and seeking to introduce more regulation in response to a significant service or system challenge, in particular given current pressures on the system, may not always be the best response."

Paragraph 77:

"The Department has acknowledged, however, that the current legislation underpinning the regulation and inspection of health and social care services and the roles and functions of the RQIA dates back to 2003. The delivery and provision of health and social care has evolved significantly in the intervening period. A future review of regulation would provide a platform to consider any identified improvements in the regulation and monitoring of services, and to consider what is the right model of regulation across the full system and sectors of health and social care provision.

78. A new draft regulatory policy framework had been drafted prior to the COVID-19 pandemic. However, further development work is required, including consultation on the draft policy."

1
2 And then you make your point about the budgets. And
3 then at paragraph 79:
4
5 "There is also a need to balance regulatory 10:34
6 intervention with support for learning, improvement and
7 development. The Department is progressing a number of
8 policy strands designed to further support and help
9 embed an open, just and learning culture across our
10 HSC, aimed at better supporting staff and patients and 10:35
11 ultimately delivering improved care. This work
12 recognises and takes account of emerging evidence and
13 practice."
14
15 And then just to finish that at paragraph 80: 10:35
16
17 "A core ambition of this work is to further enable an
18 environment which identifies and learns system wide
19 lessons when things do not go as planned in delivery of
20 care, to deliver system improvement and leading to 10:35
21 better outcomes for patients and staff providing
22 services. This is best achieved by creating a
23 psychological safe space supporting staff to engage
24 openly in learning processes as part of an open and
25 learning culture, avoiding a blame culture, which is 10:35
26 counterproductive. This also supports staff to
27 communicate early with patients and families in a
28 compassionate, open and honest manner. Where an
29 incident or event requires accountability for action,

1 this should be proportionate, just, and prompt, taking
2 account, where relevant, of system factors. An open
3 just and learning culture which co-exists with
4 appropriate and just accountability is key to support
5 delivery of safe and compassionate care and protecting 10:36
6 the welfare of our staff."
7
8 Just in relation to paragraph 80, that seems to set out
9 in general terms the basis for any regulatory system or
10 governance system, in that people should feel safe to 10:36
11 either trigger or bring to other's attention concerns
12 that they have, and that those concerns should be dealt
13 with swiftly, justly, and speaking with all relevant
14 stakeholders.
15 10:36
16 Given that the regulatory pause that's been put on the
17 developments so far because of budget constraints, are
18 you content that that pause will not detrimentally
19 impact the current governance arrangements that are in
20 place through the Trusts? 10:37
21 A. Yes, as I tried to draw out in the answer to my
22 previous question, I think the budget is one thing, but
23 there's also if you try to change everything at once
24 then in my experience that doesn't work well. So I've
25 tried to set out why there's a logic in trying to 10:37
26 address the kinds of projects that we are taking
27 forward in relation to SAIs, the Being Open Framework,
28 which I didn't reference earlier, the work on MHPS
29 those are all things that I think are enabling measures

1 that should support the review of regulation and make
2 that work better in due course. So, yes, budget is a
3 constraint, but it's not the only reason why we've done
4 it the way we've done it, and I think if you try to do
5 all of those things at the same time, that would be 10:37
6 more change than the system could reasonably be
7 expected to accommodate at any one point, and then you
8 end up with the risk that people don't understand what
9 it is that you're trying to put in place.
10 14 Q. And just to complete the point, you've mentioned some 10:38
11 of the work underway, and at paragraph 82 you deal with
12 -- provide some examples of that. Paragraph 82 says:
13
14 "Work underway led by the Department to support this
15 policy agenda includes, but is not limited to, an 10:38
16 emerging Being Open Framework, the redesign of the SAI
17 procedure, early work on an underpinning charter, the
18 recently published Raising Concerns HSC Regional
19 Framework..."
20 10:38
21 -- and you've provided a copy to us:
22
23 "Ongoing review of Maintaining High Professional
24 Standards, work due to commence shortly with the
25 Northern Ireland Public Sector Ombudsman to review the 10:38
26 HSC complaints procedure and a review of HSC
27 Occupational Health services."
28
29 Now that's work that's ongoing and is it the case that

1 the issues that have arisen through this Inquiry, and
2 that have been made public through evidence, is the
3 learning from that on an ongoing basis being used to
4 inform, where appropriate, some of the work that's
5 already planned or in place? 10:39
6 A. Yes, that's absolutely right, and it's also the case
7 that previous inquiries have made recommendations in a
8 number of these areas as well, particularly the
9 Neurology Inquiry. So we've been seeking to take the
10 learning from all of these incidents and inquiries to 10:39
11 make sure that we put in place something that is
12 designed to make the system work better in the future.
13 All of the areas that are referenced in that paragraph
14 that you quoted there have involved very heavy levels
15 of engagement with clinicians and people who work 10:39
16 within the health and social care system. So this
17 isn't something that's being done in some sort of
18 isolated way, it's very much being done engaging with
19 people who work in the system in a number of the areas.
20 There has been relatively recent reviews and changes 10:40
21 made, for example in England, where we can also look to
22 learn from experience there, and I think that that's
23 been very helpful to us in a number of areas, because
24 these problems are not unique to Northern Ireland.
25 They are -- some of the challenges you face trying to 10:40
26 create a system that has the right balance is true
27 everywhere and, you know, we need to make sure that we
28 are absolutely focused on getting the right balance
29 rather than if you move too far in one direction then

1 you often find that that has unforeseen consequences
2 that also bring about negative outcomes in different
3 ways.
4 15 Q. So there is an active focus on looking at what has
5 already been learned from other jurisdictions? 10:41
6 A. Absolutely.
7 16 Q. And importing that as is possible.
8 A. Yes. And a number of the reviews will either have
9 individuals who have direct experience or will have
10 made a point of going to talk to those individuals 10:41
11 themselves.
12 17 Q. I just want to ask you a couple of questions about the
13 new commissioning model. You've mentioned it in
14 explanation of the restructuring around SPPG and the
15 HSCB. There had been some suggestion in the evidence 10:41
16 given by Chief Executive of the PHA, and just for the
17 Panel's note Mr. Dawson's evidence is at TRA-10732 to
18 10736, and in general terms, Mr. May, he set out some
19 of the changes the new legislation has brought in, and
20 one which is that the previously legislative 10:41
21 requirement of a dual mandate for commissioning between
22 the PHA and the HSCB, SPPG, no longer requires the PHA
23 signoff under the new legislative framework, and I just
24 want to ask you -- I think that was before your time
25 that the legislation was drafted and the legislative 10:42
26 intent, I don't want to ask you information about
27 background to legislation that you've no knowledge of,
28 but do you get a sense that that was intentional to
29 streamline commissioning services, and do you have any

1 concerns that the absence of a dual mandate for
2 commissioning services in any way dilutes potential
3 oversight or governance?
4 A. So my understanding is that the intent was not to
5 somehow cut the Public Health Agency out of the 10:42
6 commissioning process. I think I'm clear that the PHA
7 needs to work hand in glove with SPPG in order to
8 deliver, whether you call it commissioning or planning
9 process, whatever, the way in which you go about
10 procuring the services that are needed from the health 10:43
11 and social care system. They have unique expertise
12 around population health and a range of other areas,
13 which are absolutely intrinsic to the delivery of that
14 system.
15 10:43
16 My sense, although I have not seen this written down,
17 my sense is that this may well have been a consequence
18 of -- a natural consequence of the way in which the
19 Board was being, it's role was ending and being brought
20 within the role of the Department, because prior to 10:43
21 that the legislation, as I understand it, had said that
22 -- it was, as you say, a dual mandate between the Board
23 and PHA, but in the event that there was not agreement
24 then it would be for the Department to decide. Clearly
25 if SPPG is also the Department then that becomes, 10:44
26 legislatively it becomes a bit of a nonsense. So I
27 suspect that the decision was taken not to make it a
28 requirement on the first hand when the port of appeal
29 would be to another part of the same entity, but rather

1 -- so I think that was the intent that lay behind it.
2
3 As I said, I think I am clear, I know SPPG is clear
4 that this is -- this has to be a joint enterprise and
5 one that works together. So I don't, I have not 10:44
6 identified any difficulty in practice yet with this
7 approach. Of course if there are, and I don't believe
8 that Mr. Dawson drew out any practical challenges in
9 his evidence, so I'm happy to keep that one under
10 review if there's a need to look again. 10:44
11
12 I do know in other areas, for example, in safety and
13 quality, there has been a service level agreement put
14 in place between the PHA and SPPG that defines roles
15 and responsibilities, and I know there's ongoing work 10:44
16 to look at how that could work more widely as well.
17 18 Q. And you've provided an example in your statement of how
18 that new arrangement and the expectation of the parties
19 may be reflected in the HSC Framework Document. I'll
20 take you to that at WIT-107065, paragraph 20. Yes, 10:45
21 paragraph 20. You say:
22
23 "Following the minister's decision, the HSC Framework
24 Document will be updated to reflect the new
25 commissioning approach which cements the role of SPPG 10:45
26 and PHA in jointly planning and managing health and
27 social care services, following its implementation
28 later this year."
29

1 At 21 you say:
2
3 "In the interim, SPPG and the PHA have continued to
4 work together to support the planning and management of
5 HSC services through, for example, effective 10:46
6 implementation of agreed care pathways, addressing
7 variation of performance and service reconfiguration."
8
9 And at 22 you say:
10 10:46
11 "Whilst the Department ultimately has approval for the
12 commissioning of services, this could not be discharged
13 without the joint endeavours of both SPPG and the PHA.
14 For example, in recent years, SPPG, in partnership with
15 the PHA, have reviewed and developed plastic surgery 10:46
16 services, introduced post-Covid services, and
17 progressed the reform of maternity services."
18
19 Mr. Dawson in his evidence highlighted the areas of
20 expertise his staff have and, as you say, they have 10:46
21 expertise around population health and also individual
22 expertise among their own, some of which are clinicians
23 and other health care professionals?
24 A. Indeed.
25 19 Q. So we can take from what you've said in your statement 10:46
26 that it's anticipated that partnership agreements,
27 drawing on expertise in order to better inform
28 commissioning and planned services decisions is
29 something that should be taken as read at this point?

1 A. Yes.
2 20 Q. I wonder if I could take you to just an extract from
3 evidence from SPPG from Sharon Gallagher. It's at
4 TRA-11055. And this is around the delivering of safe
5 services. Line 15 is my note, but I might need to take 10:47
6 you back to the question just so you know the context.
7 Yes. I was asking a question in relation to what
8 Mr. Devlin had said in his Section 21, and giving he
9 had set out some criticisms, his views of the way the
10 SPPG and the HSCB were operating at that point at the 10:48
11 time of the Section 21 to give Mrs. Gallagher and Mr.
12 Cavanagh an opportunity to update and explain what they
13 considered about his view. And Ms. Gallagher then,
14 just the next page down, please, at line 16 -- I'll
15 start at line 8 because it will give you the context. 10:48
16
17 "In terms of the delivery of high quality services, I
18 mean we've talked about this earlier, that sits within
19 the purview of the Health and Social Care Trust, so the
20 targets are part of the picture, but safe quality 10:48
21 services sit within the domain of the Health and Social
22 Care Trust. In Mr. Devlin's defence our demand
23 capacity gap has increased. That was made even worse
24 by Covid. So the provision of high quality services as
25 described by Mr. Devlin had, of course, diminished, 10:49
26 because we were in a position with ever increasing
27 waiting lists and, you know, during a period of Covid
28 and recovering from Covid. So I can understand why his
29 perception would be that these things had conflated.

1 But as I mentioned earlier, this is a very complex
2 working environment with many, many factors coming into
3 play."
4
5 Now, Ms. Gallagher has said that the delivery, the high 10:49
6 quality delivery sits within the purview of the Health
7 and Social Care Trust. Just before we move on from the
8 commissioning topic. Who, in your view, has ownership
9 of commissioning safe services?
10 A. Well, the responsibility for commissioning of services 10:49
11 would sit with SPPG and PHA working jointly in the way
12 that we've just described. I think -- I don't know if
13 it's helpful or not, but I wonder if I try to draw out
14 -- for me I always think about safety and quality of
15 services in two interlocking ways. So the first of 10:50
16 those has the individual patient at the centre, and the
17 role that individual clinicians play around that
18 individual, and then all of the clinical governance
19 arrangements that work within the Trust environment,
20 and I think, you know, in a delegated accountability 10:50
21 system such as that that operates in health and social
22 care, that's an entirely appropriate model and one that
23 no department or central body could ever hope to play a
24 role, and obviously professional regulators play a role
25 there to. 10:50
26
27 The second interlocking way is to think of all patients
28 at the heart, and that is fundamentally the role of the
29 Department, and everybody, to think about how safety

1 and quality is delivered for all, and there are
2 inevitably -- and Sharon Gallagher was referring to
3 this in her evidence -- if you have a very long waiting
4 lists then the overall quality of care is being
5 affected. So keeping those two interlocking concepts 10:51
6 together, and understanding the respective
7 responsibilities for each is the way I tend to think
8 about safety and quality. I don't know if that's
9 helpful, but that's just to try and explain for me,
10 otherwise words around quality and safety can be asked 10:51
11 to bear too much weight because they're being asked in
12 different contexts to apply to slightly different
13 things.
14 21 Q. And you've referred to standards for quality and
15 patient safety in your statement, and perhaps just on 10:51
16 the back that of we'll move on to that particular topic
17 and look at the way in which the Department views those
18 issues.
19 A. Sure.
20 22 Q. WIT-107075. 107075. At paragraph 51. Thank you. 10:51
21 Just in the context of this, for the Panel, we asked
22 you:
23
24 "What is your view of the importance of setting
25 appropriate standards around, for example, quality and 10:52
26 patient safety for health care providers? Who is
27 responsible for doing this? Do you have a view on the
28 effectiveness of any groups, committees or
29 organisations in agreeing these standards?"

1
2 And you say at paragraph 50, just by way of
3 introduction:
4
5 "Delivery of health and social care services is 10:52
6 increasingly complex. It is in the interests of all
7 stakeholders, including HSC Trusts and other service
8 providers, commissioners, and service users and carers
9 to try to minimise complexity where possible. The use
10 of standards is one mechanism to help achieve this." 10:53
11
12 Then at paragraph 51:
13
14 "The Department of Health's Quality Standards For
15 Health and Social Care were published in 2006." 10:53
16
17 And for note they can be found at DOH-71901.
18
19 "These standards remain extant and set out the quality
20 standards that the Department considers people should 10:53
21 expect from HSC services."
22
23 Now, just on reading that, the standards would appear
24 to be 18 years old, and the landscape has changed
25 enormously in health care. I'm sure you would agree 10:53
26 with that. Is this document reflective of these
27 quality standards for health care that would be
28 expected now, or is it something that's under review or
29 potentially to be re-visited?

1 A. Well I think it's good practice to look again at
2 things, you know, after a certain period of time, and
3 so, you know, in due course we would want to do the
4 same with these standards.
5 10:54
6 I have to say though, in contrast to the likes of MHPS
7 and SAIs, where I think it's very clear that there are
8 material problems with the process that is in place, I
9 haven't, in the two years I've been in the Department,
10 had anyone come to me to offer a view that these 10:54
11 quality standards are badly out of kilter with what is
12 needed today. So I'm not saying they're perfect, I'm
13 sure there are ways they can be improved, but for me
14 that makes them of a lesser priority than the work
15 we've described now and, indeed, the review of 10:54
16 regulation that we've already discussed as well.
17 23 Q. And you've been frank about that at paragraph 54, where
18 you say:
19
20 "The Department recognises that there are likely to be 10:54
21 opportunities and benefits from evaluation and review
22 of the 2006 standards. The Department is currently
23 operating within a constrained budget and is required
24 to make decisions in relation to the work that can be
25 delivered within current resources. In that context 10:55
26 work to review the 2006 standards is not currently
27 planned for the 2024/2025 business year."
28
29 And as you've said, that's entirely reflective of

1 prioritisation of where problems may be?
2 A. Yes.
3 24 Q. And the need to address those. And, again, just back
4 on the point that you had made earlier about there
5 being learning from other jurisdictions. You say this 10:55
6 at paragraph 56:
7
8 "Given the relatively small size of the health care
9 ecosystem in Northern Ireland, we do not have the
10 resources to replicate work undertaken by national 10:55
11 standard setting bodies and expert groups. To seek to
12 do so would not be good use of public resource.
13 Instead, Northern Ireland is well placed to avail of
14 such standards and to consider these for application in
15 Northern Ireland to protect and improve safety and 10:56
16 quality and to participate in development of such
17 standards. Northern Ireland has local processes and
18 systems for assessing and adopting, or otherwise, such
19 standards when they are developed. Consideration is
20 also given to any unique considerations which would 10:56
21 require a bespoke Northern Ireland response, although
22 in reality there are few such factors."
23
24 And an example of -- you mentioned service level
25 agreements and the potential for use of those at local 10:56
26 level, but just on the issue of quality and patient
27 safety, you mention at paragraph 57, one with the NICE,
28 you say:
29

1 "One good example of this is the Service Level
2 Agreement (SLA) that NI has in place with the National
3 Institute For Health and Care Excellence. NICE's role
4 is to improve outcomes for people using the NHS and
5 other public and social care services in England by 10:57
6 producing evidence based guidance, quality standards
7 and performance metrics and a range of information
8 services for Commissioners, practitioners and managers
9 across health and social care. The Department
10 established formal links with NICE on 1st July 2006, 10:57
11 whereby guidance published by the institute from that
12 date is reviewed locally for its applicability to
13 Northern Ireland and, where appropriate, endorsed for
14 implementation in health and social care. This link
15 has ensured that Northern Ireland has had access to 10:57
16 up-to-date independent professional evidence-based
17 guidance on the value of health care interventions.
18 NICE technology appraisals, clinical guidelines, public
19 health guidelines, and COVID-19 Rapid Guidelines are
20 considered and endorsed for Northern Ireland as 10:57
21 appropriate. In Northern Ireland HSC Trusts are
22 responsible for implementing NICE Guidelines and the
23 Department's Strategic Planning and Performance Group
24 works closely with the PHA to monitor and seek
25 assurance on implementation." 10:58
26
27 The Inquiry has heard evidence on the way in which NICE
28 Guidelines find their way through the filter from the
29 Department. It's clear from your statement that the

1 Department's responsibility is to access information on
2 standards and quality, or have that fed through the
3 Department and to disseminate that among the Trusts,
4 and then to focus that on areas of clinical practice
5 that would be best informed by those guidelines. So 10:58
6 there is that continuity of quality and standards. Is
7 that a fair summary of the Department's role?
8 A. Yes. And in addition, depending on the nature of the
9 guidance that is being passed out, so there may be some
10 assurance sought from Trusts or others about the way in 10:58
11 which they have sought to comply with that guidance.
12 25 Q. So there is a level of oversight or an ongoing
13 relationship around that?
14 A. Yes. Usually through SPPG and the PHA they will be
15 making those judgments. The Department can do so as 10:59
16 well, and the Chief Medical Officer would often be
17 involved in looking at what comes through from NICE,
18 for example.
19 26 Q. Is that an example, perhaps, of what we were speaking
20 about a moment ago, about how the commissioning of safe 10:59
21 services is almost embedded in the system by the fact
22 that the standards and quality assurances, there's an
23 expectation that Trusts will reflect best industry
24 standards?
25 A. Yes. 10:59
26 27 Q. And, of course, in mentioning quality standards for
27 health and social care, you've also made reference to
28 the statutory regulators for the different professions;
29 the GMC, the NMC, and the way in which they interact

1 with other aspects of standards that are applicable. I
2 wonder if I could just touch on the Trust's Boards and
3 their relationship with the Department. It would seem
4 from the evidence received from many witnesses that
5 they have an important role in overseeing the standards 11:00
6 of quality and patient safety, and I just want to just
7 bring up a couple of things that have been highlighted
8 by some of the witnesses.
9
10 First of all, we'll look at your statement where you 11:00
11 mention the succession planning for Boards, WIT-107113.
12 Paragraph 168. We've asked you generally questions in
13 relation to problems around recruiting and retaining
14 and developing Board members, both at Executive and
15 Non-Executive members, so we've asked you a few 11:01
16 questions around that, and I want to highlight some of
17 your answers. Just paragraph 168. You say:
18
19 "Succession planning within the Boards of ALBs is a
20 priority for the Department with end dates for current 11:01
21 appointments actively monitored when planning the order
22 of competitions and reserve lists created and utilised
23 to address vacancies that occur between competitions."
24
25 Then at 169: 11:01
26
27 "Within my Department the Public Appointments Unit has
28 a comprehensive programme planning process in place.
29 This includes consultation with ALB Chairs on issues

1 such as monitoring term end dates, agreeing extensions
2 to terms, and second term reappointments, competition
3 scheduling, and once competitions are completed,
4 agreeing the commencement date for new appointees.
5 Where possible Board appointments are sufficiently 11:02
6 staggered to ensure that there is appropriate retention
7 of experienced Board members balanced by the influx of
8 new members bringing fresh challenges."
9
10 One of the things that had been highlighted had been 11:02
11 that there had, on occasion, been swathes of lost
12 expertise or corporate knowledge around Boards at one
13 time because of the way in which tenures were awarded
14 all at once. Is that something that from those
15 paragraphs would seem to be in the past and there's a 11:02
16 recognition that staggering this is a more appropriate
17 way to maintain both expertise and corporate knowledge?
18 A. It's certainly something that we've been trying to do
19 more of. I suspect we still have, you know, a bit more
20 to do, but we have made some progress in that respect. 11:03
21 In the past, if I go back I don't know, 10 or 20 years,
22 it would quite often have been the case that a minister
23 may have decided to, to have a kind of automatic
24 reappointment for a second term, as it were. Most
25 ministers, in my experience over recent years, have 11:03
26 taken the view that they would like anyone who wishes
27 to serve a further term to go through the same process
28 as anyone applying for the first time. That then can
29 mean that you end up losing more experienced Board

1 members at one go than is desirable, and that's why
2 some staggering is helpful. And also, of course, you
3 can't rule out there may be a group of people coming to
4 the end of their second term and best practice is that
5 they wouldn't serve more than two terms. So, yes, we 11:03
6 are working to make this better and I think we are
7 making progress in it.
8 28 Q. Now, you mention at paragraph 171 that:
9
10 "The primary responsibility for providing the resources 11:04
11 required to enable Board members to discharge their
12 duties appropriately lies with the individual Trusts
13 within the overall funding provided by the Department
14 of Health."
15 11:04
16 So there is that autonomy for Trusts to -- can they
17 make local decisions around how they structure and
18 operate their Boards, or is there a requirement that
19 Boards are set out in the same way across all Trusts?
20 A. Boards -- Trusts have a lot of delegated authority in 11:04
21 respect to how they work. I mean there are some
22 requirements on all Boards to meet best corporate
23 governance standards. So you would always require, for
24 example, an Audit and Risk Committee or whatever it
25 might be. So, you know, there'll be some basics, but I 11:04
26 don't think that they are contested.
27
28 The point around resources may be one that emerges on a
29 number of occasions in today's evidence. I think what

1 I've been trying to do is to move away from a model
2 where the Department might provide money for very
3 specific purposes, because then you start ringfencing
4 funds, and that then, in my experience, often leads to
5 inefficiencies in the way that resources are spent, and 11:05
6 a rigidity in the system. Whereas, if you're providing
7 the Trust -- and most of the Trusts are, you know,
8 receiving the best part of £1 billion, Belfast
9 significantly more than that -- if you're receiving
10 that amount of money with a clarity about what it is 11:05
11 that needs to be delivered across various domains, then
12 that seems to me a much better way of going, rather
13 than saying "Here's a few thousand here to train a
14 Board member". I mean that becomes, for me, something
15 that invites the Department to start to micromanage in 11:05
16 a way that isn't helpful.
17 29 Q. I just want to read out to you to see if you have any
18 comment on some of the evidence from Board members when
19 they came to give evidence to the Inquiry. Eileen
20 Mullan's evidence can be found at TRA-10022. It's 11:06
21 probably unfair to Ms. Mullan to start off with her
22 sentence "These are not attractive roles". She was
23 talking about Board membership and NEDs, and to be fair
24 to her, she spoke very highly of how rewarding these
25 roles are and how committed the individuals, and indeed 11:06
26 she is, in fulfilling these roles. So just that's the
27 caveat of what I'm about to read. And she says:
28
29 "These are not attractive roles. You've got to want to

1 do this. You don't step into a Health and Social Care
2 Trust as a Non-Exec because you've some time on your
3 hands. You do it because you want to bring your
4 skills, your experience, and your absolute commitment
5 to health and social care to the table. I firmly 11:07
6 believe, and it is with my Boardroom Apprentice and
7 other hats on, people want to serve. They want to
8 learn to do that. So let's create the space for people
9 to be able to serve on our Health and Social Care
10 Boards and get that right at the beginning. Succession 11:07
11 planning needs to be thought about the moment you
12 appoint somebody. The senior executive team's
13 succession planning, I know from talking with our
14 current Permanent Secretary Peter May, this is
15 something he is focused on, something he has focused on 11:07
16 in relation to the training and development of
17 Non-Executive Directors and that induction piece, that
18 is on his agenda, and he is watching it and he wants
19 that to happen. We need to think of how we make these
20 roles, not just Non-Exec, but the senior executive 11:08
21 roles, attractive to encourage people to apply because
22 they are incredibly rewarding."
23
24 Now, you got a mention in dispatches on that issue, but
25 does that indicate that there is an ongoing dialogue 11:08
26 around this and the ways in which you jointly can
27 improve this and try to bring further stability around
28 Boards?
29 A. Yes, I think that's fair. We talked a little bit about

1 appointment processes, but obviously the more
2 fundamental thing is when people are actually in post
3 and how you work with them. For me, the Board has a
4 central role to play in the accountability mechanism
5 and they're there to both support and challenge the 11:08
6 executive team, and they need to determine what the
7 right balance of those two is, depending on the issue
8 and where things are. And I expect and look to Boards,
9 and particularly to Chairs, to raise up to the
10 Department and to me, issues that they feel, you know, 11:09
11 their Board are not able to address and are concerned
12 about.
13
14 I think Eileen is right to say that these are -- Trusts
15 are big and complex organisations. So, you know -- and 11:09
16 our risk profile at the moment, for reasons that are
17 not the responsibility of Board members or, indeed, the
18 executive teams, is, you know, it's a lot more loaded
19 than you would really like, because we do have a demand
20 and capacity gap, we do have a very significant 11:09
21 resourcing challenge at the moment, and that's likely
22 to continue in '24/'25 at least. And as a result, you
23 know, the risk that something will go wrong in systems
24 that are under very significant pressure is greater.
25 So all the more reason to work with Boards to support 11:09
26 them. We do provide a basic induction for all
27 Non-Executives, but in addition to that the leadership
28 centre has put in place a series, a half day course for
29 Non-Executives to invite them to come together from

1 various health and social care organisations, and I've
2 been to a couple of those events recently to offer a
3 departmental perspective, and I know each Board is
4 being offered a day for its Board to go away and to
5 think about how it operates as a collective, again 11:10
6 through the leadership centre, and I think those are
7 good initiatives and ones that we would want to
8 support.
9
10 I don't think that those are things that the Department 11:10
11 should run itself because, again, that's inviting us to
12 get into the space of trying to tell Boards what they
13 need and what they don't need, and I think this needs
14 to be much more something that Boards themselves
15 determine, and we provide, as I said, the support that 11:10
16 is needed and, indeed, the input that's needed to any
17 training they do decide to take forward.
18 30 Q. And, of course, the Department has a vested interest in
19 Boards operating effectively and being...
20 A. And as accounting officer I have a particularly vested 11:11
21 interest.
22 31 Q. Yes. And the personnel and the expertise on that. The
23 evidence before the Inquiry, and it's for the Panel to
24 consider that evidence, but there has certainly been a
25 spotlight on the absolute essential nature in the 11:11
26 governance train of an effective Board?
27 A. Yes.
28 32 Q. So for the Department to have that quality assurance,
29 it would seem that Boards are a particularly

1 fundamental requirement that that is both properly
2 manned but also properly functioning.
3
4 I'll just go to what Maria O'Kane said at her evidence
5 at TRA-11670. And this was around Board composition. 11:11
6 And I take the point you've said that there has to be a
7 line of demarcation so the Department isn't seen to be,
8 I use the word "interfering" in a neutral way, but
9 getting overly involved in the management of the Trust.
10 But the sentence that has been asked is: 11:12
11
12 "Can the Department do anything to assist Trusts in
13 this respect?"
14
15 And, again, this is around Board composition. And 11:12
16 Mrs. O'Kane said:
17
18 "It's possible. I know that certainly, you know, the
19 foundation Trust structure in England is different in
20 that there are councils and there are Trust Boards, and 11:12
21 there's probably a lot more input from the public.
22 But, again, I imagine one of the limitations on this is
23 we are working in a really financially restrictive
24 environment currently and all of these things,
25 obviously, have to be accounted for. But certainly, 11:12
26 you know, anything at all that can add to the breadth
27 and depth of the expertise and the time allowed to the
28 Non-Executives I think would be welcome."
29

1 So there's no particular directed expectation from the
2 Department in Mrs. O'Kane's evidence, but she does
3 raise the resource issue, and one of the issues that
4 came up in evidence in relation to the Board was the
5 remuneration of Board members and how reflective that 11:13
6 may be to the time commitment and the level of
7 expertise some of the individuals bring. I just wonder
8 if you have any view in relation to that or is it
9 anticipated that there will be any review of fee
10 structures or does the Department -- what's the 11:13
11 Department's view on that issue generally?
12 A. Well, I think firstly I would commend those who put
13 themselves forward to be on Boards for their public
14 service, and I always say that when I meet them. We
15 currently provide three days a week for Chairs and a 11:13
16 day a week for Board members. Of course if I see a
17 strong evidence base that suggests that that's
18 inadequate, then we could look at it. We don't
19 currently have plans to look at it.
20 11:14
21 What I would say is that inevitably in a big and
22 complex organisation like a Trust, it would be possible
23 for Non-Executives to spend all of their time on Trust
24 business, and if you end up with full-time
25 Non-Executives I think you then run a risk of blurring 11:14
26 the line between what's an Executive and Non-Executive
27 responsibility. So the Non-Executives are there to
28 hold the Executive team to account, to support and
29 challenge them in the work that they do, not to do it

1 themselves, and I think that's an important
2 distinction. So I can understand particularly when
3 Board members are newly appointed and they're going
4 through induction, as well as learning lots about the
5 organisation, it may be that, you know, they feel the 11:14
6 recognition of that in terms of the time isn't quite
7 right. So there may be things that we should look at
8 there, I don't rule it out, but it's not something that
9 has been -- I've not had representations on this
10 specific in the two years I've been here. I've had 11:15
11 representations from Boards and Chairs on a range of
12 other things, but I don't think, you know, this is one
13 that has been particularly strong. I have read and
14 heard the evidence that's been provided, so I recognise
15 there is some sense of a need here. So let's -- by all 11:15
16 means, I'm happy to reflect on that.
17 33 Q. I wonder if we could just finish, or go to another
18 topic before we take a short break? It's Information
19 Systems in Health and Social Care, and it's a short
20 topic, but I'd like to just ask you about some of the 11:15
21 improvements that have taken place. If we go to your
22 statement at WIT-107069. The question we asked in your
23 Section 21:
24
25 "What is your view of the importance of enabling a 11:16
26 health and social care information system that can be
27 used by organisations to drive improvements in safety,
28 quality and performance, and inform integrated
29 governance at each level of the system? Is such a

1 system envisaged? If so, set out the details."
2
3 So at paragraph 30 you say:
4
5 "The Framework Document 2011 sets out the extant roles 11:16
6 and responsibilities and arrangements for discharging
7 same across the Department and health care system."
8
9 Paragraph 31:
10 11:16
11 "The use of information systems to drive safety,
12 quality and performance operate at a range of different
13 levels and require both ready access to the right data
14 and the ability to combine a variety of datasets to
15 provide a complete picture. For example, in relation 11:17
16 to how HSC Trusts are overseen, during 2023-24 the
17 Department tested the use of a Balanced Scorecard
18 approach at the ground clearing meetings which were
19 held in preparation for subsequent accountability
20 meetings with the HSC Trusts. This approach is 11:17
21 expected to involve the extraction of pertinent
22 information from a wide range of systems to support a
23 holistic view of Trust performance as part of
24 accountability arrangements across a number of domains,
25 including, for example, performance, safety and 11:17
26 quality, patient experience, and productivity and
27 efficiency."
28
29 Paragraph 32:

1
2 "The Balance Scorecard approach will be evaluated
3 before any decision to embed this as a new process to
4 support departmental accountability arrangements with
5 HSC Trusts." 11:17
6
7 So just on the Balance Scorecard approach, is that a
8 new way of bringing in data that allows an overview to
9 be taken in relation to performance and safety and
10 quality? Is that to inform the Department or both the 11:18
11 Department and the Trust? What's the sense of that?
12 A. Well, it would be designed -- it would be something, a
13 tool the Department uses, but it would absolutely be
14 something that is visible to the Trusts and the Boards.
15 So there'd be a clarity that that's what we were 11:18
16 looking at in terms of each of those domains. We
17 actually, as a senior team, had a meeting to discuss,
18 yesterday, the kind of measures that could be
19 introduced against each of those domains, with a view
20 to trying to minimise those, to keep them to a small 11:18
21 number of really important measures. The risk is
22 always that you can identify 6 or 10 other things that
23 you could usefully measure as well, and then it becomes
24 a very cumbersome process. But if we're clear what we
25 think is really important, that can also help to focus 11:18
26 Trusts and their Boards on what's important. And as
27 with all of these processes, the data will give you a
28 starting point, but there's also then a need to use the
29 experience that, you know, the Department has of its

1 engagement with each Trust, to understand, you know,
2 whether that correlates with the experiences that we're
3 seeing.
4
5 So your question was whether this was something just 11:19
6 for the Department or for the Department and Trusts,
7 and it is for both. But it is something the Department
8 would put in place, because it would be the
9 accountability mechanism that it would use and it would
10 support then, and essentially replace the commissioning 11:19
11 process as a result.
12 34 Q. Is this anticipated that this is information the
13 Department will interrogate or be curious about so that
14 they can go to the Trust and say "We need a little bit
15 more explanation about what's behind this." I presume 11:19
16 from your explanation it's both qualitative and
17 quantitative?
18 A. Yes.
19 35 Q. So is there an expectation -- and the context of the
20 question is in some of the Board information that was 11:20
21 received by the Southern Trust Board, there was some
22 suggestion that there was an absence of curiosity to
23 get underneath the data, or underneath the one
24 dimensional lines of information that they were being
25 provided. Is this something, is there learning from 11:20
26 that for the Balance Scorecard?
27 A. So I don't think -- assurance processes shouldn't be
28 tick box exercises where you get a piece of data and
29 you say "well that's all okay then". As I said, you've

1 got to correlate that then with the experience that,
2 you know, the organisation, the Department of Health in
3 this case, has multiple interactions with each of the
4 Trusts on a very regular basis. So it's also about
5 understanding those interactions alongside whatever the 11:20
6 data is telling you.
7 36 Q. Given some of the evidence that the Inquiry has heard,
8 is there a sense, from your perspective and your
9 interaction with both this Trust and other Trusts, that
10 the quality of communication has improved, or the 11:21
11 ability to question information, is there any sense
12 that there is a greater sense that people are unafraid
13 to raise issues of concern at the earliest point?
14 A. Well I don't think I can offer a comparative view,
15 because I wasn't here prior to two years ago, but what 11:21
16 I would say is that it's been a focus of mine to try to
17 engage with Trusts, both at Executive and Non-Executive
18 level, and the feedback I think suggests that that is
19 succeeding both in individual and at a systemic level.
20 So -- sorry, could you just repeat the question again? 11:21
21 I think I'm going off on a tangent.
22 37 Q. I'll try my best! The context of why I was asking you
23 that is, we've been here as long as you've been in
24 post, we're nearly the same age, I suppose, in that
25 respect. Has there been incremental learning in your 11:22
26 position as Permanent Secretary where there is more
27 openness, that there is a sense of learning as we have
28 gone along, that the Department has also gone along in
29 their learning as to how to interrogate Trusts or to

1 oversee governance, has that been an organic thing?
2 A. Absolutely. We've certainly been putting time and
3 effort into how we do -- take a helicopter overview of
4 where a Trust is in order that we can understand what
5 support they need and whether there are any 11:22
6 interventions the Department can contribute to. And,
7 you know, then where we do identify those then there'll
8 be a more detailed conversation with the Chair, or with
9 the Chief Executive, or with both. I think it's one of
10 those ones where you can never be sure that you've got 11:23
11 it completely right, but I think that we have made some
12 good process. I don't, myself, have a sense that there
13 is a reluctance on the part of Trusts to be open with
14 us about problems that they're facing, and I welcome
15 that, and I think that that is an important part of 11:23
16 creating the right kind of culture. So, you know,
17 obviously that goes to how we react when we're told
18 that things are not where they need to be in specific
19 areas and how we build together confidence around the
20 plans that the Trust should initially put in place to 11:23
21 address those difficulties.
22 38 Q. You've also mentioned the Electronic Patient Record
23 system. Obviously our focus is on governance and the
24 way in which some of these systems may assist in
25 improving that. At paragraph 33 you say as follows: 11:24
26
27 "Looking at how clinical information is joined up, the
28 successful introduction of the Electronic Patient
29 Record (EPR) at the heart of the Encompass Programme

1 required a review and standardisation of clinic
2 pathways by health care professionals. Going forward
3 the information from the acute and community care
4 sectors that the EPR makes available will significantly
5 enhance the drive for improvements in safety, quality 11:24
6 and performance, and inform integrated governance and
7 will compliment existing data and information systems.
8 The system will provide near real-time data which can
9 be used to benchmark HSC acute care and community care
10 services across Northern Ireland, and with other Epic 11:24
11 system users in the UK and worldwide."
12
13 Now that's clearly an attempt to joined up thinking of
14 data provision around patient information at the point
15 of clinical need, and you've mentioned Encompass, which 11:24
16 seems to be quite a significant project. You've
17 mentioned that at paragraph 43. We'll just look at
18 that. 107073.
19
20 So you're explaining the Encompass system. We've asked 11:25
21 you specifically to explain the purpose of it, the
22 extent that it has been rolled out, how it functions
23 and how it is intended to benefit health and social
24 care organisations, and staff, and patients and carers,
25 and what is the timescale? And you've provided the 11:25
26 following information:
27
28 "The Encompass Programme is a clinical and operational
29 transformation programme with an Electronic Patient

1 Record solution supplied by Epic at its heart.
2 Northern Ireland is the first system to adopt this
3 unified approach to an electronic health record at
4 integrated care system level and is the first in the UK
5 to incorporate social care as part of this endeavour. 11:26
6 It is the largest implementation of the Epic platform
7 in Europe.
8
9 The flagship programme will see Encompass replace or
10 link with the vast majority of clinical systems 11:26
11 currently in operation in acute and community care
12 settings, replacing existing often end-of-life Patient
13 Administration Systems and clinical record systems
14 across HSC NI. The EPR will provide those working in
15 acute and community care with a single holistic, 11:26
16 appropriate view of a patient or service users'
17 interaction with those sectors. Primary care
18 professionals will also have appropriate access to the
19 information."
20 11:26
21 I wouldn't want to put Encompass in a nutshell because
22 it does seem incredibly complex, but is this a way of
23 trying to get everything that's relevant and necessary
24 clinically about people together in one spot so that
25 they can be accessed by the relevant primary care 11:27
26 professionals at the point of need? Is that at least
27 one aspect of it?
28 A. Yes. I mean Encompass is probably the largest single
29 change programme that health and social care has

1 undertaken because it requires everybody who has
2 contact with individual patients to do things radically
3 differently to the way they would have done them
4 before. And as a result, as with any major change, you
5 will find that there is a spectrum of views about how 11:27
6 easy or otherwise it is to use that system. But I was
7 talking to the Chief Executive of the South Eastern
8 Trust, which is the Trust that has already gone live
9 recently. She was identifying clear benefits in
10 relation to patient safety, in relation to patient 11:27
11 experience, and in relation to efficiency in a range of
12 different ways. So we've got more to do because
13 there's still a few teething challenges, as you often
14 find with the introductions of new systems, but I am
15 confident that the Encompass system will be a big step 11:28
16 forward, particularly assisting actually the safety and
17 quality agenda, and I think that's been the experience
18 elsewhere of where it has been brought in.
19 39 Q. And the rollout of Encompass involves training all of
20 the staff on that I presume? 11:28
21 A. Yes.
22 40 Q. What's the sort of timeframe for that? Is there an end
23 date for final integration?
24 A. Do you mean when will it be rolled out across all of
25 the Trusts? So our current target is that by this time 11:28
26 next year all the Trusts will have gone live with
27 Encompass. The Belfast Trust will go live in June, the
28 Northern Trust in November, and then the Southern and
29 Western Trusts are March/April next year. That's

1 obviously subject to readiness assessments which are
2 detailed in relation to each of the Trusts, but that's
3 the programme, and I think that may be set out
4 elsewhere in the statement.
5 41 Q. And given that the expectation that Encompass will help 11:29
6 the health and social care in Northern Ireland work
7 more effectively and efficiently through regional
8 standardisation based on best practice, which is from
9 your statement, it's anticipated that one of the wins
10 of Encompass as well as the efficiency will be better 11:29
11 governance?
12 A. Yes. So as I said, there's a big safety and quality
13 dimension here. By creating agreed pathways, pathways
14 that are set by the clinicians in each speciality for
15 how conditions will be managed, you should remove 11:29
16 unwarranted variation from the system. You are
17 reducing the likelihood or the risk of medication being
18 done in a way that's not appropriate, you are
19 increasing the ability of patients to track their own
20 engagement through the My Care portal, the patient 11:29
21 portal. And, as I said, in addition, there should be
22 some efficiency benefits. The other way in which the
23 patient experience is improving, and the fundamental
24 way, is that they should only be telling their story
25 once and then every clinician can come and see what 11:30
26 that story is, rather than having to ask the same set
27 of questions, and anyone who has been had in a health
28 and social care setting will know that that's a big
29 challenge.

1 42 Q. And the Inquiry has heard evidence that in this
2 jurisdiction patients don't automatically or routinely
3 get letters about their care from hospitals, it's
4 usually sent to the GP. There is some individual
5 practice that it does happen, but there's no uniform 11:30
6 policy or standardised approach in relation to that.
7 Is Encompass a way in which people could access a
8 section of that to find out if they have been referred
9 for tests or if a letter has been sent to the GP and,
10 indeed, what it says? 11:30
11 A. So, certainly I think it could do some of that, it may
12 not do all of it. I think things like the discharge
13 letter, if you're leaving hospital, then that would be
14 available to you on the My Care portal. You would be
15 able to access the results of some tests at least. I 11:31
16 think though, importantly, we shouldn't forget that
17 there is a human dimension to some aspects of this, so
18 there are some tests that you wouldn't want to be
19 telling people the answer by them going on to an app to
20 find the result. So, you know, I don't think -- I 11:31
21 think we just need to make sure that we have a nuanced
22 view of how that patient portal will work in practice.
23
24 Similarly, the language used by some consultants, at
25 least in writing to GPs, wouldn't be accessible to 11:31
26 members of the public, so we just need to make sure
27 that what's being made available to members of the
28 public is stuff that we can reasonably expect them to
29 be able to use and make use of sensibly.

1 43 Q. And, indeed, a lot of members of the public may not
2 have access to the technology to be able to...
3 A. Well, I think that's a relatively small number now, and
4 a decreasing number, but I accept that there will be
5 cohorts that that applies to. 11:32
6 44 Q. Chair, I wonder if that is a convenient time?
7 CHAIR: Yes. We'll take a short break and come back in
8 15 minutes time, which if I've worked it out is ten to
9 twelve.
10 11:32
11 THE INQUIRY ADJOURNED FOR A SHORT PERIOD AND RESUMED AS
12 FOLLOWS:
13
14 CHAIR: Thank you, everyone.
15 MS. McMAHON: Mr. May, I wonder if we could move on to 11:49
16 some of the issues of reform and reviews that you've
17 mentioned in your Section 21, and if we go to your
18 statement at WIT-107116, at paragraph 178. Now this is
19 in relation to the reform of maintaining high
20 professional standards, and you say: 11:49
21
22 "A review of MHPS commenced within the Department in
23 2023 with the establishment of an independent review
24 panel under the direction of the MHPS Review Steering
25 Group. The Panel consists of three individuals who are 11:50
26 external to the Department of Health, HSC NI. Each
27 bring differing expertise to the project covering
28 operational experience of the MHPS framework, medical
29 leadership, governance, employment law, rights,

1 knowledge, and restorative just and learning
2 practices."
3
4 And then you give us an update at paragraph 179. If
5 you could just move down to 181, please? And in 11:50
6 relation to the outcome of the review of MHPS you say
7 at paragraph 181:
8
9 "An initial working draft report will be produced and
10 presented to the Steering Group by the end of March 11:50
11 2024. This will contain the review panel's initial key
12 findings and recommendations on the way forward for
13 MHPS within the HSC. It is hoped the final report will
14 then be presented to the Department by June 2024."
15 11:51
16 And you say can a copy can then be shared with the
17 Inquiry once published. Just in relation to those
18 timeframes, where are we at the moment?
19 A. The Panel met the Steering Group at the end of March
20 and made a presentation rather than offering an initial 11:51
21 draft report. I'm not on the Steering Group, but the
22 presentation covered, I think, the main areas. I had
23 met the Steering Group a few weeks before that just to
24 understand where they were, and my understanding is
25 that their key finding is essentially to say they're 11:51
26 not clear, they don't believe there should be a
27 separate process for managing standards for doctors
28 compared to other employees for health and social care,
29 other practitioners, so I haven't seen the detailed

1 outworking of that yet, and they're going to develop
2 that into the report. We are still anticipating
3 receiving that report by the end of June, and I'm
4 conscious that it is part of the Inquiry's Terms of
5 Reference, so we would be keen to engage and share that 11:52
6 with the Inquiry, not least to understand if the
7 Inquiry has any views on it. I recognise that in
8 timeframe terms there could be a tension here, because
9 the Inquiry report is likely to be some way off, with
10 the best will in the world, but we may -- if the -- if 11:52
11 there was some way, and perhaps more informally, of
12 discovering whether the Inquiry felt that was the right
13 direction of travel, that might be extremely useful to
14 us, because I don't think the Inquiry would want us not
15 to start doing anything on MHPS until after the Inquiry 11:52
16 report is published. So we might just need to have an
17 engagement about how that would work in practice.
18 CHAIR: There should be no difficulty with that,
19 Mr. May. There should be no difficulty with some sort
20 of engagement once we see the report. 11:53
21 A. Thank you.
22 45 Q. MS. McMAHON: Just for the Panel's note when they're
23 looking at the evidence again. Maria O'Kane's evidence
24 on this issue can be found at TRA-11730, where she
25 says: 11:53
26
27 "The Trust was asked to give feedback to the Department
28 on their MHPS review and they offered suggestions."
29

1 Also at TRU-306519, there was a review of the MHPS
2 stakeholder engagement questionnaire and the extent to
3 which that was fed into the review. So that's -- the
4 update on MHPS, then there was a review of SAI
5 procedure, and you deal with this at WIT-107117, at 11:53
6 paragraph 183, and I think we're actually on that page.
7 Yes. So you say:
8
9 "A redesign of the current Serious Adverse Incident
10 (SAI) procedure is progressing led by the Department. 11:54
11 This will result in a new framework replacing the
12 current SAI procedure. SPPG and HSC Trusts, amongst a
13 range of other partners, sit on the programme Board
14 Redesign Development Group."
15 11:54
16 And then at 184:
17
18 "The programme of work will seek to address relevant
19 recommendations arising from the IHRD..."
20 11:54
21 -- which is the Hyponatraemia Inquiry, and the
22 Neurology, INI Neurology Inquiry,
23
24 "...alongside recommendations from the RQIA review of
25 systems and processes for learning from SAIs, which 11:54
26 together have provided a clear and strong evidence base
27 underpinning the need to fresh and redesign the current
28 approach to learning following SAIs."
29

1 185:
2
3 "The SAI Redesign Programme is being progressed by a
4 redesign working group and a redesign development
5 group. Membership of these groups comprises senior 11:55
6 colleagues from the Department and from the HSC,
7 including Trusts. This programme of work will
8 introduce a new framework to deliver learning and
9 improvement from patient safety incidents events
10 through a new streamlined and simpler review process. 11:55
11 The Departmental work will not focus on reviewing and
12 refreshing all local systems across HSC Trusts and
13 delivery areas, rather it will deliver a clear
14 overarching regional framework together with supporting
15 methodologies, learning and improvement tools, and 11:55
16 relevant guidance."
17
18 CHAIR: Sorry, Ms. McMahon, I hesitate to interrupt
19 you, but there seems to be a drone. I don't know if
20 that's internal or external. 11:55
21 MS. McMAHON: I thought that was just local to me.
22 CHAIR: No, definitely not you, Ms. McMahon.
23 MS. McMAHON: I can hear it as well.
24 CHAIR: I don't know if it's inside this chamber or
25 whether it's something happening outside. Can I just 11:56
26 ask PI-communications if they would check the equipment
27 isn't creating it in any way. It seems to have
28 stopped.
29 MS. McMAHON: It does. It stopped when I stopped

1 speaking, but I won't take any correlation to that
2 droning. I'll go back. If that's okay, I'll go back
3 and it's paragraph 188.
4
5 "It is anticipated the new framework will deliver a 11:56
6 fundamental change in how HSC organisations review and
7 learn from patient safety incidents resulting in
8 improved care. The new framework and supporting
9 guidance will be less detailed and prescriptive in many
10 aspects in contrast to the current SAI procedure." 11:56
11
12 Then you set out at paragraph 189 the areas of key
13 focus for the current phase of the SAI redesign work,
14 which include:
15 11:56
16 "Further involvement and co-production activity with
17 both patients, families and staff, and wider
18 stakeholders, to seek views and to build confidence in
19 emerging proposals.
20 Redefine and rebalance the oversight and assurance 11:57
21 functions, local and regional, as part of the new
22 framework and how these will work in practice.
23 Achieve correct balance between greater organisational
24 autonomy and flexibility and redefined organisation and
25 regional oversight and assurance roles. 11:57
26 Further drafting of the new framework in supporting
27 guidance.
28 Opportunities for managed prototyping aspects of the
29 emerging framework and planning to deliver a managed

1 transition to a new framework.
2 The policy team is targeting a consultation on the new
3 framework in autumn 2024."
4
5 Now, I think you mentioned from a section I read just a 11:57
6 moment ago that there had been information gathering or
7 suggestions or advice sought from other key
8 stakeholders in relation to this. The Inquiry heard
9 evidence from the Chief Executive of the Patient and
10 Client Council, they had undertaken a specific piece of 11:58
11 work around the voices of patients and service users
12 and the way in which they experience the SAI process,
13 and they gave - Ms. Monaghan gave detailed information
14 about the way in which some people were dissatisfied
15 about the process, and I'm sure that's not a surprise 11:58
16 to you that there are considerable flaws perceived or
17 in reality from both clinicians who have to inform the
18 process, but also end users whose experience perhaps is
19 used as a basis for an investigation. So, is it
20 anticipated for the Inquiry's purposes around 11:58
21 governance that this new framework will result in
22 better outcomes for all of those stakeholders in the
23 SAI process and also tighten up aspects of governance
24 that are arguably absent in the current process?
25 A. I think the obvious thing to say is if it doesn't 11:59
26 achieve that, given the shortcomings that have been
27 identified, as you say, in various sectors, then it
28 won't have achieved what it set out to do. So, as with
29 -- and I think similarly to MHPS, the delivery of the

1 report or the outcome is one thing, implementing it
2 well is actually a bigger and more important task. And
3 often it's not the words on the page that are the
4 problem, it's the way those words are interpreted
5 within organisations or in the way processes work. 11:59
6
7 I think SAIs, it is also fair to say, there will -- we
8 should not imagine that there'll be a world in which
9 everybody is always happy with everything, and SAIs I
10 think is particularly one of those areas. The purpose 11:59
11 of SAIs is to produce learning, and in particular
12 learning for the organisation for the individuals,
13 learning for the system. There will be people,
14 including potentially those who have been affected by
15 incidents, who have a different focus as they approach 12:00
16 an investigation and see it as an investigation rather
17 than as a learning exercise, and that will be -- it
18 will be really important to try and be clear what SAIs
19 do and don't do, and at the moment I think there's a
20 risk that people -- there's a kind of obscuring of that 12:00
21 in people's minds.
22
23 So I suppose I'm saying that with a view to
24 conditioning expectations about what will and won't be
25 possible through a review of SAIs. But you are right 12:00
26 also to draw out that the review should also improve
27 the speed in which the SAI takes place, the way in
28 which learning is disseminated, and in particular how,
29 for example, learning is identified, including from

1 multiple SAIs, and there's an important role for the
2 Department through SPPG and the Public Health Agency in
3 trying to look at those systemic lessons and draw those
4 out. So those are all things I think it's reasonable
5 to expect that should happen, and it should improve 12:01
6 people's experience in a number of ways. As I said, I
7 just think we need to be careful not to assume it will
8 make everybody happy all of the time, because that
9 probably won't be the case.
10 46 Q. I think to be fair to the witnesses who gave evidence 12:01
11 on this issue, there was a recognition that at times
12 there was a mismatch of expectations what SAIs were
13 meant to do and what they could do and what people
14 thought they might do?
15 A. Yes. 12:01
16 47 Q. So there was -- as you've said, hopefully there will be
17 some clarity gained with the new framework document.
18 We had asked you about other developments, in
19 particular a review of Early Alerts, and you say --
20 just if we move down to paragraph 192. Sorry, my 12:01
21 mistake, 191, and you say:
22
23 "On 15th November 2022..."
24
25 -- which is when you last gave evidence: 12:02
26
27 "I committed to a review of the Early Alert system when
28 giving evidence at the Urology Inquiry."
29

1 And then you give us the evidence that you gave. If we
2 move down to the next paragraph, at 192 you indicate
3 that:
4
5 "Due to resourcing pressures this work has not yet 12:02
6 substantively commenced although some early planning
7 has taken place. It is currently anticipated that a
8 review of the Early Alerts process will be undertaken
9 by the Department in 2024."
10 12:02
11 Is this again just an example of competing priorities
12 around what can be done and what needs to be done more
13 urgently?
14 A. Yes, essentially it's a prioritisation exercise. I
15 hope that the Early Alerts will be a less major piece 12:02
16 of work than SAIs, and I think it is realistic to
17 expect that that is the case. But I'm also conscious
18 that not only are the team that will be taking this
19 forward leading on a number of the areas that we've
20 already talked about, but they also are likely to be 12:03
21 drawn into supporting the Covid Inquiry quite
22 substantially due to other tasks they took on during
23 that period. So it is just a question of balancing and
24 making sure that we are able to deliver on the targets
25 that we set ourselves. 12:03
26 48 Q. Again on the Lookback Guidance Review at 193. If we go
27 to 195. It had been anticipated there would be a
28 review of this, and you say at 195:
29

1 "A review of the Regional Lookback Review Guidance has
2 been agreed and the completion of this work will be
3 subject to staff resource availability."
4
5 Again is that for the same reasons you've just 12:03
6 outlined?
7 A. Yes.
8 49 Q. If we go to 196, in relation to reforms and action that
9 has been taken and move forward, you say at 196:
10 12:03
11 "In February 2023, the Department commissioned the
12 Getting It Right First Time team to complete a review
13 into Urology services. One of the key reasons for
14 undertaking this review was to ensure that
15 recommendations could be identified and implemented at 12:04
16 the earliest possible opportunity to facilitate the
17 improvement in the extensive waiting lists in this area
18 and to ensure that patients are treated as quickly as
19 possible to ensure best possible outcomes."
20 12:04
21 Then we move to 199, the outcome of this Getting It
22 Right First Time Report, and you say:
23
24 "The report has identified a series of 40
25 recommendations to improve the service in addition to a 12:04
26 list of recommendations for each HSC Trust. These
27 recommendations have been accepted in principle by the
28 Department. Work is already underway on many of the
29 recommendations. However, others will require funding

1 and resources. The recommendations focus on the themes
2 of maximising surgical assessment, diagnostic capacity,
3 and improving efficiency, strengthening pathways and
4 protocols, exploring non-consultant grade skills mix
5 and training and regionalisation of services. Funding 12:05
6 requirements have yet to be fully quantified but will
7 include investment in the workforce, which includes
8 creation of additional posts and training of staff,
9 along with capital funding for equipment and
10 infrastructure." 12:05
11
12 Now, the Inquiry has had sight of that documentation,
13 but for their note, the Recommendation Action Plan
14 dated 6th March 2024 is at TRU-306468, and when one
15 looks at the Action Plan, and the recommendations and 12:05
16 the RAG that they have applied to it, the red, amber
17 green way of designating priority for recommendations,
18 quite a significant amount of work appears to have been
19 done on what can be done at this instance, but it's
20 clear that the Department has a role in relation to 12:06
21 funding and some oversight in relation to improvements
22 in that respect. The updated position on that, is
23 there any movement forward? Does the Department
24 envisage any extra capital raising for the
25 implementation for those particular recommendations? 12:06
26 A. So, for the purpose of the '24/25 year, we're still
27 waiting for the budget outcome as things stand. I
28 mentioned earlier that that budget outcome looks as
29 though it's going to be very constrained, and the

1 ability to do new things may well not be easy. So I
2 don't want to prejudge the outcome of that. But I did
3 get -- I did have a meeting with the team in the
4 Department who are leading this work, and they did say
5 that there was a strong clinical buy-in to the 12:07
6 recommendations that is have come forward from the
7 GIRFT Review, and real momentum in terms of taking the
8 actions that we can take. So they were clear that they
9 thought it would be possible to make progress in most
10 of the areas, in pretty much of the areas set out. 12:07
11 There may be limits to how far they can go, in the
12 absence of new money, but they can at least start the
13 work in a range of those areas. So that I think was,
14 for me, a positive signal, both in terms of orientation
15 and of progress, and we will be issuing a progress 12:07
16 report formally, probably in the summer, as to where
17 we've got to against each of the recommendations.
18 50 Q. You've mentioned about the restriction in capital and
19 the difficulties then that will be faced by constrained
20 budget. When Mrs. O'Kane gave evidence, she gave us an 12:07
21 example certain audit and tracking functions that had
22 been funded by the Trust at risk, which she had said
23 they yielded real on the ground improvements in some of
24 the areas where harm was in the past caused, and as a
25 result of that they have seen significant improvement 12:08
26 are. And for the Panel's note that is Mrs. O'Kane's
27 evidence at TRA-11742 line 6 to TRA-11744 line 16.
28 Now, the nature of the functions of the audit and
29 tracking functions that she had identified, didn't seem

1 to face some of the major hurdles and obstacles of
2 other requirements, such accessing nurses and doctors
3 and requiring significant funding, and they were more
4 about filling in of admin roles and reconfiguration
5 that the Trust had funded at risk. Given the 12:08
6 identification by Mrs. O'Kane that those sort of
7 changes yielded real on the ground improvements in
8 areas where harm had been caused in the past, is that
9 something the Department might consider funding going
10 forward rather than on an at risk basis by the Trust? 12:09
11 A. I'll come to the specifics in a moment, if I may, but
12 just perhaps at the risk of repeating myself go back
13 to, you know, the Trusts are given large budgets, and I
14 think it is for them to determine where their
15 priorities should be. Clearly if we want to commission 12:09
16 new services then there should be an expectation that
17 with new services comes additional funding.
18
19 In relation to urology, I think the Southern Trust has
20 seen quite a significant investment in urology services 12:09
21 in recent years, around 2.9 million over a number of
22 years. In relation to the specific administrative
23 functions, my understanding is that in 2019 there were
24 three of these roles that were being funded. Through
25 SPPG that's now increased to 11. Obviously I'm not 12:10
26 cited on whether the Southern Trust has more than 11
27 people in post or not, and I think that's getting to a
28 level of detail that probably isn't where I would want
29 to be anyway, but it's just to signal that there was a

1 recurrent investment of about 180,000, I don't have the
2 precise number, over to support those additional
3 administrative roles in the area that you describe.
4 51 Q. And when you mention around the issue of money, and
5 it's not always about money it's the way the money is 12:10
6 allocated as well, rather than just the amounts, that
7 was something that was given in evidence by Sharon
8 Gallagher of SPPG, and we don't need to go to this but
9 I'll just read this out for the Panel's out at
10 TRA-11015. Ms Gallagher said: 12:11
11
12 "We are in a demand capacity deficit. Waiting lists in
13 Northern Ireland are longer than anywhere else in
14 England, Scotland or Wales, and that is something that
15 as a senior team in the Department we pay huge 12:11
16 attention to. Over 50% of the block grant is allocated
17 to health, so around £7 billion a year is allocated to
18 health."
19
20 She also said: 12:11
21
22 "It is a matter of public record that no service is
23 currently achieving or receiving the funding that is
24 required to meet the deficit, and in that regard it is
25 really important that we provide safe services because 12:11
26 the provision of them or access does not come at a
27 premium to safe services."
28
29 And in relation to urology, we have mentioned the

1 funding that has been allocated there. Mr. Cavanagh in
2 his evidence says at TRA-11017:
3
4 "I think only one other acute speciality has received
5 more funding in the last 15 years than urology." 12:12
6
7 So that's to tie in their evidence. There has been a
8 lot of mention of culture and changing cultures in the
9 Trusts, both in relation to the individuals feeling
10 safe enough to raise issues, but also for others to 12:12
11 feeling confident enough to ask questions, and people
12 to highlight issues in the first place. What do you
13 consider is the role of the Department in assisting
14 Trusts around the culture regarding governance to
15 ensure that there is an environment in which anything 12:12
16 touching upon patient quality or risk does find it's
17 way to the right ears and that change is effected?
18 A. I think the Department is responsible for setting the
19 overarching policy and strategic agenda for developing
20 detailed frameworks that may be needed to support that, 12:13
21 and then for seeking assurance from the Trusts as to
22 the extent to which they have been able to meet the
23 terms of those policies and frameworks that are put in
24 place. So to use an example, we've employed an
25 independent expert, Peter McBride, to lead some work on 12:13
26 a Being Open framework for HSC, and he's done that
27 initially at the request of Belfast, starting in
28 Belfast, because of the challenges they faced in the
29 Neurology Inquiry, and then the Southern Trust, again

1 at the request of the Chief Executive. He is now
2 working with the other Trusts also to engage clinicians
3 about what is needed in such a framework? What is it
4 that is stopping people from coming forward and raising
5 concerns? How do we get to a place where being open is 12:14
6 the norm and not just when things have gone wrong? In
7 other words, it's an all of the time piece. And he's
8 developing that framework at the moment, and I hope
9 that will be available fairly shortly. And, again,
10 would be a task around how that is then implemented and 12:14
11 brought about.
12
13 But culture is absolutely the heart of all of the work
14 here, and something that I and the team in the
15 Department are really focused on as to how do we 12:14
16 develop the right kind of culture, both in terms of how
17 the sorts of examples that you've raised about people
18 being willing to raise concerns, but also in terms of
19 the engagement we have with our -- all of our arms
20 length bodies as well. 12:14
21 52 Q. And I think you've written to the Boards recently in
22 September, 23rd September 2023, around the HSC Board
23 Member Handbook, emphasising, re-emphasising the
24 importance of the existing responsibilities and other
25 policies that applied, and for the Panel's note, that's 12:15
26 referenced in Mr. May's statement at WIT-107103,
27 paragraph 137. And you've kindly provided a copy of
28 that letter which can be found at WIT-107560, and the
29 following three pages from that.

1 A. I think one of the useful things about that handbook
2 was that it had quite a long section towards the back
3 giving some case studies that tried to draw out how the
4 kinds of concerns that might find their way to a Board,
5 what is the kind of checklist of things that you may 12:15
6 then want to, a Board member may want to consider and
7 look at, and I thought that was something -- it was
8 done before my time originally, but I thought that was
9 a really good part of the handbook. It wasn't just a
10 long list of things you should do, it tried to make it 12:16
11 something that had been applied in a way that would be
12 useful to Board members.
13 53 Q. Now in relation to driving change, you've highlighted
14 some of the areas of developments in your statement,
15 and if we go to paragraph 90, WIT-107086. Sorry, 12:16
16 107087. Where you mention the HSC Performance and
17 Transformation Executive Board, and you say:
18
19 "It brings together leaders from across the health and
20 care system to bring a collective approach to driving 12:16
21 change. The Expert Clinical Panel (ECP) brings
22 together senior clinicians to collectively consider key
23 transformation initiatives. There is also an ongoing
24 commitment within the Health and Social Care Workforce
25 Strategy 2026 to continue to align and support a 12:17
26 collective leadership culture within the HSC through
27 the full implementation of the HSC collective
28 leadership strategy. This action is the responsibility
29 of HSC employers. HSC Trusts devote resources to

1 learning and development, which include support and
2 training for staff taking on leadership roles."
3
4 So, is that a further way in which people with the
5 right information and the right knowledge and 12:17
6 experience can come together to help transform care
7 where that's needed?
8 A. Yes. I think somewhere else in the statement we had
9 set out that the three different groups at overarching
10 strategic level, the Performance and Transformation 12:17
11 Executive Board, the Expert Clinical Panel that's
12 co-Chaired by the Chief Medical Officer or the Chief
13 Nursing Officer, and then the ITAB, the Independent
14 Transformation Advisory Board, that brings in some
15 people within health and social care, but also 12:18
16 representatives from outside, including from some
17 business in third sector organisations as well. And
18 that's the kind of overarching strategic frame. And
19 then within -- under that there are a set of detailed
20 programmes, of which the Workforce Strategy would be 12:18
21 one.
22 54 Q. And you mention the Workforce Strategy in the next
23 paragraph. If we just move down to 91?
24
25 "The Department's ambitions for the development and 12:18
26 Health and Social Care Workforce are outlined in the
27 Health and Social Care Workforce Strategy 2026
28 Delivering For Our People, which was published in May
29 2018. This was in response to a recommendation in

1 Health and Well-Being 2026 Delivering Together. The
2 outworking of the expert panel led by Professor Rafael
3 Bengoa, tasked with considering the best configuration
4 of health and social care services in Northern
5 Ireland." 12:19
6
7 And then you go on to explain the way in which the
8 strategy was developed. Now we're closer to 2026, the
9 timeframe mentioned. What's the position in relation
10 to this particular strategy at the moment? 12:19
11 A. So there has been a lot of work undertaken. I think
12 there are -- there are still major challenges in
13 relation to workforce in health and social care. There
14 is no doubt at the time this was written in 2018, no
15 one was predicting the pandemic, and that has obviously 12:19
16 materially impacted on the experience of the workforce
17 in work and something that has required some
18 adaptation.
19
20 The headline figures show that since 2018 there have 12:19
21 been really significant increases in all areas of
22 workforce, including all of the major health
23 professional areas. I think it's around 18% for
24 doctors, and over 15% for nurses and allied health
25 professionals. So there has been major investment, but 12:20
26 we know that there remain real challenges within the
27 workforce, and you've referenced already on a number of
28 occasions the demand and capacity gap, and that is
29 absolutely driving this, because it means that people

1 are working really hard every day, but at the end of
2 the day their workload is either the same or greater
3 than it's ever been as a result of that demand not
4 being met. So we aren't unique in facing those
5 problems. They are and feel really acute for our 12:20
6 region, and it is something that we are all working as
7 hard as we can to resolve. But we are also facing
8 constraints. And so it does feel sometimes as though,
9 you know, you're trying to deliver that change with
10 your hands tied behind your back because you don't have 12:20
11 the wherewithal in order to make the investments that
12 are going to be needed in a variety of areas that will
13 make the change that's needed.
14
15 Not all of that investment -- I know this Inquiry has 12:21
16 focused on urology, which is a hospital based service,
17 but not all of that investment is needed in the acute
18 sector and there's actually a need, a particular need
19 to invest in primary care and in social care in order
20 to stabilise those sectors and in order to ensure that 12:21
21 they are able to deliver the maximum that they can do
22 in order that that can assist the acute sector.
23 55 Q. And you've provided a breakdown of some of the figures
24 in relation to staff retention across the HSC in your
25 addendum statement. For the Panel's note, that is 12:21
26 WIT-107634, and relevant paragraphs are 45 to 48. At
27 paragraph 48 you say:
28
29 "All staff groups have seen a decrease in vacancies

1 actively being recruited since 31st December 2022. At
2 31st December 2023, there were 5,906 vacancies actively
3 being recruited across health and social care in
4 Northern Ireland. This equated to a vacancy rate of 7%
5 and was a decrease of 2,410 vacancies since the serious 12:22
6 high point at 31st December 2022, which was 8,316. The
7 total number of vacancies under active recruitment at
8 31st December 2023 is 29% lower than at 31st December
9 2022, and 18.4% lower than at 31st December 2018."
10 12:22
11 So that gives the Panel a snapshot of some of the
12 challenges faced in both recruitment and retaining
13 staff.
14
15 Now there has been movement in the development of new 12:23
16 roles, advanced practice roles?
17 A. Yes.
18 56 Q. Has that been as a result of demand from the Trust, or
19 is that led by the Department, or is it a match of
20 both? 12:23
21 A. Well in principle it should be led from within Trusts
22 on the basis that, you know, that they identify the
23 need. I think the Department does have a role to play
24 both obviously in terms of the commissioning of the
25 training needed, but also in terms of drawing out 12:23
26 whether it is best practice from other jurisdictions
27 that could apply to our region to help with that, and I
28 know in the context of advanced nurse practitioners,
29 the Chief Nursing Officer, Maria McIlgorm has been a

1 really strong advocate of that and trying to
2 demonstrate and help Trusts to understand where those
3 roles can really add maximum value, often being able to
4 perform functions that are currently undertaken by
5 consultants who could then be freed up to do other even 12:24
6 higher value work as a result.
7 57 Q. And is that -- are they posts that would be expected to
8 be funded from existing budgets rather than there being
9 any capacity to provide additional monies?
10 A. So there's two aspects to this. There's a training 12:24
11 cost, and training costs would be met predominantly by
12 the Department for all training pre-graduate and
13 post-graduate training. There may be areas where there
14 is a sharing of cost, and if a Trust identified a need
15 to go and, you know, really develop this in a big way, 12:24
16 you know, there may well be constraints as to what we
17 could afford to deliver.
18
19 In terms of then appointing somebody at the end of it,
20 then it would be for the Trusts to identify the role 12:24
21 there. You wouldn't necessarily expect that the ANP
22 would be an entirely new role, and you would expect
23 that they might be surplanting some of the work of a
24 doctor, for example, or existing nursing staff. So
25 it's not necessarily all additional. I think we need 12:25
26 to guard against the sense that any idea always has to
27 have a check that goes with it, because that I think
28 then reduces people's innovation, and particularly in
29 the current climate will make it harder to make the

1 kind of changes that we need to make.
2 58 Q. Now, you've mentioned that this transformation around
3 the way in which workforce is used, not just new ideas
4 around it, the way in which the specialist skills of
5 people are identified and focused where they're needed, 12:25
6 that that might help increase capacity, with the
7 capability of retaining people, because there is a
8 pathway through which people may move from a career
9 perspective.
10 12:26
11 One of the things that the Department has identified,
12 and you say this at paragraph 109:
13
14 "A lack of exposure of training grade doctors to HSC
15 Trusts outside of Belfast can impact negatively on 12:26
16 recruitment to the substantive consultant posts in
17 these locations."
18
19 Was that something that just was organically
20 discovered, that the failure -- people weren't 12:26
21 attracted to working outside Belfast because they
22 hadn't been sent there as part of their placements?
23 A. It's a case that has been made by a number the Trusts,
24 in particular the Chief Executive of the Western Trust,
25 has made that argument strongly and, you know, we do 12:26
26 want to take a look at how our training grade doctors
27 are distributed. We need to make sure we get the right
28 balance here, because they are training grade doctors
29 so they need to be going into roles that will give them

1 the experience they need to enable them to develop, but
2 that ought to be possible in a range of locations. So,
3 I wouldn't want to suggest that it's only Belfast that
4 has training grade doctors, because that's not the
5 case, but we will look at whether we've got the 12:27
6 distribution right and we'll work closely with our
7 doctor training agents in order to achieve that.
8 59 Q. Does that in some way also dove-tail slightly into the
9 hospital reconfiguration blueprint that you mention at
10 paragraph 29, where it will describe Northern Ireland 12:27
11 hospital system and emphasise the importance of viewing
12 it as an integrated hospital network, is that a way of
13 getting away, I suppose, from what we in Northern
14 Ireland might see as different Board areas, and where
15 people may have to go for treatment, is it more seeing 12:27
16 it as holistic service provider and focusing on where
17 people are best placed to access health care?
18 A. Yes. I mean it's looking at how we -- we have done a
19 lot to develop centres of excellence through day
20 procedure centres, elective overnight centres, and 12:28
21 rapid diagnostic centres, and those are showing good
22 benefits now. So for the last six quarters our
23 treatment waiting times have reduced, and that is a
24 positive, but we have still got a long way to go, and
25 we need to build on that. So how do we maximise the 12:28
26 use of those centres of excellence? How do we draw on
27 the speciality reviews? So there was a review of
28 general surgery conducted in I think 2022, and that
29 made various findings about the standards that needed

1 to be applied in hospitals, and as a result there has
2 been some quite significant changes to how general
3 surgery is delivered across the region to meet the
4 safety and quality standards that are required, and
5 often in response to challenges recruiting staff. And 12:29
6 then within -- at a more granular level, one of the
7 things that the GIRFT Urology Review drew out was the
8 importance of, even within specialties, having centres
9 of excellence and not expecting all our procedures to
10 be conducted in each Trust or in each hospital. So 12:29
11 that's something that is being looked at and taken
12 forward in the implementation of that, which you
13 referred to earlier.
14
15 The final point perhaps to make in relation to the 12:29
16 blueprint and the network is that there's also
17 logically a consequence for how we would see our
18 clinical workforce as well. So in principle the
19 clinical workforce can work in more than one Trust and
20 in more than one hospital, but often in practice that 12:29
21 doesn't happen that much. Whereas, you know, I think
22 in order to meet the networked ambition, that's
23 something that we do need to look at in more detail.
24 60 Q. The blueprint, is there a timeframe, or is this the
25 very early stages of the evolution of the way in which 12:30
26 service may be delivered in Northern Ireland and,
27 indeed, the way people may view Northern Ireland health
28 care service provision?
29 A. The work is well developed in terms of the blueprint

1 and a kind of summary document that tries to draw out
2 the conclusions, and we're currently engaging with our
3 minister about how we would like to take the next steps
4 of that forward.
5 61 Q. You've mentioned some of the other developments, and 12:30
6 we've talked about those earlier. Just for the Panel's
7 note, the Department has also completed strategies and
8 service reviews in a range of areas which set out clear
9 plans for the future, these include published cancer
10 and mental health strategies as well as the review of 12:30
11 urgent and emergency care services in Northern Ireland
12 and the Elective Care Framework. That framework can be
13 found at WIT-51386 to WIT-51461.
14
15 Now the Elective Framework was published in June 2021, 12:31
16 and sets the direction of travel, as you say in your
17 statement, as to how change would be brought about to
18 improve elective capacity and capability and reduce
19 waiting lists, and you say at paragraph 129:
20 12:31
21 "The Inquiry will be aware from my earlier answers that
22 progress has continued to be made against the actions
23 in that framework with the most recent update being
24 published February 2024."
25 12:31
26 You go on to say in that paragraph, and you've
27 mentioned this before:
28
29 "The elective capacity has been enhanced by the

1 development of elective care centres, two rapid
2 diagnostic care centres at Whiteabbey and South Tyrone
3 Hospitals, and megaclinics have been introduced to
4 maximise patient throughput. There has also been
5 service reviews in general surgery, orthopaedics, 12:32
6 urology and gynaecology. Work to date has delivered
7 results with the overall treatment waiting lists
8 reduced by over 12% in the 12 months ending 30th
9 December 2023, with six quarters in a row with reducing
10 lists. Our longest list, general surgery and 12:32
11 orthopaedics, have been reduced by 20.8% and 7.6%
12 respectively between December 2022 and December 2023.
13 The scale of the problem is significant, but
14 transformative work and recurrent investment would go a
15 long way to address some of the core issues within the 12:32
16 system. This transformation work sits alongside
17 ongoing performance management and monitoring of
18 achievement against HSC service delivery planned
19 targets which were set for 2023/2024."
20 12:33
21 A lot of the evidence before the Inquiry has been
22 around waiting lists, waiting times, the difficulty in
23 delays people face in accessing services and, indeed,
24 some of the documentation would seem to have set a
25 pattern of escalation clearly from 2010 waiting lists, 12:33
26 and the numbers that were being concerned about then
27 by clinicians and managers almost seem like halycon
28 days when we look at some of the waiting list figures
29 now, and even during the tenure of this Inquiry there

1 have been many press stories around waiting lists and
2 the way in which the service arguably is unable to cope
3 with the demand and capacity issues. The word "crisis"
4 has been used for the health sector quite a few times
5 in the Trust, in the press, and do you -- is it 12:34
6 something that you would accept is the health system in
7 Northern Ireland in crisis?
8 A. So everyone can chose their own language. I would say
9 that all parts of our system are under very severe
10 pressure and, you know, there are major challenges in 12:34
11 terms of being able to deliver the kind of health and
12 social care system that all of the people who work in
13 that system want to be able to deliver and to be proud
14 of. There are -- we are at a stage where the scale of
15 those problems means there are no quick answers, but 12:34
16 the risk, as I see it, is that the current budgetary
17 constraints actually risk making the situation worse
18 rather than enabling the work to be done that would
19 make it better.
20 62 Q. Could you expand on that a little bit more, why that's 12:35
21 the case?
22 A. Well, as I explained on a couple of occasions already,
23 you know, the risk is that the budget will not be
24 sufficient to enable the existing work to continue,
25 there may need to be reductions in service in some 12:35
26 areas, obviously depending on the outcome of that
27 budget, let alone actually moving to put in place the
28 transformation that's going to be needed across all of
29 the areas. I've mentioned primary care and social

1 care, as well as a focus on waiting lists and the acute
2 sector as well.
3 63 Q. I just want to finish up on the issue of the learning
4 from previous inquiries, and hopefully from this
5 Inquiry, and you've very helpfully provided an update 12:35
6 in your addendum statement at WIT-107628. And for the
7 Panel's note it's paragraph 17 to paragraph 44. I'd
8 just like to read some of this out to give a flavour of
9 the current framework around the way in which the
10 Department manages information that they've received 12:36
11 from these various Inquiry recommendations and what's
12 anticipated they will do with that information. And
13 this part of your statement is entitled:
14
15 "The Department's progress on implementing 12:36
16 recommendations from previous public inquiries."
17
18 At paragraph 17 you say:
19
20 "In April 2023, the Department agreed to formally 12:36
21 amalgamate the Hyponatraemia related deaths and
22 independent Neurology Inquiry Programme Management
23 Boards into a single Department of Health Inquiries
24 Implementation Programme Management Board..."
25 12:36
26 And you have attached a copy of the Terms of Reference.
27 Then you've set out what these, the reasons behind
28 this, and the commonalties and the potential benefits
29 of amalgamating these issues. Sorry, the

1 recommendations from both of those inquiries.
2 And at paragraph 19 you say:
3
4 "The first meeting of the IIPMB took place on 21st
5 April 2023. The IIPMB Terms of Reference will be kept 12:37
6 under review and will be refined and revised as
7 appropriate."
8
9 At paragraph 20 you say:
10 12:37
11 "The IIPMB will also explore, if appropriate, how best
12 to bring oversight of the implementation of
13 recommendations from other public inquiries, such as
14 the Infected Blood Inquiry, Urology Services Inquiry
15 and Muckamore Abbey Hospital Inquiry, under the scope 12:37
16 of IIPMB in due course. The importance of integrating
17 the implementation workstreams being progressed by
18 external delivery partners is recognised by the
19 Department. This includes engagement and collaborative
20 working between the Department, the health care 12:37
21 organisations, the General Medical Council and the
22 independent sector organisations as well as partnership
23 working with other relevant organisations."
24
25 Just on that particular point. Is there an 12:38
26 understanding and perhaps a broad commitment from the
27 Department that should it need to bring in other
28 sources of expertise to help bring about the
29 recommendations from this and other inquiries, that

1 it's prepared to do so? For example, in the RHI, the
2 Audit Office was responsible in some respects from
3 overseeing the outworking of those recommendations
4 because of the nature, obviously, of the
5 recommendations, but is there a recognition that there 12:38
6 may be some cross-fertilisation of oversight needed to
7 bring home these different recommendations?
8 A. Yes, absolutely. I think there's a number of different
9 dimensions, and perhaps I could just briefly break them
10 out. So in relation to taking forward individual 12:39
11 recommendations, there may well be the need for
12 external input in the way that we've described already
13 in terms of MHPS and SAIs and there being open
14 framework. Those are all good examples where there are
15 external people who are playing a leading role in 12:39
16 taking that work forward to assist the Department.
17
18 The second is, in terms of oversight, what we've done
19 through the Integrated Programme Board that you've
20 highlighted here, is we've introduced, in addition to a 12:39
21 Steering Group that I Chair, there is a panel led by
22 and exclusively populated by people who are not in
23 health and social care, who are providing an assurance
24 role as to whether or not a recommendation properly is
25 signed off or not. So it's not us signing off a 12:39
26 recommendation saying that's okay without -- so it goes
27 through an assurance panel and the assurance panel look
28 at it, there's a very detailed approach taken to ensure
29 that not only the words on the page have been done, but

1 the spirit under-pinning it is in place, and then that
2 will come forward to the Steering Group with that
3 imprimatur on it. So just to be clear, there's also a
4 service user group that also looks at those elements of
5 the work, particularly in relation to the Neurology 12:40
6 Inquiry.
7
8 It's my expectation, obviously you haven't written or
9 let alone us having sight of the report yet, but it's
10 my expectation that this Inquiry will raise some themes 12:40
11 that are very similar to INI in particular, and that,
12 therefore, integrating the implementation into the one
13 place will be the most sensible thing to do because,
14 you know, this Inquiry is in arguably a more
15 challenging place in that work is already proceeding as 12:40
16 a result of other inquiries having taken place. So
17 part of what may well come out of this Inquiry is a
18 sense of whether the direction of travel that is
19 already in place is the right one or not. And insofar
20 as it is, you know, hopefully that will put wind in the 12:41
21 sails of what needs to be done, and insofar as it
22 isn't, then it allows for corrective action to be
23 taken.
24 64 Q. We haven't touched on everything in your statement, but
25 the Inquiry has all of the information you've provided 12:41
26 to update them, so thank you for that. I don't have
27 any further questions for you. Is there anything -- I
28 know you made some comments at the beginning of your
29 evidence, but is there anything else you wish to add at

1 this point, anything further to say?
2 A. No, I don't think so. Thank you.
3 MS. McMAHON: Thank you. The Panel will have some
4 questions for you.
5 CHAIR: Thank you, Ms. McMahon. Thank you, Mr. May. 12:41
6 Just a few questions from us, first of all from
7 Mr. Hanbury.
8
9 MR. MAY WAS QUESTIONED BY THE PANEL AS FOLLOWS:
10 12:41
11 MR. HANBURY: Thank you, Mr. May for your evidence.
12 You'll be pleased to hear that Ms. McMahon has already
13 asked a good few of them. Starting off with GIRFT,
14 we've mentioned this already before.
15 A. Yes. 12:42
16 65 Q. MR. HANBURY: And you mentioned there was good buy-in
17 from the clinicians, which is excellent to hear. And
18 we've already heard about in particular
19 sub-specialisation, where Southern Trust are taking on
20 the complex stones, and Western seems to be taking on 12:42
21 penile surgery and this kind of thing, although that
22 might have been going on before.
23 A. Yes.
24 66 Q. MR. HANBURY: Are you aware of any other specific
25 sub-specialisations that the urologists are discussing, 12:42
26 or is that level of detail...
27 A. I'm afraid you're taking me outside my comfort zone.
28 I'm happy to try to ask -- because there is a group
29 which has the unedifying acronym of PIG, it's the

1 Planning and Implementation Group, that draws together
2 clinicians and members of the Department, and I can
3 certainly ask whether there are other examples. I
4 think the GIRFT Report was recommending that we would
5 go beyond what was already being put in place by way of 12:42
6 the stones, so I imagine that this will be -- there
7 will be others, but I don't have the detail I'm afraid.
8 67 Q. MR. HANBURY: But you would generally support
9 initiatives from the clinicians, I would hope,
10 following all this? 12:43
11 A. Yes. Absolutely.
12 68 Q. MR. HANBURY: Okay. So moving on to waiting lists. We
13 heard back in about 2018 that Mr. Haynes and
14 Mr. O'Brien put together a sort of document to say --
15 with the analysis of the theatre capacity essentially 12:43
16 they had, they could really only just do red flag and
17 urgent work, and it didn't sort of seem to go any
18 further, sort of escalations and this kind of thing. I
19 mean, was that sort of situation something in
20 retrospect your department should have been aware of at 12:43
21 the time?
22 A. So I would have expected that at least the, what was
23 then the Health and Social Care Board, would have been
24 engaged in that conversation, because I know that today
25 SPPG looks at theatre utilisation, theatre availability 12:43
26 in respect of services. So I imagine that that was
27 happening in 2018, although I confess to not knowing
28 for sure what the situation was then.
29 69 Q. MR. HANBURY: And...

1 A. So your question was then about the department...
2 70 Q. MR. HANBURY: I suppose sort of what should have
3 happened then, that looking back if you were in charge
4 then?
5 A. Yeah. Well I guess perhaps rather than trying to 12:44
6 answer a 2018 question, if we identify a capacity
7 challenge today, the question is how best do we address
8 that? And what I'm signalling, given the current
9 financial climate, which isn't the one that I would
10 like us to be operating in, that we have to make the 12:44
11 best use of the resources we've got. So we do need to
12 look at how we do things and how we make better use.
13 So, for example, in urology my understanding is that
14 there has been a very significant shift towards day
15 case procedures in all sorts of areas. Now, for me 12:44
16 that is a win/win. It's a positive for the patient
17 because the patient will have a better experience, will
18 have a quicker recovery time almost certainly as a
19 result of that, but it's also a positive for the wider
20 system because it's freeing up capacity that otherwise 12:45
21 previously would have been used for overnight stays and
22 all of the rest of it. So there's a range of different
23 ways where we need to look at all of those things. I
24 don't think we've got to the end of the list of things
25 that we can do in that respect. 12:45
26
27 If, at the end of that then there's still further
28 capacity, then of course that's the area where the
29 investment is then needed in order to address that. So

1 that's my thinking process as to how we would go
2 through that.
3 71 Q. MR. HANBURY: Okay. Thank you. Just one last thing on
4 waiting lists. I saw you had your change and
5 withdrawal policies. So obviously some more critical 12:45
6 look at what actually is on the waiting list and
7 looking, I guess, at the sort of lower priority
8 procedures, for example, vasectomy, in the sort of
9 context of people waiting a long time for more urgent
10 things. I mean is that something that clinicians are 12:46
11 now looking at, not just for urology but for other
12 specialties where there's a conversation about lower
13 priority treatments and whether the health system can
14 and should fund them?
15 A. We've certainly started to look at that. It is a 12:46
16 complex area, because I think it's fair to say at the
17 moment the public expectation remains that if there is
18 a procedure which they have a need for, a clinical need
19 for, then it should be delivered. But there is a
20 reality that for those who are facing priority -- 12:46
21 procedures, for example, which are routine in nature,
22 and perhaps then our waiting lists are not moving
23 quickly enough and they're not getting to the top of
24 those lists any time soon. So I do think that that is
25 a conversation that needs to be developed and grown. 12:46
26 As I said we are, I think, really in the footholes of
27 that.
28 72 Q. MR. HANBURY: Okay. Thank you. Moving on to national
29 audits. They can be a sort of good driver of quality

1 and change. Talking to the urologists, there was legal
2 or administrative difficulties submitting Northern
3 Ireland patients to BAUS, the British Association of
4 Urological Surgeons Audit. I mean is that something
5 that's still a problem in your view, or if it is, is 12:47
6 that something that you can help us with?
7 A. Yeah. So, there have been some challenges in terms of
8 how patient information is shared. It's and
9 information governance challenge. There was some
10 legislation passed in 2016 that needs to be updated in 12:47
11 order to enable that. I think at the time that the
12 legislation was passed a number of Assembly members had
13 some concerns about how patient information would be
14 used. But there are, I think, strong arguments as to
15 why being part of national clinical audits would be a 12:48
16 good thing for everybody, including for those patients,
17 in terms of giving greater assurance about safety and
18 quality and identifying any areas of concern at an
19 earlier stage, which is part of the fundamental problem
20 that underlines both this Inquiry and the Neurology 12:48
21 Inquiry. So it is something that, you know, I don't
22 know whether it's something the Inquiry is going to
23 make a recommendation around, but I can absolutely see
24 the benefits of removing anything that would be an
25 inhibitor in that area. 12:48
26 73 Q. MR. HANBURY: Thank you. Just the last one from me
27 really. Long outpatient waits and waits for follow-ups
28 and things is a recurrent theme in England as well as
29 Northern Ireland. I was interested -- just one comment

1 from the Royal College of Surgeons action thing was
2 about 82% of patients don't mind travelling up to an
3 hour, which was I think in your statement. In view of
4 that, do you think looking back the initiative to do
5 lots of outreach clinics is still a good one or has 12:49
6 that thinking changed?
7 A. I'm not aware of there having been a change in that
8 area. I think where it is sensible to do so,
9 delivering outpatient clinics close to where people
10 live is a good thing. But, you know, obviously one 12:49
11 needs to ensure that that's not at an unreasonable cost
12 in terms of what else could be achieved. There is a
13 move more generally to look at where patient initiated
14 follow-up might be a sensible way forward. Obviously
15 that doesn't apply to all areas, but there are plenty 12:50
16 of best practice as to where that co-operate. So that
17 too, whilst it's not quite the question you asked, is
18 another area that is being looked at at the moment.
19 MR. HANBURY: Thank you. I think I'll stop there.
20 Thank you, Chair. 12:50
21 CHAIR: Thank you, Mr. Hanbury. Dr. Swart.
22 74 Q. DR. SWART: Thank you. I think you've helped us to
23 understand how things are at the moment in a very clear
24 way. I'm interested in the whole area of implementing
25 recommendations from inquiries, and this is something 12:50
26 that has been looked at recently in England, and I
27 have, myself, been on the end of many, many
28 recommendations over many, many years, and the overall
29 learning seems to be that the recommendations are

1 accepted, but they're not always implemented, and that
2 I'm sure won't surprise you. So that's one feature.
3 The other feature is that in nearly all the inquiries
4 the themes are similar. They're not exactly the same,
5 but there's a definite congruence around things like 12:51
6 culture, commitment to learn, promise to act, safety
7 and all of those things. So you've put together this
8 group, which hopefully will try and bring sense to the
9 recommendations from a number of inquiries and a number
10 still to come. 12:51
11
12 What discussions have you had in that group of trying
13 to put some proportionality into that? Because you've
14 got already a lot of recommendations. It's a very
15 broad range of things. Not all of it will be 12:51
16 achievable. Not all of it is resource dependent, but
17 quite a bit may well be. What discussions has the
18 group had about how to pull the building blocks out?
19 Now you've mentioned a few things that you're
20 concentrating things on straight away in advance of 12:51
21 regulation, and I can see that. But have you had other
22 discussions about "these things are the most important"
23 and what those things might be in your head, what's the
24 sense?
25 A. Well, part of the reason for trying to join together 12:52
26 the implementation groups on the different inquiries
27 was to enable that wider view to be taken and to
28 understand where there are inter-relationships, because
29 not every inquiry recommendation necessarily points you

1 in precisely the same direction. So, you know, I'm
2 clear that we're trying to take the spirit of the
3 recommendation, you know, and that includes, you know,
4 obviously the Neurology Inquiry is more recent, but
5 being able to talk to those who were on the Panel for 12:52
6 that Inquiry to understand precisely what they meant,
7 because sometimes the words don't translate as well or
8 it's harder sometimes to be sure that we've got that
9 exactly right. And then from that to try and take an
10 approach that by having the themes that are set out, 12:53
11 themes set out in the statement that they offered,
12 that's a way of trying to join this up with normal
13 work, because we shouldn't see -- you're doing an
14 Inquiry over here and you've got this over there. So,
15 you know, if the issue is around workforce, how does 12:53
16 this get embedded in the workforce strategy so it
17 becomes a part of business as usual as soon as
18 possible, whilst still needing to be able to report on
19 the implementation of that recommendation to satisfy
20 proper accountability mechanisms elsewhere. 12:53
21
22 For me, you know, this is all about culture really.
23 75 Q. DR. SWART: Yes.
24 A. And it is about the supporting -- all of these
25 mechanisms are mechanisms to support the delivery of 12:53
26 the culture you're trying to achieve. I think I'm
27 clear that there is a will within the system to take
28 action, because no Trust, no clinician or senior
29 manager wants to be subject to an Inquiry in the

1 future. And so I think that there has been quite a
2 positive response, a willingness to learn and take on
3 board what is intended here. And for me that's a
4 positive sign, and one that means that, you know, we're
5 certainly not -- we've not got there yet, but we are 12:54
6 making good progress in a number of areas, and that
7 whole focus for me around the Just, Open and Learning
8 Culture, the idea that that could become a patient
9 safety framework essentially, an English patient safety
10 framework that we could draw on that we've been looking 12:54
11 at. So for me that would be one of the critical things
12 that might emerge from this series of inquiries and
13 might then act as a strong pillar for the future, if
14 that - does that answer your question?
15 76 Q. DR. SWART: That's exactly what I was asking about. So 12:55
16 my own experience is that patient safety is the one
17 thing that everybody can easily align around. However,
18 it's a glib word, and people have to understand what it
19 means, and I don't just mean managers and people who
20 aren't clinicians, the clinicians themselves need to 12:55
21 have a common understanding of what that is, and that
22 requires training, it requires attention, the same kind
23 of attention up and down the line, if you like. So I
24 think if you look at the inquiries, they recommend
25 various things in that area and it generally doesn't 12:55
26 happen in a coordinated way, and that leads me to the
27 question about what, what discussions have you had
28 about the need for a common understanding around values
29 and safety, and the safety culture dimensions across

1 health, social care, and so on in Northern Ireland,
2 because it isn't just about the acute sector, if this
3 is to work well it has to involve primary care and
4 social care and so on. Has that been built into
5 discussions at any point? That's really stealing from 12:56
6 the English Patient Safety Framework documents that are
7 out there. But where has that gone? Is there thinking
8 in that space?
9 A. So I think the Patient Safety Framework that I've seen
10 from England has around 10 different segments to it. 12:56
11 77 Q. DR. SWART: Yes.
12 A. And what we've done is we've begun working on a number
13 of those segments, but we haven't yet taken it forward
14 in all of the areas. So there will already be
15 excellent guidance in relation to safety in a range of 12:56
16 areas, but I'm not conscious that we have necessarily
17 drawn that altogether in one place yet.
18 78 Q. DR. SWART: Yes. Well I think it's the area that
19 people have struggled with, despite recommendations in
20 England where there has been a lot of work in this 12:56
21 area, it's still not really embedded, for a variety of
22 reasons. And that brings me to the Board as well.
23 You, obviously, correctly have stated the
24 responsibility of the Health and Social Care Trust
25 itself, and of their Board, and of the importance of 12:57
26 the Board. But training for Boards in this area has
27 not, I don't think, necessarily been undertaken in a
28 systematic way. Is that something which could receive
29 some sort of Department support, rather than each Trust

1 being asked to invent their own programmes, modelling
2 again on things that have happened in England?
3 A. Certainly. Look, I mean I agree that we should haven't
4 five different versions of something like that. I'm
5 open to discussion. The Trusts have been -- I've been 12:57
6 very keen to try and encourage a system wide approach
7 and to try to -- in all sorts of areas, not just in
8 relation to patient safety.
9 79 Q. DR. SWART: Yes. Yes. Yes, I'm just using that as a
10 pin. 12:57
11 A. And to be fair, the Trust Chief Executives have been
12 keen to take that up. So they are looking at the
13 development of what they're calling a provider
14 collaborative, that might be a way to try to work out
15 which bits need to be done on a common basis, as it 12:58
16 were.
17 80 Q. DR. SWART: Yes.
18 A. Now whether it's the Department or that patient
19 collaborative that were to lead something like the
20 development of training in this area, I'm happy to 12:58
21 consider further. But your point that, you know, we
22 should have something that enables Board members to
23 understand their roles in this area is a valid one and,
24 you know, if we need to do more in that area I'd be
25 happy to look at that. 12:58
26 81 Q. DR. SWART: This again comes from learning in England
27 where the comments made in various bits of
28 documentation that the Non-Executive Directors are not
29 actually able to challenge around quality and safety

1 issues and so on, because they haven't had appropriate
2 training and haven't been expected to do so. Now that
3 may not be universal, but it is also my own experience
4 that its variable.
5 A. Yes. 12:58
6 82 Q. DR. SWART: Mostly these people are very receptive to
7 understanding more about it, it's not too difficult,
8 too time consuming, nor too expensive, frankly?
9 A. And I think we just need to be clear on what we're
10 training them on. 12:59
11 83 Q. DR. SWART: Exactly.
12 A. We're not asking them to become clinical experts.
13 84 Q. DR. SWART: No.
14 A. And they need to work out what assurance they can take
15 from those who are tasked with providing those 12:59
16 assurances.
17 85 Q. DR. SWART: Yes. No, that's why it has to be targeted
18 in a certain way.
19 A. Yes.
20 86 Q. DR. SWART: On a similar vein, but not the same, we 12:59
21 have heard quite a lot about difficulties in the
22 medical leadership hierarchy at Southern Health Care
23 Trust in terms of dealing with certain issues, and that
24 might be dealing with concerns about doctors leading up
25 to MHPS, it might be an operational professional 12:59
26 confusion, a lot of it is around the time for medical
27 leadership, the development of medical leadership. If
28 clinical leaders are going to be in positions of
29 "authority", just to use that word, it does need

1 development and training. What is your view on whether
2 Trusts should do that all individually or whether that
3 should be a department leadership centre endeavour and
4 how comprehensive that needs to be?
5 A. So, the leadership centre already offer a range of 13:00
6 leadership courses that are open on a
7 multi-disciplinary basis, and I was at an event a
8 couple of months ago hearing some of the conclusions
9 from the work, and there were doctors, and nurses, and
10 AHPs, as well as managers, and I think in that kind of 13:00
11 leadership training the multi-disciplinary approach had
12 a lot to commend itself, and I was -- the energy in the
13 room was really good to feel as well.
14
15 There may, in addition, be some clinical leadership 13:00
16 that is required, and one of the things that I am keen
17 to try to inculcate is a sense that, you know, the
18 problems that we face as a system are problems that we
19 need all parts of our system to come together to try to
20 resolve, and I've been talking to our Chief Medical 13:01
21 Officer and Chief Nursing Officer about how we might go
22 about perhaps, you know, starting with some sort of a
23 conference or something like that that will enable that
24 to happen. And from that, I think rather than -- I'm
25 always a bit reluctant, not being a health expert, to 13:01
26 sit at the centre and say "What we need is one of those
27 over there somewhere", much better if that emerges from
28 within the group, drawing, as you say, on best practice
29 as to what might be needed. So, you know, I think

1 absolutely I'm sure that there's something that we need
2 to look at in that space.
3 87 Q. DR. SWART: Okay. Finally just the Encompass Epic
4 thing sounds amazing, if that can all work.
5 A. Yes. 13:02
6 88 Q. DR. SWART: What are the risks identified so far in
7 terms of this programme and what are the mitigations
8 against that that have been built-in?
9 A. Well at a granular level there is a very extensive risk
10 register, and set of mitigations, as you might expect. 13:02
11 89 Q. DR. SWART: Yes. Yes.
12 A. And, you know, the risk is that, you know, there have
13 been Epic implementations that haven't worked, but the
14 vast majority do work, and all the more recent ones
15 have worked. I have to say given the experience in the 13:02
16 South Eastern Trust, that's given me confidence about
17 the ability for the future. We do have some
18 challenges. There was a downturn in terms of the level
19 of both outpatient and in-patient and day case
20 procedures in the immediate period of implementation, 13:02
21 and that is normal, but we've found it more difficult
22 to get back to the level that we need to be at. So
23 that is a core focus at the moment, because clearly
24 Belfast is a much bigger Trust and as a result the
25 impact would be still greater if we weren't able to 13:03
26 achieve that more quickly.
27
28 But part of my confidence lies in the fact that the
29 South Eastern Trust have acted as the pathfinders and

1 that, therefore, many of the problems will have been
2 resolved before other Trusts get there. Belfast have
3 some regional services, so for them they'll be doing
4 some things for the first time, so that's an area of
5 particular focus. But beyond that, you know, it is 13:03
6 about enabling the capacity to change within the
7 workforce because, as I said, it affects everybody and
8 requires everybody who interacts with a patient to do
9 things differently, and that is a big change if you've
10 spent many years doing things in a particular way. So 13:03
11 it's not just about attitudes to change, it's also
12 building capacity and so on.
13
14 So there is -- there was a really strong systemwide
15 effort at the time the South Eastern Trust went live, 13:04
16 both in terms of surging people into the South Eastern
17 Trust, but also an acceptance that there would be a
18 need for other Trusts to help out in terms of some
19 urgent procedures, and that's still ongoing at the
20 moment. So those are the kinds of mitigations that 13:04
21 exist. So I don't know if I've answered your question?
22 I can give you a much more...
23 90 Q. DR. SWART: I mean it's not really answerable in that
24 way.
25 A. Okay. 13:04
26 91 Q. DR. SWART: I was really just wanting a sense of, you
27 know, did you have enough clinical involvement in it,
28 enough ongoing support?
29 A. Yes.

1 92 Q. DR. SWART: You know what -- how is this being sold in
2 terms of safety? I mean, you know, these things have a
3 major impact, don't they?
4 A. Yes. I mean I think everybody sees that it has a
5 massive patient safety impact, for the kinds of reasons 13:04
6 I described earlier. There is strong clinical buy-in
7 and, you know, that's been really important as part of
8 this. So this isn't something that someone in an IT
9 Department thinks is a good idea. This is a major
10 change driven by technology, but it's the major change 13:05
11 that we're focused on, the technologies to enable us to
12 get there.
13 93 Q. DR. SWART: And just -- I started off with learning
14 from inquiries. We will obviously be producing a
15 report. You will have looked at lots of inquiry 13:05
16 reports, you've got this group set up, what is most
17 useful in terms of how these things are phrased? So,
18 you know, just to start you off, it's probably not
19 useful to have 300 recommendations that are very
20 specific, if I was on the receiving end of it. But 13:05
21 what is most useful? Is it more useful to do what Bill
22 Kirkup did in East Kent, which is to say "Look here
23 guys, I've written lots of inquiries and nobody
24 implements them and it's all too complicated, so I'm
25 going to phrase these recommendations differently", and 13:05
26 really what he's doing is getting to the spirit, to use
27 your words, what is most useful?
28 A. So for me, as I think I said in my earlier evidence,
29 I'm conscious that you are coming to this after other

1 inquiries have reached recommendations. So I suppose
2 my -- what would be most useful to me is if, in looking
3 at what you recommend, you try to build on what is
4 already there and, as I said, put wind in the sails of
5 what you think is going in the right direction and be 13:06
6 clear about what different or additional is needed in
7 order to address the challenges. You've heard lots of
8 evidence. Because time has passed quite significantly,
9 the world has also moved on. So part of the -- so for
10 me this is -- I would encourage you to take a system 13:06
11 view of this. What is it that's needed systemically in
12 order to address things? There may be some specifics,
13 of course, but as you've helpfully hinted, vast numbers
14 of recommendations can be, you know, if you start
15 chasing ticks in boxes rather than a focus on what 13:07
16 really matters. So it might be just because of the
17 positioning of this Inquiry in the context of other
18 inquiries, it just takes a slightly different approach
19 in order to land it, and then again, if the Panel were,
20 or representatives of the Panel were willing to be 13:07
21 engaged with afterwards to make sure we had understood
22 properly, that would be extremely helpful as well.
23 DR. SWART: Yes. Thank you. That's all from me.
24 94 Q. CHAIR: Thank you, Dr. Swart. Well if it's any
25 reassurance, I'm a great believer in less is more, 13:07
26 Mr. May, so I don't think you'll be getting 300
27 recommendations from this Inquiry.
28
29 Just a couple of things just when you were giving

1 evidence that I wanted to ask you about. One of the
2 things that we heard that went wrong here was the fact
3 that because of financial constraints money was
4 diverted from governance systems essentially to
5 frontline services, and as a result people weren't 13:08
6 picking up on things. I talked to Dr. O'Kane about
7 this when she gave evidence, how could we ensure that
8 the auditing of systems and the governance systems are
9 sustainable and that that does not happen again? And
10 one of the things she suggested was ringfencing for 13:08
11 governance in the financial package that a Trust is
12 given. And I wondered, given that you don't like
13 ringfencing and being dictatorial, but is that one area
14 where there maybe a call for ringfencing that type of
15 finance? 13:08
16 A. I think I'm just very sceptical about ringfencing and
17 the impact that ringfencing actually has on the way
18 organisations work, and whether it really delivers,
19 because you're only really measuring an input. You're
20 not measuring what is delivered with the money. So, 13:09
21 you know I'm conscious -- if you look back, the Trust
22 each year reports on how much it spends on governance
23 activity, which would include all of that
24 accountability piece. For the Southern Trust that has
25 increased from 20 million to 30 million over recent 13:09
26 years. So even allowing for inflation, a more than
27 inflation increase, and when SPPG makes an investment
28 for a new service or a new development, there's a 10%
29 add-on designed for additional governance requirements

1 and/or, you know, the sort of basics that are needed to
2 make it work, as it were. So it's not that there is
3 nothing already provided in that space, that is normal.
4 I would, I think, prefer to be clear what, you know --
5 this is somewhere where the assurance mechanisms fell 13:10
6 down. If there wasn't a function performing these then
7 there was no assurance being provided in this area.
8 And, so, I think it's about being clear on what's the
9 minimum standard that is required in terms of the
10 outcome? Rather than looking at the minimum input 13:10
11 required in terms of bums on seats.
12 95 Q. CHAIR: So it's basically directing the Trust not in
13 terms of finance and how they deliver, but what has to
14 be delivered?
15 A. Yes. 13:10
16 96 Q. CHAIR: Okay. And coming back to -- well two more
17 questions from me. You'll be glad to know you'll be
18 getting away soon. But joined up information,
19 Encompass is designed to give joined up information to
20 any clinician faced with a patient and to allow a 13:10
21 patient a say in their own health care by giving them
22 information. If I've got it in a nutshell that's what
23 it's really designed to achieve. But in the current
24 situation where a lot of people are now taking the
25 situation that they find themselves in into their own 13:11
26 hands and are paying for treatment privately, where is
27 the interface between the private treatment and the
28 Health Service treatment? How does that join up in
29 terms of Encompass and providing a clinician who is

1 maybe to see someone in a private setting who then ends
2 up in the health care system for other treatment?
3 Where is the join up? I mean, for example, we saw a
4 difficulty when there was a waiting list initiative
5 with information being given to the private sector, one 13:11
6 of the patients who came to speak to us, that
7 information -- their file wasn't handed over, resulting
8 in complications, and very serious complications for
9 the patient. So where is the interface between the
10 private sector and our health care system? 13:11
11 A. Yeah. So that's an interesting area and one where I
12 might be able to give a fuller answer, if I was able to
13 write. There is no -- clearly the independent sector
14 won't have the Encompass system, so there's no
15 automatic interconnectivity. Primary care have access 13:12
16 to Encompass and so can have a sort of a read access to
17 it. So one of the ways in which any connection might
18 be made is through primary care. But we do have, and
19 this goes to -- I think I made a point earlier about
20 safety in two dimensions, one of which has the 13:12
21 individual patient at the heart and one of which has
22 all patients at the heart. So with information
23 systems, Encompass might have the individual patient at
24 the heart, but actually if you look at all of the data
25 that's going to be needed Encompass isn't the answer to 13:12
26 that problem, and so we're looking to create, something
27 called a data institute, that would enable different
28 sources of data to come together and for us to make
29 sense of that in a better way. And that would then

1 inform the likes of the Balance Scorecard that I
2 described in terms of Trust management. But I haven't
3 specifically answered your question about the
4 connection with the independent sector. And I think, I
5 think it did come up in a meeting I was in, but I don't 13:13
6 remember the detail of it, so I'd like to be able to
7 write to you, if I may?
8 97 Q. CHAIR: That certainly would be useful just to know,
9 because obviously from a patient safety point of view
10 it is important that there is that connection in some 13:13
11 way.
12 A. Yes.
13 98 Q. CHAIR: Then just one other thing. We're hearing this
14 week from Mr. O'Brien, and we're very well aware of the
15 waiting lists, and one of the points that he makes is 13:13
16 that the emphasis in dealing with waiting lists and
17 tackling them is always on the red flag, the cancer
18 patient, whereas there are a lot of people languishing
19 on waiting lists who are equally meritorious in terms
20 of the treatment that they need, but the emphasis is 13:13
21 always on the performance of cancer treatment. Now
22 that's not to say that that's not important, but I just
23 wonder has the Department thought about how can we
24 address those people who aren't seen as red flag but
25 may be urgent, may be routine, but who are actually 13:14
26 suffering?
27 A. Well, I think that's at the heart of the challenge that
28 we face at the moment. There is properly a clinical
29 prioritisation, and that goes to the harm that might

1 come to the individual or the potential from
2 intervention. And, as I said earlier, there is a
3 reality that those on routine waiting lists are not
4 getting to the top of those lists in anything like the
5 timeframe that is acceptable. So our system needs to 13:14
6 be able to -- we need a way both of being able to meet
7 the new ongoing demand that is coming in every day,
8 week, month, year, and alongside that we will need some
9 additional investment to address the backlog, because
10 the backlog is causing ongoing challenges in all sorts 13:15
11 of areas that are then making it more difficult to
12 deliver. So primary care, seeing people who are on
13 waiting lists, coming back to them to say their
14 complaints have got worst, or "Am I closer to the top
15 of the list yet?" Our urgent and emergency care 13:15
16 departments are seeing people who are on a waiting list
17 who maybe their condition has worsened and are then
18 becoming patients there. If we were able to do those
19 two things together then -- and that's easy to say and
20 difficult to do, and I keep coming back to the 13:15
21 challenges that we face in the short-term, but our
22 approach here is to try to develop an approach that
23 will grow our capacity and then to recognise we are
24 going to need some additional way of addressing some of
25 the very significant backlog that we have at the 13:15
26 moment, because no -- investment just in more of what
27 we've got is going to get us to where we need to get to
28 in anything like an acceptable time period.
29 99 Q. CHAIR: I suppose part of that will be managing

1 expectations for patients. You know, you're saying
2 that everybody expects if they have an issue that they
3 can be treated straight away.
4 A. Well, yes, or -- yes, indeed.
5 100 Q. CHAIR: But equally I think one of the success stories, 13:16
6 if you like, in the urology field is Lagan Valley and
7 the day cases that are there. And I just wonder is
8 there an education task here that the Department has in
9 educating the public, "Look, you might have to leave
10 Fermanagh and go to Belfast or vice versa, but it'll 13:16
11 mean you'll get seen sooner", and I think there is
12 something to be said for informing the public about how
13 they can -- how you're setting about improving the
14 health care system?
15 A. I absolutely think that there's always more that can be 13:16
16 done by way of communication. We have had some recent
17 examples where services have moved. Both -- for
18 example, general surgery is not now -- emergency
19 general surgery is not being delivered at either Daisy
20 Hill or Southwest Acute Hospital, and the numbers of 13:17
21 people affected are very small. There is -- there are
22 some people who are concerned, but I actually -- I do
23 believe that most people are accepting of the need to
24 travel further to get a proper service, to make sure
25 that the service they're getting is of the same quality 13:17
26 there as they would be getting everywhere else, and
27 we've got more to do to persuade others who have not
28 yet got that far, and there's often a concern that
29 because that service is leaving it means we don't need

1 the hospital at all, and that's not the reality. It is
2 about working out what each hospital is for, and the
3 blueprint document is designed to help to explain that
4 and to say that, you know, this hospital might become a
5 centre of excellence for these things rather than 13:18
6 trying to deliver the full gambit of services. And,
7 yes, that will mean some people will need to travel
8 further and that there will be some inconvenience
9 associated with that. But it is still -- it is
10 actually practically going to be the only way that we 13:18
11 can deliver a service. Clinicians don't wish to be
12 part of small services where they don't feel they've
13 got the necessary skill set because they don't get to
14 do procedures often enough, and so on, and we can't
15 assure the safety and quality of those services either. 13:18
16 CHAIR: Okay. Thank you very much, Mr. May. Your
17 evidence has been very helpful.
18 A. Thank you.
19 CHAIR: So I think that's us finished for today and
20 I'll see you all again tomorrow at 10:00 o'clock. 13:18
21 Thank you.
22
23 THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 10TH APRIL AT
24 10.00 A.M.
25 13:18
26
27
28
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