Urology Services Inquiry

Oral Hearing

Day 52 – Tuesday, 13th June 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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THE INQUIRY RESUMED ON TUESDAY, 13TH DAY OF JUNE, 2023 AS FOLLOWS:

CHAIR: Morning, everyone.

MS. McMAHON: Chair, the witness this morning is Melanie McClements, a former Director of Acute Services with the Southern Trust, and she wishes to take the oath. 10:01

MELANIE McCLEMENTS, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:01

1 Q. MS. McMAHON: Morning, Ms. McClements. Thank you for coming along to give evidence to the Inquiry. You have already provided two witness statements to the Inquiry and I just want to take you to those to confirm those represent your also evidence. If we could go to WIT-24123, which is your reply to Notice No. 23 of 2022. It's signed on 8th July at WIT-34283. Do you recognise that as your signature? 10:01 10:02

A. Yes.

2 Q. And do you wish to adopt that as your evidence?

A. Yes, please.

3 Q. We then received a further addendum statement that can be found at WIT-96844, with a signature at 96847 dated 8th June 2023. Is that your signature? 10:02

A. Yes, thank you.

4 Q. And do you wish to adopt that as your evidence?

A. Yes, please.

5 Q. I am just going to start off by summarising your background and some of your features of your role as Director of Acute Services, before moving into the more substantive issues. Your statement sets out you have a background in nursing, midwifery and health visiting. You have held other posts since then; you were the Assistant Director of Promoting Wellbeing in August 2007, and that was your first post in the Southern Trust? 10:03

A. That's right. 10:03

6 Q. You then became the Assistant Director for Older People's Services on 1st June 2012, before moving to become the Director of Older People and Primary Care on 19th September 2018?

A. That's correct. 10:03

7 Q. Then, for the Inquiry's purposes, you commenced the Director of Acute Services post to cover sick leave for Mrs. Gishkori, initially for I think it was a planned period of six weeks. So, you were temporarily redeployed from your Older People and Primary Care directorship? 10:03

A. Mm-hmm.

8 Q. You became the interim Director of Acute Services on 7th June 2019 and held the post substantively from 31st October 2020 until you retired on 31st August 2022. 10:04

Now, you say in your statement that you had the option to return to Older People Directorate after 16 months

but elected to stay as Director of Acute Services. I think you were here or listened into the evidence of Gillian Rankin?

A. Yes.

9 Q. She was followed by Debbie Burns and Mrs. Gishkori, and also Anita Carroll held the post in the interim just before you took up. Is that who you immediately took over from; was it Mrs. Gishkori or was Anita Carroll in post at that time? 10:04

A. Anita Carroll had been covering at an earlier stage before I took over. Mrs. Gishkori had gone off on sick leave before I took over, so I was subsequent to Mrs. Gishkori. 10:04

10 Q. You set out in your witness statement your role. The Panel will be familiar with the parameters of the role, having heard from Mrs. Rankin, but I will just highlight some of the key aspects. As a director, you were a member of the Trust SMT and reported back to the Trust Board. You were line-managed by Shane Devlin, and Anne Marie O'Kane subsequently when she took up post. In your post, you line-managed all of the assistant directors, Barry Conway with the Cancer Services, Ronan Carroll for SEC, and Anita Carroll for Functional Support. You also were responsible for line-managing Tracey Boyce, the Director of Pharmacy, and Patricia Kingsnorth, who the Panel have heard from. 10:05 10:05

You say you never actually received a job description but that the job description that you have attached -

and for the Panel's as note that is at WIT-34314 - accurately reflects the role that you undertook. Is that right?

A. That's right.

11 Q. Now, if we go to WIT-34123 at paragraph 1, you have identified the key function. I will read out the quotation: 10:06

The key function is described as to "operationally manage the vast array of Acute Services and maximise the collective working arrangements of divisional Medical Directors, Assistant Directors, Heads of Service and their operational multidisciplinary teams, and to mobilise and ensure the services delivered are in line with the Trust's objectives of delivering safe quality patient-centred care, and improving services." 10:06 10:06

Of course within that, your role as director touches upon all aspects of governance; would that be right?

A. That would be correct, yes. 10:07

12 Q. When you took over initially, Mrs. Gishkori wasn't in post. What was your sense of taking up the directorship that had been vacant for a period of time?

A. It had only just been vacant but there had been a range of problems in Acute Services. As SMT director, I would have been aware of that and I knew the organisation needed the post to be filled and needed some form of interim cover. I sort of tried to dodge it for a while, but the third time I decided, right, I 10:07

am going to have to do this. I didn't go looking for it but I was happy to do it, and I knew I had transferrable skills from a directorship role. I had a pre-meeting with the Assistant Directors, chaired by Mr. Devlin, Chief Executive, and some of the Associate Medical Directors I believe also, to say to them that I was willing to do it but that I acknowledged their skill set as Assistant Directors and AMDs actually they being very expert in Acute Services, and what I brought to it was a different blend of leadership and directorship and decision-making and oversight of services, and I was happy to blend their expertise and my expertise together; we would do our best efforts to deal with the Acute issues. That worked well. 10:08 10:08

13 Q. Your expectation from the outside was that all of the various disciplines that you have mentioned would share information so that everyone would have a good oversight of the areas of responsibility and know what was happening and where crossed their brief, basically? 10:08

A. Absolutely. Broader than sharing information, worked very proactively with me on the range of issues. 10:08

14 Q. Did you receive any induction or briefing when you took up the post or shortly after having done so?

A. No, I didn't. That's why I set about early one-to-ones with the Assistant Directors so that I could induct myself through them in terms of understanding what the range of issues were. 10:09

15 Q. How would you describe the outlook of the team at that point, 2019... Sorry, 2000 and...

A. I think the team were downtrodden at that stage. I think they work extremely hard. There had been a lot of issues in Acute Services, a lot of pressures across the services, a lot of change. I think I was maybe their sixth director for some of the people in post. 10:09
There had been a lot of change. But my feeling was they were very committed, dedicated, expert and delighted to have me on board, and were very willing to share and come up with ideas and work in partnership and really work on that collective leadership model. 10:10

16 Q. You had line management responsibilities in relation to Mr. Carroll?

A. Yes.

17 Q. And he had in turn direct operational and governance responsibility for the Urology Service. Was it your 10:10 understanding that he worked closely with the Head of Service, Martina Corrigan, in that respect?

A. He did.

18 Q. Now, did Mr. Carroll give you a briefing as to what had occurred in the years prior to your taking up post that 10:10 had raised governance issues?

A. Not with regard to Mr. O'Brien. He did give me a brief of the issues that were current, which were around the three sites, which was the Urology ward. There were a lot of risk issues in that ward at that time, and 10:10 workforce issues, and a lot of quality indicators in terms of care. We put together a response to that with the corporate nursing team as well to try and stabilise 3 South. But that was the real emphasis for Urology in

June '19.

19 Q. So, the emphasis was on the immediate --

A. Yeah.

20 Q. -- issues that you were facing. Did Mrs. Corrigan ever raise the issues with you about what had preceded your tenure as regards governance? 10:11

A. No. Again, I believe that those were felt to be in hand at that point in time.

21 Q. Are you saying that with hindsight?

A. I am saying that with hindsight. I didn't know about them at the time, I wasn't sure of that. But as things emerged, that was my perspective, that they probably felt they were being managed. 10:11

22 Q. Knowing what you know now, do you think that you should have been told? 10:11

A. Absolutely.

23 Q. If you had have known then, what would you have done to reassure yourself about what was in place to prevent any reoccurrences or to ensure good governance?

A. I would have wanted to understand what range of intelligence there had been, not just that led to the MHPS but before that. So, I would have wanted a chronological list of all of the issues that had been raised over years or all the concerns that had been raised over years, but in particular the MHPS and the recommendations from it, and the monitoring processes and the impact of those. 10:12 10:12

24 Q. Now, there has been some evidence given to the Panel around the necessary confidentiality of the MHPS

process and some of the perhaps barriers or challenges that puts up in relation to sharing of information, it's important for good governance.

A. Yeah.

25 Q. Do you have a view on the appropriateness of information not being shared to maintain confidentiality? 10:12

A. I respect confidentiality but I believe that when there are an operational team working, or there is an operational team working on issues that are referenced in that report as needing to be further addressed, and people referenced like the Assistant Director, I think they are entitled to have that information shared with them so that they can be fully informed and be part of that, and that wasn't the case. So yes, I do believe there should be a sharing with the appropriate people. 10:13 10:13

26 Q. Now, we won't go to it but for the Panel's note you mention at WIT-34184, paragraphs 2, 3, 5 and 6, some of the meetings with Mr. Carroll on the issues that arose, workforce challenges. At that time the impact of Covid, obviously, was a big factor. The unscheduled care pressures. That was an opportunity for gaps to be identified in relation to capital investment for additional equipment, and those were the immediate sort of issues. 10:13 10:14

But in terms of the issues that subsequently emerged during your role as director, in terms of the issues that had previously arisen, was there any sense when

you took up that post that you were concerned that the directorate was operating in a potentially unsafe way or that there were concerns of patient risk? What was your feeling of just exactly what the position was about Patient Safety at that point? 10:14

A. Specific to Urology or the whole service?

27 Q. Well, perhaps generally the whole service and then specifically, if you don't mind.

A. Generally, definitely very aware of the risk right across in terms of capacity, in terms of access, in terms of backlogs, waiting lists, bed stock, workforce issues, governance concerns, a range of bits that were on my table that I was understanding bit by bit. 10:15

On the more specific Urology perspective, my concern really at that stage in the early days was around the stability of the service in three sites for Urology patients. I had no insight into a history of an individual practitioner, Mr. O'Brien, and I had no history of any greater Urology concerns about practice that potentially evolved later. 10:15 10:15

28 Q. You perhaps give a little bit of insight in your statement. I think one of the things you mention is that at that point, the nursing capacity was met by, I think, 80% agency or non-core staff? 10:16

A. Yeah.

29 Q. Would that have been something that was replicated throughout the Trust or was that something specific to Urology?

A. No. It certainly was a particularly high ratio of flexible staff, agency, bank in 3 South, but it was an issue across all Acute services, across maternity services, across surgery, medicine, it was right across the sites. It depended which ward and which people had chosen which career. So, for example, surgery nurses who wanted to deal with surgery, when there was reduced surgery in Acute Services at that stage because of capacity issues and theatre nursing staff and all the different issues, a lot of staff were voting with their feet and moving because they weren't getting their satisfaction professionally within services. So, there was definitely wards which had higher turnover because of a range of contextual features within Acute at that time. 10:16 10:16 10:17

30 Q. I will just mention it now. The Panel are taking a note, and we have a stenographer as well. I am trying to slow down because it's usually my fault but if we could just... it's very important that we get everything that you say. 10:17

A. Yes.

31 Q. Just before I move on, Patricia Kingsnorth had indicated that the staff turnover and the transient nature of staff in a Trust can cause concerns and challenges for good governance. Would that be a view that you would agree with? 10:17

A. Well, it's a view that I agree with but it's also evidence-based, so we know that where you have high turnover of people into an area, they may not be

familiar with policy, with procedures; they may not be familiar with the working environment or the operating procedures; there isn't the same continuity of care for the patient. A lot of that translates into service delivery issues. There were issues with, for example, how we measure quality in the nursing care that we delivered, and there were a range of issues in poor performance that were directly linked to that high flexible agency and bank staffing. We were able to compare that with other wards where there were stable core staff and they weren't such an issue. The management styles, capability issues, there were a range of issues ongoing but very definitely linked to high turnover and workforce concerns in that ward. 10:18 10:18

32 Q. Now, I just want to ask you about a specific issue in relation to one of the Section 21s from Mrs. O'Kane. If we go to WIT-91956. WIT-91954 is where it starts. 10:19

This is a statement that was submitted by Mrs. O'Kane who had previously given evidence to the Inquiry. This is a part of the transcript where I had asked her a question, and she gives the answer. In the transcript we then send out questions to ask for more detail. I'm drawing this to your attention because you are mentioned in it so I just want to give you the opportunity to comment if you wish. She is asked when she gave evidence: 10:19 10:19

"Can you expand a little bit more on what that

criticism was aimed at and how it may have impacted your choice of behaviour at that time?"
Answer: There was certainly on a number of occasions when I was very robustly challenged by middle managers within the Trust, not Martina Corrigan and not any of 10:20
the other people who worked to her, in relation to what my role and function was, why I was asking these questions, and I think were a bit alarmed. I think about the level of curiosity in relation to how this worked. That doesn't stop me asking the questions but 10:20
it did make it more difficult in that I had to keep coming back and back and back to try to get the answers that I needed.
Question: Did you consider that to be a difficult working environment, that the culture had been robust 10:20
towards the Medical Director", which Mrs. O'Kane was at this point?
Answer: Yes. Probably a little bit ambitious for a people to take on the most senior medic in the SMT.
Question: Did you see that as a sign that there was 10:21
some reluctance to do things differently?
Answer: Yes.
Question: You have mentioned who it wasn't, you haven't mentioned who it was in your Section 21. You were clearly going not to say any names, you are very 10:21
free to do so now if you wish to, but obviously the Inquiry would like the opportunity to certain individuals, if we had the information, how their behaviour may have impacted on clinical

decision-making? I will leave that thought with you."

Then we followed that up, asking her to identify by name the middle managers to whom she referred in her oral evidence. She names Anne McVey and Ronan Carroll. 10:21
Then she is asked to "set out the details of your interaction with those individuals". If we just go down to her answer, where she says:

"I have contact with both Anne and Ronan through 10:21
clinical directorate meetings during the overlap in their tenure and mine and usually in different formats and on average about one to two times weekly."

Then she guess on to say: 10:22

"They both adopted a defensive approach to my questions following clinical and social care governance. The general explanation for this appeared to be that when staff were asked about any activity in the past, that 10:22
they felt criticised. This then seemed to have set the tone across the Acute Directorate. I was left with a strong sense that they viewed me as interfering, and that inquisitiveness was viewed as questioning with a negative agenda rather than a curiosity in a bid to 10:22
understand. Comments were made about me being an outsider. The approach to me at times was of sarcastic comments being made, particularly by Anne to me in front of others, if I asked questions, even as

a relatively new person learning my way in a new organisation. When I drew others' attention to this, there seemed to be an acceptance that this is the way business was done in the Trust and couldn't be challenged. This was disappointing as when I worked in 10:23
a previous Trust and had studied together with Anne, I had thought the working relationship was constructive. On one memorable occasion in 2019, I was in the patient flow control room with senior nurses and Anne, reviewing patient activity in the context of 10:23
overcrowding and waits in Craigavon Emergency Department. I asked about pathways that had been agreed the previous week were not being implemented. Anne abruptly left the room, demanding to speak to me in her office, stating that she had had enough of me 10:23
and she wouldn't be answering questions like this again. I spoke to her, but her determined attitude was that I was interfering and she would not engage with me. I spoke to Vivienne Toal, Director of HR, and explained the situation and was then asked to the 10:24
office of Melanie McClements, Director of Acute Services. Melanie was angry that Anne had been upset and reiterated that I had to stop asking questions. I discussed this with the Chief Executive, Mr. Devlin, and his view was aligned with mine, that as Medical 10:24
Director I should be curious in relation to patient care. I discussed this at a later stage with Melanie when she was less irritated and explained that she had only been given one side of the story and that I was

disappointed that she would choose to give credence to an assistant director and none to an executive director with the responsibility for Patient Safety and governance. I reminded her that I would not be able to do my job if I didn't try to understand how systems worked. She accepted this and acknowledged this and stated that she had not had a full appreciation of the role of Medical Director. 10:24

Until she retired, the relationship with Anne was professional but not warm. This was disappointing. I don't believe that she recognised the impact that her behaviours had on the relationship. I was also aware that she had the capacity to be extremely kind towards others, particularly patients. I was very mindful of the fact that as someone who is recently new into the role of Acute Director with limited experience in that directorate, Melanie was extremely dependent on the support of the ADs in order to get the job done. Particularly before the onset of the pandemic, the organisation felt quite split at times. Acute held on to its own information under the guise at the time of managing its own governance, which is a system that had been instigated in the past. As a result of this, it was very difficult for the Director of Nursing, and me as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. 10:25 10:25 10:26

By the same token, Acute regularly believed that it was left to fend for itself in isolation while regularly being wary of those of us trying to support it."

It's quite a long extract. I just needed to read the context to you and the parts in which you were mentioned. Do you recollect this incident as described by Mrs. O'Kane? 10:26

A. I recollect it but not necessarily as described.

33 Q. What's your recollection of the incident? 10:26

A. My recollection of the incident was it did happen in the patient flow room; Anne had left the room because she was annoyed. She was not annoyed at the inquisition, she was annoyed at the style of how the questions were asked. Anne asked me to escalate that to the Chief Executive actually because she was so upset by it. Now, three other people came to me after that to say that what had happened in the control room was less than satisfactory in terms of good interpersonal relationships between staff. So, there was comment that Dr. O'Kane's style had been not as interactive and maybe pleasant as it should have been. Anne felt criticised because the pathways had been agreed, the previous work had been attempted to be implemented and hadn't been possible for a range of reasons. So, I agreed to discuss it with Maria. She said she didn't say anything whatever, and she said to me she thought Anne had misheard it because she thought she didn't hear her, and I says, well, she didn't hear 10:26 10:27 10:27

you because she is hearing-impaired and she wears two hearing aids. So I said she didn't hear you maybe as well as she could have; however, the other people in the room heard you and came to me. So that was what prompted me to discuss with Maria. 10:28

I have no problem with inquisition or curiosity. In fact, I would be known to be of that style myself so I have no problem with that. I agree with the Chief Executive, it's right that a Medical Director is 10:28 inquisitive and holds people to account. From an Acute Assistant Director perspective, I believe that the style of previous Medical Directors had been as operationally facing or involved as Dr. O'Kane would have been. They would find it difficult to get used to 10:28 where does the operational bit take over and where is the responsibility of the Medical Director, and I think there was some of that behind it. I do think there are different personalities in any team and there probably was a bit of feeling annoyed and maybe a bit defensive 10:28 as a result of that, but that incident in 2019 just wasn't as clearcut as described there.

With regard to the model within Acute, the model in the organisation for clinical and social care governance 10:29 was devolved, and still is actually because it hasn't actually flipped yet. Therefore, the information that is held within directorates from a governance perspective is the same as the information that's held

in Older People and Primary Care or Mental Health Directorate and so on. It isn't in the responsibility of one person to have that information. Anne didn't even work in Urology Services, for example, she was in the medicine side of the house. That information was 10:29
shared at our governance meetings, at our Acute governance meetings. The actual collective leadership structure I talk about in my statement talks about the Clinical Director and the Divisional Medical Director and their professional accountability line to the 10:30
Medical Director. So, there are a range of mechanisms to interact and get information, and a range of fora that allow us to share that information. There would have been no evidence, and no awareness certainly from my perspective, that anybody would have withheld or 10:30
made it difficult to get information.

34 Q. Setting aside the understandings or misunderstanding of communications of the individuals, some of the comments here would seem to suggest that there was a difficulty. I'm relying in particular on "Acute held on to its own 10:30
information under the guise at that time of managing its own governance".

Would that be a sentence that would you would agree with? 10:30

A. No. There may be particular things individuals might decide to withhold; I can't control that. But any information that would have been pertinent to be escalated would be information, if it hadn't been

shared or wasn't known, that if I had known it, I would have shared it. It wasn't an issue. There was no covert information that wasn't being shared purposefully.

35 Q. Well, I will just take you back to one of your answers just at the start when I asked you was what happened in relation to the governance issues arising around Mr. O'Brien and the systems something that you should have been told about by Martina Corrigan and Ronan Carroll and you said yes; is that an example of information that wasn't shared? 10:31

A. I said yes because, in hindsight, it would have been good to know that but at the time I genuinely believed their reason would have been the matters were in hand, and the monitoring of the four issues was underway and there had been no breaches, and they may well have thought that it was potentially resolved. 10:31

36 Q. We will come on to look at whether -- I think you said Martina Corrigan had indicated the October 2019 breach was the first breach that had occurred, and there is evidence that there had been breaches during the two-year period. Prior to that is that something that you know about? 10:32

A. The 2019 was the first that I was aware of, and I think the first potentially that Martina uncovered. I believe there had been other breaches - I'm not sure of the detail - in 2018 when Martina had been on a period of sick leave. I wasn't aware of those. My understanding was that the September '19 breaches were 10:32

the first. I was corrected in that when I was informed about --

37 Q. Well, I will take the Panel to notes of breaches when Mrs. Corrigan was in post in 2018 as well.

A. Okay. 10:32

38 Q. I suppose that is an example of you only being able to rely on the information that you are given by others. Is that one of the vulnerabilities of governance, that you are dependent on people both identifying the issues that need to be identified providing you with enough 10:33 information so that you can properly provide some remedial action?

A. I think it is a weakness and I think it's a weakness also from a professional perspective, because there are lots of issues that potentially would be considered to 10:33 be in the medical line in terms of control and inaction, and that, as operational director, I would still want an awareness to be shared with me about that.

10:33

You know, how much that communication around the MHPS and whatever, I mean, Mr. Carroll, for example, had not shared the report following that, so there may be sort of tensions there across the operational professional worlds that we could reduce by better 10:33 information-sharing.

39 Q. Would you have knowledge now of the issues that the Inquiry has heard evidence about going back over many years?

A. Yes.

40 Q. You know about that now. Now that you know about what subsequently you became aware of and what subsequently became known and played out, I think, during your tenure later on when you were trying to put other systems in place -- 10:34

A. Yes.

41 Q. -- was there ever any sense, did you ever pick up any sense that people wanted to keep all of that under wraps, or that things had been going on for so long and it had been difficult to try and resolve, that individuals were trying to manage themselves without actually sharing information that would have been value adding to people who were more senior? 10:34

A. I don't think it was about the information being kept under wraps, as such. I genuinely think there were a series of people involved over the years and a tolerance within the system that an issue is raised, it's dealt with and it appears to have been sorted, and then it hasn't really been sustainable and it raises its head again. I'm not sure there was a correct joining of the dots over those people and over the range of issues that raised. 10:34 10:35

Again, when I look back now at that record of concerns, you know, you think maybe there was definitely an earlier opportunity to act, and some of the individuals concerned feel, on reflection, there's an opportunity to act, but I don't think there was a concerted effort 10:35

to keep things under wraps. I think they genuinely felt they were dealing with things as they went and it was resolved.

42 Q. You have mentioned about there being various people in your post prior to you taking that up. There was turnover at that level, turnover at Chief Executive level. Now, obviously some individuals like Mr. Carroll and Mrs. Corrigan were there for the duration of events as they unfolded from early 2012, 2014. What impact do you think the turnover of staff at a high level like that has on good governance management? 10:35 10:36

A. Very definitely, the turnover definitely affects our governance arrangements, and the styles definitely affect our arrangements in terms of -- I mean, if I use the example of Dr. O'Kane again. When she came in, right from April '19, she was very proactively following up issues of concern from a governance perspective that perhaps could have been dealt with at an earlier stage. But she was a very proactive mover and shaker in terms of clinical and social care governance. She'd also come from Belfast Trust and had experienced a different model of clinical and social care governance, so therefore she probably saw flaws in our system which I would imagine prompted the clinical and social care governance review. I think there have been significant changes made over her tenure to date that are about trying to improve some of those vulnerabilities and some of our systems and processes. 10:36 10:36 10:37

So I think some of it is about style, but definitely an impact of change in personnel at the different levels.

43 Q. When you were listening to the evidence of Mrs. Rankin, she gave significant evidence about the structures she either inherited or put in place in order to ensure that she had good oversight of governance. I know you said you didn't get a hand-over and you did instigate one-to-one meetings from the outset. What was your feeling at that point about the governance structures that you had inherited by that point? 10:37

A. I actually was very impressed by them. There was a series of planned dates in your diary every week and every month that allowed you to sit down with the operational Heads of Service, OSLs - Operational Support Leads - and Assistant Directors; allowed you to look at all of the data sources and intelligence that we had right across the gambit and analyse those. It allowed us to work through all of the traditional clinical and social care governance areas like complaints and serious adverse incidents and litigation, risk registers and clinical audits, and some of the indicators that were brought in to us from the audit facilitators, which was much lower than it could or should have been but was what it was at the time. 10:38

I also was very impressed by the Acute Clinical Governance inform monthly, where the Divisional Medical Directors, the Clinical Directors and the Assistant

Directors came together with myself and Clinical Social Care Governance Coordinator and shared a very frank, open challenge and scrutiny of practice and incidents and issues that needed to be addressed. I actually thought, having come from a directorship in community, it was quite a rigorous governance model that I had inherited.

I took over responsibility for the Clinical and Social Care Governance Coordinator, Patricia Kingsnorth, after I commenced in Acute, because I felt that Patricia had been reporting directly to Tracey Boyce, which was probably a job that Tracey hadn't capacity for as Director of Pharmacy. 10:39

44 Q. Let's just look at that particular point. That's one of the examples I wanted to use as to the landscape when you inherited the governance aspects of your role. I want you to look at Tracey Boyce's Section 21 at WIT-87634. 87633. 10:39

10:40

As you say, when you came into post, Tracey Boyce was in the role of Clinical Social Care Governance. Just for the transcript, I will need you to answer.

A. Mm-hmm.

45 Q. Is that right? 10:40

A. Yes. She was -- Patricia Kingsnorth was coordinator but she was line-managed by Tracey Boyce.

46 Q. Tracey Boyce was put in that post by Esther Gishkori, or was it your understanding that was someone else?

A. I am not sure whether it was in Debbie Burns or Esther Gishkori's time.

47 Q. Let's see what she says at 87633. Paragraph 4.4, please. Patricia says:

10:40

"In October 2014, I was asked by the then Director of Acute Services, Mrs. Deborah Burns, to manage the Acute Governance Team for a few weeks while the Acute Governance Lead post was being recruited. This was because the previous post holder, Margaret Marshall, 10:41
had moved into the Corporate Governance Lead role. I was asked to take this on as out of the six Assistant Directors in the Acute Directorate, I had the most governance experience. I had set up the Northern Ireland Medicines Governance Pharmacist team in 10:41
a previous post, and I also completed a postgraduate Doctor of Pharmacy Practice on the subject of medication-related patient safety.

Shortly after this, I was told at an Acute team meeting 10:41
that the Acute Governance Lead was not going to be replaced as the salary had been given up as a cost efficiency saving. I was not happy about this decision as I had been told that I would be managing the team on a temporary basis until the post had been filled. 10:41
I already had an extremely large workload as Director of Pharmacy and Trust Accountable Officer. In February 2016, the Director of Acute Services at the time, Esther Gishkori, agreed to the replacement of the Acute

Governance Lead, and Trudy Reid was recruited into the role. She started this role on 4th April 2016. Mrs. Gishkori was not prepared to take back direct responsibility for interfacing with the Acute Governance Lead, despite it being part of her remit. I was told of this decision verbally at one of my one-to-one meetings with the Director. I do not believe there was a note of what was said at this meeting. Therefore, I continued to mentor and support the governance lead as they needed someone to facilitate their work. They involved meeting Trudy Reid every Tuesday morning to discuss any issues the team were having, and accompanying her to brief Mrs. Gishkori on governance issues once per week. 10:42 10:42

I put this weekly governance briefing meeting into Mrs. Gishkori's diary when I realised she was not going to take back the director's responsibility for governance. I decided that the meetings were necessary as Ms. Gishkori was attending senior management team meetings where issues of governance and risk were being discussed. In my opinion, she needed to be briefed to be able to represent the Acute Directorate position accurately. Unfortunately, the meetings were often cancelled by Ms. Gishkori. I do not have any notes of these meetings as they would have been in my paper diary for the year, which I no longer have in my possession. Ms. Reid may be able to provide notes of these meetings. 10:43 10:43

During Ms. Gishkori's time as Director, I was also often asked to chair the Acute or the monthly Acute Governance meeting, the Acute Clinical Governance meeting and the twice monthly Standards and Guidelines meeting in her place. Around that time, Ms. Eileen Mullen, Chair of the Trust Governance Committee, asked me to attend the full Trust meetings in future, which I did. Up until that point, I had only attended the beginning of the meeting in my role as Director of Pharmacy to present the Medicines and Safety report. After I did this, I left the meeting. This allowed me to assist Ms. Gishkori when necessary with any non-executive director's questions about Acute governance issues. 10:43 10:44 10:44

When the next Director of Acute Services, Melanie McClements, took up post in June 2019, she immediately took back her responsibility for governance as Director of Acute Services. I stopped the weekly briefing meetings as they were no longer necessary as she had scheduled one-to-one meetings with the Acute Governance Lead, and routinely chaired the various Acute governance meetings each month." 10:44 10:44

You had said when you took over that you were surprised that - the word "robust" was used - the systems for governance. Just in relation to this aspect of it, was that something that surprised you wasn't held by

Mrs. Gishkori when you took over?

A. Very much so. I think those last two paragraphs in particular are telling, that, you know, Tracey would have gone to the Governance Committee about pharmacy-related issues traditionally, and to be asked to stay for the whole meeting will have been because by line-managing the Clinical and Social Care Coordinator, you have the breadth and the depth and the understanding, you are fully aware on a weekly basis of what the issues are because they are escalated through that coordinator role. I think to have been asked to stay for the duration of the Governance Committee, they needed that intensity of knowledge and awareness to be shared. 10:45 10:45

That's my style of working. I need to understand what the feel of the organisation is, and the core tenets of how we need to do the job to get our proper focus on patient safety and care. That was my reason; it's in line with the description, it's how I had worked in Older People and Primary Care Services as director. I just felt it was a detached route if Tracey was the in-between. She did a brilliant job, and I don't know how she took it on top of her Director of Pharmacy role, but I was very happy to take it back and I felt it was safer to have that span of control. 10:46 10:46

48 Q. There's two aspects of potential concern in relation to that, both the delegation of, as you say, the director's responsibility overall around governance,

even though, of course, it is up to you to put in place measures that you see fit to ensure you are informed, but also Mrs. Boyce' indication that Ms. Gishkori wasn't always available to be updated in relation to any issues that might arise. Of course, Ms. Gishkori will give evidence and can speak to that herself.

A. Yes.

49 Q. But if that is the case, do you think that her approach created a risk to governance?

A. Well, Tracey would have filled that breach as much as she could, but the fora that the Director of Acute exists within at Board level, at Trust Board level - the Board being the Health and Social Care Board - Trust Board level, SMT, there's a broader map that you are working across, and I think there would have been gaps that Tracey wouldn't have been able to fully be present in all of those different fora. Therefore, I do think there was a vulnerability by having that working model.

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10:47

50 Q. Of course, Tracey wouldn't have the directorship of Acute Services to consider in the round?

A. Yes.

51 Q. So, the potential gaps perhaps --

A. She would have worked very tightly with her Assistant Director colleagues, so she would have had good relationships and interactions on that. I do think the reason why it sits in the Director portfolio is because of the added advantage of that governance loop.

10:47

10:48

52 Q. Given that you immediately took back responsibility for

governance, you clearly assessed that that was something you needed to bring back to your responsibility?

A. I don't think -- when I say immediately, because I thought I was there for six weeks originally, I don't think I took it back in that six weeks. Once I knew the sick leave was extending and I was going to be there for a while, I took it back probably about eight weeks after I started. 10:48

53 Q. When you took it back, knowing the system that had been in place prior to that, the potential breakdown in communication and a delegation as perhaps someone who didn't have the capacity, what steps did you take to assure yourself that patient safety and risk management was sufficiently robust at that point? I know you have mentioned about the one-to-one meetings but specifically what sort of audit did you carry out? 10:48 10:49

A. Well, I used those one-to-one meetings to get a complete history of what the issues were and what the current issues were within governance in Acute. That was right across all the domains that would be within Patricia's portfolio. She had the Standards and Guidelines team, she had the SAI team, she had the Complaints team, and she might have had another branch and I can't remember what it was. She had a team of 12 that worked across the multidisciplinary teams in Acute, across those range of briefs, and she was able to give me that history but also the current picture. Now, I was very interested in the current picture but 10:49 10:49

I also needed to have some background of what had gone before. Incrementally, we built that week on week with the current and some of the lookback. Didn't do formal audits as such, I really started from a point in time and trying to understand issues and deal with them as they arose.

54 Q. You have mentioned clinical governance, the Acute governance monthly meetings and the Acute clinical governance meetings. What's your understanding of the difference between those two, apart from the word "clinical"? 10:50

A. The first one is the operational team meeting, and it's us doing, in many ways, a preparation of everything that's gone on within each of the divisions across the Directorate. We have at it the clinical facilitators and, on occasion, Heads of Service feeding us data, audit outcomes, the monthly audits that regularly took place; and also the Clinical and Social Care Governance Coordinator giving us the absolute picture of what was current in terms of complaints or serious adverse incidents, whatever. That form allowed us to address many of the issues, challenge each other, put actions in place to actually deal with some of the issues that were being raised. 10:50 10:50 10:51

We took that same suite of data and intelligence to the Acute clinical forum which added on the layer; same people, but added on the layer of the Clinical Directors and the Associate Medical Directors, now

called Divisional Medical Directors.

55 Q. Did they frequently attend those meetings?

A. There was a really good attendance. You didn't always have everybody. We put it to 8:00 on a Friday morning to be pre-theatre, and that was the preferred time. I know Mr. Haynes, for example, had difficulty meeting that because Friday was his day in Belfast. We tried to move dates, and we did move it at one stage to a Wednesday, but it didn't work any better. In fact, it was worse on a Wednesday so we reverted. They were very well attended and were very stimulating meetings, but not everybody attended all of the times. 10:51 10:51

One of the key roles of that forum was to scrutinise the Serious Adverse Incident Review reports. The divisional Medical Director and/or Clinical Director and Assistant Director would have actually talked through and reported on the SAI from their service area. In advance of that meeting, we made sure we had the right people in the room because if that week Urology, for example, was going to be discussed, we needed to make sure we had somebody representing Urology present. So sometimes we had to work around our agenda to try and work with the clinical commitments to get it as relevant as possible to the subject areas. 10:52 10:52 10:52

56 Q. For the Panel's note, there's example of those meeting notes at WIT-34522 to WIT-34550. Now, there's not an awful lot of detail in the notes. There's a lot of

documents embedded in them; obviously you have referenced reports or specialty presentations, those sort of documents. But as regards discussion, analysis to and fro, there would be very sparse save for one meeting, which, if the Panel come across, they will notice it, it is at WIT-34545. I note it just because it is quite detailed in the discussion, but the rest of the notes are quite sparse. Was there a decision taken in relation to that or was that dependant on the note-taker? 10:53

A. It was probably the tradition when I got there. On reflection when I look at them now, I don't know how we didn't look for a bit more detail in them. It's a fair point, they should have been more detailed. But the actions that were agreed as a result of the discussion, and the debate and the challenge, were recorded in those and were followed through fastidiously. 10:54

57 Q. Those meetings where there was debate and challenge and pushback and difficult issues discussed and possibilities explored, were they those sort of meetings from a Governance and Clinical Governance perspective? It's not a feeling you get when you read them because of the sparsity. So you, having been there, was it your experience? 10:54

A. That was my favourite meeting in Acute every month, and it was my favourite meeting because you had the right people in the room across that medical and operational divide. There was a respect and a healthiness in terms of how people interacted with each other, but there was 10:54

an absolute honest, open discussion around the issues and the challenge of practitioners, and also with empathy for practitioners who were going through a difficult time. I feel it was a really good working model of collective leadership and action and dealing with quite acute - well, obviously acute - but quite complex governance issues.

58 Q. Would that be the environment in which, if there were clinical concerns about a practitioner or even thematic clinical concerns, they would be openly spoken about? 10:55

A. On an individual level, they tended not to be. That sat within the directorates -- the Doctors and Dentists Oversight forum, which was under the Medical Director and the Human Resources Director remit, that I was also a member of. Themes would have been discussed, for example triage themes or whatever. Themes would have been discussed but it wasn't a naming and shaming forum. It would have been under consultant whatever or nurse whatever; it would have been on a non-identifiable. The likelihood is most people or a lot of people in the room would have known who we were talking about in the range of different professions. 10:55 10:56

59 Q. It might not have been a naming and shaming, and I wasn't sort of heading down that path in my question, but was it an arena at which all individuals could speak freely about, for example, triage, so that someone might be triggered to explore beneath those statements to find out what was really happening? Did 10:56

you feel you were getting the information you needed to stand over assurance around patient safety?

A. At that time I did. Now I look back and I think we could have had a deeper dive across a lot of our areas because some of the learning. The whole purpose of having the SAI Review is to learn and to cascade that learning. 10:56

A lack of triage, for example, I keep going back to that example, but lack of triage in one area could be in other areas. I'm not sure we had the scrutiny across because we didn't have enough audit or enough attention to some of those learning approaches. 10:56

60 Q. There could have been a greater concentration of information provided without having to reveal the individual? 10:57

A. I think so.

61 Q. A bit like the MHPS we mentioned earlier, you could have been across the issues without any breach of confidentiality? 10:57

A. But the responsibility at the end of that report is the recommendations and the cascade of those. Each team are charged with going away, and when there's an issue, whatever the issue is in this case, say triage, they were responsible to go and make sure the processes were embedded across all of their divisions. It wasn't just for the division that the issue had arisen in. 10:57

62 Q. We will come on to look at how effective that was.

Mark Haynes makes a statement in his Section 21 at WIT-42317. It's in relation to his sense of an absence of support. You can see 49.1. The question was:

"Did you feel supported in your role by your line management and hierarchy? Whether the answer is yes or no, please explain by way of examples." 10:58

Mr. Haynes says:

10:58

"I do not feel that I have been supported in my role by my line managers or the medical or operational hierarchy in the Trust. Interaction between the medical managers and myself was very limited before 2020. Only when Minister Swann announced the USI did the senior managers engage with the Urology consultants. Despite all the problems in the Trust, we were - mainly urology consultants - asked to take on more activity to cover service gaps and address the patient risks identified by the various inquiries. This feels overwhelming and I have said so at meetings with Shane Devlin, Maria O'Kane and Melanie McClements. I will not take on more work when I know that I cannot safely deliver. I have not received any specific support other than sign posting by Dr. O'Kane to Occupational Health and Psychology should I feel that I need to self-refer." 10:58 10:59 10:59

Now, do you recall Mr. Haynes saying this?

A. Does that definitely belong to Mr. Haynes? I have that as potentially Mr. Glackin.

63 Q. I have it as Mr. Haynes in my note. If we just go right to the top of that. I don't know what page it's on. Anthony Glackin, yes. I apologise. 10:59

A. No problem. It didn't resonate.

64 Q. Do you recognise that as something that Mr. Glackin brought to your attention?

A. Yes, and I feel sad that anybody in our system, no matter what role they have - patients, relatives, or 11:00 our staff - feel unsupported. I'm not trying to defend but I typically would not have known all of the consultants and teams across Acute, I couldn't possibly have, I relied very much on the team model of the Associate Medical Director, Clinical Director and 11:00 Assistant Director and Head of Service co-working, and that worked actually very well. So I wouldn't have had any reason -- I would have done an occasional visit into the Urology Unit but I wouldn't have had any reason to interact in any deep way with the consultants 11:00 unless there was an escalation, and the Inquiry brought about that escalation. That's when Shane and Maria would have also accompanied me and we had the series of meetings with the staff.

65 Q. What sort of area is this? Are we talking about post 11:01 establishment of this Inquiry?

A. Yes.

66 Q. Mr. Glackin specifically mentions about he cannot safely deliver that. Did that raise concerns with you

there were current Patient Safety issues, or did you think he was --

A. I knew the team were overwhelmed to begin with because of the backlogs and the lack of capacity in the team because they were short consultants. For the most part in my tenure, they had 4.5, or 3.5, depending on the time, out of six. It's now seven consultants. So when the issue arrived post June '20 and additional patient reviews needed to be done, we were asking, going back with the begging bowl to the same staff, urging them to do a bit more to allow those patients to be reviewed and for us to be assured that their care and treatment and diagnosis was safe. 11:01 11:01

So, he did say at a meeting that he didn't want to take on any more work because he didn't want to put patients at risk by taking something on that was too much and it would be unsafe. I appreciated that is where he was and I wouldn't have pushed that. So, I totally empathise with the situation, and I know they probably felt as a team that they were being asked to do more and more with less and less, and that was sort of a fallout from the situation we found ourselves in. It's regrettable but it's totally honest and I totally identify it. 11:02 11:02

67 Q. In your role did you have any sense of a tension between meeting performance targets and providing safe care?

A. I didn't really think there was tension because, to me,

if you need to perform at a certain level, you need to have metrics and you need to have measures and you need to have your eyes on that. The intelligence that we got from that, it showed us what we weren't doing. It showed us the backlogs, it showed us the length of the waiting lists. It allowed us to come up with every sort of creative solution we could to increase capacity, by working differently, by working across professions, by working with the independent sector, by working across Trusts. So, I don't think there was tension but I think there was a big focus on performance. Uncovering that actually allowed us to scrutinise and act. 11:03 11:03

68 Q. Well, we will look at your statement at WIT-34156. This is where you mention risk registers. Paragraph 121. You say: 11:03

"From when I assumed post as Director of Acute Services, breaches in waiting times, waiting lists and cancer pathway targets relating to Urology were regularly highlighted in performance and governance meetings, including Risk Registers". 11:04

The Panel will be familiar with the occasions when they have been reflected in the Risk Registers. 11:04

You use the word "regularly" there, was there any sense that people got used to have the breaches sitting on Risk Registers with a sense of powerlessness about what

they could do, or was there still active attempts made to address the risks on the register?

A. I honestly think both. I mean, they did feel overwhelmed and they did feel powerless because every month seemed to be worse, despite everybody's best efforts. However, there was always a proactive how do we deal, who is the most at risk here, why is that person the biggest outlier, for example, what's the reasons behind that, let's look at the individual story for that to see is there anything else we should be acting upon. So, they had a great attention to being able to progress any of the issues and seeing individuals and patients within those lists. 11:04 11:05

I honestly think the answer to that is both. There was a powerlessness because we didn't seem to make a difference, but we were making individual differences week on week by making sure the priority patients were being brought to attention and being offered services. 11:05

69 Q. Did you have a sense, just by your description of that, that services were working at an optimal level, that work had been done to try and facilitate people to maximise output? And was it just a capacity issue or was optimising the service still an active ingredient to try and meet targets? 11:05 11:05

A. I believe people were working extremely hard but there were so many barriers to enabling them to deliver at a more efficient level. For example, if you had a pile of medical outlying patients in surgical beds, it

affected the ability of surgeons to get their patients in. That may have resulted in cancellation of a list because there was no bed to admit the patient into, regrettably. Don't forget, in my tenure we had the nursing strike, we had Covid, we had stand-down of a lot of our theatre staff to actually double our size of our Intensive Care Unit. That shrank our theatre lists. We had an issue with theatre nursing, so there wasn't capacity. There were lots of other factors that were frustrating people to be as efficient with the patients they wished to see more than they could have been. There were a range of issues. But did I ever think there was a problem of them under-performing? No, I had no concerns in that direction. 11:06 11:06

70 Q. You mention in your statement, just for the Panel's note, at WIT-34138 at paragraph 45, working with the Commissioner to ensure replacement of two clinical nurse specialists in August 2020. I think there were various initiatives set up. This is on the recruitment strategy you have mentioned. The growing use of specialist nurses then obviously increased the need for those posts to be filled. 11:07 11:07

What was your understanding of your relationship with the Commissioner? Did you feel supported; did you feel they really had a grasp of issues that were being faced at ward and service delivery level? 11:07

A. Well, I was aware there had been a commitment to grow the CNS pool. There was two had been funded, and I

think the third post was actually funded by Macmillan, if I'm right. Then the two additional posts that came in in 2020 were the Commissioner honouring that commitment. Now, it was a wee bit long in gestation but in that time we got. Yes, there was an awareness of the benefits, and that's why some of the work areas were set up that the CNS being in post could actually offload some of the pressure from the urologists and actually allow them to concentrate on something that it could only be a urologist to do. So, there was an appreciation of the scope and the extended scope of the CNS role, and the ability to share the approaches for the patients between the nursing and medicine professions. So, there was commissioner support for it, yeah. 11:08 11:08 11:09

71 Q. That's the specific example of that. We have heard of the protracted nature of the funding around that and it seems that's not unusual in the Trust. Is that your experience as well?

A. Absolutely. 11:09

72 Q. From idea to gestation to realisation can be quite a long period of time.

Just to point more widely in relation to the relationship between HSCB - SPPG as it is now - what is the nature of that relationship, and do you have any views on how that relationship might assist better governance in a Trust generally? 11:09

A. Well, in many ways it was a holding to account

relationship in that the services were invested in, we were the provider of those services and we were reporting on that. But where there were issues of concern or escalations, either we were escalating to the Commissioner or issues that the Commissioner wanted to discuss with us, there wasn't really -- there wasn't really much solutions coming from commissioning side of the house. You know, you would have been guided with some novel approaches that maybe we could take or whatever, but we weren't really getting much traction, especially with regard to backlogs and waiting lists and waiting times, despite efforts to try lots of different ways to bring that about. The relationship was respectful and proactive and we could have had discussions about new investments, so that was all very healthy. Some of the discussions around what else we could do and the holding to account bit were a bit frustrating because we didn't really develop new approaches. We might have had a bit of non-current investment or a contract development with the independent sector, there was always something we were moving forward, but we weren't really turning things around despite the two-way processes. 11:09 11:10 11:10 11:11

73 Q. I just want to take you to your statement at WIT-34163, paragraph 144. You make reference to an email in this, and it wasn't an email you were copied into but Ronan Carroll shared it with you, and that will become apparent when we read it. For the Panel's note, the email referenced in this is at WIT-34902 to WIT-34904. 11:11

This was just two days after you took up post.

"In an email exchange on 12th June 2019, two days after I commenced post, from Mark Haynes, Associate Medical Director, to the Medical Director, Dr. Maria O'Kane. Mr. Haynes had summarised his concerns as...". 11:12

And these are his concerns around Urology.

"In short, no, we are not working at elective capacity or at maximum efficiency simply because we do not have the resource to do so. Regarding efficiency and what we deliver, one aspect that was eternally frustrating is equipment investment within Acute Services and, from my perspective, SEC ET ICS. We have multiple items requiring investment sitting on a long list", which he attaches. 11:12

"In total there are 54 items of equipment totalling approximately 2.6 million. As you know, bed capacity is a major issue. In order for secondary care to deliver elective care maximum capacity and maximum efficiency, we need to fix the unscheduled care issues. Fundamentally, this means an increase in bed capacity. No Trust can manage elective care while bed occupancy runs in the high 80s to 90+%. A first step in moving towards this is a corporate recognition that the primary issue affecting the Trust is a lack of capacity for unscheduled care. Regarding increasing demand for 11:12 11:13

Trust services, I believe the underlying issue comes down to how services are commissioned and delivered within Primary and Secondary Care."

As a result of that email you arranged 11:13

"... one-to-one supervision with Mr. Ronan Carroll, Assistant Director, for the following week to allow you to meet and fully understand the scale of the problem and the range of actions ongoing and required to be 11:13 implemented."

This is the next paragraph. I will read out some of the changes that you have sought to bring about after a one-to-one. 11:13

"On 17 June 2019, I carried out my first one-to-one discussion with Mr. Ronan Carroll, Assistant Director, where he highlighted a number of vacant posts: 1.5 vacant urologist consultant posts out of 6 funded posts 11:14 and the added load on the core consultants resulting in a need for locum cover. He also highlighted that 3 South Ward ENT Urology was operating with an 80% agency non-core staff, and four beds had been closed as a Patient Safety measure. Two of these beds reopened 11:14 in November 2019, which indicates the scale of the nurse staffing problem and the benefit of taking action until the situation improves. He also noted the range of ongoing rebanding agenda for change submissions,

including ward staff and nurse endoscopists in Urology. A range of ongoing processes to increase capacity, address vacancies, allocate available medical time to priority patient and Outpatients, Inpatient theatre lists, and also holding a Risk Register on the equipment concerns with a range of control measures to increase Patient Safety."

Now, it's a long list and specific to Urology. How did that sit in relation to the other areas of responsibility you had in Acute Services? 11:15

A. Well, across the surgery family, it was probably a similar feeling in terms of needing additional equipment, needing access to their surgical bed stock, which quite often had unscheduled care admissions into it. We did have some turnover of staff who were disgruntled with their grading in nursing, in surgery, and who had left for other Trusts, which impacted on the workforce. Some of those we were able to redress by having rebandings and new posts appointed. 11:15

The equipment concern was -- I nearly had a heart attack when I started and found there was a £2.6 million gap on safe equipment in theatres.

11:16

So, Mark - back to Mr. Haynes' bit at the top. They weren't working as efficient, effective capacity - I think that's the same as I said earlier - because of all those other factors that were some resourceable,

and some you resolved for a week or two and then they went back, like bed capacity or whatever. That was a real picture, and we just were -- and Mr. Carroll had a good handle on all of those issues and was working through them. Whatever support I was able to offer in terms of flexing the capital resource towards theatres, help that. We put a range of other plans in place for theatre nursing and for fair banding to some of our staff who we were trying to retain; a range of different processes to try and make Urology work at a higher level by building the infrastructure. 11:16 11:17

74 Q. What was the equipment issue? Deficiency there in safety equipment; how did you move that forward, or was it ever resolved by the time you left?

A. Well, we moved it forward. We will never resolve it because it's an ever-changing feast. What we did was, instead of going with a £2.6 million ask, we put a prioritisation system in about which were the absolutely critical ones. Before the service wanted to highlight I need all of these, that wasn't working because then there wasn't a priority and it wasn't getting prioritised at the capital table. So, we did a prioritisation of the equipment which allowed us -- I can't remember the sum, my memory tells me it was 500,000 or whatever that we were able to get allocated towards equipment by saying these are the absolutely critical first pieces that we need to get. Therefore, we got some traction with the allocation of equipment, which again made the team at least feel we were 11:17 11:17

listening and acting.

75 Q. Mr. Carroll, you have quoted in your statement at WIT-34215, he told you that a range of governance issues kept him awake at night. We will find that at 381. 11:18

"Mr. Carroll has indicated to me on a couple of occasions that one of the things that kept him awake at night was the lack of capacity to fully focus on governance issues within his division." 11:18

Do you recall him saying that?

A. Mm-hmm. Several times.

76 Q. What was your feeling or sense whenever he said that? Obviously, you sit above him. If he is concerned, did it engender significant concern for you? 11:18

A. Absolutely. I don't like to think anybody's being kept awake at night as an overhang from their working day. I have set out in this statement the four key areas of all of our jobs in the service, which was around our human resource responsibilities, our workforce responsibilities, our governance responsibilities, and our performance responsibilities. Those four made up the ingredients of us working effectively as a team. 11:19

I totally acknowledge there was additionality needed in governance support for the divisions, no problem about that. But I also needed to -- I also needed to highlight from a governance perspective and an

assurance perspective from me that I expect attention to all of those four areas - in equal measure is probably not right - but that we need to prioritise governance time in the mix of the busy stuff we do and how we work around the busyness to make sure that we are attending efficiently the governance.

But I did act on that in terms of I knew the governance review had taken place from 2019. We were waiting on the outcome of that, hoping that it would give us some sort of acknowledgement that there was capacity issues for the volume and scale of what we were dealing with in Acute. I did put in post a Quality Improvement Project. To me, quality and governance are very interlinked, so our Quality Improvement Project dedicated some time to the Assistant Directors to actually look at some of the gap areas they were most worried about, like action plans, and implementing recommendations post serious adverse incidents, and dealing with some incidents on the Datix system. 11:20

77 Q. That's one of the things that Mr. Carroll actually refers to in this paragraph, the inability to deal with action plans, the implementation of recommendations following serious adverse incidents, or to deal with the volume incidents that require active management and the complex complaints that required attention. 11:21

A. Mm-hmm.

78 Q. Now, what was the scale? There's quite a breadth of governance concerns around that. Did you ever get

underneath what the scale of all of that work was? For example, what were the number of complex complaints that required attention; what were the SAIs; which standing; what recommendations were awaiting implementation? What was the detail behind that? 11:21

A. So, we got that detail every month. If you notice in the Acute governance papers that came, we would have got how many complaints are outstanding, how many are awaiting answer, which Assistant Director is sitting with or which Head of Service? So we would have known 11:21 through the Governance Coordinator where there was glitches in the system that we needed some action.

When we had a Serious Adverse Incident Review, we did have an action plan that was pooled together with the 11:22 Clinical and Social Care Governance Coordinator to outline the recommendations of that review. What we were missing was has it been actioned? Has it been implemented? When was it implemented? How can you evidence it was implemented? They weren't missing it 11:22 all the time but we didn't have a clean sheet in terms of we had a thorough process end to end for that action plan and implementation process. So, that was the focus of me trying to put in place, number one, the Quality Improvement Project and some of the areas 11:22 around that, but, more importantly, getting funding secured for a Band 5 Governance Officer for each of the Assistant Directors, who would be their person who would work with them and hold their hand to keep a bit

of momentum going within the Directorate.

79 Q. Those posts were filled before you left, were you?

A. Yeah.

80 Q. Were they two Band 5s?

A. No, there was four. There was one for each division. 11:23

81 Q. They actually tried to follow through on the outworkings because what this paragraph seems to suggest is the systems are effective in bringing the issues to the surface by and large --

A. Yeah. 11:23

82 Q. -- given that we are here, but that the actual remedial work and outworking of what's needed to make sure that doesn't happen again is the stage that has some hold-up?

A. Yes. The purposes change in learning. To bring about 11:23 the change in learning needs capacity, and that's what we were missing. We had some capacity in different job roles. I mean, I think somebody said last week Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it. We 11:23 were missing a wee bit of momentum. That's why both the quality project and the Band 5s for each AD, and now in place, were to try and accept that there was a reason to be kept awake at night and we needed to do something about it. 11:24

83 Q. Just a last question on this issue for the moment. Was it your experience that there was a difficulty with people taking ownership around, for example, action plans or recommendations and driving those forward?

A. It's not that I think there was a difficulty in them taking ownership, I think it was on their to-do list. On the daily operational busy environment, it might have been deselected to 'I know I need to do it but it might be further down the list'. It's not as attractive as some of the daily functions that people enjoy in their jobs when you are sitting updating action plans or whatever. I would say it's not that they didn't want to do it or know they needed to do it, but the capacity was often veered to other things. I don't think there was a lack of commitment, I'm trying to say, but it wouldn't have been the number one thing every day when you came in that was on your list. 11:24 11:25

84 Q. You have mentioned the review in 2019 and given I am going to move on to that as a new topic, Chair, perhaps that's a convenient time. 11:25

CHAIR: 11.40.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:30

85 Q. MS. McMAHON: Just before we move on to the 2019 review, just a couple of other topics to touch on just to get your views on those. You say in your statement at WIT-34145 and paragraph 379 in relation to the five SAIs: 11:43

"The delay in progressing SAIs from 2016 to 2020, five 2016 cases are agreed by Mr. J Johnson, I believe prevented earlier pick-up of issues regarding the care

given by Mr. O'Brien to patients. I became aware of this delay on 10th September 2019 when the Clinical and Social Care Governance Coordinator, Patricia Kingsnorth, brought to my attention for the first time that there were five 2016 Serious Adverse Incident Reviews relating to Urology which had not yet been completed by the external panel. These were subsequent to an index case NH 2016 and all are patients of Mr. O'Brien". 11:43

Now, you reference a delay in that, given that it's three years after the events. What was your understanding of the reason for that delay?

A. I did approach Trudy Reid, who was the previous Governance Coordinator, in whose tenure the SAIs had been picked up and commenced, and she did the liaison with Dr. Johnson, who was the external panel Chair. I never really got any reason except that they hadn't delivered them, and he would pay his attention to them and we had -- Mr. Haynes was on that panel as well. We got them through, I think it was in October then, we got them through from Mr. Johnson, but the problem is it came as an aggregated five-person review. Normally we share reviews with families but you can't share other people's information. Therefore, we had to then do a wee bit of footwork to get them disaggregated. The intent was that that was to be done by the Trust, which I thought no, this is an external report, it has to be done by the author. We then got this aggregated 11:44 11:44 11:45

individual reports through, and the one overall. Then the reports went to Mr. O'Brien for factual accuracy checks, which he is entitled to, and there was a delay in receiving those. In fairness, our first ask of Mr. O'Brien was to turn them around in two days because we were keen to get them to the families. He resisted that, rightly so, and we then extended the timeframe for him. We got those, I think in December. Mr. Johnson didn't necessarily agree with the suggested comments from Mr. O'Brien and felt that the substance of the review was still appropriate to the issue of triage, and he didn't accept the changes and then issued the report in the New Year. 11:45 11:45

All of those things together delayed. We got them to the Acute Clinical Governance forum, my memory tells me, February '20. 11:46

86 Q. That's all the steps that were taken after you became aware, a delay that had been in existence prior to your knowledge? 11:46

A. And I don't know the reason for that --

87 Q. You don't know the reason for that.

A. -- except this hadn't happened.

88 Q. You say about that that "the delay", you believe, "prevented earlier pick-up of issues regarding the care given by Mr. O'Brien to patients". 11:46

What do you mean by that?

A. I mean that we should have been dealing with the issues

three years ago, not in 2020. By 2020, we actually delivered on most of the recommendations around triage processes and whatever. I believe that a different scrutiny of the issues earlier would have allowed a broader look at what else was going on outside of triage but, by the time the reports came through, it was almost past the post. I just believe there was an opportunity there to actually have a wee bit more scrutiny and maybe look into any other potential issues. 11:47

89 Q. Would you be of the view that delay and inefficiency in these cases were typical of the challenges faced in Acute, trying to promote good governance?

A. Not always typical, no, typical maybe in pockets. Delays in efficiency in definite areas and other things were expedited quite well, so it just depends on the subject and the issue. But it was unusual for SAIs to be so protracted. I think the following series of Urology SAIs show that when attention is paid and timelines are monitored, that you can expedite at a higher level. 11:47 11:48

90 Q. Well, the subsequent identification of issues post Mr. O'Brien's retirement, you have mentioned the secretary wasn't escalating some issues and they became apparent after Mr. O'Brien left. Does that not illustrate that there were difficulties both embedding good governance but also in identifying issues and remedying them at the time? 11:48

A. It does.

91 Q. Some of the issues you mention there, of course, Mr. Johnson, his involvement as an external, they are issues somewhat out of your control?

A. Yeah.

92 Q. Just in relation to some of the collection of patient data - you have mentioned this specifically in your Section 21 - at WIT-34219, paragraph 398. You say: 11:48

"Overall, the data efficacy of the systems that captured patient data depends on timeliness of clinicians reading results, dictating letters and following up patients' episodes. This will result in the patient data being accurately recorded on NIECR. The system is not sophisticated enough to alert if clinicians are not dictating in a timely way, and this places a reliance on the secretary to disclose that in the Backlog Report. This is dependent on accuracy, openness and transparency by the secretarial staff" 11:49 11:49

I think the simple point you are making there is that the Backlog Report may not always reveal the true picture? 11:50

A. Yeah.

93 Q. Is there any difficulty with pushing the responsibility, even to a limited extent, of keeping an eye on things that have an impact on governance on to the secretary? Did you have any concerns about that as an effective means of governance oversight? 11:50

A. Well, it is expected as part of their role and remit

that if there are issues that the secretary has difficulty with, that they should be escalated. In actual fact, the Backlog Report was initially developed to be an admin resource tool to actually say I'm having difficulty here because I have too much work and to allow that to be smooth across, as opposed to a governance tool originally. But you depend on individuals having either the confidence or the whatever to do that. There is, I think, a tension between the secretarial relationship and the consultant relationship because there is a loyalty there and maybe a hierarchy, but that doesn't defend why, when we knew there were issues, that we didn't deal with them earlier. 11:50 11:51

94 Q. Now, Sarah Ward, ward sister, in her statement at WIT-88537, makes reference to nursing quality indicators. At 21.1, sorry. Go to 22.2. It's 22.1 and 22.2. The questions she is asked is: 11:51

"What is your overall view of the efficiency and effectiveness of governance processes and procedures within Urology as relevant to your role?" 11:52

She says:

"I would say I've found some of the governance processes and procedures to be outdated with regard to nursing. I say this as I felt there had been no updating or refreshing of audit frameworks for many 11:52

years. Within my ward sister role, I was continuously reviewing and updating my own templates that provided me with assurance over the standards within my ward. Every month I reviewed the findings and if there was anything missing, I would update the template monitor thereafter. 11:52

In reply to the Director, Mrs. Melanie McClements, who asked if I was going to improve NQI", which are nursing quality indicator results, "I said the audit would need to be improved first as I did not find that it reflected what was actually happening. I recall her being taken aback by this comment. At the time the ward sister completed all the NQIs. I felt this enabled a potentially better picture to be presented than was actually the case. My intention was that on completing my independent documentation audit, that the findings would match the findings in the NQIs. This proved to be very effective as teams now knew I was completing independent audits that could contradict what was recorded in their NQIs and build a much more honest approach to auditing and assurance. I felt the staff on the ward saw audit as a paper exercise. It was only with a different approach and encouragement from ward sisters to include all staffing improvements that the mindset towards audit changed. Teams started to take pride and wanted to improve. This was particularly so in Ward 3 South." 11:52 11:53 11:53 11:53

Do you recall this interaction with --

A. Yeah.

95 Q. -- Ms. Ward? She seems to be suggesting that the formal indicators that were being relied on for governance purposes, and I presume other purposes, were not actually providing accurate information, and she seems to have developed a system whereby she felt the information she was providing was more accurate. Now, she said you were taken aback at that. Was that issue not being brought to your attention before? 11:54

A. Well, I was taken aback for a couple of reasons. First of all, Mrs. Ward would be a lead nurse who would cover a few wards, and the responsibility sat with the ward manager, who is a registrant, to complete those audits. Now, I would expect that the audit completed by a registrant to be accurate and honest and maybe not give a better picture of whatever. I think Mrs. Ward took a very proactive step to actually decide what else, what are the other domains that should be included in that audit, and I came up with a more effective audit tool and I will double-check that the findings are accurate. She used that as a tool, not just to audit but to actually teach the ward how to audit effectively and how to give an accurate process. The timing of that was shortly after I started, and the corporate nursing team were supporting me, and Ronan, with 3 South and risk assessment and improvement work with regard to nurse quality indicators.

I suppose I was a bit saddened that the nursing audits were outdated - because I am a nurse - they were outdated and hadn't been changed for years. So, I would have expected that that would have had a higher level efficient audit. But I think this is about learning in practice, and Sarah's example was here is an audit, we will test it, we tried it, and that audit ended up actually being rolled out to other areas as a result of her innovation. 11:55

So, she was taken aback because I couldn't believe that it was outdated, I couldn't believe there was a disparity between what I would audit and what somebody else would audit if you were using an effective tool, but it was in the search for the improvement that we needed. To me, that's an example of using the expertise of the staff on your team to do the bits they are good at and together to make it better together from a governance perspective. 11:56

96 Q. Is it also an example of proactive governance? 11:56

A. Absolutely.

97 Q. Rather than reacting to situations arising?

A. Absolutely.

98 Q. You started in June 2019 interim, and then substantive in October, and the 2019 reviews commenced in September. This was a corporate review of clinical and social care governance led by June Champion. You make reference to that at WIT-34216, paragraph 381. Back up to 382, please. Back up to 381, sorry, I just need to 11:56

get my first line. It's halfway down paragraph 381, the sentence that begins "There was a review". Do you see?

A. Mm-hmm.

99 Q. "... of clinical and social care governance corporately in September 2019 which looked at the system within the Trust and the potential to realign structures and increase resource available of the clinical and social care governance function. It was my hope that this would present the opportunity for additional support into the operational directorate teams. Whilst the proposals of the 2019 review were presented to SMT in September 2020, they were not fully accepted and required further work with regard to the corporate versus operational implementation of same. In November 2021, a further presentation to SMT agreed to establish a clinical and social care governance working group to strengthen assurance mechanisms and to realign the resources into a corporate team to facilitate standardisation and equalisation of processes and workloads with delivery arms within each operational directorate." 11:57 11:58 11:58 11:58

Then you say, just to finish that part off:

"In the interim I was conscious of the request for additional governance support within each division, and in the absence of adequate commission governance posts, I realigned some support from the recently established

quality improvement team in Acute services to support the Assistant Directors and Heads of Service to address some of the backlogs in incidents and action plans. This was in place from summer of 2021, and by May 2022 I had secured investment for four divisional governance officers, one for each division, which as I write are in recruitment."

You have said you have left obviously, and the posts were filled? I will just need you to speak the answer for the purpose of the transcription. 11:59

A. Sorry, yes.

100 Q. I don't want to sound like I'm speaking to myself.

In relation to this clinical and social care governance review in September 2019, what was your understanding of the background of this particular report? Was this something that the Trust did every now and again or there was a specific reason? 11:59

A. There had been a couple of reviews in earlier years since the Trust had formed, I think it was 2012 and 2015 potentially. Again, I think it was following Dr. O'Kane joining the Trust, seeing some vulnerabilities, potentially assisting with the potential of a better model, actioned by the Leadership Centre. June Champion was the Leadership Centre author was carried out the review. She worked, in fairness, intervening teams and relevant stakeholders to make sure she put together a comprehensive report. 12:00

101 Q. Were you interviewed?
A. I was interviewed. It was a very comprehensive report, I think it had 40-odd recommendations right across restructuring, Board agendas, SMT, risk. I can't remember them all but quite broad. Maybe it was too big. The first time it went to Trust Board in 2020 was that it needed more work, particularly around the operational versus corporate. I know there was a fear, I have to say, from an operational team that sometimes corporate teams function corporately, get the resource for that but still expect the operational teams to continue to do everything we used to do. So there was a tension, I believe, in terms of for this model to work, we have to have a corporate team that is actually visible and working with the operational teams, not making a call to do something and expect somebody else to do it. 12:00 12:01 12:01
102 Q. Was that something that was only identified as a result of this report, or was that information or views people had held before the review? 12:01
A. It was definitely a feeling before but the fact that we had our own directorate teams made it easier to influence their work plans. There was a fear that if they were all going corporate, we wouldn't have the same capacity. We were actually looking for more capacity to focus on clinical and social care governance and we didn't want less, so it was just that tension. 12:01

It then was modified and came back to Trust Board - I thought it was Trust Board - the following year; I think it probably went to Trust Board as well in '21. In the interim there were progressions with some of the areas that needed attention anyway. But the full review, when I left in 2022, was still in the process of being worked through and wasn't necessarily adopted. There was certainly elements of it that were in place but not all.

103 Q. If we could just go to the terms of reference of the review at WIT-35726. The purpose of the review, it's "Terms of Reference Southern Health and Social Care Trust Governance Review". It says: 12:02

"The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on Patient Safety and that helps people learn. The objectives: The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like. It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach through the organisation. It will include a review of both clinical and social care governance. Specifically, the work will include gaining an understanding of the current governance structure and processes in place; meeting stakeholders to identify what works well and 12:02 12:03 12:03

areas for improvement; undertaking a benchmarking exercise to identify best practice; review of existing and draft documentation, including a new governance assurance strategy. The outcome will be a written report outlining key findings from the review, and recommendations." 12:03

The governance assurance strategy, did it ever come to fruition?

A. I don't believe I ever saw one. 12:04

104 Q. For the Panel's note, the draft report - I think it was only ever called a draft report because of the inability to sign off aspects of it - but the draft report is at WIT-35725 to WIT-35782. The draft response from the Trust is at WIT-35783 to WIT-35803. 12:04 It might be helpful for the Panel to look at the Executive summary, given the issues we are going to come on to following the MHPS recommendation, which can be found at WIT-35929. That's one page, WIT-35730. 12:04

The first paragraph of the general background:

"The request came from the Trust to the Health and Social Care Leadership Centre to undertake an independent review of clinical and social care 12:05 governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation. This independent review was undertaken during the period of 5th May to the end of

August 2019. A total of 15 days were allocated for the review. The review was undertaken using standard methodology review and analysis of documentation and stakeholder meetings. During the course of the review, senior stakeholders provided the context to the development of integrated governance arrangements from the Trust's inception in April 2007, and from recommendations arising from an internal clinical and social care governance review that was undertaken during 2010 and implemented in 2013, and the subsequent revisit of the 2010 review undertaken in April 2015. 12:05 12:06

Senior stakeholders identified that there had been many changes within the Trust Board and the Senior Management Team over a number of years which had had a destabilising impact upon the organisation. They cited a number of individuals who had held the Accountable Officer Chief Executive in interim and active roles as having the most significant impact, and welcomed the appointment of Chief Executive in March 2018. It was also noted that the role of Medical Director had also been in a period of flux since 2011. 12:06 12:06

There were many areas of good practice outlined during interviews with senior stakeholders, including leadership walk-rounds conducted by members of Trust Board; a controls assurance group to continue to focus on systems of internal control; and patient and Service User experience initiatives, including the development 12:06

of a Lessons Learned video on engagement with a mother who had been involved in a Serious Adverse Incident Review involving the death of her child. This video has been used regionally at the Department of Health Inquiry into the hyponatraemia-related deaths, stakeholder for shared learning. The analysis also demonstrated that many of the building blocks for good integrated governance are in place. The Trust has an integrated governance framework incorporating a Governance Committee structure, a Board assurance framework and corporate Risk Register, and a risk management system with underpinning policies and procedures, for example, adverse incident reporting, health and safety and complaints and claims management. The analysis has identified good practice across these systems. However, a number of areas for improvement in gaps and control have been identified which will require action. 12:07 12:07 12:07

Similarly, there are areas of good practice as identified above which have been developed in operational directorates which stakeholders consider have not necessarily been shared or applied across the organisation. Some senior stakeholders identified a lot of connectivity across the integrated governance framework. Many stakeholders referred to the lack of a robust streamlined accountability and assurance reporting framework, which added to the perception that integrated governance was being delivered in silos. 12:08 12:08

In considering recommendations for the Trust, the reviewer took account of the Inquiry into hyponatraemia-related deaths by IHRD report and recommendation, and the ongoing work of the IHRD Implementation Group and Department of Health work streams. The report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 Findings and Analysis, and are broadly categorised under the following themes: Work governance, culture of being open, controls assurance, risk management strategy, management of SAIs, complaints and legal services, health and safety, standards and guidelines, clinical audit, morbidity and mortality, learning for improvement, Datix, clinical and social care governance structures. A summary of the recommendations is provided in appendix 1." 12:08 12:08 12:09 12:09

As a brief overview, do you agree or disagree with any of the contents of that executive summary? Do you think it's a fair assessment? 12:09

A. I think it's an accurate and fair assessment.

105 Q. Now, your involvement was on the SMT in trying to implement some of the recommendations. You mentioned about the operational risk versus corporate. 12:09

I wouldn't call it a struggle because I am not sure that's a word you would use but was there a tension between the competing expectations or demands that

perhaps ultimately led to the delay or the failure to implement these recommendations?

A. Yes. I think the time-lag doesn't help when there's a review happens in August '19 and, a couple of years later, or three years later, we are still moving forward with it. You then have pockets of developments to try and strengthen where we are now as opposed to the root and branch review being implemented. However, I think changes that have been made have been felt and felt positively. Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you. 12:10 12:10

106 Q. In relation to the directorate which you have or responsibility for, did you recognise some of the shortcomings and some of the potential areas for improvement? 12:11

A. I recognised the good stuff and I recognised the areas for improvement, and I particularly recognised the learning for improvement one, the need for actually learning and improving our systems as opposed to repeating a range of governance processes without necessarily having a focus on why. 12:11

107 Q. Were there any areas that were brought up that you hadn't been aware of? Given your one-to-ones and your communication with others, were you fairly familiar with the contents, or were there any areas you thought well, I wasn't over that or I didn't know about that or 12:11

it hadn't been brought to my attention?

A. No. Nothing in my world would have surprised me in any of the conversations or review findings.

108 Q. Now, under the Board governance aspect of that, which is the first one there, there are a number of recommendations related to the Trust Board, Board subcommittee, SMT structures meetings and procedures. For example, item 12 accepts: 12:12

"The integrated governance framework should be reviewed to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders." 12:12

Would that be something that you would endorse?

A. Yes. I mean, I think one of those was bringing the Director of Finance in to make it a more integrated approach because of the financial statutory responsibilities to the organisation. There were elements of that that absolutely made sense. 12:12

109 Q. Another recommendation was item 9: 12:12

"Provides for the integration of short term oversight groups into the governance structures".

Is it possible that the MHPS recommendation about a review of the administrative processes, which we will come on to, could be an example of such a short term oversight group, looking at one specific issue? 12:12

A. Absolutely. Although I think there was an independent

board in that recommendation, that maybe a leadership centre person driving that would have been the independence that we needed. But absolutely, that oversight function to pick up some of the unfinished business and some of the bits that needed attention, I think, is a good mechanism going forward. 12:13

110 Q. Giving the timing of this report and the September 2018 recommendation in the MHPS about an admin review, and this clinical and social care governance review then coming after that, was there any thought given that this was a possible vehicle by which that admin review could fall under this umbrella and perhaps gain some learning from that, given the independence of June Champion and, as you say, the requirement for the MHPS recommendation to be independent? 12:13 12:14

A. I'm just looking back at the terms of reference there, I don't know whether June Champion would have taken that on because, if I remember the wording correctly in the MHPS recommendation, it was "a full independent systems and processes" or something review within Acute Services. It was bigger than an admin and clinical review. That might have been how it ended up but it was bigger than that in intent, I believe. We probably haven't fully bottomed that out. It might have been too big to lump in, but the spirit of the potential of oversight, taking themes like this going forward, I think is a good one. 12:14 12:14

111 Q. There's mention also of it being "an open framework", and it refers to developing an interim solution pending

developments regionally.

Can you just explain that, what being an open framework as to what is being done?

A. It was part of the IHRD recommendations and the need -- the duty of candour. There was regional work going on led by some regional experts, and our staff were actually actively involved. I know Dr. Tracey Boyce, who is our Director of Pharmacy, was actively working with the Duty of Candour Working Group to feed in from the organisation and also to take some of the early learning and frameworks. I don't believe that has -- at least in my time it hadn't fully bottomed out, but there was definitely a drive in the organisation for openness and honesty, and in line actually with values of the organisation. That was the drive. You will see repeated emails exchanges in my witness bundle where I am asking is it right to share this; in the interests of openness we should be sharing this. There are different examples where we have actually been challenging each other to make sure we are delivering to the spirit of openness. 12:15 12:15 12:16

112 Q. So there has been a general improvement in the culture around that?

A. I definitely think so. One of those, for example, was the post Dr. Johnson report, and his comments back, you know, do we share these with Mr. O'Brien or do we, you know... Just challenging across the Medical Director and myself what's the right way forward to deal with 12:16

the openness angle that we are trying to cover.

113 Q. The report also made -- or the review, sorry, made some recommendations around risk management strategy. I will just give two examples. One of them is item 18, that: 12:16

"The Trust Board specifically should consider the application of the risk appetite matrix in respect of the organisation's corporate objectives and associated Board Assurance Framework and Corporate Risk Register". 12:17

Then item 20: "The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the risk management strategy". 12:17

21: "A standardised Directorate Risk Register template should be considered when Datix Risk Register module is implemented."

A. Mm-hmm. 12:17

114 Q. What are your views? Would they be recommendations or suggestions you would tend to agree with?

A. The first one on the Corporate Risk Register, I believe -- not only do I believe it but I also believe we implemented that, because we did have a new matrix for 12:17 the Corporate Risk Register because the Corporate Risk Register previously had been a wee bit of a nightmare in terms of the content and the oversight and whatever. So, it was worked through to a much higher level.

The responsibility for the -- what was it, the risk management strategy going to the Medical Director?

115 Q. It was "The management of the Board Assurance Framework and the Corporate Risk Register should be delegated to the Executive Medical Director". 12:18

A. I am not sure about that one. I worry that the Medical Director has too much already in her brief. I would be worried that we can be aligned to something and understand it and influence it without necessarily having the direct responsibility for it. I would want to think about that a bit more. And the third one? 12:18

116 Q. The last one was the standardised Directorate Risk Register template?

A. Again, that follows from the corporate, so if we have a new matrix for the corporate, our directorates have to fall in line with that so when we are escalating issues, there's a seamless transition, so that makes absolute sense. I am not sure we had got to the implementation yet of a new directorate one, but definitely the path was set with the corporate one. 12:18

117 Q. If we just go back to your statement at WIT-35792. I will read this out. The shared learning for improvement - and you may recall this in any event - six recommendations have been accepted to improve how the Trust manages SAIs. Do you recollect that, not specifically but that there were improvements suggested? 12:20

A. Sorry, where are you reading from? I can't see.

118 Q. I am reading from my note.
A. There are six recommendations --
119 Q. -- accepted to improve how the Trust manages SAIs?
A. Mm-hmm.
120 Q. "The implementation of the shared learning recommendation, and in particular the lessons learned forum, is said to be influenced by aspects of the SAI process". 12:20
A. Yes.
121 Q. You recognise that? 12:20
A. Absolutely.
122 Q. Given that, given those recommendations, and they seem to blend together some of the shared learning, as I have said, have there been any significant or practical improvements in how SAIs are conducted or managed, and how the lessons learned are disseminated? Before you had left, are you aware of anything? 12:20
A. Conducted and managed, not necessarily much changed except additional training and a capacity-building by virtue of that training, because you have more people. But the model of SAIs and the potential of further models hadn't really changed, you know external panels whatever. But definitely the lessons learned forum has been piloted and has had several iterations in terms of learning from what's working and what isn't working, and how we actually have a genuine model of cross directorate corporate approaches to learning in a way that everybody in the organisation can tap into that. There's been different approaches to a forum with the 12:21 12:21

great and the good, and then a forum with more interactive people who can experience some of the learning, and SAIs that aren't about one area or one directorate but that have learning across. So there is ongoing work, and there was when I left, around how we can actually have a more vibrant lessons learned forum. 12:21

123 Q. The shared learning forum that you just described, how does that operate in the context of Urology specifically; do you know?

A. Well, Urology would have had the opportunity, if they wanted to, number one, participate in it, share something from their world. There's always calls out from lessons learned. You know, does anybody want to share an example of something people need to know that I wish I had known earlier, or something that you want to celebrate? There's different angles on lessons learned. There would have been a callout for people to actively participate in that, and that would have been open to everybody across the organisation. I am not sure that Urology actually attended the MHD; might have attended as part of Maria's medical infrastructure but I am not sure Urology was presented at such. I don't know that. 12:22 12:22 12:22

124 Q. Just finally on the review. Under the clinical audit, there's an acceptance that the Clinical Audit Committee should be reinstated. Were you aware of that as being done? 12:23

A. Clinical Audit Committee? No, I am not aware that it has been done but there definitely has been a drive to

increase clinical audit. There were papers presented to Senior Management Team to secure additional funding for clinical audit because there had been a sort of decrease from what previously had been within the organisation, as I believe.

125 Q. Is that as a direct outworking of this review or that was another issue?

A. I think it's probably connected to this review, but it's a direct learning probably from some of our SAIs where we realised there wasn't great audit potential and capacity within the organisation and we needed to improve that. The nine SAIs is a good example of that.

126 Q. Were there clinical audit committees being established --

A. It wasn't in my time that I know but --

127 Q. (Inaudible due to over-speaking).

A. -- it might be now.

128 Q. I just want to move on to your awareness around Mr. O'Brien, some of the issues arising from that. WIT-34252, paragraph 557. You say:

"On 27th August 2019, I first became aware of issues regarding Mr. O'Brien. This followed a communication from the GMC triage team seeking further information from Dr. O'Kane following Dr. O'Kane's referral of Mr. O'Brien though them on 3rd April 2019. Ten points were raised by the GMC seeking a response in advance of 6th September 2019. Dr. O'Kane forwarded the email to Mr. Simon Gibson, Assistant Director, Medical

Director's office, Siobhán Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs. Vivienne Toal, Director of Human Resources & Organisational Development. On 10th September 2019 I was further copied into an email reminder for the requested information to the same email recipient." 12:25

If we go to WIT-34273, and paragraph 652. You say:

"I was never made aware of any issue relating to Mr. O'Brien's suboptimal administrative processes which led the management to learn of referrals and treatment of patients that there was some clinical issues. These came to light following the 11th June escalations by Mr. Haynes of the ten patients of Mr. O'Brien's requested by Mr. O'Brien to be added to the urgent bookable list on the same day." 12:25

We will go on to look at those issues in a moment. Were you surprised that the directorate had failed to spot and address the clinical issues sooner, when you learned of them? 12:26

A. Yes, because I was always told Mr. O'Brien was a top-notch clinician, and his issues were of administrative nature. So, I was surprised. 12:26

129 Q. How do you account for not being told or the directorate not being made aware generally of these concerns?

A. I account for it because I think people were naively looking through a lens of admin delays. But at the end of an admin delay is a patient, who delays impact on their access to services and their potential for a diagnosis and a safe treatment plan and a potential for harm.

So, you know, it's easy to say now but if there's a recurrent theme of tardiness in terms of administrative procedures, I'm surprised that there wasn't a greater look at what else because there's often other issues with staff, not just one issue. My experience is that when there's something, look a bit deeper because there might be something else. I am surprised nobody over the years ever looked underneath rather than at the top level issue that was obvious. 12:27

130 Q. Do you think that the failure for you to know or for others to be made aware was a weakness in the system of governance, in the culture generally, or a combination of both? 12:27

A. I don't think it was -- I think it was definitely a failure in the governance. Was it a cultural thing of withholding information or not being open? I don't believe so. I think it was genuinely a case of people thought we have this in hand and hadn't actually considered what else might be there. It was only in 2020 that that was really prompted at a higher level. 12:28

131 Q. Just in the next paragraph, 653, you say:

"One of the themes identified to date is with regard to compliance with standards and guidelines for the prescription of medication, Bicalutamide in this instance. The usual mechanism following an identification of a medicine governance concern within the Trust is to record an incident on Datix, escalate serious issues to me through the Director of Pharmacy, and include the issues in a quarterly medicine report to the Governance Committee. However, with regard to the specific medication, Bicalutamide is prescribed by general practice on the advice of the urology consultant, and therefore the clinical team or the Pharmacy Department in the Trust would not have been aware of the anomalies. If a GP receives a dosage of medication for prescription from a urologist, they may be guided by the urologist's clinical expertise and not query what appears to be an unusual dose. This highlights the necessity for effective auditing of systems and processes used by individual clinicians across primary and secondary care interfaces." 12:28 12:28 12:29 12:29

Now, you seem to be suggesting in that that the issue that has arisen around Bicalutamide fell through the cracks of existing governance systems in place because it's an individual clinician's practice and may not be picked up? 12:29

A. And also fell through the cracks of the MDM process and the outcomes and the audit of those.

132 Q. That may explain, at least in part, some of the reasons

why matters weren't highlighted, but other issues around the alleged use of nurses' delays in referral, not actioning results and not bringing matters back to the MDT, would you have any explanation as to why they weren't spotted? 12:30

A. It never ceases to amaze me that there wasn't a process, and I didn't understand there wasn't a process and I should have been more curious about that. But normal process is if a range of experts are guiding with an effective treatment plan, there should 12:30 be some sort of process embedded for monitoring or oversight, or taking back to the MDM if there's any further guidance or change or whatever. So, I was disappointed and amazed that that wasn't automatically built into the process, and that's my lack of scrutiny 12:30 to understand that that wasn't in place.

133 Q. Now, you go on to say in paragraph 654 -- I just want to look at it because it gives an overview of what you didn't know when you came into post. You say at this paragraph: 12:31

"I was aware of governance concerns regarding the Urology Service from early June 2019 as described in earlier responses, including the aggregation of several SAIs that were related to Mr. O'Brien's patients. As I 12:31 have progressed within the Acute Directorate post, I have become more aware of things I didn't fully appreciate, including the following:

Dr. Neta Chada and Mrs. Siobhán Hynds did the MHPS investigation into Mr. O'Brien with governance and Patient Safety at the cores".

And my comment now for the transcript: We have previously spoken about your view that there is a way to share that and maintain confidentiality. 12:31

"And that Mr. O'Brien had been previously excluded from work. Dr. Ahmed Khan's case determination report was based on the MHPS investigation. The determination report had been shared with the CEO and was paused due to the grievance being lodged by Mr. O'Brien." 12:32

Just pause there. That information that had been shared by the CEO and was subsequently paused as a result of the grievance by Mr. O'Brien, where did you get that information from, do you recall? 12:32

A. I presume in some of the follow-up meetings from the Oversight from October '19 and February '20. 12:32

134 Q. Then you weren't aware that one of the recommendations in the MHPS case determination report was for a system-wide review in Acute broader than Urology.

Given how specific that is to your role and to your responsibility - we will go on to when you find out - what was your view when you find out that recommendation had been made and you weren't informed? 12:32

A. I couldn't believe it but nor could I believe that the

Assistant Director hadn't been informed. My route from evidence and intelligence from the operational team would be for that to be shared and escalated to me, but Mr. Carroll didn't know that. The only excuse, if it is one, that I would think why, is because of the word "independent". You know, maybe somebody thought somebody else was doing it because it was an independent review, and it never been directed directly to Acute staff. I couldn't believe that a recommendation like that hadn't been shared and actioned. 12:33

135 Q. You have subsequently seen the recommendation and we will come on to it. If you had have read that at the time, how would you have actioned that or who would you have assumed would have taken lead on that? 12:33

A. To me it would have been somebody external because it was an independent review of Acute services not of one element and not of one theme, like admin and clerical.

136 Q. Who within the Trust would take that forward to an external reviewer? 12:34

A. I would be looking for somebody from the Leadership Centre with the expertise in system-wide processes to potentially take that forward.

137 Q. You also weren't aware there appears to have been enough concern in 2016 to merit close monitoring, and further scrutiny to proceed. You say: 12:34

"I didn't know when I commenced my tenure in June 2019 that Mr. O'Brien had been referred to the GMC in April

2019. I didn't know from the outset how many SAIs were four-years-old and not concluded, how many had been significantly linked to Mr. O'Brien and pro rata appeared at a higher level than other urology consultants". 12:34

That's a list of matters not only did you not know, but would you now say that you should have known even if there was a confidentiality thread throughout?

A. Absolutely. I mean, you can't be an operational director and work in an absolute silo away from professional confidentiality. You have to be part of that loop. And you are part that have loop in a lot of other fora that we have, for example the Doctors and Dentists Oversight Group. So if it can go in that window, it can go in different windows. 12:34 12:35

138 Q. At WIT-34247, paragraph 533 - this is when issues were highlighted to you - you say:

"The two main issues that were escalated to me of a more serious nature during my tenure as Acute Services Director were the breaches, already significant, regarding the MHPS return-to-work action plan escalated by Mrs. Corrigan in September 2019, and the escalation from Mr. Haynes in June 2020 prior to Mr. O'Brien's retirement." 12:35 12:35

If we go to WIT-34144, at paragraph 75 you talk about the breach on 16th September 2019 being

"... a breach of Mr. O'Brien's agreed administrative return to work action plan were escalated. An email was sent detailing the breaches from Mrs. Corrigan to Dr. Khan, Case Manager, and copied to Siobhán Hynds. These related to noncompliance with Trust policies and procedures in relation to triaging of referrals, contemporaneous note-keeping, storage of medical records, and private practice, following issues originating in 2016. Mrs. Martina Corrigan, Head of Service, was monitoring his administrative processes. In the email communication, it was highlighted that noncompliance had been identified with lack of timely triage of referrals, some of which were urgent, which was in breach of his agreed action plan. The second concern related to the action on digital dictation which was not complied with." 12:36 12:36 12:37

You have mentioned halfway through that paragraph "noncompliance with Trust policies and procedures" specifically in relation to triage and contemporaneous note-keeping. Are you aware of any Trust policies and procedures that govern those two aspects of patient care? 12:37

A. We use the Integrated Elective Access Protocol as the yardstick for the triaging of referrals. It gives timelines and whatever around the triaging of those. That would have been what I was referring to there. 12:37

On contemporaneous note-keeping, I can only speak, is a professional expectation from all of our record-keeping across our professions. From a professional standards perspective, that's expected. But also in our standard operating procedure within the secretarial teams and Referring Booking Centre, that's why a backlog was created, to try and highlight where we had issues with note-keeping delays and how that then backlogged for particular secretaries. 12:38

So, they were the two routes that we would have had to professionally guide the note-keeping but also to monitor it from an admin perspective.

139 Q. In relation to the September 2019 breach that you referred to, you have mentioned how it was handled by Mrs. Corrigan. Do you think that was properly handed? 12:38

A. Again, I think I am back there to the professional loop of the MHPS closed loop. Martina would have escalated to Ahmed and Siobhán, as the HR and case determinator, whatever the term is, in that loop to let them know. Eventually, because Martina was part of the operational team, it came to light through the Medical Director, and it would probably would have also come up the route from Martina to Ronan to myself. But again, I would have expected first off that I'm in that email, because I can't operationally manage something that I don't know is happening because it's in a closed professional or HR loop. 12:39 12:39

140 Q. Do you think that closed loop, that hangover of the

maintaining confidentiality and dealing with things through individual processes when a breach does happen, the loop stays closed?

A. Yes.

141 Q. Do you think that should have been the point at which you were made aware? 12:39

A. Yes, and I think Mrs. Corrigan was probably following due process but I think that due process needs looked at.

142 Q. If we go to WIT-34202, paragraph 320. This is your account of the breach and when you became aware of it. You say: 12:40

"With specific reference to patient risk and safety in Urology Services, my first challenge came in October 2019. Mrs. Corrigan, Head of Service, had escalated concerns to Dr. Khan and Siobhán Hynds." 12:40

Move down just slightly, please. You can see the last part of the paragraph here at 34203: 12:41

"I was informed by Mrs. Corrigan that this was the first breach detected by her following ongoing monitoring for a two-year period. Ongoing monitoring was agreed as part of the assurance going forward, and this continued with no other non-compliance noted in this regard until Mr. O'Brien retired in 2020." 12:41

In evidence, I have taken Mrs. Corrigan to examples of

breach and we will do so again, but for the Panel's note, there were breach examples on 23rd January 2018, TRU-275135, about triage. Then, another example on 30th March 2019; it's at WIT-55773. That's an email trail about non-triaging again, but your understanding was it was the first time? 12:42

A. I don't believe I was informed about either of those and I believe I was informed that this was the first breach.

143 Q. Did Mrs. Corrigan tell you this face-to-face or was it by e-mail correspondence, or how was that communicated, that particular aspect? 12:42

A. I think from memory we had the Oversight meeting where the detail was discussed, because we had the email trail circulated through Dr. O'Kane's office and at that I believe it was the first breach, is my memory. I may be wrong but I believe that that was the first -- the note of the first breach. 12:42

144 Q. There were also some breaches when Mrs. Corrigan was off work at one period of time. If you had known about the history of breaches, might that have changed your view of and your approach to the September 2019 breach? 12:42

A. Yes, it would, because I think there was evidence of inability to sustain a commitment to compliance with triage, and other action areas. 12:43

145 Q. What might you have done at that time had you been aware that, in fact, this wasn't the first breach?

A. Well, I would have liked to get a group of representative people together from operational and

professional staff and say, okay, this keeps coming to the fore, we need to dig underneath and look is there anybody coming to harm as a result of this, and I don't think we had lifted the potential for patient harm lens at that stage.

146 Q. If we go to WIT-34248, paragraph 539. The first issue was the breach. The second issue that you have referred to at paragraph 533:

"The second serious concern was escalated to me by Dr. O'Kane, Mr. Carroll and Mrs. Corrigan on 11th June 2020 was the incident relating to patients identified by Mr. Haynes Mr. O'Brien had requested to be added to the urgent bookable list that they should have been added to the waiting list any time between 18th July 2019 and 4th July 2020. This was as a result of an email from Mr. O'Brien on 7th June 2020 to Fiona (inaudible) and Jacqueline McIlveen, temporary secretarial cover, adding the ten patients who required urgent admission and, he advised Mr. Glackin of same on 4th June 2020. Mr. Haynes had already arranged to admit one of those patients to Kingsbridge Private Hospital. This is a serious concern as standard procedure is that a patient is added to the PAS waiting list at the time of listing and not at time of offering a date for surgery. The concern expressed by Mr. Haynes was that there could be other patients who were not administratively on the waiting list but should be, with the risk that patients could be lost to

our care. Out of the ten patients who were reviewed by Mr. Haynes, four were classified as having malignant disease and one with potential malignant disease. A response from Dr. O'Kane on 11th June 2020 highlighted how concerning this finding was, and the need for an urgent meeting to be planned to assure ourselves that these patients were safe, identified others that had been delayed, and referencing spirit of openness regarding conversations with patients that might be made to make them aware. She also was concerned that this appeared to be it a continuation of the behaviours that led to the serious adverse incidents previously."

Now, do you remember this particular issue about the waiting list? 12:45 12:45 12:46

A. Mm-hmm, yes.

147 Q. The Inquiry has heard evidence in relation to this from Mr. Haynes, and we will hear from Mr. O'Brien as well on the issue. Now, given the fairly unique context of that at that time, it seems to have been an issue that hadn't previously been brought to your attention anyway. Did you take any steps to check the validity or the veracity of the information that you were given? Firstly, who gave you the information? 12:46 12:46

A. Well, the email trail came through Mark Haynes, and I can't remember if I was copied directly at source or whether Maria sent me it. I think I was copied from Mark at the time.

The short answer is no, I didn't, because I wouldn't have access to the systems and I wouldn't be interrogating those systems. So I would trust the daily users of the system that if patients aren't on the waiting list or don't appear to have been added at the time of the appointment, which in some cases was back in 2019, I wouldn't have followed up that, I would have trusted that and presumed the clinician to have been right. 12:47

148 Q. Accepted that information.

A. Yes.

149 Q. So you wouldn't have any knowledge of the databases the patients were allegedly added to or if they had already previously been added to the database? 12:47

A. No.

150 Q. You have said in that that Mr. Haynes had already agreed to have one of these patients admitted to Kingsbridge Hospital?

A. Yes. 12:48

151 Q. Now, there was email correspondence back and forth, but your evidence is that you relied on what you were told?

A. I relied on what I was told, took it on face value and believed it to be a true and honest picture of the waiting list information. 12:48

152 Q. Mr. Haynes gave evidence and the Panel is aware of this. One example of his oral evidence is that when he did put the patient's name in, he had a filter on and, when he took the filter off, one of the patients did

appear, so there was some rectification of actual events. But you weren't aware of any of that -- did you ever become aware of that?

A. The first I became aware of that was reading my bundle.

153 Q. Did you ever speak to Mr. O'Brien about this issue? 12:48

A. Absolutely never.

154 Q. Did you ever speak to Mr. O'Brien at all about any issue?

A. I never spoke to Mr. O'Brien.

155 Q. I think you met him in the lift once? 12:48

A. I met him in the lift and I asked who he was when he got out of the lift, but I never actually knew him.

156 Q. Did anyone ever say to you that there was, in fact, no delay in entering any of the patients on the waiting list for admission; no? 12:49

A. No, and I'm not sure when the system became aware of that but I never knew that. Therefore, a lot of the communication that flowed to the Board and to the Department would have referenced that information as being our trigger but was then, if what you are telling me, it would have been inaccurate. 12:49

157 Q. After being made aware of the breach, you became aware of the first Urology Oversight meeting?

A. Mm-hmm.

158 Q. For the Panel's note, reference to that in Ms. McClements' witness statement is WIT-34212, paragraphs 367, 368. The email trail around that on 4th October 2019 can be found at WIT-35720. 12:49

The Trust Urology meetings then flowed from this, from this initial Oversight. They were attended both operationally and clinically; is that your recollection?

A. Are we talking 2019 or 2020? 12:50

159 Q. 2019.

A. 2019, yes.

160 Q. This was the 4th October, the timeline. This is just when issues had arisen.

A. Yes. 12:50

161 Q. So you had become aware --

A. That's right.

162 Q. -- and there was a concentration, I think, or a focus to see what was happening, and you were involved in that. This dealt with all of the matters, including 12:50 reducing patient risk associated with delays in accessing services. A pretty broad range of topics that were discussed - establishing the mechanism for patient reviews, and timely follow-up on agreed actions and compliance with S&Gs. 12:51

Was this the first time when -- obviously you cover all of Acute Services, but your focus on Urology, was this the first time for you that you were able to get beneath some of the issues that had come across your 12:51 desk or you had found out what was really going on?

A. This was the first opportunity, yes.

163 Q. Given the range of topics discussed at it and the intentions around trying to move things forward, both

in patient care but also in governance - perhaps not separate issues at all - do you feel that these Oversight meetings and the Urology meetings actually achieved --

A. I actually think they were effective because had they not been in place, we would again just have been approaching this in a singular fashion. But to have clinical staff, Medical Director, operational staff in the room definitely had benefits and gave clarity on roles and remits. 12:51 12:52

164 Q. WIT-34252 and paragraph 561. This was the first meeting that mentioned the admin review from the MHPS, at least as far as you were aware. You say "It was agreed at the Oversight meeting", and this is the 8th October meeting we are talking about? 12:52

A. Yes.

165 Q. "That Dr. O'Kane would ask McNaboe to discuss the concern with Mr. O'Brien and to make him aware that this had been raised with the MHPS Case Manager, Dr. Ahmed Khan". That's reference to the breach. 12:52

"Dr. O'Kane also agreed to consider the escalation, including the potential option to exclude, and also to consider progressing the full system review noted in the 28th September 2018 MHPS review. This later point 12:53 references the final conclusion and recommendation in the MHPS Case Manager determination report dated 28th September 2018 authored by Dr. Ahmed Khan, which states the following".

I just want to read the last part which is relevant to the review. It says:

"In order for the Trust to fully understand the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system-wide problems to understand and learn from the findings." 12:53 12:53

You have mentioned it earlier and there it is, the word "independent" review. We will go on to look at who, if anyone, took up the mantle of that. It does seem to have drifted slightly. This is September 2018, this is the 8th October meeting 2019, it's the first time that you have become aware of it. What was anticipated at this point whenever this was on the agenda and people's attention was brought to it? 12:54 12:54

A. I think, from memory, the notes of that meeting were that Dr. O'Kane had undertaken to go and progress that. Again, probably because of the wording in it, I would have seen that as something from a governance corporate perspective and Medical Director perspective, that would have been appropriate. There wasn't another Oversight meeting until February '20, so there probably were conversations between Dr. O'Kane and myself in 12:54

that intervening period - and there may not have been, I don't recall them - but there was no formal meeting about the actions again until February.

166 Q. Was there an expectation, from your part at least, that Dr. O'Kane was taking the lead on this? 12:55

A. Yes. I think that's what the -- there's an email trail in my bundle. That actually is Mairéad, and Mairéad's handwritten notes from the meeting -- or email. My understanding is she undertook to progress.

167 Q. There are notes, we will go to those. TRU-252529. In the Panel's note, you will find the agenda for this meeting at WIT-35720. They are described, I think in Mrs. O'Kane's statement or someone else's, as rough notes of the meeting which sound like bullet points. This is from Maria O'Kane, 8th October 2019 at ten to three in the afternoon to you, Mr. Haynes, Ahmed Khan and Siobhán Hynds, discussion draft notes. They are just in bullet points. I will read them out for the record: 12:55 12:56

12:56

"Discussion draft notes: 1, concerns re escalation. 2, concerns re process. 3, concerns re PP and making arrangements for investigation through the NHS. Interface with PP policy, letters no longer on NIECR. Now that patients are on this without letter, consider how tracking. 1.1. How can each be monitored and how is this escalated if concerns monitored through the information office. Concerns re notes at home, weekly spot-check, meant to sign notes out. He has a 12:56

condition on his action point that he is not to take notes home. Make assumption that if notes not in his office or clinic or theatre, they are in his home? No transport to take notes between CAH and SWAH. Monitoring difficult.

3. Martina can only monitor what she is given. His secretary has not engaged. Martina has had to go on to ECR to check if notes uploaded."

The next point: 12:57

"IR1 went in from MDT on Wednesday last. First cancer patient AOB letter on patient sent Friday. Second patient did not come to harm following escalation to MDT by trackers which puts contingency checks into system for all clinicians in Urology". 12:58

Then the plan is to ask Mr. McNaboe

"To discuss concerns with AOB to make aware that this has been raised with the MHPS Case Manager on leave until Monday. Will consider escalation plan including option to exclude. 3. Will consider the full system review September 2018 and progress." 12:58

12:58

So, not much detail on the last point but --

A. I assume those three actions to be Medical Director actions when I get that.

168 Q. Including the full system review?

A. Yes.
169 Q. That was a Medical Director action?
A. Yeah, well --
170 Q. From Mrs. O'Kane?
A. Yes. 12:58
171 Q. Chair, I just see the time. I am just going to move on to some other emails and references, so if this would be convenient?
CHAIR: We will come back then at 2:00. Thank you. 12:58
THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

172 Q. MS. McMAHON: Ms. McClements, just before we broke for lunch, I had asked you a question in relation to the 14:00
waiting list issue about which you said you had no knowledge or information; the information provided by Mr. Haynes. Now, the point I was seeking to put to you was in relation to whether you had any knowledge about the data or information that was relied on from 14:00
Mr. Haynes, and I gave you an example of him removing a filter on one of his searches, and you had indicated you don't know anything about any of that.

The Panel will have heard Mr. Haynes' prolonged 14:01
evidence on that issue and can make their own decision around it. The point I sought to put to you was to try to ascertain if you knew any of the background information and, as I understand it, your answer is that you didn't? 14:01

A. That's correct.

173 Q. I just want to start the next section about the MHPS proposed admin review at the end submitted by asking you -- I know that we will come to the draft review that was eventually submitted, the short review that 14:01
the Panel will be familiar with. Was that the only review that you knew had been completed by the time you retired or was there anything more substantive done in relation to that recommendation?

A. No, that was the only one that was completed.

174 Q. Chair, what I propose to do, rather than take you through all of the references and emails to show the inaction, I will take you to the chronology of references to the review and the opportunities to perhaps do something in chronological order, and you will have then a pathway to the end of what was produced. 14:02

You can perhaps answer this. Was it the case that the GMC inquiry about the update on a review was what really triggered or focused people's minds in August 2019? 14:02

A. That's correct.

175 Q. This first date for reference is 27th August 2019, and it's the letter from the GMC asking for an update. That can be found at WIT-345001. Sorry, 34500 and 34501. In the response to that, the Trust advised that the admin process had not been commenced. The second date is 30th September 2019. That's an email from Maria O'Kane to you and others seeking an update on the MHPS recommendations as she was to meet with the GMC, and that's at TRU-252526. Then, on 4th October 2019, an email from Mrs. O'Kane to you again and others to set the agenda for the meeting that we looked at earlier, to discuss issues with Mr. O'Brien and to include an update on the recommended review of admin processes from the MHPS report. That can be found at WIT-34484. 14:02 14:03 14:04

The next mention of the review is an email from Mrs. O'Kane to, again, Ms. McClements and others on 8th December 2019, drawing attention to the recommendation of the MHPS report in that the Urology system should be reviewed. That's at TRU-252611. The next mention is 30th January 2020 from Ronan Carroll to Ms. McClements, stating he had not been involved in the process or received any report, and he hadn't been able to read the recommendations or the role that the AD was expected to play. That can be found at TRU-252713. That's your recollection as well, that Mr. Carroll wasn't aware of the recommendations? 14:04 14:05

A. That's correct. I think I had forwarded the email of 8th October with three attachments on it. I don't think Mr. Carroll believes he received that but I felt I had sent it on 8th October. 14:05

176 Q. Around the time of the first Oversight --

A. Yes. But again even on reading that, he probably wouldn't have read it as his action because it said "independent". 14:06

177 Q. "Review". In fact, it wasn't attached to anyone. There was an initial attachment to Maria O'Kane and there's a later reference to Martina, but it wasn't explicitly stated. 14:06

The next date is 10th February 2020, and that's an email from Maria O'Kane to Ronan Carroll, sharing the MHPS report and recommendations, where Mrs. O'Kane says

it predated her and she had discussed a number of times with Esther Gishkori. That's at TRU-252712. Mrs. Gishkori had never passed that on to you?

A. No.

178 Q. Then we have 12th February 2020. This is the Oversight meeting you had mentioned just before lunch. Actions agreed to try to progress the recommendation. You make reference to that in your statement at WIT-34235, paragraph 473. 14:07

14:07

There's a further email on 14th February 2020 from Siobhán Hynds to Maria O'Kane and you and others, with the note of the 12th September meeting. One action is for Siobhán Hynds to draft terms of reference for independent review of SAI and MHPS recommendations with the terms of reference to go to the group, Urology Oversight group? 14:07

A. That's right.

179 Q. That can be found at TRU-252760 and 61. There is actually a document I would like to go to. Before that, it's 13th February 2020. If we go to TRU-252765. This is a confidential response to the RQIA, who the GMC had shared with the information with under their memorandum of understanding, as I understand it to be. The RQIA had sought some assurances from the Trust about what was the current position and what measures were in place? 14:08 14:08

A. That is correct. Yes.

180 Q. This is dated 13th February, for the Panel's note. You

will see on the action side on the left:

"The Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system-wide problems to understand and learn from the findings".

The responsible person on this is Mr. Carroll. Now, do we know how Mr. Carroll's name found its way on to the responsible person at this point? 14:09

A. I think it had been forwarded to him to populate that section because they were aware some admin and clerical processes had been put in place. And because it was within Urology, I think it was sent to him, that he was -- he pre-populated, I believe. 14:09

181 Q. When we look at responsible person, is that to be interpreted as the person responsible for populating or the person for responsible for taking the action? 14:10

A. I think that was given to Ronan pre-populated probably through the Medical Director's office, who were coordinating the response. The progress update, I am reading, will have been populated by Anita Carroll, who is the Assistant Director of Functional Support Services. 14:10

182 Q. This information was provided to them --

A. Sorry, I am probably wrong there reading. It was probably populated by Ronan because they reflect

Martina's monitoring.

183 Q. The progress update on that:

"The Trust has not undertaken an independent review of the relevant administrative processes within the Acute Directorate. However, the Trust does have in place the following processes: Continuous monitoring of triage of letters; continuous monitoring of storage of medical notes and records; continuous monitoring to ensure clinical dictation is undertaken in a timely manner; continuous monitoring to ensure that private patients are reviewed according to clinical status". 14:10 14:11

Anita Carroll has put this part in in B:

14:11

"The Trust monitors the administrative and clinical aspects of the patient's journey, producing this Backlog Report which is shared with each division on a monthly basis."

A. Yeah. 14:11

184 Q. Given the vulnerabilities of the backlog report we discussed earlier, would you accept that as an assurance it's probably not as robust as it might be?

A. At that point in time it was the best they had, and that led to the follow-up work. 14:11

185 Q. In relation to the vulnerability of the information?

A. Absolutely. Absolutely.

186 Q. There doesn't seem to be any other major reference until July 2020. This is an email from the GMC

investigating officer to Vivienne Toal and Dr. O'Kane and others, asking whether the review of relevant administrative processes recommended by Dr. Khan has been completed. That can be found at TRU-292466. Dr. O'Kane replies on 21st July 2020 to indicate that: 14:13

"The independent review of relevant administrative processes as recommended by Dr. Khan has not yet been completed. This is scheduled for conclusion by September 2020". 14:13

That email in that chain is at TRU-292465.

I think, in reality, the review hadn't been started; would that be fair? 14:13

A. That would be fair.

187 Q. On 31st July 2020, Stephen Wallace shares the terms of reference with Martina Corrigan and confirms that there's a meeting the following Thursday to commence. If we go to that at TRU-292694. You will see the terms 14:13 of reference in this email. The body of the email tells us that Drs. McCullagh and Donnelly are agreed to conduct this work and will commence next week. I understand they are GPs?

A. They are also employed sessional by the Trust as 14:14 Divisional Medical Directors or Associate Medical Directors in Primary Care.

188 Q. The purpose of the review is set out as being:

"The purpose of the review is to review the Trust Urology administrative processes for management of patients referred to the service".

Then it sets out the matters that the review will look at. 14:14

"The review will consider the present Trust Urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following: The administration processes regarding the receipt of and triage of patients referred to the Urology Service from all sources; the effectiveness of monitoring of the administration processes, including how and where this information is reviewed; the roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes; the effectiveness of the triggers and escalation processes regarding non-compliance with administrative processes, and to identify any potential gaps in the system where processes can be strengthened." 14:15 14:15

In relation to those objectives, were you spoken to about those or consulted with on those? 14:15

A. I presume I must have been.

189 Q. Because?

A. Because it would be normal process. I think I must

have been but I actually can't recall it.

190 Q. The next in the sequence is 10th December 2022. This is from Dr. McCullagh, saying that she and Ms. Donnelly had been tasked with the admin review and are asking to discuss with booking staff. This is forwarded to you. 14:16
It's at WIT-22854. You respond on the same date, saying "It is a prospective review of the admin systems and processes". This is the email where you say Martina is guiding the scope of it. By this stage, there had been a shift in who was deemed to be holding 14:16
the reins of taking the process forward?

A. Well, if Ronan had been aligned in that previous confidential response, he would have naturally delegated that to Martina, who was Head of Service, to do the legwork with it. 14:17

191 Q. Can I ask you just to put the mic. Sorry, it's just the sound is a bit difficult in this room. Thank you.

You had no decision-making around the delegation to anyone doing the review or undertaking that oversight? 14:17

A. That would have happened within the operational team.

192 Q. Next is 29th September 2022 at TRU-293276. This is when Mrs. Corrigan shares a copy of what used to be the draft report. If we could just go to that, TRU-293276.

CHAIR: Was it not 2020 rather than '22? 14:17

MS. McMAHON: Sorry, 2020. Sorry, my mistake.

193 Q. So, this is an email from Dr. Donnelly to Mrs. Corrigan, 21st September 2020, to say:

"Just to let you know, Rose is going to complete this and has taken on some additional duties with (inaudible) practice. If you have any comments would you mind e-mailing them to Rose at her gmail account as above. She is on leave this week." 14:18

So, Martina Corrigan then sends this on to you, Mr. Carroll, Siobhán Hynds, Mark Haynes, Maria O'Kane, Vivienne Toal, Stephen Wallace: 14:18

"Dear all, can we discuss please. Document 2 is what Maria sent me and I have attached what the ToR were as conscious this needs to be complete and sent to RCS by tomorrow." 14:18

The last part of that sentence, what did you think --

A. Royal College of Surgeons, sorry.

194 Q. Had you understood that there had been some timeline for them to be provided with this information?

A. I presume there was a timeline but I didn't know where the college were actually in that loop. 14:19

195 Q. If you just move up and we will see - the Panel have been brought to this before - Siobhán Hynds e-mails Vivienne Toal to say "Surely this can't be it" and Vivienne Toal says, "I have no words for it, none at all". 14:19

You had a look at the report at that point, and you have a long history of governance; what was your view?

A. Sorry. They are Divisional Medical Directors and primary care who are also GPs, and I think Dr. O'Kane would have said it was good to have a GP perspective on the referral routes and the processes wrapped around that. 14:19

When I look back now on the terms of reference, it was too narrow to begin with in terms of what the MHPS recommendation was. But when it came back, it was just not really of any fit purpose for -- and we were 14:20 disappointed in it.

196 Q. Then we move post the receipt of this to 8th October 2020, and that's at TRU-255798. It's a handwritten note but, as I understand it, there are some phrases that can be extracted from this. I'm not exactly sure 14:20 how or where but it seems to indicate that there's some reference, halfway down there at number 2, "Closer look at systems processes, Anita". Then there's a reference to SAI recommendation, MHPS and work to date. Was Anita given responsible for progressing this? 14:21

A. Yes.

197 Q. This is just really part of the chronology. I won't ask you to read any of that unless you think you can.

A. That's us undertaking we were now going to have to take on a closer look at the systems and processes because 14:21 the external view hadn't been that helpful. That led to - maybe you don't want me to say this yet - but that had led to Anita working with Martina to refresh a lot of our systems and processes and assurances within

that, but also to work with Belfast Trust because that was our best option, to have an external viewpoint and to compare our Southern Trust processes for the same things in Belfast Trust to see were we really out of line, could they give us good ideas, how was that. So they did work with Mrs. Lynd in Belfast Trust.

198 Q. That was the outworking of it?

A. Yes.

199 Q. But this is a process aspect of it, and they did work as well on the report? 14:22

A. Yes.

200 Q. If we go to email of 9th October 2020, at WIT-22866. This is from Anita Carroll to you on 19th October. Sorry, the bottom one is from Anita Carroll to you on 9th October. She says: 14:22

"Following on from our conversation I have included a few things for consideration. Admin review doc. Looked at what Rosemary produced and added some context and we did the recommendations." 14:23

Then she sends you another version of the same thing. It seems that Mrs. Carroll has taken the reins of this and is modifying or amending the report?

A. Yeah. 14:23

201 Q. Would that be fair?

A. And working, I think it is fair to say, with Martina from an operational perspective as well.

202 Q. Then there seems to be a reference - we don't need to

go to this - on 28th October 2020, which makes a reference, a handwritten note "MHPS protected timeline, four years grievance". That's at TRU-255820. Again, on 3rd November 2020, a handwritten note with reference to "MHPS recommendation re AP", which could arguably mean admin process, found at TRU-255827. Then on 10th November 2020 we have an email from Mrs. Corrigan, TRU-271688, to various members of management including Vivienne Toal. It says "Attached admin processes for comments." 14:23 14:24

TRU-271688. Mrs. Corrigan sends this "attached admin process for comments". Then:

"As discussed, the actual numbers in the description of issue is just for us internally so as to provide you with the scale of the issue at the time. These figures will be removed for whoever will be looking at this for us independently." 14:24

Can we just look down at the next document. Just go down to the next page. This is the way in which the document now appears, and you would agree that it's substantially different from the initial iteration?

A. Yeah. 14:25

203 Q. There's been a lot of information put in, and modification. Just, the word "independently" jumps out from Mrs. Corrigan's previous email. Was the plan that the review would be -- well, tell me what the plan was.

A. Well, the plan was we wanted to get this progressed, so we were prepared to look at our own systems and processes and what we had and what we could improve on in place, and then we wanted to honour the expectation of independence and work with somebody else to say this is what we have, this is what we do, have you any other thoughts from an objective perspective to guide us on what else we should do to improve Patient Safety and better fail-safes.

204 Q. Was this supposed to be a form of a briefing paper for whoever the independent reviewer was? 14:26

A. This was to check from an organisational perspective for all the people who were copied into that email that we need you to check this is what we have done so far, does it feel right before we go towards the independent person. 14:26

205 Q. I will just ask that question slightly differently. Was this to provide an evidence base of what was being done so that an external independent reviewer, as anticipated by the MHPS recommendation, would build on that? 14:26

A. Yes.

206 Q. So this wasn't meant to be the report?

A. Oh, no. I think we ended up getting version 11 so we were only ever incrementally building it. 14:26

207 Q. Did it ever get any independent oversight?

A. The only independent oversight came from Belfast Trust, and I think the girl was called Denise Lynd, who was in charge of their admin process, so a similar type role.

She was able to give us some insight from how the system worked in Belfast, and what policies and procedures or standing operating procedures they had in place. She gave a few tweaks and a few thoughts, but there was nothing really significantly different happening in Belfast than what was happening with us. So, we were fairly assured that, for what it was as a review of those four areas, that it was a reasonable process that had been invigorated as a result of the extra piece of work. 14:27

208 Q. But it was done entirely by Trust staff?

A. It was done by that but with an external set of eyes on it afterwards and a few thoughts put into it.

209 Q. Just so we are clear, the external set of eyes was a comparator with what the process was in Belfast, and not someone coming to the Trust and interrogating the systems -- 14:27

A. No.

210 Q. One aspect of one interpretation of the MHPS recommendation was that such a review was carried out? 14:28

A. Yes. It wasn't that and it wasn't any broader than admin and clerical. It wasn't a full system review.

211 Q. The next date is 25th February 2022, just an email from Mrs. Corrigan to Siobhán Hynds:

14:28

"Discussed at our last Urology Oversight meeting, Ronan and I have revised the admin review process to anonymise and make it more generic to all areas".

That can be found at TRU-293812. 18th March 2021, Mrs. Corrigan to Siobhán Hynds, email:

"Can you have a look at the revised version of the attached, please? I have tried to capture that it was the result of one consultant in an introduction."

That's at TRU-293880. I think you have said at another point in your Section 21 that the SAIs were about systems, not about the person? 14:28 14:29

A. Yeah.

212 Q. Does that surprise you then that there was a linking in with the one consultant with the issues?

A. And that's why, because it had generated from the one MHPS recommendation. However, that was why the attempt to cleanse the data out of it, because it was clearly relating to Mr. O'Brien's practice, and the numbers and whatever that had been the issue pointed to those categories. So that was the piece of work that was ongoing to try and cleanse it. 14:29 14:29

213 Q. Given that Mrs. Corrigan and Mr. Carroll had been in post for a significant duration of the history of the issues that culminated in this Inquiry, would it be your view that that process and analysis and interventions from them on their report lacked the independence that was envisaged? 14:30

A. Well, I definitely think it lacked the independence, but I think they did it as a default because there was no other option for an independent person coming in

over the hill that was going to take it forward. From a full systems perspective, that was never thought through at a higher level.

214 Q. When you say there was no option, it wasn't pursued?

A. Yeah, it wasn't pursued. 14:30

215 Q. The next date is 12th April 2021. It's a handwritten note, we don't need to go to that. It says "Admin escalation process, AC, Anita responsible". That's at TRU-255874. You will be glad to hear we are coming to the end. That seems to be the last reference to it. 14:30 There may be more emails back in forth but that timeline, I presume, doesn't surprise you as regards the elongated nature of attempts to bring this recommendation home and also the various individuals involved. You say it's something you are familiar? 14:31

A. Yes, I am familiar with it. Disappointing but it's reality.

216 Q. Now, if I go to WIT-34276, paragraph 663. It's the very last line of that paragraph. You say:

14:31

"The review of administrative processes has resulted in a systemic way to prevent these untimely delays and due escalation to address".

It seems you are speaking about the review that we have 14:32 just gone through.

A. Mm-hmm, yes.

217 Q. Is it your view, given that sentence, would you say that that review process and the outcomes were

a success in identifying what you say has been identified and dealt with in that last paragraph?

A. Well, what I have say there, let's say, is that it was an administrative process, it has been reviewed and because it happened in Urology or it was picked up in Urology, we've made that process Trust-wide; that systematically the secretaries and the administrative staff have standard operating procedures in place now for those range, regardless of where you work. That's what I tried to say. I mightn't have said it like that. 14:32

218 Q. Those processes you have just relied on, did they emerge as a result of that review?

A. Yes.

219 Q. Now, I think we have touched on the staffing issues, the difficulties. The Panel have heard of issues in relation to staffing that seemed to persist even currently. Obviously, the Patient Safety and risk aspects of that don't need to be spelled out. 14:32

I want to go now to the steps taken by you once you were aware of the concerns. There are quite a few, so I am going to touch on some that the Panel would be familiar with. For the Panel's note, this is covered in Ms. McClements's witness statement at the following paragraphs: WIT-34240 to 34241, and that's paragraphs 494 to 502. Also at her statement at WIT-34258 to 34259, paragraph 581. The assurances you received can be found at WIT-34241 to 34242 at paragraphs 503 to 14:33 14:34

506. It brought to mind different threads and rather than individualise each one, that's the totality of them for the note.

Now, you took actions, as you say, both individually and on a collective basis once you were aware of extent of the issues. Did you ever feel that you were totally on top of everything that had happened and that you understood exactly what had gone wrong and why it had gone wrong, and what then steps you might take? Did you feel like you got underneath things? 14:34 14:35

A. Can I check, is this in reference to 2020?

220 Q. Yes.

A. So, following the escalations in June 2020? Yes.

221 Q. Yes, and your knowledge of the five SAIs and the incremental. So it's the story towards the end. 14:35

A. Yes. So we've done the MHPS and the follow-up work for that, albeit not as comprehensive as we could or should have. We have worked through the five SAIs and the learning from those with regard to triage, and are assured that the recommendations of that report have been implemented. 14:35

Then the escalations for June '20 suddenly, I think, took us on a different trend because that makes us start to think clinical issues as opposed to purely administrative that had been followed up until that. The approach that followed relied heavily on the clinical and operational team to trawl the systems and 14:36

trawl the data and do some sort of preliminary investigation. And then -- am I answering right?

222 Q. Yes, yes. Different aspects. One of the things I did want to ask about was your engagement with the Urology colleagues of Mr. O'Brien and the Urology team generally, and you said to ensure fully informed clinical decision on the way forward was agreed? 14:36

A. Yes.

223 Q. Just in relation to my previous question on that, were you content that at that point, they had full sight of all the issues for you to be able to make an informed step forward to seek to approve systems? 14:36

A. The picture was evolving, I think it's fair to say, on a daily basis. There was an intensive piece of work done, particularly by Martina, I think about two -- early July is in my head, around the emergency patient review and the elective stent review. We were already beginning to aggregate a picture of potential concern or concern across a range of domains. That was being shared with the -- obviously Mark Haynes was actively involved in that, but it was being shared with the Urology team in terms of some of the issues that were being picked up and some of the need to progress, potentially progress at that stage, to a lookback review and some sort of patient review, potentially patient recall. So, a lot of the interfacing in those early days would have been directly across the team with Ronan, Martina and Mark to the consultants. 14:37 14:37

CHAIR: Sorry, I don't want to interrupt but you are

speaking rather quickly and we are trying to get a note of this because it is new evidence of us.

A. Do you want me to go back? So, it was an evolving picture and that information was being shared operationally with the team. 14:38

224 Q. MS. McMAHON: This was around July 2020?

A. Yeah. And beginning to react to priority areas that needed some sort of closer look or potentially clinical appointments for the patients.

14:38

The team would have been aware there was an issue raised, and would have been aware that they were going to be part of the solution in reviewing patients. I am not sure there was a team approach initially because I think Mark took a lot of the weight in the early days 14:38 to try and get underneath that.

225 Q. Why was that?

A. I think probably because he was Divisional Medical Director; they were a stretched team; they were -- Mr. O'Brien had retired. They were, I think at that 14:39 stage, down to 3.5 consultants plus a locum; they were funded for 7. They were already dealing with emergency red flag backlogs, not getting to the routine. I think at that stage he was trying to look at the priorities. Then eventually I think there was four consultants 14:39 eventually were part of reviewing those patients, but in the early days it was trying to keep a priority on the other patients who were planned to come in to those consultants.

226 Q. You also liaised with the British Association of Urology Specialists. Was that around the same point, to increase the capacity for patient reviews?

A. And was also looking -- there was lookback review guidance. There was lookback review guidance that the Department of Health had issued. Now, this was 2020 so it was an older version. It was refreshed, and we adopted our terms of reference in 2021 in respect of that. That was guiding us to do this preliminary piece of work, and it was guiding us to get subject matter expertise in place to have some sort of independence and oversight and support the clinical opinions. And also as a governance look for us to be assured that what we were thinking we were finding, that we were getting an external viewpoint on that. 14:39 14:40 14:40

227 Q. That lookback guidance that you referred to was the document you used to find a way forward?

A. Yes, yes, and we formed our terms of reference based on that.

228 Q. Was that the document that also suggested - or was it from another source - the commissioning of the services of experts to deliver patient services, including the structured clinical record reviews? 14:40

A. It was definitely the engagement of the subject matter experts in that capacity. Then the issue of the Department of Health had our -- we had obviously escalated, there had been an early alert. There was a meeting set up with the Board, a HSCB interface, but then there was also an accountability meeting called 14:41

which was called the UAG, Urology Accountability Group, which the Department of Health called. I think that might have been October.

229 Q. Yes. The summer period was looking at everything that was happening -- 14:41

A. Yes.

230 Q. Putting in place --

A. Starting to identify SAIs. I think we got to seven, and then nine in October. When we were at the Urology Accountability Meeting with the Department, there was 14:41 a feeling that the SAI Review process was not necessarily the best option and that we needed to scope alternatives. We were guided, I think with BAUS and their members and some of the conversations across Dr. O'Kane's office, to SJR, Subject Judgment Review 14:42 process. As I understand it, the SCRR, which is Structured Clinical Record Review, was an evolution from that SJR process.

231 Q. Were you involved in any of the decisions around those processes and choosing them and assessing their 14:42 robustness? Were you involved in that?

A. Not really, except in understanding that they were being guided clinically by experts in the fields; understanding that the Department wanted us to move away from the SAI process to a different process. 14:42 Understanding that --

232 Q. I am sorry, just in relation to the Department wanting you to do that, tell me why that was the case. You had mentioned numbers earlier.

A. I think, from memory, the SAI Review process was designed for individual case reviews and not for a lookback review-type process, and therefore it didn't seem to fit in terms of the terms of reference for SAI, and that we needed a different process. Also, if we were dealing with larger numbers, we needed to have a process that we could actually expedite and deliver. 14:43

233 Q. Who made the decisions around the other processes?

A. I think the Medical Director was heavily involved because of her clinical expertise. She would have involved Mark, and he would have worked closely with the subject matter experts to guide him and to participate in that process as well. Stephen Wallace would have been the Assistant Director Systems Assurance, I think is his title, who works in Dr. O'Kane's office. He would have been actively involved in a lot of those discussions with the clinicians involved. So, I would have been -- 14:43

CHAIR: If you could slow down, please. This is important information. If you could just take it a bit more slowly, please. 14:44

A. So, Stephen would have probably done a lot of the engagement on behalf of Maria through her office; she would have been obviously involved as well. That was reported back because we had the Urology weekly meeting, which had Maria's office, the clinical staff, the operational staff, myself, HR. We were all there trying to make sure we were getting this right from each of our perspectives. We were sharing the 14:44

information. We were agreeing actions that we could actually deliver in an efficient way. So that's where the discussions around some processes that we needed to adopt, including SCRR and the refinement of the Subject Judgment Review tool. That was what threw us, there was also an agreement we would seek an opinion from RQIA that the SCRR process that we used was actually fit for purpose and that they were happy with the process we were adopting. 14:44

234 Q. MS. McMAHON: Just I was going to ask you when you were giving us the information, the movement away from SAIs was driven by potential volume rather than any other reason? 14:45

A. And for the appropriateness of the SAI process for a lookback review, and guided very much by the Chief Medical Officer in the discussions we had at the UAG. 14:45

235 Q. You mentioned the weekly Urology review meeting, and there was feedback given from all the different governance actions that you have given us an oversight of, including reporting and screening. In relation to the screening for cases, who did you understand to be responsible for that? 14:45

A. In terms of identifying the patients at risk?

236 Q. Yes.

A. There were agreed cohorts considered to be high risk, which was really a clinical decision based on the most likely patient that we need to be concerned about who considers who deserves to be reviewed quicker is in the last 18 months. We needed to agree a process that we 14:46

would use to do that. The rationale for that was that patients who had been in our care longer than that may have already seen another consultant, may have already come in via the Emergency Department, may have already had different treatment options. So, the higher risk were the last 17, 18 months to make sure that we were identifying people who were sitting on a waiting list that we could review in an expedited way. 14:46

There were cohorts agreed by the Urology working group, which was myself and Dr. O'Kane and Mark Haynes and Martina Corrigan and Ronan Carroll, and all the component players, to actually agree those patients. They were the breakdown that in the Trust Board escalation -- well, the Trust Board update in the November, highlighted the patients whose results potentially hadn't been read, the different treatment plans, some were on the implementation plan of actions, prostate patients, elective patients. There was a list of prioritised patients guided clinically. 14:47 14:47

237 Q. In relation to the patients themselves, you also oversaw the operational planning of identified priority patients for face-to-face review?

A. Yes.

238 Q. And you ensured communications were sent to patients who had been under the care of Mr. O'Brien from January 2019 to June 2020? 14:47

A. Yes.

239 Q. And you established a patient information line?

A. Yes. And a GP line.

240 Q. And a GP line. Given the myriad of activity around this time and the summer and the autumn and winter of 2020, had you been involved in a process like this before? 14:48

A. No.

241 Q. It's not the case, is it, that you go into an office and pick down a file that tells you what to do in all of these circumstances?

A. No. 14:48

242 Q. Is there an emergency file like that; when something happens, here are a list of steps to be taken?

A. There were some steps in that lookback review guidance that made a reference, that gave us some indications about the need for databases, the need for recording, 14:48 the need for patient involvement. But it was very informed by the clinical teams. On review of the different cohorts over the 17 months, they were picking up things that were concerning. Once they picked up concern, they were looking deeper into that. Where 14:49 patients were desktop reviewed to see if there were any concerns, that was the patient that was called in for a face-to-face contact.

There was also a screening form devised which was based 14:49 on four questions originally, and that was to try and work out is the current diagnosis safe, is the treatment plan safe, is the medication safe, and, if not, what else do we need to do?

243 Q. Was that derived from the lookback guidelines or was that something that was developed ad hoc as things emerged?

A. From memory it was lift from a tool that had been used in Belfast Trust during their statutory inquiry for neurology. Therefore, the Board had guided us that it was a good starting point for us. The problem with it was it only looked at current practice, or current experience of the patient. Mark Haynes and Prof. Sethi, I believe, felt when the patients were being reviewed, they needed a historical look as well. Today might be okay but previously, two years ago/three years ago was the diagnosis safe, were the diagnostics put in place, was the primary -- I can't remember the ten questions. Was the medication in the treatment plan. So, two doctors were using the ten question review. 14:49 14:50 14:50

244 Q. Yes.

A. It was found out in that that it was better because it picked up things that the four questions wouldn't because it didn't have the historical lens, and we then moved to the ten questions for everybody. 14:50

245 Q. So, there was a degree of flexibility built in?

A. Yes. We were evolving, we were learning on our feet and it really was governance in action, how do we keep this as safe as possible with patients at the centre. 14:51

246 Q. Do you think it might be helpful to have a toolkit for incidents like this where there are lists of suggestions, different routes, built in flexibility, a

checklist of things to make sure they are done?
A. Absolutely.
247 Q. Would that be something that might assist?
A. I think because of the Belfast experience and because at the end of a lookback review, one of the stages is the outcomes and the recording of the learning, I think there's a natural opportunity there to learn and to share a lot of the tools and processes that we adopted. 14:51
248 Q. You also worked with Dr. Hughes on the nine identified SAIs at this time as well? 14:51
A. Yes, yes.
249 Q. Was the approach adopted by Dr. Hughes to conducting the reviews something he did himself or was there guidelines for him? Was he au fait with the way in which to carry it out? 14:52
A. There's terms of reference that would have guided in advance which would have guided. But how he would have met those terms of reference would have been flexible for him to apply the approach that he felt was best across him and the panel. 14:52
250 Q. You also worked at the same time to increase capacity by establishing contracts with the independent sector. Was that have given the extra burden that the Department was under, given this, or was that ongoing anyway? 14:52
A. No, it was new. And it was obviously -- and I know Mr. Glackin saying earlier he didn't feel supported, and maybe we weren't overt in how we were trying to support. Bringing in that additionality was to try and

offload. We brought in, from memory, the first independent sector contract was for 236 oncology patients who were considered highest risk. So, they went off to Orthoderm and Mr. Keane to review their care. But we developed other independent sector -- we were using the independent sector for other Urology work, but this was specific to the lookback that we were taking on Orthoderm and then subsequently, I believe, two other contracts. 14:53

251 Q. You also established the Task and Finish Service Implementation Group, which was tasked with addressing the eleven recommendations from the nine SAIs? 14:53

A. Yes.

252 Q. There was also learning over and above Urology Service in those. What was the position on the roll-out of those recommendations or their implementation by the time of your retirement; can you recall? 14:53

A. When I retired, there were nine out of the eleven delivered and the other two were embedded but subject to audit; we needed to evidence that they were effective. So all eleven are now implemented. I have to say that that process was extremely innovative because we had -- this wasn't about a Urology Department, this was about learning for the whole organisation in Acute Services. So, we had medicine, we had everybody sitting around that table taking responsibility because function of their MDMs, for example, was something that had read across. We had a really good process, and we had a subgroup and we had 14:54 14:54

designated tasks that the different people around, say, job planning or audit, whatever, would work through and develop with the groups.

But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work. 14:54

253 Q. You also participated in the Doctors and Dentists Oversight meetings. Obviously you were privy to professional issues being discussed at that point, and you supported the clinical and operational teams as the impact of the concerns having been raised and the commencement of the public inquiry caused some anxiety. 14:55

"And we established within the Trust support mechanisms including one-to-one psychology support, peer support and Executive Director support from Dr. O'Kane and Mrs. Trouton." 14:55

In relation to support from Mr. O'Brien, were you ever involved in either offering that or facilitating the provision of it, or did you know if Mr. O'Brien specifically sought support at any time? 14:56

A. He was certainly offered support, not personally through me. By the time we were communicating with Mr. O'Brien, my understanding at that time the communication was directly through his solicitors on

his request, but there was information that was shared, I believe by Dr. O'Kane, offering one-to-one support, her own personal support, I believe, and the access to Carecall and Inspire, and psychology, and the support groups that we would normally offer through the Trust for people who may need a wee bit of support through a difficult time.

254 Q. Who would be responsible for liaising with Mr. O'Brien under the Trust duty of care to see if he wished to access that sort of assistance? 14:56

A. Well, normally in a case like this it would be the Medical Director is the responsible officer, but she was no longer the responsible officer because Mr. O'Brien had retired. Typically, it might have been Human Resources because there was ongoing processes, 14:57 but we had been guided that he wished the communication to come directly. So, it went by letter to his solicitors for sharing.

255 Q. Now, the Panel will have heard from Zoe Parks in evidence. Her evidence was that Mark Haynes, as 14:57 Associate Medical Director, had discretion in conjunction with the Service Director in determining whether Mr. O'Brien would be permitted to return to part-time employment. You may not know anything about that or you may understand that's the structure, as you 14:57 understand it?

A. Yes.

256 Q. Did you have any communication or discussion with Mr. Haynes concerning Mr. O'Brien's return to part-time

employment prior to Mr. Haynes phoning Mr. O'Brien on 8th June 2020?

A. No. But can I add something to your question before that because I have just remembered? Mr. Haynes in his letter to Mr. O'Brien in July offered support if he wished to avail of it, so he was offered it through Mr. Haynes as well. 14:58

No, I wasn't aware. I had been shared that his intention to retire from Ronan in the April, and I was then aware in the June that he wished to return. I didn't know the conversation had taken place with Ronan, Mr. Haynes and Mr. O'Brien, but, following that, Mr. O'Brien made contact with Vivienne Toal, the HR Director, and wanted to invoke his retirement - it's probably the wrong term - application. Vivienne then sent a message to Dr. O'Kane and myself that she wished to discuss it. 14:58 14:58

257 Q. You say you spoke to Mr. Carroll about that in April 2020? 14:59

A. Yes.

258 Q. This is before the phone call to Mr. O'Brien with Mr. Haynes --

A. I didn't speak to him, I don't think. He sent me a copy of the retirement letter by e-mail, or a copy of his retirement application by e-mail. 14:59

259 Q. Did you have any discussions with Mr. Carroll about Mr. O'Brien coming back to work or not?

A. I think he said at that stage he was hoping to return

part-time, and Martina may also have said that to me.

260 Q. Did you speak to anyone else? You got an email or did you get an email or speak to Mrs. Corrigan?

A. It was probably a conversation in the admin floor. We had a lot of conversations just in the busyness of it. 14:59
It wasn't necessarily an e-mail trail. Definitely got the email from Ronan but I probably had a conversation. I was aware, let's say, from either Martina or Ronan, that he had an intention to return part-time or he would like to return part-time. 14:59

261 Q. Were you asked your opinion about that at all, whether you agreed with that?

A. To be honest with you, at that time he was working full-time for us and we were very short of staff. At that stage if you were -- and this was in March '20, we 15:00
haven't uncovered the issues. To have a part-time retired consultant available to come back and give us some capacity, I wouldn't have balked that, I would have said that was reasonable; if he is good today for us, that was probably reasonable. It was only after 15:00
the awareness in June that there was some sort of Trust guidance that we didn't progress returning retired people or people who were in the middle of a formal HR process.

262 Q. Were you involved in that process at all of making that 15:00
decision?

A. I can see an email trail that Vivienne sent to Maria, "now can I discuss" when Mr. O'Brien wasn't happy after the phone call. I don't remember what happened next

but I think it was probably a discussion at the end of an SMT that there's this guidance and it's not within our guidance.

263 Q. This was after the 8th June phone call?

A. Yes. 15:01

264 Q. It was post the call from Mr. Haynes and Ronan Carroll?

A. Yeah, yeah. My memory is it was after the 8th because he then was revoking his resignation after that, so it would have been following that.

265 Q. Was it ever discussed, his retirement or his coming back at the SMT meetings? Did anyone share views about what they thought about -- 15:01

A. I think he had discussions with the clinical team with Martina and with Mr. Young, and Mr. Haynes, I think, was the third person. I think he had intimated to all three that he would like to return. I'm not aware there was any commitment that he could return, because it's always 'I would like to' as opposed to a right to return. 15:01

266 Q. So it's a hope rather than expectation? 15:02

A. Yes. I don't think there was any false promise given. We were just aware that he was keen to return. I think that was also contained in his retirement communication.

267 Q. Before we go on to your reflections, I just want to... 15:02

There's reference in your statement to monitoring, that Mr. O'Brien did not agree that monitoring should still have been in place post the MHPS formal investigation,

and that this frustrated the return-to-work monitoring process and attempts to meet him to discuss. You set that out at WIT-34241, paragraph 499. You say:

"The first agreement that I was aware of since my tenure was the action plan that was implemented during the 2017 and 2018 MHPS investigation and determination report. This was agreed with Mr. O'Brien during that period and was monitored weekly by Mrs. Corrigan. She completed this by reviewing the Backlog Reports cross-referencing patient administrative systems, Northern Ireland Electronic Care Record patient data, and e-triage. Whilst non-compliance was picked up in September 2019, Mr. O'Brien did not agree monitoring should have still been in place post the MHPS process. This frustrated the return-to-work monitoring process and attempts to meet him to discuss."

Now, in relation to Mr. O'Brien not agreeing to the monitoring process, where did you learn that from? Who did you learn that from? 15:03 15:03 15:04

A. In the terms of reference for the MHPS investigation.

268 Q. Is it your understanding that the oversight of Mr. O'Brien, or the monitoring, was still in place in 2019? 15:04

A. Yes, but the wording, I think he felt that it was during the investigation, but the investigation and the grievance and whatever, there hadn't been a concluded process. So to us, we were still within the -- this

process is ongoing and we hadn't bottomed it out yet, so our commitment to monitoring continued. He had a different perspective on that.

269 Q. The grievance was something that was triggered and could be about separate issues rather than just the monitoring? 15:04

A. Yeah.

270 Q. Was there any sense that the monitoring was set up for a defined period of time and was completed, and the grievance was something that ran parallel and had no impact on that? 15:05

A. Our understanding until we got to an agreed, accepted way forward, we needed to continue to monitor it, and I would still feel that today.

271 Q. Where did you derive that expectation from? 15:05

A. Well, it's just my summation of it was written at the time of the investigation; we never fully got to an end-point with that process; we had it embedded; if it had been a brief call to say we will stand it down now just because the process hasn't concluded, and there's no outcome as yet. So, it had continued and when I came in and knew it had continued, I was glad it had continued. 15:05

272 Q. But you found out retrospectively it had continued?

A. I mean yeah -- 15:05

273 Q. It might have been --

A. I found it had already continued but I understood where he was coming from in terms of his interpretation of the rule. But we hadn't got to an end-point, so

governance-wise I'm glad it was continued.

274 Q. If we just look at paragraph 50.

"Following the MHPS determination report, the lodging of the grievance by Mr. O'Brien and the subsequent appeal resulted in an inability to act until the outcome of these were known. We now know this resulted in further patient harm." 15:06

Would you accept that the lodging of the grievance, whatever view may be taken on that, didn't actually prevent the admin process, one of the recommendations from the MHPS, from proceeding? 15:06

A. I accept that.

275 Q. When you say "We know this resulted in further patient harm", can you explain what was the harm. It seems to be in the line of thought there that the grievance introduced an element of delay; would that be fair? 15:06

A. Yes. Had we got underneath that there and put in place perhaps a relationship with NCAS, or an action plan or whatever, we may have scoped earlier than we actually ended up in 2020. 15:07

276 Q. When you say we know "this resulted in further patient harm", can you just explain that sentence; what do you mean by that? 15:07

A. The patients, between that and 2020, the patients that we were picking up in that 18-month review, and we know in that review patients were picked up with actual harm or potential harm. So, had we acted earlier, we could

have circumvented that.

277 Q. You were involved, I think, in the preparation for the briefing information for the Minister in announcing the -- informing the Assembly about the public inquiry?

A. Yes. 15:07

278 Q. In his statement on that date, on 24th November 2020, the Minister informed the Northern Ireland Assembly that the initial lookback at that point, which considered cases

15:08

"... over an 18-month period of the consultant's work in the Southern Trust from 1st January 2019 to 30th June 2020 concentrated on whether patients had had a stent inserted during a particular procedure and if the stent had been removed within the clinical 15:08 recommended timeframe".

He went on to say:

"The initial lookback identified concerns with 46 cases 15:08 out of a total of 147 patients who had the procedure and were listed as being under the care of the consultant during the period addressed by the initial lookback exercise".

15:08

Does that the information in that paragraph ring a bell with you?

A. Absolutely.

279 Q. And you were part of a group that generated that

information or from which that information came?

A. Yes.

280 Q. Who identified the 46 patients with whom there were concerns out of that total of 147?

A. Well, Martina did the first preliminary investigation into the system. As she was picking anything up, she brought those to Mr. Haynes' attention. So, from memory there was 147 in the elective pool, and I think 46 -- I might have those figures wrong but I think 46 had further scrutiny from Mr. Haynes. 15:09

281 Q. So, Martina Corrigan did the first trawl and Mr. Haynes then looked at them in more depth; would that be --

A. Yes. And then there was the emergency. There was the elective stent and there was the emergency care. So, there were concerns picked up in both those initial preliminary trawls. 15:09

282 Q. Do you recall what the concerns were or what the causes of the concerns were?

A. I can't remember, I honestly can't remember, but it was around the issues of delay and treatment plans. 15:09

283 Q. Did those patients, as you recall, require further management of their stents; do you recall that?

A. I believe they did. I believe from the nine SAIs we picked up, I don't know what pools they came from but they came from each of the cohorts that we had stratified. So, there was validity in having stratified the patient groups and interrogated them. I should say, everybody was struggling with backlogs and clinically agreed time scales. All consultants 15:10

would probably feel, well, I wasn't seeing my patients outside clinically agreed time scales because I couldn't. But, as I understand it, these were other issues and more protracted delays, say, in the patient journey. 15:10

284 Q. Do you have any recollection of when the management of those patients was completed, when things were resolved for those as had been, you say, identified?

A. They were the patients that then went forward for the in-depth review by Mr. Haynes and with the support from, I think it was Prof. Sethi at that stage, and eventually then the other patients. They were the patients who were either screened out at desktop or who were brought in to face-to-face. They eventually were the ones that worked towards the other processes that we put in place such as SCRR or SAI. 15:11 15:11

285 Q. Would that have been dealt with more by the medical side considering it involves clinical treatment?

A. The clinical bit, absolutely. But with multidisciplinary nursing and whatever. 15:11

286 Q. Was there ever a process of updating the Minister, the Department, about the nature of the concerns and the details of the further management that these patients required?

A. There was an update regularly that went to the UAG, the Department of Health. They had discretion what, from that report, that they would have shared with the Minister. 15:11

287 Q. Now, I --

A. I should say the statement for the 24th November announcement from the Minister had been proofed by Dr. O'Kane and myself. I know the issue of the two patients was included in that, but at that stage that was the information that we believed to be accurate. 15:12

288 Q. Is this the waiting list issue?

A. Yes.

289 Q. Again, the point made on that was you were relying on information that you were given?

A. Yes. 15:12

290 Q. And you saw no need to interrogate the robustness of that to satisfy yourself of its veracity?

A. Yes.

291 Q. The reflections, I think we have peppered throughout your evidence. You also say in your statement at 15:12 paragraph 661 that you thought:

"Mr. O'Brien was allowed to drag out many processes, including his lengthy subject access requests, grievance process and his delayed feedback on SAIs. 15:13 Time was lost".

Just on that last point, would you accept that feedback from Mr. O'Brien forthcoming and his engagement with the SAIs is something that would be very valuable? 15:13

A. Absolutely.

292 Q. And his instigation of those various employment-related processes is entirely within his gift, really?

A. Absolutely, but when there's a patient at the end of

why we are in public service, I think it's important to try and expedite whatever well-intentioned systems or processes to get to a better place for Patient Safety.

293 Q. Your point is if there's Patient Safety or a risk in the mix at all, then there should be an expedited process for any one of those -- 15:13

A. Yeah.

294 Q. -- to circumvent the normal timeframes?

A. There should be timelines and priority actions within a certain period or we have to move on. 15:14

295 Q. You also say at paragraph 662 that the MHPS escalated through the Medical Director and Chief Executive lines with no communication to the Director or the Assistant Director was a missed opportunity?

A. Yes. 15:14

296 Q. We know that Ms. Gishkori was aware that information didn't find its way to you?

A. Well, didn't find its way to the operational team at that stage, and didn't find its way to me because she had departed before I got there. 15:14

297 Q. You have said that MDT needs to be watertight.

"Cases presented in a quorate representative forum where a range of skilled clinicians discuss the cases, agree the actions and have a follow-up mechanism." 15:14

What, in your view, made it not watertight before, now that you have had time to reflect?

A. I always knew there were issues with some specialties

not attending, such as oncology or pathology or radiology because of capacity, capacity regionally and capacity locally, but I never for a minute thought that treatment pathways or decisions made by the MDM wouldn't have been implemented or wouldn't have been audited so that we could evidence that. I wouldn't have believed that anybody would change that plan without coming back. So I trusted that process to have inbuilt procedures and safety valves. I wasn't actively involved in an MDM, there was no concern escalated to me about them, so I was disappointed that we didn't have a more watertight way. We certainly had escalated, for example, from Mr. Conway that there was capacity issues with some of the staff like radiologists or pathology or whatever. I knew those but the other bits I had no insights into the under-performance in terms of the rigour within the MDM. 15:15 15:15 15:16 15:16

298 Q. You have said this previously but just to give you an opportunity to say anything else about it:

"A deficit in one area of practice should provoke curiosity and require sampling of other areas of practice".

We can see in the timeline there's a possibility of that thinking pre-MHPS, post-MHPS September 2019, 2016, 2017; there were signposts perhaps along the way. Do you acknowledge that that should have been the lens

through which things were looked at various parts of this journey?

A. I am a great believer in always lift a stone, don't take it on face value, and I don't think we took that opportunity as an organisation early enough. 15:17

299 Q. Again, you have said there was a potential to focus on clinical practice at an earlier stage without comprising due process and confidentiality. When do you think was the optimal point to engage with that?

A. I think 2016 was a real missed opportunity. I think 2018 was another suppressed opportunity with the elongation of the process. So, both of those. I can't comment really any earlier because I don't know enough detail on what the evidence was earlier, but they are two junctures that there was enough concern for action and a deeper clinical review. 15:17

300 Q. Just a couple of reflections on the success of the systems put in place to rectify the problems with Urology. For the Panel's note, this is at WIT-34243, paragraphs 510 to 512. In short form, you say: 15:18

"With regard to performance, it has not resulted in reduced waiting lists but assured that every possible mechanism is in place to improve performance." 15:18

By the time you had left, you were confident that the system was working with optimal performance, that the demand was increasing, and the capacity was not being fulfilled?

A. Yeah. And we were recovering from Covid and we had lots of patients who stayed away because they are maybe afraid to come, or they didn't go with symptoms to their GP and weren't referred. We had a lot of under-representation of conditions that we were really struggling to encourage them to come to us because we were trying to get as early diagnosis as possible and deal with our other backlogs. But, yes. 15:18

301 Q. You say: 15:19

"The broader governance issues have been supplemented by additional capacity within Clinical Directors, Divisional Medical Directors, increasing focus on stimulation supports, job planning approval and sign-off and revalidation compliance", which you say is the evidence in greater scrutiny and oversight? 15:19

A. I think there's a lot of good work has happened down the medical professional lines in terms of building that resource and infrastructure. That's something that Dr. O'Kane drove and I supported operationally in terms of some of the unavailable budget for it, but we got an agree that some of those processes at risk, it was important that we did that. But I think the Divisional Medical Directors and Clinical Directors worked very tightly with the operational teams and myself, and that's something I think is a really good reflection on that. There's a lot we didn't get right but I think that worked really well. 15:19 15:20

302 Q. You retired last year. What was your view on the state

of governance in the directorate at the point you left?

A. I think it was in a state of flux because we were waiting on the outcome of the June Champion recommendations and the full implementation at corporate level. But - this is going to sound terrible - the boring side of clinical governance, like the systems and processes for incidents and SAIs or whatever missed the point of people at the middle of it. I think we evidenced throughout, especially that last year, the 15 months that I was in post, that we were realising there's patients who are needing additional care and support and safety mechanisms built in by us. We want to improve our governance and to embed systems quite often as we went. I think that's something I think was really good focus on Patient Safety and governance and action. 15:20 15:21 15:21

303 Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves? 15:21

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern. Also patient information and patient involvement. We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services. I think the Task and Finish work showed even when patients and 15:21

relatives had been through a difficult time, they engaged with us, they trusted us to try and improve our services. I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public.

MS. McMAHON: I have no further questions for you. Thank you very much, Ms. McClements, for your evidence today.

15:22

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIR: Thank you, Ms. McClements. I am going to hand you over first of all to Dr. Hanbury. 15:22

MR. HANBURY: Thank you very much for your evidence. I just have a few clinical questions hopefully.

We know recruitment was a difficulty, and obviously there's a huge workload with between 3.5 and 4.5 consultants for a funded service that should have six or seven. Presumably that meant that a relatively small number, three or four, had to do the Urologist of the Week rota and that took them out of elective surgery. How did you backfill that or did that not happen? 15:22 15:23

A. So, I think the best we ever had in my time was 4.5 full-time equivalent. There was a one in six rota, but quite often those extra bits were picked up either by

locums but sometimes by our substantive consultants. That did mean that if you run the Urologist of the Week, you were down-turning something else to enable that part of the system to work, so that was a difficulty and did suppress some of the activity. 15:23

There was also a reliance on locums. We recruited five times in my tenure for consultants and I think once we appointed two but they didn't take up post. So, there was a real lack of substantive posts. We did get some 15:24 joy with locums but they were fairly short term.

304 Q. Thank you. I notice in your statement there was a lack of a Urology Clinical Director in the last couple of --

A. Yes.

305 Q. What was the reason? 15:24

A. Mr. McNaboe was it. When the work in June '20 triggered a lot of the patient review and whatever, we really wanted to get a focus on service improvement. Mr. Haynes remained Divisional Medical Director but with a lead for service improvement. That meant his 15:24 role as Divisional Medical Director needed to be backfilled, and Mr. McNaboe applied for and got that. We just didn't have anybody jumping at that time to become Clinical Director in the service. Unfortunately we are still -- I presume it's still vacant, I don't 15:25 know. I presume that's still vacant. That was the gap, so Mr. McNaboe tried to ride two horses.

306 Q. Equipment, just a short question on that. Urologists did depend on telescopes and other things. What was

the majority of that huge application of 2.5 million which you trimmed down? Was that some basic cystectomy-type equipment?

A. The 2.6 million was across surgery, it wasn't just Urology. There was everybody looking for the bits that they needed for their own specialties, but some of the stuff was around scopes and cameras and different bits. We had a good model in radiology, where we had a ten-year replacement programme where we highlighted here is what we need this year, next year and whatever, and we planned for that. Because we had to rock bottom in many ways with the equipment in surgery, nobody wanted to have a ten-year plan, but we are getting towards that now because that prioritisation has been embedded. 15:25 15:25 15:26

307 Q. Okay. Thank you. You had a comment about deep-dives, and made a comment about not all are brave enough to do it. That's an interesting choice of words. What did you mean by it?

A. Again I am back to that expression I used there about lifting the stone and seeing what else. I think you should never -- especially when you have recurrent issues, say for example like triage and delays and patients who are not being seen in as timely a way as we could offer. I think hold on a minute, we need to have a deeper look here; we need to actually sample; we need to audit some of the work. You can't just accept, and we did in many ways accept he is a really good clinician and take that as read. We should be able to 15:26 15:26

evidence that in this day and age. We audit our own performance and our peers. I think we should be able to do that and I think that takes bravery.

308 Q. Thank you. One quick question about the structured clinical review process. It was interesting that you used a number of two consultants for the screening but the actual SCRR process, there was just one reviewer? 15:27

A. Yes.

309 Q. Did you think of having two or more?

A. I couldn't honestly answer that because I don't know whether the one review and then somebody checked it or whether it was one review in the interests of the volumes they were trying to get through. I don't know. I know we certainly used structured judgment review in some of the other services, and there was like a mentoring-type because they were all using it as a new process. I couldn't honestly answer for Urology. Mark, Mr. Haynes, would have to answer that one. 15:27

310 Q. That wasn't your decision just to limit it?

A. Yeah, yeah. 15:28

311 Q. Okay. Just a last question. You mentioned right at the end patient information. We have been aware that historically patients aren't copied into letters. Do you think that would be a good thing going forward?

A. To some degree. The feedback we have had where they do is really welcomed, but I am also thinking patient information on, for example treatments like Bicalutamide and choices, I don't think we can evidence that we are rigorous enough at that. I think 15:28

information is in a range of different domains.

312 Q. Thank you. That's all I have.

DR. SWART: I want to start with something that I picked up in one of the attachments to your statement, which was about your attendance at the regional cancer group. I think you were there when there's a minuted action about learning from the SIs and some useful comments. What was your perception of the atmosphere of that group and how people in the region supported or didn't support, or were interested? 15:28

A. It was an interesting meeting because we had a mix of commissioning patients, families, specialists from the range of different worlds, and Department of Health reps, and cancer-specific obviously experts. They listened. Dr. Boyd, who would be a haematology background and retired, would have a lot of respect in that forum, so when she is saying there's learning and there's a need for roll-out across the region, I mean I believe we were the first Trust that were picked up with MDM issues. 15:29

313 Q. Mm-hmm.

A. But I don't believe we are any different from a lot across the region. I think a lot of the capacity issues and backlogs and workforce issues have pushed our hand with that. So, she was very well received, so I was glad she presented it because it was a more objective presentation. It was interesting that the Commissioner was there because when we were putting in posts, or when I was putting in posts at risk, like the 15:29

MDM Chair support and the information officer to try and kick-start some of the processes we needed, we funded those at risk. Every organisation needs those.

314 Q. Yes.

A. So, it was really good to have a commissioner starting to listen and another consultant saying at the start that in actual fact there's regional learning here. 15:30

I think also the NCAT tool, which is the National Cancer Audit Tool, the cancer managers right across the region were being guided by NICaN to develop an appropriate audit tool. So, it got a wee bit of clout because the recommendations were now being accepted in a really well-respected forum. 15:30

315 Q. I think that's very important. Were you able to take that back to the Trust? 15:30

A. Absolutely. We went back and shared that.

316 Q. Because it must have given you a little bit of solace there was some learning from this?

A. Yes. 15:31

317 Q. Did they make a commitment to carry that forward then?

A. Yes. We embedded it and we were the test-bed for that tool. We used it as the baseline audit across all of -- I think it was first five originally but I think it's now rolled to all of the MDMs across the specialties. So, that's has been a good piece of work. I have to say that isn't my work. That's the work of the Macmillan staff, the cancer clinical services staff across multidisciplinary, working with all the other 15:31

units.

318 Q. It's come out of this, hasn't it?

A. It's really good work from the teams.

319 Q. Presumably looking at that now as you look back on those nine SAIs, those recommendations, everything that's happened, and you reflect on the general issue of action plans and SAIs, you perhaps realise a bit more that there's a huge problem in actually embedding this. 15:31

A. Yeah. 15:31

320 Q. Do you think the Trust has made progress on that in a general way, because this isn't really just about Urology governance, is it, it's about learning from error?

A. I think it unnerved a lot of people at the start when they knew we picked up a range of issues aligned to one consultant, thinking over the sort of initial stages. Then there was a realisation, no, this isn't about one person -- 15:32

321 Q. No. 15:32

A. -- this is about a system --

322 Q. Yes.

A. -- and this is about how we govern. I think that whetted their appetite because they knew as Divisional Medical Directors or Clinical Directors or Assistant Directors, they needed to be part. That Task and Finish group, for example, had every division, every specialist practice built in in that, which was really good. It moved then from that place of being unnerved, 15:32

or it couldn't happen to me, to a more rigorous system-wide approach to how we embed, how we do some of our systems and processes. The journey isn't over.

Yes, I believe, the organisation learned. The leaders of the collective leadership team that I keep referring to, really came on board to try and make a difference. I really hope that continues in the -- 15:33

323 Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it. 15:33

A. Mm-hmm.

324 Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting? 15:33

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture standing back a wee bit, I think there's somebody thinking, no, there's a 15:34

different way to do governance, I think, not just a series of tick box exercises.

325 Q. Absolutely. Another thorny thing that's come through from a number of people, and it's on your Risk Registers at the Trust, is about standards and guidelines. Clearly a lot of bureaucratic things are involved when you try and make sure they have been read and the Department has looked at them. It would appear that there has been no systemic way of ensuring that when a standard and guideline is adopted, there's any kind of measures of whether people are actually using it. Is that correct? 15:34 15:34

A. I wouldn't say it's entirely correct. Caroline Beatty, who let the standards and guidelines work in Acute Services for many years, has now moved to corporate. She has moved to corporate because there was an acknowledgement that she had a best practice model - that was also acknowledged in June Champion's report - but that it needs to be corporate. A lot of standards and guidelines don't relate to Acute, but there's a lot that relate outside of Acute and there wasn't the same focus. 15:35 15:35

326 Q. But how would you know if a consultant wasn't following it?

A. The audit and the checking and the role of the change leads is critical here, for them to be able to evidence for us. I am back to the issue of clinical effectiveness and clinical audit and we need more of it. 15:35

327 Q. I think you would agree that we don't actually have any measures of the clinical outcomes in specialties, for many specialties. There are in some but certainly not in many surgical specialties.

A. Yeah. 15:35

328 Q. Has the Trust fully embraced that now, do you think? It's not very easy just to put it in if you recognise the deficit, but is there a full recognition of that?

A. I think they are on that journey. I think they are starting to think even MDM outcomes for different 15:36 specialties is part of that.

329 Q. But MDM, it's still the same thing in that you are following a guideline?

A. Yes, but I still think there's a piece of work to get us to a watertight place. 15:36

330 Q. Another thing that you talked about, I think, was the admin review. Now, having read the MHPS determination and the substance of it, it's quite clear that people have interpreted that external admin review as different things. 15:36

A. Yeah.

331 Q. If you'd interpreted it at the time and you'd read the statement that there were managerial failings and there needed to be external review, what kind of review would you have envisaged that to be? I know you weren't in 15:36 charge of it.

A. I think we would have looked broader at roles, remits, responsibility, governance, actions, escalations, evidence of a concern materialising into some process.

332 Q. Yes.
A. It would have been bigger than is there triage happening or whatever. It would have been literally a root-and-branch review of how our systems working, and have we got the right balance between operational busyness and governing our systems and ensuring the patient is safe in our care. 15:37
333 Q. That's I think how many people would have interpreted that. Why didn't that happen, do you think? What was responsible for that inaction? 15:37
A. I think a ball was dropped. There was a recommendation that appeared to look like it was belonging to Acute but, in actual fact, it never said it belonged to Acute. It said independent but it had Acute in the middle of it, so I think somebody thought an Acute will deal with that and it wasn't dealt with. 15:37

I think also the sharing with the operational team, I know Mrs. Gishkori had it, but Ronan had no idea that there was implications for him as Assistant Director, even for, you know, some of the oversight. I think it's back to the sharing appropriately, even of what had started as confidential type processes. 15:38
334 Q. The Champion report refers to silos of professional operational nursing management and so on, and I presume you recognise some of that. Has that changed? 15:38
A. It's got better. I mean, if I look at the work in 3 South, for example, where we had the corporate nursing team working with us on the risk assessment, on

the workforce plan, on the remedial actions to get through to a safer place, with our Operational Lead Nurse Sarah Ward, and the operational managers and the ward manager, that's a really good example of when we do that. 15:39

I also think that we have weekly communications upwards - well, when I was there - from the governance coordinators to corporate, so there was an awareness at corporate level of the week's concerns, progress, 15:39 whatever. That was going up and some direction coming down. They were also shared weekly with SMT. So there's lots of things that have been put in place.

I think the fortified structures also across medicine 15:39 have allowed a bit more responsibility and capacity in the job plans for doctors to actually have time to do some of the governing that they were actually keen to do but couldn't get at it.

335 Q. Yes. 15:39

A. So, it has improved.

336 Q. It's improved. Presumably there's quite a lot of work to go but that all sounds very positive.

A. I haven't been there since last July so I don't know what has happened since. 15:39

337 Q. I'm sure. What's the biggest change that you have seen as a result of the events that started from the June 2020 issue and the SIs and eventually this Inquiry? What's the biggest positive change that you have seen?

I know the Inquiry would have put a big strain on everyone.

A. I think two things. How quickly we were able to do that preliminary investigation amazed me.

338 Q. Yes. 15:40

A. That we did a deep dive quickly in, how concerned are we. Credit Martina and Mark were the ones driving that. So that was a big piece that I think I didn't realise it was going to be that easy that fast. I am not saying it was easy, I know they didn't sleep in 15:40 their beds. But that's the first thing.

I have to say the Task and Finish implementation of the eleven recommendations from the nine SAIs has been an amazing piece of work. 15:40

I also would say the family liaison role, it has been new for us. To see families appreciating - even when they have been on the wrong side of us in terms of their experience - that we want to work with you, we 15:40 want to support you, we want to hear your story and we want to use that to shape the future, I think that's something that has legs for the future.

DR. SWART: Thank you.

CHAIR: You will be very glad, Ms. McClements, that I 15:41 have no questions for you.

We will leave it there today and we will start again, I think, at half past nine tomorrow morning. Thank you

very much for your evidence.

THE INQUIRY WAS THEN ADJOURNED TO 9:30 A.M. ON WEDNESDAY, 14TH JUNE 2023