Urology Services Inquiry

Oral Hearing

Day 78– Wednesday, 10th January 2024

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON WEDNESDAY, 10TH JANUARY 2024 AS FOLLOWS:

CHAIR: Good morning everyone.

MS. EILEEN MULLAN, HAVING BEEN PREVIOUSLY SWORN, CONTINUED TO BE DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS:

1 Q. MS. MCMAHON: Good morning, Ms. Mullan. We finished off yesterday indicating that this morning's session would cover some of the learning, some of the issues you've identified in your statement as on-reflection issues that you consider there were concerns about or some learning about. And in order to properly reflect your reflections, I'm going to read in the extracts from your statement that cover those aspects. So we'll start by looking at WIT-100544. At paragraph 46.1, and I will just read this in and I can ask you some questions about it. And you say at 46.1: 09:57 09:58 09:58

"Looking back across my tenure through the lens of what has evolved to my knowledge since 2020, it is clear to me now that the Trust's governance systems were not fit for purpose." 09:58

46.2: "At the centre of this unfitness is what appears to me to have been a lack of triangulation of information and/or culture of working in silos.

Separate processes were being undertaken with no joining up of the intelligence. MHPS, appraisal and serious adverse incident investigations. There was also an unhealthy churn in the key roles of CEO, Medical Director and Acute Director over the period 2016 to 2020 which did not help matters."

Now we spoke yesterday - just pausing there - we spoke yesterday about the staffing issues and I think we've covered your concerns around that. In relation to the separate processes, no joining up of the intelligence, and you've mentioned the three that probably dominated a period of time in Urology, MHPS, appraisal to a certain extent and then the SAIs; is there any difference now in a joining up of intelligence around those sort of issues or is the situation that they still remain separate but that there is better communication? 09:59 09:59 10:00

A. There has been changes in relation to this and it is an outworking of what the Inquiry would be familiar, the Champion Report, and bringing in a level of operational governance oversight that feeds through then to the Governance Committee. In that process then the triangulation of data is coming through those three sub groups to a risk assurance group which then is, I suppose, is the filter and tester of what the challenges and issues really are and allow those then to bubble up to our Governance Committee as a result. So they are not now seen in isolation. So the MHPS 10:00 10:00

process, I mentioned yesterday we have a more robust approach now to reporting that through our confidential meeting, and I am very content with the level of robustness on that front. The appraisal and re-validation of doctors comes through now from a Medical Director. It did so before, but it is more robust in my view at this point. The re-validation and appraisal process is taken more seriously, and I am content with that. The Serious Adverse Incident investigations, the panel may be aware that there is a regional piece of work being done through the Department of Health on a redesign of the Serious Adverse Incidents and it should be reporting on that in due course. 10:01 10:01

But when I consider the Governance Committee's considerations in that period to now, these things are now looked at together rather than in isolation. So is there a flag appear, a connection and a dot between these and we are more alert to that now, which I find certainly much more beneficial in relation to the joining up and the intelligence. 10:01

2 Q. That's in terms of the information coming to the Board and you all having a proper look at that and being able to interrogate it? 10:02

A. Yeah.

3 Q. Are you content with the learning that might emerge from these processes that will go back on to the clinical areas so that people are informed of

opportunities to improve service or reduce patient risk?

A. I am, I am content. There is a real focus now on the lessons learned piece and how that information then is shared and distilled across the organisation. We have a lessons learned forum where those pieces come to at an operational level. It doesn't -- there is a Non-Executive Director attached to it loosely, but that's done at an operational level in relation to getting doctors, nurses, allied health professionals and others in the room to talk about these lessons and share it at that point. 10:02 10:02

4 Q. If we go back to your Section 21 at paragraph 46.3, you say:

10:02

"I did not raise any specific concerns about the governance systems at the time. However, I did raise the below areas for consideration because I believed that they would support the Trust Board in its learning from others and in its development of the Board." 10:03

And you have provided a table, and we have talked through those issues. "Knowing our blind spots", we looked at that email that you had sent to Roberta Brownlee and Shane Devlin yesterday. You also mention an email and note that you sent to the Chair and the other Non-Executive Directors given that you wouldn't be in attendance in the meeting in May 2019. There is no reference in the minutes that your email or note was 10:03

discussed. You've also mentioned the Chief Executive performance targets to Mrs. Brownlee and the Non-Executive Directors on 28th October 2018 when you requested the culture be placed as part of the CEO performance targets. Now in relation to that particular request what was the outcome of that?

A. Putting culture as part of the CEO performance? Yeah, that will become part of the conversation between Roberta and Shane in relation to his performance on an annual basis. And culture, having talked - sorry, forgive me, Shane Devlin - having talked to Shane Devlin, culture was an important aspect for him too.

5 Q. When you talk about culture in this context what does that represent to you?

A. For me it's how the organisation operates, the feel of the organisation. If we consider some of the evidence that's appeared before this enquiry, people's ability to be able to speak up at any point no matter their level or their role that they have in the organisation, so the culture to be focussed. From my perspective I wanted culture to be a focus of the Southern Health and Social Care Trust under the leadership of Shane Devlin and his appointment.

6 Q. Then you say at paragraph 46.4:

"As Chair of the Governance Committee I also sought improvements to reporting, in particular in respect of Clinical and Social Care governance. This was ongoing with each committee meeting, highlighting the need for

additional different information to support its work. Each of the three Medical Directors, 2016-2019, had their own way of reporting. Dr. Maria O'Kane brought significant changes to reporting and practice with the outworkings of the Champion review. This included standards and guidelines, SAI process and complaints."

You have just mentioned the Champion review and other changes that have come about. Just to make sure you have covered what other improvements there might have been in relation to reporting aspects of clinical and social care governance, is there anything else new or that has evolved since the Inquiry has started that you wish to bring to the Inquiry's attention? 10:05

A. The next phase of the changes - yes, there has been - and the next phase of the changes are around the clinical audit, the governance leads and bringing them in in a unifying manner. And, forgive me, it will come back to me, there is a third bit. So we have taken the Champion review, these three bits have been worked through and continuing. There is a continual journey with this in development. Then the next section is around the clinical audit and certainly bringing together unified governance leads rather than working in silos and that reporting then through to the operational groups that I spoke about earlier. 10:06

7 Q. If we go to WIT-100546, at paragraph 47.1. You were asked a question: Are you now aware of governance concerns arising out of the provision of Urology

Services which you were not aware of during your tenure? And you have identified the following examples. We have covered a couple of these, but I just want to deal with the first three so that the Panel are aware of what your reflections are. 10:07

The first concern that you have identified was concerns regarding Mr. O'Brien prior to the MHPS process, and you say:

10:07

"I am now aware that there had been concerns about aspects of Mr. O'Brien's practice for several years prior to the institution of the MHPS process in late 2016/early 2017. It appears that there was a failure to grapple successfully with these issues or to 10:07 escalate them. I am unsure as to whether these concerns in and of themselves ought to have made their way up to the Trust Board or its committees. However, the failure of Trust systems to resolve the concerns, and their continuation for years as a result, probably 10:08 ought to have come to the attention of the Governance Committee at an appropriate point."

Now given what the Inquiry has heard and the evidence that has been heard and the evidence yesterday, do you 10:08 have any more of a firm view as to whether those issues that both existed at the time of the MHPS and the years prior to that actually ought to have made their way to the Board?

A. Yes, I do, they should have made their way.

8 Q. Can the Panel take from what you've said in your answers over this morning and yesterday that you're content that were those issues to arise now across any department that they would in fact find their way through the proper governance channels to either the Board committee or the Board itself? 10:08

A. I would.

9 Q. The second issue you mention in relation to governance concern, over the page, for the transcript, at WIT-100547, is the MHPS process. And your comment is this: 10:09

"The absence of detailed reporting of MHPS cases, and providing the right route for this information to make its way to the Trust Board, is a concern of which I am now aware. The Trust Board or its Governance Committee should have been made aware of the progress of the MHPS process, the difficulties experienced in the MHPS process, the issues with Mr. O'Brien's adherence to his action plan, the outcome of the MHPS process, the implementation of the Case Manager's recommendations and the issues with Mr. O'Brien's adherence to the action plan after the determination." 10:09 10:09

Now, just pausing there, when we spoke yesterday about this there was a clear dichotomy between the operational requirements of Human Resources around staffing and processes involving potential disciplinary

and the governance oversight of the Board, and I think you acknowledge that and drew a line as to what information should actually be brought to the Board as regards hard copy information, but you were content that you should have had an idea of these issues and what might be holding things up or getting in the way of processes being completed, whatever that reason might have been; are you content now that your systems in place allow for proper communication if MHPS is triggered and being followed through? 10:10

A. I am.

10 Q. Now there is a review of the MHPS, is that something that you're involved with with the Department, is there engagement with the Trusts and with the key personnel to inform that review? 10:10

A. I would expect that our Medical Director or people within the Medical Directorate Team would be involved in that, yes, but as a Chair of the Trust Board, no, I am not involved.

11 Q. Do you think that might be something that the Board might helpfully contribute to or do you think you are content with the level of engagement that you understand is taking place? 10:11

A. There was a request for Non-Executive Directors to contribute to this. So John Wilkinson was offered that opportunity to contribute and I think he did, I would need to double check that. But certainly to have Non-Executive Directors have an input into that, that has been the case my understanding is. 10:11

12 Q. The third issue you mention is the underresourcing with governance support functions. And you say:

"Whilst it is correct that the Chief Executive, Shane Devlin, had raised concerns about underinvestment in governance within the Trust and that the Champion review, along with Dr. O'Kane, had started the process to identify where governance needed strengthening and change, I believe that I wasn't aware of the scale of governance deficit that has become apparent through the Inquiry. This information ought to have been brought to the attention of the Board."

10:11 10:12

Now when you mention there "the scale of governance deficit", just give us an overview of what it is you are referring to?

10:12

A. Okay. So the machine of governance behind the hospital door or behind the hospital bed is immense. And, as I have mentioned, it has been working in silos. But what has come through for me very clearly is, and you touched on it yesterday when you asked about the expectations of the Department in relation to the money coming to the Trust for additional activities, there is a need to have governance activities going on behind the scene of the patient within directorates to provide assurance on patient safety and quality safe care. What has come apparent is that those weren't at the level they needed to be. There needed to be significant investment put in to ensure that those

10:12 10:13

governance arrangements were working collectively together and not working in silos. So that is the piece of work that has been ongoing now for just over two years as an outworking of the Champion review. This required financial resource and this required additional staff in order to deliver this governance, these governance roles within the back office, we'll say, of what goes on within Health and Social Care.

13 Q. When you consider now with the knowledge that you've gained from the Inquiry process and undoubtedly within the Board, information that has come to the Board and Board reflections on all that has happened, is there any suggestion that, once the governance processes commence, the MHPS, SIA, just for two examples, that the core issues of patient safety being protected and risk being reduced almost became secondary considerations where those processes dominated attention of staff?

A. Yeah. So people get caught up in the process rather than focusing on patient safety, certainly my observations from what I've gleaned to date, yes.

14 Q. If we go to WIT-100553 at paragraph 48.1. Again you've covered some of these, but I just want to read in the first entry, you were asked the question:

"Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?"

And at paragraph 48.1 you say the following: "The first issue is not dealing with the issues fully or in a timely way."

And your comment is: "Issues in Mr. O'Brien's practice, which were known about prior to 2016, appear never to have been properly addressed in the period prior to 2016. On March 2016, whilst Mr. O'Brien was advised in writing by both his AMD and AD of clinical governance and patient safety concerns, the issues raised with him continued to go unresolved." 10:15 10:15

Now that's information that you've learned in retrospect even though you were on the Board -- no, you weren't at that time? 10:16

A. No.

15 Q. But at that time, whenever you say that the issues remained unresolved, what would you expect to have happened once patient safety and clinical governance concerns were raised with the clinician, what's your expectation now as chair of the Board? 10:16

A. My expectation would be that the MHPS processes are put in place, patient safety is first and paramount in relation to the practice of that doctor in line with the frameworks that are there. Yesterday, you talked through a range of moments where urology and pressures or urology concerns were raised prior to 2016. As a Board member, for me joining the dots out of all of that, if I had have been sitting at that time you could 10:16

see a repetitive theme coming through. My expectation then would be of the Board to be able to see that and raise it and ask questions and then request information about what is being done, but patient safety should be first and paramount.

16 Q. The next point that you mention under this heading is:

"An MHPS process not commenced until very late 2016, early 2017 was protracted and failed to examine what we now believe were all of the issues with Mr. O'Brien's practice."

Is that a recognition that there was an opportunity, at least in 2016, early 2017, if not arguably before, for there to be a broader and perhaps more in-depth look at some of the issues around clinical care and administrative, potentially administrative failings?

A. Absolutely.

17 Q. Who do you say should have led the charge on that front given what was known at the time?

A. Yeah, the Medical Director is the primary and then reporting it through to the Chief Executive at that time.

18 Q. Your next point is:

"A number of related SAI investigations, those chaired by Dr. Johnston, appear also to have been unnecessarily protracted."

Has there been a need to or have you put in place any safeguards to try and hasten the way SAIs are dealt with satisfactorily?

A. The length of time to do SAIs is a continual challenge, not just for our Trust but for all Trusts. One of the main factors is getting the staff time to be able to carry out these investigations in the timeframe allotted. They are still actually practising clinicians, either doctors or nurses involved, so they need to be able to set that time and that's not protected as such. I'm hoping that the redesign, I think we are moving to more of a, I will use the term slimmer down process, but a quick, prompt, slimmer process to come through from the redesign which will allow these activities to take place more efficiently. But there needs to be, for this in particular I would be asking for a task force of individuals that are protected to carry these out across the region because it is very difficult as a Trust to have your staff away from clinical time to carry out these activities and then it creates delay and delay, plus also they are inherently connected and involved. So my view is that it should be external to the Trust and a task force assigned for these activities. 10:18 10:18 10:19 10:19

19 Q. And is that a view you have been able to feed into review? 10:19

A. Yeah.

20 Q. You go on to say, at paragraph 48.1:

"There appear to have been delays in addressing and/or escalating issues with Mr. O'Brien following completion of the MHPS process in late 2018, including, for example, his failure to adhere to the standards expected of him in his return to work action plan."

Just to ask you in relation to that, the Inquiry has heard evidence and conflicting evidence about the understanding of the action plan and what its purpose was, how long it was meant to last and its effectiveness overall, that's detail that the Board may not be expected to know operationally, but are you content that, as things are now and how they may be after the MHPS review, that there will be less ambiguity or potential confusion around the outworkings of any MHPS process?

A. Yeah, I am. I can qualify that by conversation at a Governance Committee meeting where I discussed this with the Medical Director in terms of his assurances that these were being dealt with and him providing assurance then to us as a committee.

21 Q. Now, we've covered the next point you've raised. We spoke yesterday about the comments about the doctor unwilling to be managed; we move on down the table, the conflict of interest, we have also addressed that; at WIT-100555, the role of the Non-Executive in the MHPS process. Again is that something that has been resolved? You say there was an absence of clarity and training in the role for the NED?

A. There is more clarity now, but, again, I would have a similar view to that to the Serious Adverse Incident is this is a process that should be set external to the Trust.

22 Q. The next point you raise is about culture, and we spoke about this yesterday. But you say in this comment: 10:22

"There was a culture of workarounds for Mr. O'Brien which allowed for issues not to be addressed. The culture was not sufficiently open, transparent and safe to allow for the bringing forward of issues and raising of concerns without fear. This criticism applies both inside and outside the boardroom." 10:22

In relation to the culture and when you talk about workarounds, in one regard it is a pragmatic approach to try and facilitate resolution of an issue at local level on the ward or on the clinical area, is the comment here more to do with the fact that, if workarounds are not neither effective nor successful, then there should be some ownership of that and the matter should be escalated to be addressed? 10:22

A. I agree with you on the pragmatism of workarounds, but if we are having a process and we have a framework in place then that should be deployed in my view to the letter, and the workarounds then should not be a reason to move from that and not deal with the issues in hand. 10:23

23 Q. Is there an inherent difficulty with people who work together trying and oversee each other in some regard,

does that itself in a workforce in your experience of Boards generally cause a barrier?

A. Absolutely, it is. It brings me back to my previous point around the MHPS process being external to the Trust. So if you had a task force externally covering that for the region, then you limit that potential for that connectivity and that closeness of people who are investigating each other. 10:23

24 Q. And that applies to the SAI process as well?

A. Yes. 10:23

25 Q. So any process that touches upon clinical concerns, patient safety risk, which invariably most things in the Trust would do, there should be at least some level of objectivity or distance?

A. Yes. 10:24

26 Q. The next point you mention we've touched on, I just want to read it in:

"Instability at senior management team level. Between 2016 and 2018 there was a series of interim acting CEO and director roles across the senior management team. Looking back, this created a risk that no one was taking proper ownership of and responsibility for issues. This, in my view, has been detrimental to the workings of the Southern Health and Social Care Trust." 10:24

We have looked at the timeline in relation to that previously, but the position now as regards stability, what is your view of that at the helm of the Southern

Trust?

A. We have stability within our senior leadership team bar one role which is the Executive Director of Social Work. That's an interim role currently but it is going out for recruitment in the next few weeks. We have stability as of today in relation to our Non-Executive Director complement, there is two coming in to fill the vacancies. So that has, for the first time in my time as Chair, will have a full complement of Board members. But that stability will be short lived as we will lose four, if not five of our Non-Executives in the next 12 months. 10:24 10:25

27 Q. We spoke about that yesterday and the succession planning challenges that the Department perhaps face, your view was that there was a lack of focus on the need for that to be something that was prioritised? 10:25

A. Yes, but I would say that under the Permanent Secretary Peter May, this is something that has his attention. He is very clear in relation to the need for the Non-Executive Directors' roles and the recruitment, timely recruitment of that. So I am less concerned today as I would have been three, four years ago. 10:25

28 Q. The other issue you have mentioned in this paragraph is the escalation of issues of concern and patient safety, and we spoke about that at length yesterday, about the lack of curiosity from the Board and missed opportunities and you were directing your reflection on that and opportunities that had been lost and potential for follow up or follow through that also didn't 10:26

happen.

The next point is demand outstripping supply. We haven't really touched on that in any detail, so I want to read in what you have to say. And you say the following: 10:26

"The Southern Trust, like other HSC Trusts, has seen a decline in consultant and nursing staff over the last number of years. The pandemic has exacerbated this somewhat. There has also been an increase in demand for services. With this increase and the challenges of recruitment, it meant that urology service, as with other services, was under immense pressure. 10:26

The impact on this for the patient can be significant and wide ranging; delay in being seen, delay in investigations being undertaken and diagnostics carried out and delay in treatment when needed. 10:27

Ultimately, if the above steps are not carried in a prompt way, further harm can be caused. 10:27

I can also appreciate the potentially greater impact that can be caused by a shortcoming such as a failure to triage a referral letter in a service where there may be a very significant difference in the waiting times for red flag and routine patients.

I can also see now how the busyness of the service and the constant tension between demand and capacity meant there may have been little time or room to become aware of issues or to triangulate information about issues or even to address issues.

The pressure on various services across the Trust, not only urology, may also have had an impact on some of the processes involving Mr. O'Brien, such as the MHPS process, given that they often involved a range of people, all of whom were carrying significant work loads."

Just starting at the last point, it seems self-evident that in a busy and pressurised unit and department that the instigation of processes that involve staff's involvement would only add to that?

A. Mhm-mhm.

29 Q. And that goes to your point that the objectivity or level of distance would reduce that possibility?

A. Yep.

30 Q. Now when you talk about the demand outstripping supply, it's such a massive topic, but in relation to what the Board can actually do about that and what the conversations are with the Department and the potential for improvement around meeting the capacity or increasing capacity or maximizing capacity to meet the demand, is that an ongoing conversation with the Board and the Department or has the stage been reached where

everyone is just trying to get on with it?

A. It is. It has been an ongoing conversation that is actually increasing currently. The Permanent Secretary Peter May brought together the Chairs and Chief Executives of the Health and Social Care Trust along with the Public Health Agency just before Christmas to start to have a conversation about collectively as a system and what we all could be doing to support the demand and capacity issues. So that is very welcome. 10:29

10:29

There is another piece of work being done between the Chairs and Chief Executives of the Health and Social Care Trust, the six Health and Social Care Trusts. We are actually meeting again next week, and it is about what we can collectively do. A big concern for us all is in relation to the current delayed discharges and the impact it has on patients that are waiting to come in to hospital and the patients then that need to be going elsewhere. So, in short, the conversation is continuing but it is intensifying because we all are agreed that, as it is right now, cannot continue. So what can we do collectively together to bring about the change that is needed. 10:30 10:30

31 Q. If we just go to paragraph 49.1, it is just further down the page, and you're asked the question: 10:30

"What do you consider the learning to have been from a Board governance perspective regarding the issues of concern within urology services and regarding the

concerns involving Mr. O'Brien in particular?"

The first point, we have covered some of this, but there are two points I just want to draw your attention to or the Panel's attention to. The first point is, you reference culture, and you say this:

"An open and honest culture that is psychologically safe begins in the boardroom. That culture then needs to penetrate throughout the organisation no matter your role or perceived actual level of authority or seniority.

I have since taking up the role of Chair prioritised the issues of culture and how the Board works. I was very mindful that I was taking on a team of Directors who felt damaged and hurt. There was a need to build trust with each other and as a team. This work continues."

I will just stop at that point. When you talk about building up trust and work as a team and that that continues, can you just give us a flavour of what has been done and what you plan to do?

A. When I took up the role of Chair I spent a great deal of time meeting with all the directors, operational executive and non-executive, to get a sense of their views of how we work as a Board, what works well for them, observations that they would like to share.

I then created what was in essence my manifesto as Chair of the Board of the Southern Trust about how our Board would work and our committees would work. I streamlined some of the processes around that, but primarily I was being very clear that I would be working in partnership with the Chief Executive, this is not a Chair and Chief Executive. We are both seeking the same aims here in the delivery of safe high quality care. My expectation would be that as a Board that everybody plays their part at those meetings. I touched on it yesterday when I talked about the role of Executive Directors and exactly what I expect from them and contributing to those conversations. So I have spent the last three years building up the environment for the Board. That has filtered through to the committees as well in all fairness where I am seeing Directors freely come and share their concerns that might not necessarily be on the agenda and Directors freely challenging and engage in the conversations and the discussions that we are having. I can see very clearly the topics that we are covering. Whilst they are very difficult, everybody is approaching them with the same vigour and the need to be open and transparent in what we do.

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The final thing I will say on that too is that one of the important things is an organisation that is public sector, particularly Health and Social Care, is how members of the public and our staff can engage with the

Trust Board and that the Trust Board is not seen as some group of people who meet in a room with closed doors. So I very, very clearly have opened that up. People are welcome to join our meetings in person. A previous chair had opened it up as well in terms of 10:33
people being able to attend, but I have made a very concerted effort. I believe if people take the time to be with us at our Trust Board meetings and they have questions about the services we are delivering, then they should be able to ask those questions at our 10:34
meeting. I have been doing that since I have taken up. They get those questions answered at those meetings and where they don't it is followed up directly afterwards through me by the Directors.

10:34

So my efforts have been to demystify what the Board is, to take away any view or consideration that this is a secret place, it is only a certain group of people can be there, to actually open it up, that what we do there is as important, it is as important what happens in our 10:34
hospital and how that comes to us on the Trust Board and how our staff can come to our Trust Board, which they do do on a regular basis, and be part of the conversations. So that's what I have been doing for the last three years or so. 10:35

32 Q. Well just on that point, when you speak about opening up the communication lines and engaging more broadly, in relation to the other statutory bodies that have certain legislative responsibilities, RQIA, SPPG, the

Public Health Agency, Patient Client Council, what is your view on the Board's level of engagement with them and indeed their effectiveness when issues such as this arise?

A. I wouldn't have a knowledge on that to be honest. I'm not even sure -- SPPG is part of the Department, so they don't have a Board anymore, it was previously the Health and Social Care Board. The Public Health Agency, I am not sure if they are required to hold their meetings in public, we are, Health and Social Care Trusts are and I think it's a good thing. But in relation to their engagement and issues, this might be the Urology Inquiry in relation to urology services in the Southern Trust. This is as pertinent to us as it should be to the Public Health Agency and other agencies within the realms of Health and Social Care, they should be as interested in it as we are. 10:35 10:35 10:36

33 Q. Indeed they will be coming along to give evidence and we will be exploring their role and what potential there may have been or may not have been and what improvements might be required in order for that communication and information to be shared more broadly. 10:36

A. Mm-hmm.

34 Q. But in relation to the SPPG, formerly the Health Board, it now sits under the Department, how would you characterise the relationship with the SPPG as regards communication about commissioning and services and generally assuring them around risk, what's your 10:36

relationship with them like?

A. The engagement between SPPG would primarily be through our Directors and Chief Executive, particularly our Performance Director. Our Performance Committee would be involved. The work that the Performance Committee does then feeds through to SPPG as well. So we are continually reporting on our performance and non-performance and raising concerns where certainly for us as a Trust where we are failing to meet standards and failing to meet care because of the issues of demand and capacity and that continues, that dialogue continues. 10:37 10:37

Part of the conversation that has begun with the Permanent Secretary and the leadership of the Trusts and Public Health Agency is around the commissioning and what commissioning should look like for Health and Social Care in Northern Ireland. That's a very welcome intervention by the Permanent Secretary. That conversation started in December and the next meeting will be in February, SPPG is part of that. So this is looking at: this is how commissioning was done, these are the challenges we are facing, should commissioning look differently in the future, and we can't do that in isolation of the current regional piece of work around the integrated care strategy. The Southern Trust is the test bed for the Area Integrated Partnership Board approach. That really is about bringing in essence the health population needs locally and how the 10:37 10:38

commissioning of that happens locally. So what goes on here in relation to commissioning regionally cannot happen in isolation of what we are looking to bring the community, voluntary, and indeed members of the public into the conversation about how commissioning of services happens in your local area.

35 Q. That operational planning and restructuring that's ongoing at the moment, is that being informed by governance learning through the likes of evidence before this Inquiry and indeed previous Inquiries, do you get a sense that, you have mentioned about silo, do you get a sense that one is informing the other? Obviously commissioning also requires an assurance about risk and the quality of service, but do you feel that people actually are joining the dots and bringing forward learning to ensure patient safety and reduce risk? 10:38 10:38 10:39

A. I get a real - yes - but it's early days. But I get a real desire, certainly talking with my Chair colleagues and talking to Dr. Maria O'Kane in relation to her engagement with Chief Executives. There is no one there sitting who wants to sit in isolation, we have to work together as a system, and patient safety is paramount to that. So the conversations over the last 10/14 days, patient safety in emergency departments, patient safety in hospitals, patient safety in relation to the ambulances that are sitting outside the hospitals, so we are all on that page. But it is early days. I'm really, I am comforted by everybody's 10:39 10:39

engagement, that this needs to be brought together and not six individual Trusts doing six individual things and not all working together for the entirety of the population. Because we can't, what goes on in the Southern Trust impacts other parts of Northern Ireland, it is not just about the Southern Trust. 10:40

36 Q. Indeed if the commissioning is looking beyond the Trust into the voluntary community sector to provide services, there is a further heightened perhaps scrutiny required about governance processes and effectiveness? 10:40

A. Oh, yes, absolutely.

37 Q. Going back to paragraph 49.1, just reading the rest of that entry, you also say: 10:40

"The bringing of urgent issues to the attention of the Trust Board can happen through a variety of ways. There should be no impediment to significant urgent issues, particularly those affecting patient safety being raised. I am, since 2021, seeing issues/concerns being raised through Trust Board and committees more readily than before." 10:40

And I think you've commented on that before. You've also spoken to already the strengthening, the internal governance, which was your next point. We have referred also to the stable Board and senior leadership team, which you speak to. 10:41

A. Sorry, if I may, on the strengthening of the internal,

would you mind? I'd like to speak about the changes that we've made in relation to our committees of the Trust Board.

38 Q. Yes, please, thank you.

A. At the beginning yesterday I talked about the structure as it was. What has happened now, in light of the Champion review, in light of the outworkings of this Inquiry, is that the committees of the Trust Board will now be non-exec and exec membership, not non-exec membership only. That's the Executive Directors of Trust Board and then Operational Directors will feed into those committees as part of that. We have reprofiled our Audit Committee to be auditing risk, our Performance Committee is changing to be Finance Performance, an additional committee is being brought in on strategy and transformation. These all flow from, I suppose, the vision of how the Champion review could really change our governance processes and systems within the Southern Trust. So that started, that work started in September and will roll out over the coming year under -- the Chairs of all of the committees will be non-executive. The Remuneration Committee and Audit Risk Committee will only have non-executive on it. But I think that's a helpful step. I talked yesterday about the importance of that collective responsibility and leadership. The Trust Board is not just non-exec led, so bringing executives into the membership of the committees of the Trust I think is an important step for us to make and I'm

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looking forward to seeing how that works. Part of this equation also comes to succession planning. Because one of the lessons that I've learned over the last couple of years listening to Assistant Directors and others who report to Trust Board is that it is a place they don't really like to go, they are scared and afraid. But actually when they get there and see and hear and be a part of the conversation, they use the word "enjoy", I'll put that in inverted comments, but they see the benefit of it for them to see the broader picture of what's going on in the Trust. I believe by having the Executive Directors as members of the committees allows the opportunity for Assistant Directors to step up and be the reporting voice and then that helps with our succession planning. So it is a natural progression and not one where somebody is sitting and has never been near a committee or Trust Board suddenly applies for a director role, thank you. 10:43 10:43

39 Q. That's helpful. Thank you for providing that update of the new structure. We had looked at the stable Board and senior leadership team, just moving over the page; the Committee escalation to Trust Board we've dealt with. Just this last point, "Oversight of the role of Chair of the Trust Board", and you say: 10:44

"A senior lead Non-Executive Director role should provide a designated point of contact for all Board members and Directors who have concerns about the Chair as part of a broader remit to provide a level of

oversight of the role of Chair. This is common practice in Boards within Great Britain."

That's a suggestion about oversight, another layer, what's the position at the moment? 10:44

A. There isn't a lead non-executive role certainly in any the Trusts, I don't think. Actually I don't think any Board, Public Board in Northern Ireland would have it. My experiences from being on the UK Regulator Health and Care Professions Council as Senior Council member, 10:45 that provided that space for people to come - Executive and Non-Exec - to come to me if they had concerns about the Chair and it will allow me then to be able to challenge and support the Chair where necessary in that. So it's not a practice that I have seen here, it is 10:45 certainly a practice I am familiar with.

When I think back about the time from - 31st July was when the Early Alert was issued - so if that had come to us all, that would have raised a flag, that would have 10:45 allowed the opportunity for the lead non-exec to start to ask about conflicts of interest. We may then could not have been in the position where we had a former Chair attending a meeting and being part of a meeting when clearly they shouldn't have been. So, for me, I 10:46 think this would be a real helpful addition to our board's, particularly in these significant complex organisations.

40 Q. Is that something that would have to be led by the

Department or could the Trust instigate that level of oversight themselves?

A. Well the Board appointments are from the Department, so the Department would need to be taking a lead on this. This is a suggestion from me, I think it would be something that's worthy of a considered view on it. But to assign a lead Non-Executive Director, Northern Ireland is an incredibly small place, you would like not to be in a position where you are conflicted as Chair. But these moments do arise, there needs to be a mechanism in place so there is a road map for the Board to know this is the route we go if this happens. There was no route at that point. There was but there wasn't because it was left to the Chair and that was where it was at at that point. 10:46 10:46 10:47

41 Q. From what you have said it is still the case, but are the conversations being had with the Department about introducing something like this, you say it is common practice in...?

A. No, I haven't had that conversation with the Department yet. This was part of my thinking when I had gone through the Section 21, I am putting it here, I am certainly more than happy to have that conversation with the Department. 10:47

42 Q. I just want you to look at paragraph 50, just below there, and we asked you this question: 10:47

"Do you think there was a failure on the part of the Board or Trust senior management to engage fully with

the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently."

10:47

The answer over the page - for the transcript it's WIT-100560 - and I'll just read this section in for completeness. Paragraph 50.1:

"As a Non-Executive Director from 2016, and apart from the Board being advised on 27th January 2017 of an MHPS process being commenced against a Urology Consultant, I was not made aware of any clinical concerns or patient safety issues regarding urology services by the Chair of the Board, by any of the Chief Executives, interim, acting or substantive, by the Medical Directors or by the Operational Directors up until the 27th August 2020."

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10:48

You say at paragraph 50.2:

10:48

"The Chief Executive is the most senior executive member of the Trust Board. As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, the Department of Health, the HSCB and ultimately the Minister for the performance and governance of the Trust in the delivery of safe, high quality care, responsive to the needs of the population in line with prevailing performance standards and

10:48

targets. In this regard I would have expected the Chief Executive to raise with the Trust Board issues of concern such as the MHPS progress and outcome, the related SAI investigations and their outcomes, and the significance of the demand, capacity, mismatch issues within urology, in particular the potentially significant impact the demand capacity mismatch could have upon patient safety in a number of ways. The Trust Board may then have delegated them to the appropriate committee for oversight on progress. 10:49

Such issues, save for 27th January 2017 meeting mentioned above, were not raised by the interim Chief Executive Mr. Francis Rice, by the acting Chief Executive Mr. Stephen McNally or by Mr. Shane Devlin until after Dr. O'Kane had raised them in August 2020." 10:49

Paragraph 50.3:

"Dr. Maria O'Kane did raise the concerns regarding Mr. O'Brien from August 2020 during her tenure as Medical Director. As Chief Executive she has continued to raise concerns to Trust Board." 10:50

Paragraph 50.4: 10:50

"The Medical Director as an executive member of the Trust Board has responsibility to advise the Trust Board and Chief Executive on all issues relating to the

professional medical workforce, clinical practice and quality and safety outcomes. The Medical Directors, Dr. Wright and Dr. Khan, were aware of the issues leading up to and post exclusion of Mr. O'Brien and did not raise these concerns with the Trust Board, save for 10:50
the single instance on 27th January 2017. I believe that the issues and concerns should have been raised with the Trust Board by them on more than this single occasion and they could then have been delegated to the Governance Committee for oversight on progress." 10:51

Paragraph 50.5:

"As a Board there was an opportunity on or after 27th January 2017 for us to raise questions when 10:51
informed about a consultant who had been excluded from practice for four weeks. The Board, which included me, asked no questions, or none of any significance that I can recall. At that time I did not fully understand the MHPS process nor the need for detailed reporting 10:51
through to the Trust Board and/or its committees. Nonetheless, we as a Board should have been more curious. This was a missed opportunity on our part."

I'm not sure if you want to comment on any of that, but 10:51
I just wanted to read the entirety of that in. Just on that point, on that paragraph, you've said at paragraph 50.1 in the second sentence, just after the comma:

"I was not made aware of any clinical concerns or patient safety issues regarding urology services by the Chair of the Board, by the Chief Executive, Medical Directors or Operational Directors."

10:52

Just for the note of the Panel, if I could ask you to go back to your answer at WIT-100488, and this is paragraph 26 of your statement:

"We have issued urology concerns and issues brought to my and the Board's attention." You have summarised some of these. I don't want to take the sentence that you have stated at 50.1 out of context, but I want to tie up some of the issues around urology that were in fact brought to the Board and give you an opportunity to comment on whether you consider some of these to represent both clinical concerns and patient safety issues.

10:52

10:53

At paragraph 26.1, you've detailed in a tabular form some of the meetings where urology concerns were raised and I just want to go through a couple of these. The meeting at the Trust Board on 30th November 2017 and in the detail column you say:

"Waits on cancer pathways. Patients continue to be in excess of the 62 day pathway target associated with demand in excess of capacity with the majority of breaches of the pathway related to urology and upper

10:53

10:53

and lower gastrointestinal specialties."

Then at that same meeting there is a mention just below that on the corporate dashboard, "cancer pathways, 62 days" and at the bottom of that table, it says, the last sentence: 10:54

"Again the majority of 62 day pathway breaches for the Trust continue to be within urology."

10:54

If we go over the page at the entry of the Trust Board meeting of 24th May 2018. Again in the detail column there is reference to the pathway again, this is seven months later, this meeting. And you say:

10:54

"Performance against the 62 day cancer pathway in 2017/2018 demonstrated a decrease in comparison to 2016/2017. The less favourable performance is associated with the total volume of patients on these pathways which present increased demand on the 10:55 resources available, including red flag outpatient and diagnostic capacity. The two predominant breaching specialities in 2017 and 2018 were urology, sitting at 46%, and breast surgery sitting at 14% which was reflective of workforce pressures demonstrated 10:55 throughout 2017 and 2018."

The next entry in that column for this meeting on 24th May 2018 relates to outpatient assessments, and

this is your comment:

"Waits over 52 weeks for SHSCT specialities are reported across 13 specialties; breast family history, cardiology, diabetology. Endocrinology, ENT, gastroenterology, general surgery, neurology, orthogeriatrics, orthopaedics, rheumatology, thoracic medicine and urology, all of which have established capacity gaps or accrued backlogs." 10:55

Then in the meeting from 29th November of the Trust Board, again the 62 day waits, the majority of these were in urology. The Trust Board meeting on 24th January 2019, the in-patient day cases comment says this: 10:56

"In-patient day case waits over 52 week at the end of December has increased with 2662 people waiting across seven speciality areas: Breast surgery, ENT, general surgery, orthopaedics, pediatrics, pain management and urology." 10:56

And again below that at that meeting in January 2019 the 62 day pathway, the majority of breaches occurred are within urology. 10:57

Over the page, in May 2019, Trust Board meeting 23rd May - for the transcript we are now on page WIT-100491 - under elective care, it says:

"In-patient day case waits over 52 weeks largely continue to increase in line with regional trends. At the end of March 2019, 2700 people were waiting across nine speciality areas for over one year: breast surgery, cardiology, ENT, general surgery, gynaecology, orthopaedics, pediatrics, pain management and urology. Whilst the average waiting time is 37 weeks within the 95th percentile wait at 119 weeks pain management the longest routine wait remains within urology at 269 weeks." 10:57 10:58

At that same meeting on 23rd May 2019 the corporate dashboard indicated that the cancer pathway 62 day breach, the majority of breaches continued to be within urology. 10:58

That was also the case at the Trust Board meeting on 28th August 2019. The meeting on 3rd September 2020 - for the transcript this is WIT-100493 - there is a Performance Committee meeting and an update, a direct quote from that meeting has been given in your comment, section, and it says: 10:58

"Mrs. Magwood stated that the Trust has received a new investment for the seventh Urology Consultant. Recruitment is currently ongoing and it is anticipated that the seventh consultant will be in post in quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and 10:58

urgent cases with little anticipated impact on routine waits."

Then the Trust Board meeting on 22nd October 2020 says the following: 10:59

"In-patient day case waits and planned repeat treatments increasing volumes of patients waiting beyond their clinically indicated timescale for planned repeat treatment. The Trust has received in year 10:59 investment of £200,000 for the urology seventh consultant. Recruitment is currently ongoing and it is anticipated that the seventh consultant will be in post in quarter 4. The additional capacity created by this post will be targeted to the red flags and urgent, with 10:59 little anticipated impact on routine waits."

That's information that came before the Board in relation to urology over that snapshot three year period. It's clear that waiting lists are getting 11:00 longer, the cancer performance objectives around the 62 day wait are being breached across the Board in some respects but specifically in urology. There is a mismatch with capacity and demand, there is staff shortages that are clear. Towards the end, the last 11:00 couple of examples that I read out, it seems to be the case that any attention being given to routine waits has all but been abandoned in favour of red flag and urgent, would that be a fair reflection on those

entries?

A. It would be, yeah. When we had an executive in place then there would have been waiting list initiative monies that would come and those would all be gear towards red flag cases, that would just enhance that too. 11:00

43 Q. Was there ever any curiosity expressed by the Board given that feedback, and urology does jump out - I know it jumps out at us for obvious reasons, but there does seem to be a bit of a theme - was there any questioning 11:01 of, for example, Mrs. Magwood around well what has been put in place about waiting lists, what measures are there at that time, because at this time you were looking just at numbers and breaches of targets effectively, that's what they represent; but do you 11:01 recall anything like that being discussed?

A. Up until the Performance Committee was established then I would have an exposure to the discussions around performance, the Performance Committee I don't attend. But I do recall conversations where we had looked at 11:01 the measures we were taking on recruitment to ensure that we had the staffing numbers in place and then whether or not we had the resources, the additional resources required then to deliver the services or additional clinics or operations in that regard. But 11:01 maybe if I could be so bold as to say that you have the Chair of the Performance Committee coming up in terms of the very specifics around, that might be helpful, but certainly where we are at as a Trust, the

decreasing of the delivery in relation to demand and capacity mismatch is just continuing, you can see the decline there. You have sight of the papers up until, I think, September 2023 and you just see the continual decline as well. 11:02

CHAIR: Just briefly, Ms. McMahon, maybe you are coming on to this, but I think maybe the question is linked back to paragraph 50 where you said that you were not aware of any clinical concerns, but surely these are clinical concerns? 11:02

A. Oh, yes, absolutely, thanks for bringing me back to that. These are patient safety issues and clinical concerns. Looking at my answer in 50 I may have answered it from the perspective of Mr. Aidan O'Brien and clinical concerns. These are patient safety issues 11:03 and clinical concerns, absolutely.

CHAIR: Thank you for that clarification.

44 Q. MS. MCMAHON: Just in relation to those ongoing concerns around urology and the issues that were arising, we've looked at Early Alerts - and obviously 11:03 the one key Early Alert that you weren't aware of in July 2020 - was there ever any sense that some of this information might have triggered an Early Alert to the Department giving the increasing and, as you have now said, continually increasing breach of both performance 11:03 standards but invariably concerns around patient safety and escalation of ill-health due to long waits?

A. Yes, and that would have happened, there would have been, I recall an Early Alert particularly around,

obviously, the beginning of the Inquiry, urology services, the lookback review, the pressures on the team that we have. There was also a written request from the then Chief Executive Shane Devlin to the SPPG - if it was SPPG at that point - asking for additional support from the region to help us to look at the routine and the new cases so that the team here could be looking at the review and the backlog. So, yes, I'm seeing more of a flow through of the patient safety concerns going up, either an Early Alert or in direct communication with the Department or SPPG. 11:04 11:04

45 Q. But were there any specific alerts raised at that time, in those periods of time?

A. Oh, forgive me, sorry, I don't recall. There would have been no continuous discussions. I know from Aldrina Magwood's role, that would have been a continual discussion on getting additional resources and support for the Trust in relation to delivery and to help meet these targets. But as regards an Early Alert, I don't recall. 11:04 11:05

46 Q. I suppose the most obvious and direct question is: Did the Board join up thinking to realise that breaches of targets and time frames and long waiting lists actually had a detrimental impact on patients?

A. In its rawest form, the focus on targets as opposed to the focus on patient safety, I would say the focus was on targets. But I wouldn't say that patient safety wasn't in the thought. But I certainly can't sit here today and say patient safety is first and foremost in 11:05

relation to our considerations and that of our Directors.

47 Q. Just while you're here there was another mention of you by a witness, I don't know whether you heard the evidence of Tracey Boyce? 11:06

A. Mhm-mhm.

48 Q. She recounted that you had requested that she attend the Governance Committee meeting, and I just want to read that to you so if you need to comment you can, and it is TRA-05852: 11:06

If we start on that page at line 6, and this is continuation of an answer by Mrs. Boyce and this is - I actually can't remember if it was me or Mr. Wolfe but somebody asked the question, if it was a good question 11:06 I'll give it to Mr. Wolfe - Ms. Boyce says in her answer:

"Around the same time I remember being shown, one of the Non-Executive Directors came on a visit to pharmacy 11:07 at the point she was getting ready to take over the Chairmanship of Corporate Governance. At that stage I would have attended Corporate Governance in my Director of Pharmacy role. The first item on the agenda was to present the medicines governance report which was a 11:07 report of my work and the team and my Accountable Officer's role and then I left Corporate Governance. I wouldn't have been present for the rest of the meeting. But at that time Ms Mullan asked me during that visit

would I mind.
Q. Mrs. Eileen Mullan?
A. Eileen Mullan, that she would like me to attend the full meeting from then on. I was then after that actually able to assist Esther at that meeting with Acute Governance, even though I was there for pharmacy because I was sort of involved still. If a question came up around the governance issues for Acute, I was able to assist Esther in a terms of answering it. Obviously I wasn't there at the other meetings, like Trust Board and SMT and so on." 11:07 11:08

I don't think there is any dispute that you asked her to attend, could you just give us a little bit of background as to why you thought that would be helpful? 11:08
A. Yeah, I was quite surprised actually that as the Director of Pharmacy that Tracey Boyce wasn't present for the entirety of the Governance Committee meeting, considering medication management is central in relation to clinical social care governance reporting, it is there. It felt odd to me not to have the Director of Pharmacy present. Tracey Boyce is an exceptional Director of Pharmacy. I found her at meetings a wonderful addition and value added to our discussions. I felt it would be good for her also to have exposure to the wider discussions that we were having on governance, particularly clinical and social care governance across the Trust. 11:08 11:08

So if the inference is that I considered that as an option in relation to the then Acute Director, it wasn't, she gave me more credit than I deserve. I actually felt that it was important to have the Director of Pharmacy at our meetings and I found the Director of Pharmacy an incredible and valuable force. I recall at one meeting where she was raising her concerns particularly around fraud and medicines management, when she raised her concerns there wasn't anybody in the room that didn't hear that. That was the value that she brought to the table. So she was raising the concerns quite clearly and openly and I found it a great addition and welcomed it. 11:09 11:09

49 Q. So just to give that context, the slant wasn't -- she was a freestanding addition rather than a supplemental addition? 11:09

A. Correct, yeah.

50 Q. Just, I had asked you questions about the Board's knowledge at the point of the October meeting in 2020, the meeting, the September meeting with Mrs. Brownlee. We spoke about whether she advocated for Mr. O'Brien and what the perception was and what the knowledge of the Board was at the time. I specifically asked you about Bicalutamide and you said you hadn't got that knowledge at that point to ask those sort of questions, you wouldn't have known that information. So just for the Panel's note I wanted to read in just two brief extracts from Mrs. Brownlee just so that you know what she says about her knowledge at that time as opposed to 11:10 11:10

yours, and this is WIT-90858.
Just the second last paragraph and the sentence begins "as Chair of the Board" and it says:

"As Chair of the Board I was not aware of the detailed information that is now before the USI in relation to clinical issues with Mr. O'Brien. As I refer later, I did not see the detailed Medical Director's report on Mr. O'Brien's clinical issues that came to the Trust Board in September 2020." 11:10 11:11

Then if we go to WIT-90867, paragraph 22, just the last paragraph there and the sentence begins "no other". And she says:

"No other Medical Director, Director of Acute Services, Head of Service Or Assistant Director ever spoke to me about issues with urology or Mr. O'Brien in particular." 11:11 11:11

I just wanted to provide those extracts of her evidence but Mrs. Brownlee is coming to give evidence so she can speak to those issues herself.

Just, finally, I wonder if you could give the Panel just a snapshot of some of the issues, for example this year, that have arisen. I would be grateful if you could include examples of your expected interactions or necessary interactions with the Department, both from 11:12

yourself - I know Mrs. O'Kane is coming back, Dr. O'Kane - the sort of time that takes up and the level of interaction that's expected given the challenges the Southern Trust has faced and continues to face, just to give the Panel a flavour of the position at the moment.

A. Okay. Yes, I will, thank you. This has been an incredibly difficult year, and I say that on the foot that it has been incredibly difficult two, three years in relation to the outbreak of Covid and the resulting to that. But this year in particular - and I'm not saying that the other trusts haven't got their challenges - but this year has been very difficult. We had -- I'll step you through it, if I have time, yep?

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Our second acute hospital, Daisy Hill Hospital, based in Newry on the border, we had nine consultants due to retirement, one to change of life, moving, we lost nine consultants which critically impacted on the general internal medicine facility within the hospital. That created its own challenges locally within the Newry & Mourne area and the concerns for the stability and the future of Daisy Hill Hospital. This happened in April and unfolded really, really quickly which required the Chief Executive and the Senior Leadership Team really to wrap around it, and this went on for a period of two or three months to get to a point of a short term stabilisation plan because a longer term plan is required for that hospital.

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We also had this year, the cytology outworkings, 17 and a half thousand slides have had to be reviewed in relation to the concerns of the work of slide reviewers within the Trust. We also had an incident where the 11:14
electronic data sign-off between the hospital and GPs, 25,000 letters went amiss in terms of that sign-off button being pushed. We have had the outworkings of the Caudery Inquiry. We have had the challenges in relation to trying to effect change and transformation 11:14
within Health and Social Care following the impact of Covid and the desires to move into a transformation mode. So it has been incredibly difficult.

It has been very hard on our Senior Leadership Team. I 11:14
have watched them give all of themselves every day and more, with no consideration of the impact on them individually, which concerns me greatly. We talk a lot about health and well-being in our Trust and that applies as much to our SLT as it does to the rest of 11:15
our staff. I am very mindful that, as a result of Covid and people not taking their leave, there has been an accumulation of annual leave. When I go back to the Daisy Hill scenario, Dr. Maria O'Kane had to wave her family off on holidays because she couldn't go because 11:15
this issue was so involving. That was a hard swallow for Maria but she needed to be here to give leadership to that scenario. Our Senior Leadership Team have not been able to get their leave when they needed their

leave. There is pressures then regionally from the Department. We have the hospital Blueprint process. We have the Integrated Care Strategy and I mentioned briefly the Southern Trust is a test bed for the Integrated Area Partnership Board. Both of those are 11:16
significant pieces of work and both of those involve our Chief Executive Dr. Maria O'Kane.

There is other regional activities, PTAB and I can never remember what the anagram stands for, but it 11:16
brings together the Chief Executives, the Department and SPPG and others. That is a regular occurrence. There is also other regional meetings in relation to cross-border work and activities with PHA and the RQIA, not to mention the requirement at a governance level 11:16
for us as a Trust, the Trust Board, the committees, the meetings with non-execs, the meetings with me as Chief and other activities that need to take place. As a result of all of these demands and pressures this year, unfortunately Dr. Maria O'Kane has not been able 11:16
to attend four out of the five of our governance meetings due to those competing demands, not intentionally, not willingly not wanting to be there, but because all of this other stuff is going on. I see the pressures certainly in attendance for other 11:17
Directors as well.

Dr. O'Kane has missed two of our Audit Committee meetings. That has caused some concern for us as Non-Execs. I have raised this with Dr. O'Kane.

Certainly she is very aware of that and the Panel can speak to her when she comes back. But certainly I have committed where we need to timetable and do things differently we will do that and to ensure that we create that space. But in talking to Maria very, very simply, every week there is either a Trust Board governance meeting of some shape or size. Every week there is a governance meeting of some shape or size at the Department level and every week there is something in relation to SPPG, so to find time to take time out has proven very difficult. So in order to take time out then she has to send her apologies. 11:17 11:18

But we have raised that as Non-Execs. I have spoken to Maria about it, I have raised it with her and will continue that dialogue. It would be remiss of me not to acknowledge that, whilst all this other stuff is going on, there has been tremendous work being done as a result of the outworkings of this Inquiry as well which the team have been doing. So actually at times I wonder how they are able to do everything they do but I know it comes at a personal cost to them. 11:18 11:18

MS. McMAHON: Thank you for that broader context. I have no further questions, the Panel may have questions for you, but thank you. 11:18

CHAIR: Thank you, Ms. McMahon. Thank you very much, Ms. Mullan, I am afraid we can't let you go just yet, there are several questions that we want to ask you ourselves. So I am going to ask Mr. Hanbury, first of

all, if he would ask his questions.
THE WITNESS WAS THEN QUESTIONED BY MR. HANBURY,
AS FOLLOWS:

51 Q. MR. HANBURY: Thank you very much, Chair, and thank you very much for your evidence which was very impressive. I have a few clinical things to ask, starting with, you mentioned in your statement, we've seen evidence in the documentation about leadership rounds or safety rounds when members of the Board visit Departments, many Trusts certainly in England have adopted this and used various ways of conducting it, so what's your experience of this, either as Head or Chairman of the Trust yourself? 11:19 11:19

A. Okay, thank you for your question. There have been two leadership walk styles in my time within the Trust, both as Non-Exec and as Chair of the Trust Board. The previous leadership walk was done by Non-Execs and really it was about meeting the teams, listening to the challenges, what's the environment like, even down to were the curtains clean or not, okay. As Non-Executive Directors we felt that -- it felt more like an inspection rather than leadership walk because for me leadership is about listening as much as anything else. So that leadership walk style, I can't recall when I - it's probably within my first year of being Chair of the Trust Board - at the same time the Senior Leadership Team had redesigned theirs to a 15 point plan, which was more of a clinical governance 11:20 11:20

perspective. And certainly as Non-Executive Directors we wouldn't have that insight to be able to critically look at those areas. So we have come to a space, a consensus in the middle. There is a leadership walk, it is about listening. It is about asking the team what the challenges are, what are the three things they would like to see happen. We have also moved from that to being a Non-Executive Director and Executive Director together or the Non-Executive Director can go out on their own. So we are trying to shift the culture of the leadership walk, moving from inspection to actually one about getting a real sense and feel for what is going on in that unit and bringing the Board closer to our teams. 11:21 11:21

52 Q. So how do you chose which Departments to visit? 11:21

A. Oh that is done by our administrative staff, they select. We can go anywhere. We have 238 locations that we can choose.

53 Q. It's a big Trust.

A. So we don't get to pick them, we are sent. 11:21

54 Q. Do you co-ordinate the usefulness and the sort of learning points on the Board in some way?

A. Yeah, they are collated together on a six monthly basis and reported through to the Governance Committee.

55 Q. Okay, thank you. Just moving on, we've seen some presentations to the Board relating to issues raised, particularly in urology, do you have a method of selecting what sort of presentations you ask for? We were interested, Kate O'Neill presented something for 11:22

urology but there didn't seem to be a Consultant Urologist there, was there a reason for that, or do you recall what led up to that?

A. No, on the first part there is no method, it is what is it that we need to discuss, what are the issues that are arising, who do we need to be in the room to inform us and that's where the presentations would come from. If there has been outworkings at our committees, sometimes that would trigger a presentation as well or an input from a specialist or indeed our teams. The presentation you are referring to of the Clinical Nurse Specialist. 11:22 11:23

56 Q. Yes.

A. Yes, the Consultant Urologist wasn't there. I have no understanding as to whether they weren't asked or they were asked and they couldn't attend. What I would say is there is no script or containment, certainly from me as Chair, as to who can come and what they can present. 11:23

57 Q. Did you ask urology in this instance in that they were identified as a Department in difficulty? 11:23

A. The Director responsible for urology would have been asked.

58 Q. Okay. But did the Board say 'we want to hear from urology', going a step back?

A. If something had have triggered, I can't recall exactly why that presentation. But I have a funny feeling that came as a result of the presentation of the Patient Client Experience Committee. I think that's how it arrived there. 11:23

59 Q. Thank you.
A. So the Board can ask for any contributions and things can bubble up from directors and indeed from committees. So there is no template that says this is how we do it, it can be as free flowing as that. 11:24
60 Q. Okay, thank you. Just moving slightly away, in health care staff are often upset when they can't deliver care to the standard they want to and the term moral injury has been used to describe this, have you been aware of that in the Southern Trust and what can be done to 11:24 ensure staff feel understood by the Board?
A. Yes, I am very familiar with it.
61 Q. Okay.
A. It has come up quite a bit, psychological safety has been part of many of our conversations since Dr. O'Kane 11:24 took office as Medical Director and through to now. There is a couple of things that has happened. The visibility of the Chair and Chief Executive, the visibility -- the opportunity for staff to be able to speak and see and come to meetings or not is available. 11:25 Dr. O'Kane has put in place a chat with the chief that happens every week and that's attended by quite a large number of our staff teams, it's recorded and played back across the system. The leadership walks are part of that process too as well as Dr. O'Kane and I just 11:25 randomly going out and meeting with the teams as well.
62 Q. So do you have the impression that the staff on the ground are understanding what the Board is about now in a better way?

A. More so. More so, yes.
63 Q. Again moving on to national audits and the Getting It Right First Time initiative. So we have heard in the past that audit always wasn't so well supported but there have been improvements, so has the Board had a discussion about encouraging national audits? We've heard about, for example, stroke and cardiology and how those have helped drive improvements, how does the Board respond to that? 11:26
A. Well we do get national audits through to our Governance Committee in particular, CHKS or CKHS. 11:26
64 Q. More internal though?
A. Yes.
65 Q. Okay.
A. So we do. In relation to getting it right first time, that report is actually due to come before Trust Board or a committee, whichever is first, in the next couple of months. But in answer to your question do they drive improvement, yes; do the Board recognise that, yes, because they recognise it through the work of the Governance Committee and what has been happening in relation to that particularly around stroke. 11:26 11:27
66 Q. To your knowledge, some of the clinicians have told us about downward pressure on using national audits for our national association, BOSE, you are not aware of any hold-up from your point of view that that shouldn't be happening? 11:27
A. Well I am not aware.
67 Q. I think it is more sort of a data confidentiality

issue, but that wasn't a problem with stroke and cardiology?

A. It is good sharing information nationally.

68 Q. Yes.

A. I am not familiar with that. 11:27

69 Q. Okay, thank you. Just lastly on the recruitment, we've discussed capacity demand. Even way back in 2021 the capacity was such, it seems, that the urology department at that time could only really cope with urgents and red flags and it seems as though that is 11:28 still the case. Obviously to address that, recruitment has been a big thing, and that's not necessarily just the Southern Trust. I mean, has the Board had any strategic discussions on how to manage this with differences in job planning or links with, for example, 11:28 other trusts for a rotational type, what are your views on that?

A. Yes, job planning has been part of the conversations in relation to recruitment and what we can do to make the jobs and the roles more attractive, to bring in 11:28 additional staff so, not just urology, but also in other specialties too. So, yes, that has been part of the discussions.

70 Q. Have there been any conclusions to that or any good ideas that you're working on in that respect? 11:28

A. My observations is it seems to be helping. Certainly as Non-Execs we chair all the consultant recruitment panels. So I am seeing in some parts more applications and more willingness and eagerness to want to work

within the Southern Trust coming through. The job planning has been part of that and how, particularly if I consider the Emergency Department Consultants and them being able to work in Daisy Hill hospital and also work in Craigavon hospital and the same for specialties, having that crossover so they can get to work with the bigger teams, have subspecialties beside them, all of that has been factored in and that has proven, in my view has proven beneficial. But certainly we have a way to go to be able to get to the numbers that we need to. 11:29 11:29

MR. HANBURY: Thank you very much. That's all I have.

CHAIR: Thank you. Dr. Swart?

THE WITNESS WAS THEN QUESTIONED BY DR. SWART, AS FOLLOWS: 11:29

DR. SWART: Thank you very much for your evidence, I certainly don't underestimate the amount of work that you have had to do and will be ongoing with everything that is going on. I think that applies to many Boards but particularly to the Southern Health Care Trust. 11:30

71 Q. You've described quite a few areas where you have recognised that Board development has been required and there have been needs for improvements in governance and also particularly the detail and clarity of Board discussions, what in your view has to date been the most significant improvement that you have been able to 11:30

make, or improvements, and what do you think still needs to be done and is on your big worry list from the perspective of the overall Board, just in general terms?

A. The first part, the thing that has been done. 11:30

72 Q. Mhm-mhm.

A. I think it's making the Board a collective, responsible Board together. I think that has been achieved in the last three years. My worry list would include having the resources and capacity to deliver and what we need 11:31 to do to really transform Health and Social Care for the Southern Trust but to effect the changes so that patient safety issues and concerns no longer exist. That may be

73 Q. a slightly elusive task. Do you have any explanations for the lack, what comes through is a lack of Board 11:31 curiosity over many years, not with casting blame particularly, but why was that do you think?

A. I think it comes down to a couple of things: People's understanding of what the Board is and who makes the Board -- 11:32

74 Q. Yep.

A. -- as well and not seeing it as broader than the Non-Executive Directors. And also, and it's not just within Health and Social Care, there is this viewpoint that you come to the Board, you sit, you wait until you 11:32 are asked a question and then you speak. But actually it should be the other way round, you come and you are eagerly engaging in the conversation. So I think there has been a way of working and a perception around how

Boards operate that has this in built, you just sit there and wait there until you are questioned, so that curiosity wasn't coming through and then were the questions the right questions and were we focussing our attention on the right areas. 11:32

75 Q. Now, we have heard from quite a number of people, and I think you have alluded to this yourself, that there was a tendency for people to look at operational matters, professional matters and senior oversight as separate things and that's not always helpful. This 11:33 crystallised in some way in some of the Serious Adverse Incidents where there was a tendency to say 'well we have given that to the Directorate and they are going to deal with it all in terms of the action plans', and clearly they were not able to deal with the action 11:33 plans and there was a failure of oversight, if you like, not through intent but through volume and the way it was all set up. Now you have described quite a lot of improvements, including lessons learned and more focus on SAIs. 11:33

First of all, with the lessons learned, do the right people go to those meetings now? Because the previous attendance list was quite sparse, so do you think that is really working for you or is there a way to go? And 11:33 then the learning for the Board, have you got to the stage of presenting thematic learning to the full Board in terms of 'this has been the learning this year, these are the things we have changed', has it got to

that stage, do you think?

A. I'll take the last one first. We are not there yet, we are not there yet. The outworkings of the Champion review, the operation of governance layer that has been put in place, we are only starting there in terms of that feeding through. My aspiration is it will do just that, it will do just that. But I am hoping over the course of this incoming year we will see that bed in, the committee bedding it in and the teams then certainly being able to feed up what needs to be the focus of attention for the committee and the areas of concern and risk. I do get a sense, though, listening to our Directors, because they are a few months ahead of us in terms of their delivery of the operation, that they are being exposed to more than they have ever been exposed and they are unpacking things more than they unpacked before. I am getting a sense that there is a real visibility for them across a broader piece and they are joining dots. 11:34 11:34 11:35

76 Q. Because it is quite a difficult task, isn't it? You get lots and lots of action plans for lots of things, it is not that easy to keep it all in track. But if people recognise the need and have a plan to do so, that is probably the first step, and you think that's kind of where you are getting to? 11:35

A. Yeah, and it needs to be followed up. It is not a case of, okay, well, that's done, we'll leave that there, we don't need to worry about it, we need to follow it up, is it complete, all right? And coming to your first

point which is in relation to the lessons learned, and forgive me, I am not familiar who attends just now, but certainly my reflections is it wasn't as meaningful as it was supposed to be.

77 Q. Yep. 11:36

A. And certainly we need to find other ways of being able to share the learning. An example I'll give you from our Mental Health and Learning Disability Directorate where there was a piece of work on the culture within one of our units and that learning was immense. The 11:36 advice from the Board was can you put that into a video or an audio that you can share widely instead of having people to come to a room and, as much as virtual meetings are helpful, you need the sense and get a feel for what's actually going on. So I think there is more 11:36 to be done on that.

78 Q. I think lots of people struggle with this, that's for sure. Another thing that has been quite striking is, if you look at, as an example, the cancer arena. Lots and lots of focus on performance targets. The cancer 11:37 team, everybody seems to know about difficulties in that area, and that was picked up at the Performance Committee. But there wasn't any attention paid at that committee to whether cancer was actually achieving the right things against the standards other than 11:37 performance targets, so I am talking about peer review standards. So, unpicking that, there doesn't seem to be a forum where you looked at cancer in the totality and could assure the Board in terms of: these are the

targets we are meeting or not meeting with respect to performance and these are the big gaps in peer review which would imply a quality or safety problem for patients. Now, this is a general feature, how do you bring quality and performance together because really they shouldn't be separated in that way. Has that changed? Has that been recognised or discussed by the Board in terms of what could be done about it? I think particularly from a patient perspective the patients would want to know that they are receiving best practice treatment? So do you have any views on all of that? 11:37 11:38

A. In particular in cancer?

79 Q. Yes. I'm just using cancer as an example, but it does apply to other areas. I mean, we have seen quite a lot of evidence about cancer, it is not just urology, it is cancer generally. This is something that could apply in other performance areas. So, in my Trust for example, we used to get A&E performance very regularly, obviously, but alongside there, there would be all the safety standards achieved or not achieved in A&E at the same time. Has that come into play and have you had a discussion about that at the Board? 11:38 11:38

A. The most recent example of that would be the Emergency Department, the overcrowding and the safety impact. 11:38

80 Q. Yep.

A. That came through the Governance Committee. There was a presentation from the consultants in ED about the challenges and the impacts and they had the data and

all. So, yes, there is. Certainly I'm seeing that kind of conversation coming forward more often now. But I'm actually struck by your using the cancer one as a trigger, but actually there is something in that, about those themes and taking time on thematic areas, for the Board to hear where we are situated rather than in a mask of performance.

81 Q. I asked Mr. Devlin about this because he talked about setting up performance meetings so you could have a deep dive into cancer. There was a deep dive but it was entirely performance. I mean, of course we have heard evidence that there was a failure to meet peer review standards in urology year on year on year on year and the Board did not know. There will be other - this is an area I am familiar with - there would be other specialities that struggle with some of the peer review standards, not through intent necessarily, but through staffing gaps or other operational difficulties and the Board would, I think, want to know about these things. So it was really a question as to the Board realisation of how important this is and what a unifying concept it is for staff?

A. Certainly from my observations there is a movement towards those type of conversations. The Board agenda and the Board focus then needs to flow to enable that to happen. So our agendas now for Trust Board are entirely different than what they were in 2018, okay.

82 Q. Do you manage to have a greater emphasis on safety and quality now at the Board?

A. We do now.

83 Q. So one of the drivers for this seems to have been people's perception that the focus on performance was needed because that's what the HSCB and now SPPG or whoever is interested in, so these are mandated, whereas the focus on safety and quality wasn't mandated in the same way and, therefore, fell off because everyone was so busy. Do you think that is a fair thing, this is what has come up from some of the evidence? 11:41

A. I do.

84 Q. Yes.

A. I do indeed.

85 Q. What do you think the Trust should do about that?

A. We change the narrative, you know, and we do it when we talk. It has been as recent as the conversations with the Department of Health, we are talking about performance and safety as well. So we need to change the narrative about what we are actually focusing on here because, if you get the safety right, the performance will flow. 11:41

86 Q. Has the Board taken that discussion to understanding that, if you had regular information about the quality of services which - I would put safety as part of that, - there might be other things in it - that would help the oversight, because I can't see that conversation anywhere? And also, I think there hasn't been a national conversation to say 'we want to help trusts to do this'. Some of those things can come from national 11:42

audit measures that you already have, it is just a question of are they brought together in a way and does the Board recognise that better assurance like that would help its deliberations?

A. It does. 11:42

87 Q. The other thing, there has been a lot of evidence about MHPS and you have said that the MHPS reporting is much better and we can see that in the papers from the Governance Committee, do you think that there is a more rigorous approach now to management leadership for 11:42 medical staff and the importance of that and the investment in that? Because there seems to have been a lack of time for doctors to devote to management and leadership and a sometimes poor understanding of what they were doing, what has the Board discussion been 11:43 about that and has there been any funded program of work that the Board has been able to support or the Department has been able to support, what's happened in that arena?

A. The Senior Leadership Team have been having a 11:43 conversation team about management leadership across the Trust and through the HR Directorate then there will be, I suppose, a program of offering to be created. The Board hasn't been asked yet --

88 Q. Okay. 11:43

A. -- about the resources for that, but certainly the Board is very familiar that there is going to be work done now to bring in management and leadership across the Trust and the support that's needed to do that.

89 Q. But the Board is aware generally?
A. Yes.
90 Q. Yes. Has the Board itself agreed an improvement plan as such for the Board, is there a plan that has been approved, funded and monitored? 11:43
A. For the Board?
91 Q. Yes.
A. To improve the Board?
92 Q. Yes, a self-improvement program, if you like.
A. Nothing dedicated other than the two pieces of work that I have carried out in my tenure by way of an informed direction of travel, so it's not me in isolation. 11:44
93 Q. Yes. I'm struck that Peter May produced that document which you are aware of, which is quite a good document, I think, there is a lot in it, but for that to come down from the Department without a support package to say Boards could use this as a tool for improvement or something it seems quite difficult, and you also refer to the Board's self assessment as being a bit of a tick box and it does look a bit like that looking back? 11:44
A. Yes.
94 Q. So I just wondered whether the Board had been able to sit down and say 'look, we can do something ourselves, let's have a think', other than your missive, which is clearly very helpful, have you been able to do that and have you had any support to do that from the Department of Health for example? 11:44
A. On the Board development piece, the conversations that

I have been having in the Department of Health is around the work and leadership centre is to be undertaken and my desire and expectation would be that that is supported fully by the Department of Health and resourced appropriately. 11:45

95 Q. Okay.

A. It is not just about our Trust, it is about all Arms Length Bodies. So I would see that as a mechanism for our Board to be able -- and certainly I had the meeting with the leadership centre team and I said that I would 11:45 be expecting this, this and this for our Board. Then there is a service level agreement in place between these two organisations, but my expectation would be that this is supported by the Department. I know it is something that Peter May himself as Permanent Secretary 11:45 is supportive of. Forgive me, Dr. Swart, the last part of your question I haven't answered, can you remind me?

96 Q. I'm not quite sure which bit I asked last actually. I mean, it's really about whether you are taking the time to sit down together and say this is our plan for 11:45 improving ourselves, this is our plan for improving our culture. I mean, I agree with you, culture starts with the Board. People use the term "culture" quite loosely, don't they, you set out clearly what you mean by that. But it starts with the Board, then you need 11:46 your own improvement plan, don't you? It was really to see how far has that discussion gone. I mean, bearing in mind you have got a huge agenda and loads to do and this work takes time?

A. It does. As recent as November at our Trust Board workshop, that's exactly what we did. We reflected specifically on how the Board, what steps the Board took and did not take in relation to the period of Daisy Hill Hospital and the general internal medicine crisis of April to June, what did we discuss and not discuss? How did we approach it? How did we not? We did a reflection piece on that as recent as November as well as other actions and discussions around how we are working and how we could improve that. 11:46

97 Q. That's what I meant, yes, thank you. The instability at Board level historically was quite striking. Clearly this has had an impact on the ability of the Board to perhaps agree, display and communicate a clarity of purpose. Where do you think you are now with that? Do you think your staff on the ground are clear with respect to what matters most to the Board at the hospital? Would they be able to say now the Board has changed and it cares more about safety than it did about targets? Where do you think the situation is with that? 11:47

A. I think the staff through our Chief Executives' chat with the Chiefs, which are weekly, have got a real sense of the direction of travel for this Board at this juncture in time without a doubt, I do. 11:47

98 Q. So what do you think they would say about what matters most? So a lot of staff through the Inquiry has said well we only did that because everybody only cared about targets, would they still say that?

A. I would hope they would say patient safety and themselves, those two things are really important to us.

99 Q. Thank you. Now, Ms. McMahon already mentioned this issue of having a senior responsible Non-Exec Director, do you need to wait for the Department for that or could you just decide in the Trust that one of your Non-Exec Directors would act as that role and have a mandate in some way? What is your view on that? 11:48

I have worked with that system, I find it quite helpful, both as Chief Executive and Medical Director and for the other Non-Exec Directors, there are times when people need to know who you can go to? 11:48

A. I am honestly not sure whether it is in my gift, but I have absolutely no problem having that conversation with our Permanent Secretary about feeling that it is something that would be necessary. It came as part of this process which has been very helpful to try and see how we can prevent something like that happening again. So, I am not dodging your question, but the appointments to the Boards are by the Minister. 11:48 11:49

100 Q. I realise that, I just wonder whether internally you could have some sort of...

A. Then, you know, I can see the role description already, what that might look like. Certainly I can provide help to make that a quicker process. 11:49

101 Q. I think if it is done well it is not undermining to the Chair in any way?

A. No.

102 Q. It is actually rather helpful?
A. Yes, I would agree.
103 Q. Apart from anything else it means that people have somewhere to go, even if they have no real reason to do that, you know. So there seems to be in quite a few areas a sense of sort of helplessness about the whole demand capacity issue, and it's helplessness that's been there for years and an acceptance that, you know, periodically some cash comes down and you can do a bit more. How much fuss have people made, has the Board made, say, recently, for example, in terms of saying enough is enough, this is now a huge patient safety risk, something has got to be done, how can we work together, let's not wait for the outworkings of Bengoa or whatever it is, have you made a big fuss, has the Board made a big fuss, have other boards made a big fuss, what does it feel like? 11:49 11:50 11:50
A. I would agree with the helplessness, without a doubt, and we will just wait for a pot of money and everything will be sorted. I would say in the last year or so there has been a real impetus, these challenges will not change unless we do something and we can't wait on the white horse coming over with the money bags. So, certainly talking to my fellow chairs and hearing from the chief executives, there is a real focus on that right now with the Department through the Permanent Secretary Peter May. One of the examples I can provide you is the regional control centre has been set up for the ambulances right across all the Trust, so there is 11:50 11:51

a team there looking at it globally. So that's about taking it out of the realms of the Trust and how can we assure the timely delivery of ambulances and patients in the right place at the right time and all of that. That was a collective approach from the chief executives which has been really helpful. So there is certainly a momentum on this about what we can do with what we have and how we reorientate our resources. 11:51

At a local level our focus, particularly in Newry & Mourne, and Daisy Hill Hospital in regard to that, is in relation to increasing acute care at home, how we transfer our resources from within the hospital to outside of the hospital and have more impact and keep people at home. So these little bits are all happening. 11:51 11:52

104 Q. Do you think the momentum is better and more cohesive now?

A. I do, I do.

105 Q. And finally then, you will be relieved to know, I am quite interested in the relative lack of information for patients in terms of being copied into all clinical letters, being able to be involved in service improvements and so on, so it appears; what has the Board's discussion about patient involvement been? We have obviously heard from some patients in the Inquiry who are quite keen to help with the improvements, but I am thinking much more broadly than that about getting the patients to really understand their care and be a 11:52 11:52

partner in it?

A. The board's discussion, we have a PPI panel - Patient Public Involvement panel - and that feeds through to our Patient Client Experience Committees. That gives us a real sense of how things are. They are part of that committee as full members. The PPI panel would be carrying out activities right across our Trust by way of informing the teams of what it's like to do that. 11:53

106 Q. Why aren't the patients getting copies of their letters? 11:53

A. I found that extremely strange because as a recipient of care I get copied into all my letters from another Trust, so I find it really odd that patients aren't. We also have, we are behind the times in relation to having an appropriate technological solution, it's coming down the track for us in 20205 in relation to Compass, patients taking responsibility for their own health. It is a conversation certainly we have had internally in our Trust. I have shared it and we have had it tentatively regional wise, how do we inform our public of how they can look after themselves and at what points do they enter the Health Service, for what conditions et cetera and take real ownership. Because if we are going to address this demand, capacity, mismatch, primary care is challenged, secondary care is challenged, then there is this piece here about the role of the patient in all of this and being able to access and utilise the services when they need it at the right place at the right time. 11:53 11:54 11:54

DR. SWART: Thank you, that's all from me.

A. Thank you very much.

CHAIR: We are not quite ready to let you go just yet, Ms. Mullan.

THE WITNESS WAS THEN QUESTIONED BY THE CHAIRPERSON, AS FOLLOWS:

107 Q. I have a number of questions sort of in different areas. One of the things that you talked about was and 11:54
that we know from the documentation is that your predecessor Roberta Brownlee did not bring the Early Alert to the Board's attention when she was told on 3rd August, it wasn't put onto the agenda for that Trust Board workshop, it was only raised by Maria O'Kane at 11:55
the end of that workshop in "any other business", do you see any significance in that, first of all? The second part of that question is would you have put it on the agenda or would you have emailed other members to tell them about it? 11:55

A. The significance of that Early Alert having gone to everybody, it would certainly have ended up on an agenda for me. Dr. O'Kane bringing it under "any other business" was because it wasn't on the agenda. From recollection or, sorry, I am assuming at that time the 11:55
former chair had asked the question was there anything else Directors, professional Directors needed to raise and Dr. O'Kane took that opportunity to do so. So I would have put it on the agenda. It would have been

shared. Certainly I think in my responses to counsel's questions, if that had come through earlier, the papers that came in September I would like to have seen it in August, but I understand the timeline that we got.

108 Q. CHAIR: Okay. Just in terms of the relationship that the Board has with the Department, I mean how would you describe that relationship? I mean, you've talked about Peter May and the meetings that you have that seem to be constructive, have you always felt that the Board's and DOH's relationship was good, has it improved, where do you feel it's going? 11:56 11:56

A. Certainly there has been improvements. In my time I came into this post, it was the second lockdown in Covid, so we were still in command and control territory in relation to the Department of Health and its Arms Length Bodies. So that was my experience until Covid started to ease and then our new Permanent Secretary came into play. So I am seeing a real openness coming through from our Permanent Secretary, a real willingness to engage. 11:57 11:57

We wouldn't have a lot of engagement to be fair. Our Chief Executives would liaise with the Permanent Secretary weekly, if not nearly daily, depending on the nature of the issues. So certainly from my perspective there is a recognition of the command and control and the impact it had and the desire from the Department to move away from that. 11:57

109 Q. CHAIR: Hand more back to the individual Trusts?

A. Yes. The Arms Length Body piece is certainly Peter May's focus on this, that there is a partnership agreement in place - I don't think it's signed off by the Department yet - but the partnership agreement sets out the roles and responsibilities. If we were in any other public sector organisation of a government department, you would be given your resources at the start of the year, you would tell them what you are going to do with it and you report at the end of the year what you have done, and you would report during the year if you faced any deviation from that or challenge. But within the Department of Health there is a continual reporting, reporting, reporting, reporting. In essence you could ask the question as to whether or not there is a need for a Board within a Trust, is there a need for six Trusts when the Department is so involved in the work of what happens within each of the Trusts. 11:58 11:58 11:58

110 Q. CHAIR: Okay, that's good. Can I come back, as I say there are quite an eclectic bunch of questions I have for you here, but your experience as a Non-Executive Director of Maintaining High Professional Standards and its operation, what was your personal experience, first of all, as a NED in that process? 11:59

A. I did not have any of the challenges that was faced by my colleague Mr. Wilkinson. I was given the MHPS process I think around the June/July time 2020. I had very little introduction to it. Obviously we had had the training, the two points of training at that point. 11:59

My time with that, and I am not concluded with that, has been okay.

111 Q. CHAIR: Would you personally have any suggestions for reform of the process?

A. My overriding suggestion would be that it is not carried out by a Trust and Non-Executives should not be a part of the process. That's not 'I don't want to do the work', I don't think they should be involved. We are not independent, we are not independent. We are there as custodians and guardians of the Trust, our job is to protect and to serve. You are putting us in that position, we are not independent for the doctor, so for me it conflicts. 11:59 12:00

112 Q. CHAIR: Fair enough. You talked about the Board governance self assessment form and not receiving any feedback back from the Department of Health in relation to those mandated reflective documents that don't seem to have been that reflective from what we have seen, have you had any sort of guidance from the Department as to how you really should reflect those forms or how you should fill them in and reflect on issues and seek feedback, No. 1? 12:00 12:00

A. There is guidance there, the forms are pretty self-explanatory, it is up to us how we reflect. Certainly over the last couple of years we have done it. We have had plenty of crisis and events to allow us to take time to reflect and build that into our thinking. I still come back to the point, I don't think it is an effective tool to say whether or not we 12:01

as a Board are doing a good enough job for the population we serve.

113 Q. CHAIR: I take it, although you are obviously independent and control is being given back more to the Trusts, I take it you would like at least to know that the Department was content with the job that you were doing? 12:01

A. Yes. We can get that in two ways: There is through that document but there is also through the appraisal process. So I appraise the Non-Executive Directors and that documentation is then shared with the Department. I complete the documentation for myself and then it goes to the Department and then I am appraised by one of the Deputy Secretaries as a result of that. So there is an opportunity there. There is also an opportunity at the accountability meetings with the Permanent Secretary, twice a year - my next one is on Wednesday - so there is an opportunity there for the Department to share and there is every opportunity in between. 12:01 12:02

114 Q. CHAIR: Okay. So you are satisfied really that the relationship with the Department is such that the Board is getting proper feedback as to whether or not they are doing a good job? 12:02

A. I am at the moment, yes. And I would add to that that the Board governance self assessment tool is not required to do that. 12:02

115 Q. CHAIR: Fair enough. You talked about, I think you used the words "damaged" and "hurt" when you took over

as Chair, I just wondered if you could maybe describe what the Board's reaction to the set-up of this Inquiry was, setting aside all the other difficulties that the Trust has had, which are myriad certainly in the past year, but in terms of the set up of this Inquiry what was the reaction? 12:03

A. I suppose a bit of pragmatism, this has happened, this is the necessary next step, what do we need to do to support and enable. So there is that internal piece around asking the Chief Executive what structures need to be set up. Again another - and I don't mean this in a negative way - another layer of things for our Directors to do, and they are still having to run the day to day business; how do we set up the structures. So there was the pragmatic approach around that. Then, I suppose, my own observations is the impact of losing Directors for periods of time because they are preparing, writing their Section 21, engaging with the Inquiry, you lose them and you lose their contributions for a period of time. I personally found that hard but I understood. So the Board took it as it was coming and made sure, certainly for the SLT, that the structures and systems were in place. 12:03 12:03 12:04

116 Q. CHAIR: I suppose one of the issues that feeds into, another issue, when a Public Inquiry is set up, obviously it has a task to do and it sets about doing its work and that has an impact on the day to day operation, particularly in an Inquiry like this which is related to medical governance. But if 12:04

recommendations being made are then directed or mandated by the Department, that has an impact and an effect. Also, I just wonder what your view is generally, not just whatever recommendations we ultimately make, but you have also had Muckamore review, you have had Hyponatraemia, all of those things have an impact on the day to day running of the Trust, but what support is provided by the Department to enable you to bring about those changes as a result of the recommendations? 12:05

A. I'm not sure I can give you a total answer to that, Chair. My observations being, on part of one of the working groups for Hyponatraemia, like that was an industry in itself, that Inquiry, incredibly important, recommendations incredibly important. But it has been an industry in rolling that out and it is not concluded. The expectation was 'you just do it'. So if you are taking people out of the day to day operation of running Health and Social Care, which is about people, not widgets, it is about people, then you are impacting on the capacity, ability of that Trust to deliver services and that has to be factored in. 12:05

So my view would be is there a consideration of resourcing or another way where these kind of outworkings and the Trusts involved are supported to deliver rather than it is just another layer on what is already very demanding and difficult jobs. 12:06

117 Q. So can I take it from what you have just said that,

whatever recommendations we make that will have an impact on the Trust's operation, you would like to see those implemented by way of proper resourcing from the Department?

A. I would. 12:06

118 Q. CHAIR: We were told by several people that government cutbacks and the austerity measures that were put in place seemed to impact to a greater extent on governance jobs within the Trust, I just wondered do you recognise that that was the case or can those tasks 12:07 and governance jobs be redistributed within the resources that you have or do you need more resources to do effective governance within the Trust I suppose is really what I'm asking, because we are all very conscious that there is a finite pot of money here for 12:07 whatever is to be done?

A. On your first point, I would say that certainly, as I said in my evidence, I wasn't aware of the deficit in governance until this all started to unfold. I would agree with you that there is a need for investment in 12:07 it, but it is very hard to have that conversation when you know you need three doctors and 18 nurses to run a ward that will have 36 patients in it, that will turn over their beds every four, five, seven days, that's where the priority is. So I think if I take from your 12:08 question do we reprioritise, it is going to be very hard to reprioritise when you have patient safety first and foremost and the care of the patients will always come first and that's right. Then we need to look

about how we are resourced and have we resourced appropriately for the fullness of what is expected in the delivery of Health and Social Care, not just a very visible building with beds and patients but actually what goes on behind the scenes to make it happen. That for me is the question and certainly I am hoping that the commissioning work, the conversation around commissioning which is happening now will get us to a place and it will be better. 12:08

119 Q. CHAIR: Because it doesn't really matter how good a doctor or a nurse you have, they may be an excellent clinician, but unless you have this structure to support those clinicians and to ensure that their work is safe then there is a real risk there? 12:08

A. Absolutely, I agree. 12:09

120 Q. CHAIR: Apart from the discussions that you are having with the Department about succession planning, would it be useful - I mean I don't know what the level are - but, for example, it strikes me that you need to have a pool of people to replace Non-Executive Directors when one appointment comes to an end without having a recruitment process start at the end of the tenure for that particular NED, for example. So would you be in favour of a rolling recruitment process whereby people were maybe on a list for, say, a period of five, even six years, something like that, would that be beneficial for succession planning and also whether any consideration had been given to associate Non-Executive Directors who could be trained up, they could come to 12:09 12:09

Board part-time or whatever and could be trained up ready to step into the posts as and when?

A. Okay. On your first point, on succession planning, so the recruitment exercise that has just concluded there before Christmas, when I was in discussions with the Department I emphasised the importance of creating a waiting list for the up coming vacancies knowing that I would have upcoming vacancies for the '24 year period. So the Department built that in this time, which is great, so there is a recruitment exercise to appoint 16 current vacancies. They are creating a pool of, I think, 14, 15 of upcoming vacancies. So there is a list there that they can pull off for this year. 12:10 12:10

From my perspective that list, that period is only 12 months long and it concludes just at the beginning of December. I have three Non-Execs who conclude on 31st December. So they are going to have to run a recruitment exercise. I had the conversation with the appointments unit last week about that. I also had the conversation around the upcoming two vacancies because one is our financial Non-Executive Director and that is a real concern for me not to have that specific skill set at our table. 12:10 12:11 12:11

So I agree with you that we need to have a pool, they will need to have gone through a process to ensure that they have the right skills and then we need a match. Where I wouldn't be in total agreement with you is

around the longevity of that. Because as the organisation moves on, the changes in the organisation, the skills required will change also. There is also a Commissioner for Public Appointments, which we have in London as well, has a very firm stance on length of waiting lists and it is a one year period, okay. 12:11

So it brings me to your latter point around associate Non-Executive Directors. I would love that we created the capacity to do that. Obviously I am conflicted with Boardroom Apprentice, but we need to be able to encourage and enable people to come forward for these roles, prepare them appropriately and have them ready to go, but we also must make them manageable, okay. 12:12

Currently Non-Executive Directors are asked to give up a day a week. I can see in 2016 how we could do that. We are not giving up a day, we have applied for a position, we are required to dedicate a day, forgive me. I can see how easily we were able to do that for a day a week. Seeing the growth of what we have done, particularly over the last three, four years, it is no longer a day a week. So when I met the two incoming Non-Executive Directors just before Christmas, you do the 'hello', but my next one was 'it said in the pack one day a week, I would advise you that that is your minimum, not your maximum and be ready for what is about to unfold'. So the manageability of these roles needs also to be factored in to make them attractive to people. 12:12 12:13

121 Q. CHAIR: Well is that something then that the Department needs to have a close look at?
A. Yes.
122 Q. CHAIR: I mean, a lot of these public appointments are for a very short period of time commitment, but in reality, when you start to do the job, you realise that it is a much wider role than what you thought you were signing up for? 12:13
A. Yep.
123 Q. CHAIR: Then people will drop out because they simply can't devote the requisite hours to the job, so there has to be a more realistic stance taken on what the job actually entails? 12:13
A. Yes. I would bring that back to then what we are doing and the reporting, are all the reports required necessary and, if they are not, then let's focus in on what is necessary and can we then streamline the work so that actually it makes it more manageable for those coming in. It is okay for us as Non-Execs, we have been here for a while. 12:13 12:14
124 Q. CHAIR: You are familiar?
A. We are in it and let's not change it. But for incoming certainly we need to think about how we make it attractive and manageable within the reality of the role. But there is a fear, without a doubt there is a fear, if you say - because these roles are paid just less than £9000 - there is a fear that if you say that it is going to be two to three days a week, that people won't apply. So there has to be a balance between what 12:14

are you expecting.

125 Q. CHAIR: For the money that you are offering?

A. Yes. What is it that you are expecting from them and what is it that you are giving in return.

CHAIR: Yes, okay. Well I think that kind of answers my last question which was really how would you make the Board roles more attractive. So I think you have answered that one. So unless there is anything else that you want to add or anything that you feel we haven't covered that you feel is important for us to know, Ms. Mullan, you are now free to go, I am sure you will be relieved to hear. I see Ms. Leeson waiting in the wings, but I think what we are going to do now is probably take -- is there something that you needed to ask, Ms. McMahon? 12:15

MS. McMAHON: No, no.

CHAIR: You just looked as though I had missed something there. So I think what we will do, ladies and gentlemen, is take an early lunch. I am going to suggest that we actually take an extra long lunch and come back at 1:30. 12:15

CHAIR: Okay, thank you very much.

LUNCHEON ADJOURNMENT 12:15

THE HEARING RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone. Mr. Wolfe?
MR. WOLFE: Good afternoon, Chair. Good afternoon, Panel Members, and happy new year to everybody here, it's good to be back. Your witness this afternoon is Pauline Leeson and she proposes to affirm. 13:32

MS. PAULINE LEESON, HAVING BEEN AFFIRMED, WAS DIRECTLY EXAMINED BY MR. WOLFE AS FOLLOWS: 13:32

I am smiling because it's written all over our note of our consultation with Mrs. Leeson was the word "oath", so clearly my fault.

126 Q. Mrs. Leeson, we start by reintroducing you to the statements that you have already provided to the Inquiry and we'll ask you to adopt those as part of your evidence. So the substantive Section 21 response, which I will call a statement, was received from you on 16th of August of last year. We can find that, if we bring it up, WIT-99770, and you're familiar with that. I'll bring you to the last page of it, it is WIT-99805. And that's your signature? 13:33 13:33

A. Yes, it is.

127 Q. I know that you put in an addendum statement correcting some issues relatively recently, but, subject to that addendum statement, do you wish to adopt this document as part of your evidence to the Inquiry? 13:34

A. I do.

128 Q. Thank you. Then your addendum statement received 21st December last, WIT-105930. There we have the first page of it, it's a three-page document. If we move through to the third page, just scrolling down - two-page document - your signature again, do you wish to adopt that statement as part of your evidence, Mrs. Leeson? 13:34

A. Yes, I do.

129 Q. Thank you. Now, just opening your first statement again, it's WIT-99770. You explain to us, just scrolling down, that you are a Non-Executive Director of the Southern Trust and you have been in that position since January 2017, isn't that right? 13:35

A. That's correct.

130 Q. I'll come on to ask you some questions about that in a moment, just in explaining to those who are listening to us about the purpose of you giving evidence, the Inquiry will be interested to hear from you about your experiences as a Non-Executive Director. We'll see in a moment that you have fulfilled that role primarily through two committee positions, Governance and Performance Committee, and you will be in a position to assist the Inquiry in terms of the challenges that you've faced and that your colleagues have faced as Non-Executive Directors and, if you like, any changes that have occurred over the currency or the duration of your role. And I think, if I can preempt you, you point to some positive changes in the approach to governance during your time in this position. 13:35 13:35 13:36

I suppose the second part of your evidence, which we'll come to a bit later, is more specifically focused on urology and in particular the events that you were aware of in 2017 with the commencement of an MHPS process in respect of Mr. O'Brien, how that - and I'll not preempt your evidence too much - but how that appeared to go silent, if you like, from a Board perspective, or at least from a Non-Executive Director perspective, with issues only to flare up again three or four years later in the middle of 2000 [sic] and we will take your experiences in approaching those issues in 2000 [sic] as being an important part of your evidence which we'll look at later. 13:37 13:37

So, as I have said, you have come into the Southern Trust as a Non-Executive Director in January 2017 after a 40 year career in social work, is that right? 13:37

A. That's correct, yeah.

131 Q. And this Non-Executive -- that's a public appointment, isn't that right? 13:38

A. Yes.

132 Q. And you've explained that it's an appointment made through the Minister's office, you have an expected commitment of one day per week. Tell us this, what makes you interested in a role like this, why not opt for quiet retirement after 40 years in no doubt a challenging role or roles as a social worker? 13:38

A. Well, I suppose I've got a very deep sense of public duty. I have been a Non-Executive in other Boards.

I was on the Commission for Racial Quality for a couple of years. I was also an independent member of the Belfast Education and Library Board. So when the opportunity came for the Trust, I had a background in social work and in health and I felt that I could make a good contribution in terms of our local population, our local services. So that's why I went forward for, that, and I thought also that it would be very interesting. 13:39

133 Q. Had you any prior connection to the Southern Trust? 13:39

A. I never worked in the Southern Trust, but I had a service in the Southern Trust, a children's service in the Southern Trust. So I had, you know, a very good relationship. I felt that the delivery of services there was of very good quality, so that was one of the factors in my consideration of going forward. 13:39

134 Q. You've remarked in your witness statement I think in the paragraph in front of us, if we scroll down a little. I think you've said that - yes - that you were not provided with a job description as a Non-Executive Director. But - scrolling back up - you've outlined within this paragraph some of the aspects of the role as you understood it or understand it. The role is to share the independent Non-Executive oversight, scrutiny and stewardship of the Trust's work, to hold Executive Directors to account, including access to performance of and appointing senior management, to sit on committees such as I have already mentioned, Governance and Audit; to participate in professional conduct and 13:40 13:40

competency inquiries, as well as staff disciplinary appeals; to scrutinise decision making on major procurement issues and to scrutinise the handling of complaints.

13:41

Do you think it is a shortcoming that you don't or weren't given, don't have or weren't given a job description?

A. I think the outline of the duties and responsibilities were mostly in the information that was provided at recruitment, but I do think that going forward it would be more helpful if the Department provided a more detailed job description with roles and responsibilities.

13:41

135 Q. You've indicated that you had other Board interests, Commission for Racial Quality, Belfast Education and Library Board, did they predate this role?

13:41

A. They predated this role, yes.

136 Q. So you had, is it fair to say, based on that experience some sense of how to perform the kinds of roles to be expected of a Non-Executive Director?

13:42

A. I had a good understanding of what it was like to be an independent member, a non-executive member in a very different field. Obviously the Commission for Racial Equality was about rights. The Belfast Education and Library Board was mostly about education and teachers, but I don't think anything prepares you for going to be a Non-Executive in a Health Trust.

13:42

137 Q. There was some induction training provided to you and

you spend a little time in your witness statement dealing with that. If we go to WIT-99775, at the bottom of the page. There were a number of new recruits on to the Board at that point as Non-Executive Directors and you name Geraldine Donaghy and Martin McDonald who took up the reins with you in 2017 and you have explained, as I said, how you received the induction training.

If we go to, you have enclosed I think a document within the bundle which particularises that training, WIT-99868. And if we just scroll through it. Just before we do so, I am struck - and we will come to this question I suppose for you - you've described the training that you received as basic. You've described it as not being sufficient to inform or support the role of a non-medical person such as yourself. So we'll keep these thoughts in mind and then I'll ask you some questions about that. We note as we scroll down here the kinds of training you had. So there was an initial meeting with the Chair, that was Mrs. Brownlee, isn't that right? 13:43 13:43 13:44 13:44

A. Yes.

138 Q. And she was Chair throughout your time?

A. Yes. 13:45

139 Q. Until in or about November 2020 when she stood down?

A. Yes, she was.

140 Q. So you had an initial meeting with her and we can see there the kinds of issues that she would have taken you

through?

A. Yes.

141 Q. And you would then - scrolling down - have received information in respect of the Trust Board and essentially what that Trust Board is, who we are, the Committee structures? 13:45

A. Yes.

142 Q. What you do and how it's done; then, as we can see here, what is expected from a Trust Board member and the practicalities of being a Board member. And that was delivered by Mrs. Brownlee and Mrs. Judt, is that right? 13:46

A. That's correct.

143 Q. Some of the administrative arrangements would have been outlined to you. A meeting with the Chief Executive, did the Chief Executive change a number of times during your service? 13:46

A. I think that in the seven years that I have been there we are on our fourth Chief Executive and certainly within the first couple of years there was a couple of interims. 13:46

144 Q. Yes. I mean, as a general reflection perhaps at this point, has that been an unsettling feature of your career at the Trust?

A. I think for any big organisation like that, stability is absolutely essential in terms of planning forward, in terms of taking time out to reflect on any events, so I think it has not been ideal. 13:46

145 Q. Just turning back to the training, I think you've

described the training as taking place during January, it suggests here that there were subsequent workshops that you attended. So in February there was a workshop with the interim Chief Executive at that time Mr. Rice in relation to understanding the organisation. Then there is a meeting of the Board and an introduction to the directorates as we can see in the document in front of you, taking place in February as well. Understanding the organisation, I've said that already, scrolling down sorry. This continues through March with the various directorates mentioned, Medical Performance, Children and Young Persons, Acute Services, this is continuing into May. And then - just scrolling down - meeting with the Finance Directorate, Human Resources, meetings with committee Chairs, with the Audit Committee and the various other committees. Just, finally, at page 7, training in relation to Recruitment and Selection and Maintaining High Professional Standards coming towards the end of this tranche of training. 13:47 13:48 13:48 13:49

When you've described the training - and this is paragraph 6.1 of your statement - as being basic and not sufficiently informative to support you to fulfil the role as a non-medical person, what was your concern exactly? 13:49

A. Well, I think the fact that we didn't have Managing High Professional Standards until August was an issue for me and I think it continued to be an issue for the

NEDs for a number of years. Obviously the training is a lot of information all at once and, you know, it was basic. I think that it could have been complemented by ongoing training perhaps as we got into committees, as we went to Trust Board, looking at more in-depth information and understanding of what the medical services do in the Trust. And I think in the Trust, I mean the Trust is quite different to the other Boards that I have been on, it is a huge organisation. It has got two acute hospitals. It has actually most of our service users we see outside the hospitals, so you have got community services, you've got mental health. We have a lot of residential provision. But from my point of view I wouldn't have had that much experience in terms of dealing with clinical staff. So it would have benefitted from more in-depth training and information I think maybe over the first couple of years. 13:50 13:50 13:51

146 Q. If we start from the perspective that you are being appointed in a challenged type function, it, as you've described in your - I suppose in lieu of a job description - one of the key features of the description of the work that you do as a Non-Executive Director is to hold Executive Directors to account. Now, clearly there needs to be a certain amount of training and know-how to be able to do that effectively, I've scrolled through the training that you were provided with, it looks on the face of it reasonably comprehensive, a lot of areas are being covered in a short period of time. You have now six or 13:51 13:52

seven years of being a Non-Executive behind you, if you were to sit down and compose a training suite for a new Non-Executive Director starting today in light of your experiences what would be the kinds of key features which you would include on it that weren't there in your time and may not be there as of yet? 13:52

A. Yeah. Well, I think that I would now look at maybe more training on Clinical and Social Care Governance. The governance at the beginning, you know, was fine, it's been much improved since then. But I think when you're looking at some of the performance issues, some of the challenges around hospitals in particular, I felt that it would have benefitted me to have more understanding of what that governance looks like, what you should be looking for, what questions you should be asking. I mean, I feel fine asking about performance and finance and obviously the area of expertise that I have, but I think particularly with clinical services there needs to be perhaps a more enhanced suite of training. Having said that, I think that over the last couple of years we have benefitted from a lot more exposure in workshops to data collection, quality issues, learning from the likes of Muckamore and RQIA and I think that has given the Board a lot more confidence and ability to actually ask better questions. 13:53 13:53 13:54 13:54

147 Q. Let me put a building block in place at an early stage in your evidence, I know that you'll tell me in due course that in January 2017 you're just coming into

this role, one of the first things that you are told of relevance to us at the Board meeting in January 2017 is that there was to be an MHPS investigation or process in association with Mr. O'Brien. He had been excluded from work but was to return, isn't that right? 13:55

A. Yes, that's correct, that was the first Trust Board meeting that I was at.

148 Q. Yes. Again to preempt your evidence, and I think I have mentioned this already, this issue about Mr. O'Brien from urology was not to come to your 13:55 attention again until the summer, late summer of 2020, isn't that right?

A. Until August 2020.

149 Q. Yes. I bring that out as an example but there may be other examples that you can cite. Is it the case that 13:55 any deficit in your training caused you to be either reluctant or unable or ill-equipped to ask the right questions at the right time?

A. I think that I didn't - well it was my first Board meeting - I certainly didn't understand what the 13:56 framework was about.

150 Q. This is the MHPS framework?

A. Yes, the MH - that framework - so I felt unable to ask any questions then. We certainly, we received -- I think John Wilkinson was quite proactive in terms of 13:56 saying that we needed more training. So we received training I think in December '21 but if the process that we have now in governance around this framework had been in January 2017, I think I would have

understood really how to ask questions, what the process was, to look at what the outcomes were, to look at the whole issue of delay and drift.

151 Q. Yes. I'll come back to MHPS in a moment, was there any other issues or areas where you felt I really, if I had had the right type of training, if I had been better equipped I would have been a more proactive Non-Executive Director and it's only more recently that I've gathered either the confidence or the know-how to better engage in challenging and asking questions? 13:57

A. Well I suppose on reflection you're always wanting to improve your ability to ask questions. You're always wanting to improve your ability to be curious. I think the more recent training has recently, particularly around Muckamore, I think, has enabled us to look at those sorts of issues in the round and how the recommendations could be relevant to some of our residential institutions. 13:58

152 Q. Sometimes it is not just about the training in order to equip you, sometimes - maybe 'sometimes' is the wrong word - but it is additionally about culture, isn't it, it's about how you feel you, as a Non-Executive Director, are encouraged or supported to ask questions, to challenge, to hold to account; have you noticed, quite apart from training, any changes over the period of six or seven years that you've been in post that have affected your, I suppose, your demeanour or your approach to the role? 13:58 13:59

A. I think that for me, and I've said it in the evidence,

that there was a distinct change in culture when Maria O'Kane, Dr. O'Kane, came into post. She emphasised, and I think it is not just for myself, it was for the whole Board, which is composed of Non-Executive Directors and Executive Directors, she emphasised patient safety but she also emphasised psychological safety. And certainly I think Maria, along with the current Chair, Eileen Mullan, has created a forum and a space that makes that environment much more open to people to be curious and to ask questions. The biggest difference for me is actually, I think, the Executive Directors asking questions. I think previously my own experience was that it was the Non-Executives that asked the questions and the Executive Directors replied. Now, it's a collaboration, a partnership between the whole Board. You know, some of those discussions are quite robust, they are not soft questions. And I think that for me has been the cultural change in the Trust's Board. 13:59 14:00 14:00

153 Q. Thank you, that's helpful. I will come later in the context of urology specifically to ask whether that cultural change or any deficit in the culture may have been responsible for not tackling these issues before the panic set in, in 2020, if I can put it in those terms. But let me come back to MHPS and just pull up something you've said in your statement. If we go to WIT-9976. Just allow me a moment. 14:00 14:01

So we can see in the document in front of us that, with

regard to MHPS, the MHPS framework, you received training on 30th August 2017 and again, at the bottom of the page, on 1st December 2021. If we go to WIT-99776 and scroll down to 6.1. As regards MHPS you're explaining here that the training in August '17 you felt didn't sufficiently inform or support you to fulfil your role: 14:03

"After informal discussion led by John Wilkinson, who had an ongoing complex case." 14:03

Which we now know to be the Mr. O'Brien case:

"Additional training was requested and this was delivered by Mrs. Turkington in June 2021." 14:03

You say: "I still find the role of the NED in the MHPS process confusing and vague even though I have participated as a NED in three straightforward MHPS cases. My understanding is that the NED role is to ensure that the MHPS process is staying to a timeline and is not an advocacy role for the clinicians involved but it is unclear if it is a clinical process or a HR process." 14:04 14:04

You've had the basic training, you've had additional training, you've fulfilled the designated NED role in an MHPS process on three occasions and you're still confused?

A. Yep.
154 Q. When was the last participation by you in an MHPS process?
A. I think it was last year.
155 Q. 2023? 14:05
A. Yes.
156 Q. How have you, in light of the training and perhaps conversations with colleagues, how have you performed the role?
A. Well, if I can just say that the training by June Turkington was really very, very good. I think it's not so much the training, I think it's the role of the Non-Executive Director. For me I would agree actually with the evidence of the Chair before me, that it's maybe a process that should be done much more 14:05
independently. As a non-clinical person obviously I relied on the Case Investigator and the Case Manager to do the investigations and to do the determinations but I'm not sure what I brought to that process. It seemed to me that I was making sure that it was more or 14:06
less a timekeeping process. I'm not sure what extra value or contribution I made to that.
157 Q. If we go to some of the definitional documents in relation to the role, let's pick up some of those briefly. The MHPS framework document itself was 14:06
published in 2005 by the Department. We understand it's the subject of ongoing review. There have been several failed attempts to bring reviews to completion but at the moment it would appear that we're stuck with

this. If I can bring you to WIT-18490. That's the front page, just for orientation. Then if we go to WIT-18499 and, just scrolling down, there is a definition of various roles. The Chief Executive is defined and here we have the designated Board member, this is the role you fulfilled three times. And it says, in simple terms, I suppose: 14:07

"This is a Non-Executive member of the Board appointed by the Chairman to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation." 14:07

So it's a timekeeping function, let's ensure that there is momentum, but also an interface for the staff member or the practitioner concerned. In terms of how you did the role, did you see for yourself a responsibility to engage with the practitioner? 14:08

A. I've had three fairly -- I mean, when cases come to this framework they are serious and I would take them very seriously. I've had three very straightforward cases, they have all had different outcomes. I have made myself available if the clinician wanted to approach me. None of the clinicians felt that they needed to approach me. So for me it's been a fairly straightforward process. I think the confusing bit for me is, is it to advocate for them or just to make sure that the momentum is kept going. I think I'm fairly 14:08 14:08

clear that it is just to keep the momentum going, so is that what the clinician, their understanding of what my role is?

158 Q. Did you see for yourself as having a role to keep your fellow colleagues on the non-executive side of the Board informed of what was happening, albeit these were straightforward cases? 14:09

A. Until more recently none of these cases came to Governance Committee. I think we have got quite a robust report now that is led by the Medical Director, but beforehand we would not have discussed these cases among ourselves. I think an element of that was we felt there was confidentiality, and of course the clinician is anonymous in these cases, and so they should be. But there is learning from the types of cases that come and the determinations that I think are helpful to governance in terms of seeing what the patterns and trends are, and, you know, some of the challenges and pressures that our clinicians face. 14:09 14:10

159 Q. We'll take a peek later at the new way of illustrating to the Board what's happening in the MHPS world and there is a report which comes regularly I think to both the Governance Committee and perhaps to the Board. But just sticking with the definitional confusion at the moment, you seem now settled in your view that you're not in an advocate's role, you're much more keeping the momentum going. I suppose some of your ongoing confusion about the role, to whatever extent you remain somewhat uncertain, has been reflected into the Inquiry 14:10 14:11

by a number of witnesses, let me draw it to your attention something Mrs. Toal was reported to have said or has described in 2018, WIT-41799. So she has been Director of HR, isn't that right?

A. Yes, she has, yeah. 14:12

160 Q. She is expressing the view that she has some difficulty with the role of the Non-Executive Director in MHPS cases:

"The document - I think here she is referring to the MHPS framework which we've looked at - is not clear and at times we've got completely muddled as to what their role actually is and how far they can go when contacted by a doctor going through a process. I think this needs explored as part of any review." 14:12

In her evidence Mrs. Toal, and I think Mrs. Parks as well when she gave evidence, have explained some of the work that has been undertaken to try to isolate this confusion and deal with it. They have prepared a suite 14:13 of further training which was introduced so far as I can make out in 2022. If I can bring this document to you, it's WIT-90655, and it's a training plan for various - just scroll down to the bottom - it bears the date, issue date 1st September 2022, with a review date 14:13 later this year. When both witnesses were giving evidence last year this training was being rolled out, or there were plans to roll it out. If we go forward in the document to WIT-90659. We can see that specific

Trust Board training has been developed. It's delivered or it's to involve the DLS Legal Adviser, and you had training with her in December 2021 as you've mentioned.

14:14

There is specific provision within this training, if we look at one of the bullet points, is to be clear on the expectations of role and responsibilities of various personnel, including the designated Board member.

CHAIR: Mr. Wolfe, it is very difficult to read that, can we enlarge it slightly? 14:15

MR. WOLFE: Of course.

CHAIR: Thank you.

MR. WOLFE: The Panel might recall that this is a document that we looked at with a number of the witnesses during our MHPS module. Just with you, Mrs. Leeson, have you had the benefit of this new training? You talked about doing an MHPS role last year in 2023, have you seen this new training as yet? 14:15

A. I honestly can't recall being on the training. 14:15

161 Q. Certainly, the training record that you have provided to us stops with Mrs. Turkington's training to you and perhaps others in December 2021, so perhaps you're yet to receive this. But, just before we leave it, you have acknowledged difficulties in understanding the role, you think, could I ask you this: If you were to receive further training what would be the key question that you would be asking the trainer to clarify for you once and for all about the expectations that go with 14:16

the role of the designated Board member?

A. I think it goes deeper than that. I think there is a difficulty in the NED actually being involved in this process. My own view is that it should be a clinician and it should be independent of the Trust. So it's not just about the training, it's also about the role that you're expected to fulfil and what value is the NED bringing to this process. 14:17

162 Q. Why would it be inappropriate for the NED to carry out the duties of providing some interface for the practitioner if the practitioner needed it and to be an overseer to ensure momentum is injected into the process and to ring the alarm bell if momentum isn't being achieved, why is that not in keeping with the NEDs? 14:17 14:18

A. I think if it was just that, there is probably some value in that, but that's basically a timekeeping exercise. All the clinician is asking is can you keep the momentum going. I suppose my question would be does it need a NED to be involved to do that. 14:18

163 Q. We'll come back and look at it from a different angle in terms of whether you consider that MHPS is being well pursued as an exercise within the Trust, comparing and contrasting current with what we know of Mr. O'Brien's exercise perhaps later in your evidence. 14:18

But, for now, to sum up on the training aspect of your experience as a NED, you think that there is room to do better, that those who are in charge of this kind of

thing, perhaps from the Department down, could better tap into experiences of people like you to better focus the kinds of training that's available to NEDs from the start of their role?

A. Just in relation to this process? 14:19

164 Q. No, no, more generally.

A. More generally. I think this is a good opportunity really for the Department to look at, not just our Trust but all the Trusts and anyone who is going forward to be a Non-Executive Director, to maybe look 14:19 at a more intensive training program, not just at the start but an ongoing program that would help them fulfil that role in a much more meaningful way.

165 Q. Now, in terms of how you fulfil your role, it is described as being a one day per week commitment, does 14:20 it amount to more than that in reality or is that about right?

A. I suppose in maybe 2017 it would have been one day but I think, outside attendance at Trust Board meetings, there is an awful lot of reading that we have to 14:20 undertake, which I am personally happy to do.

166 Q. Yes. Your role is exercised by being a member of the Board which meets bimonthly, isn't that right?

A. Yeah, I am a member of the Board. I am on a number of committees. I am on an Adoption Panel. We do 14:21 leadership walks. On a statutory basis we have to visit a children's home every quarter. There is a lot of activities.

167 Q. Yes, I want to focus however briefly on your role

within the two committees and one of those committees is the Performance Committee. You're the Chair of that committee, isn't that right?

A. I'm currently leaving Performance to Chair Governance.

168 Q. Okay. You have been Chair since... 14:21

A. I was Chair.

169 Q. Okay. And how long were you in that role?

A. I think it was just over two years.

170 Q. You have been a member of the Governance Committee as is every other NED, isn't that right? 14:21

A. For seven years, yes.

171 Q. But you're moving to become Chair of that committee shortly. You've said in your witness statement that, this is paragraph 10.3, it's perhaps an obvious truism, that you place reliance on good quality information 14:22 being brought to the Board through reports from the various committees and it's Directors responsible at each operational level who hold the key to providing you that information, isn't that right?

A. That's correct. 14:22

172 Q. In terms of the quality of the reports that come your way, have they always been good or have you noticed improvement over time and what's your, if you like, litmus test for deciding whether they are of sufficient quality for you? 14:23

A. I think they've improved dramatically since Dr. O'Kane came to be Chief Executive. And actually, you know, the previous Chief Executive, Mr. Devlin, was very good on performance, very good on systems. He brought that

sort of rigour in my opinion to Board processes which was really very helpful, so the reports have improved over time. Sometimes that means that there is less of them, that they are more focused, they are more concise. Certainly the cover sheets now would be looking at risks, concerns, and also at improvements. It's important on a Trust Board like this that you're not always looking at problems, that you're looking at good practice because that encourages good practice and it encourages confidence in the staff who work so hard. So the reports have got better. 14:23 14:24

173 Q. Let me just take a moment to explore the Performance Committee. As you say you've been Chair of that committee, it's a committee that came into life, I think, for the first time in 2019. You've described in your witness statement that this is a committee that meets quarterly, it's responsible for providing oversight of the Trust's performance management framework and ensuring that there is sufficient assurance as to the robustness of processes and it ensures that any risks identified are brought up to the Trust Board, isn't that right? 14:24 14:24

A. That's correct.

174 Q. You've highlighted in your witness statement, if we go to WIT-99778, 99778, and if we just scroll down, just at the bottom, thank you. One of the things you point out in your statement was that it's your responsibility as Chair of that Performance Committee to ensure that clinical governance systems are adequate and you have 14:25

escalated concerns both formally in the minutes of the committee and more immediately by email, that's just the way you work. Has it taken some time for that confidence or that know-how to develop or is that something that's always been with you? 14:26

A. Well if I can give some context to this. Previously to the Performance Committee, performance was given maybe an hour in Trust Board which was really inadequate to look at the whole raft of directorates in terms of how they were performing. So, it took the Performance 14:27
Committee, I went into chair, I think, in the second year, it took it a while to find its feet, to look at what issues should be coming to Performance and particularly what issues should be going to Governance because I think there is a difference there. So, when I 14:27
took on Chair of that committee we were still looking at what was relevant to that committee, to be discussed in that committee. I think, you know, there's an overlap almost with governance, but I was quite clear that governance issues should be going to the Governance 14:27
Committee so that we could really interrogate performance in terms of, you know, looking at where departments were not doing as well as we expected. It's always helpful when you're looking at performance not to look at one snapshot in time, you've got to look 14:28
at the trajectory, where has it come from and where it's going. If you're going to look at what sort of mitigations, what issues you can address. So you know, performance for me, you would perhaps be

looking at that over a year at least. So, once we got into the deep dives, then that was when we had the opportunity maybe to look at what wasn't going so well and inviting those - in performance they were mostly clinicians - to come and talk to us about what was happening in their Directorate, what the issues were, how could we help. So performance for us was more about an opportunity for them to come and help us understand their concerns and for us as a Performance Committee in a holistic way to look at what we could do to minimise those risks and put mitigations in place. 14:28 14:29

175 Q. So here you set out two examples, one in the context of cardiology where I think there was a Dr. McNeany came along and spoke to you?

A. Yes. 14:29

176 Q. And another in respect of stroke issues. I just want to illustrate, in fairness to you, how you went about this. Just dealing with the cardiology issue first. If we go to WIT-100052. That's 100052. Here you have -- and this is a meeting of your Performance Committee in December 2022. Could you just help us briefly by way of context, the issue that Dr. McNeany was raising was the absence of protected bed space -- 14:30

A. Yeah.

177 Q. -- for cardiology patients, it perhaps being a, the discipline or the clinical area perhaps being a casualty of the split site, Daisy Hill and Craigavon. What was your concern arising out of what he had to say? 14:30

A. Well we had just come out of Covid. Obviously a lot of beds were dedicated to Covid and recovering from that. But certainly, in terms of cardiology, my concern was that we maybe hadn't made as much progress about recovery and one of the main themes of Performance 14:31
Committee for me was a recovery plan. So we needed to look at how we were going to address those sort of concerns. I think this Consultant had been looking at national audit as well, which is always a good indicator of how we are doing, and it seemed to me that 14:32
we could improve our outcomes if we had protected bed space. Now, that's a very, very difficult thing to do, particularly when you have got such busy emergency departments. But certainly Dr. McNeany came and made his case. And I think -- was there an issue about a 14:32
scanner there as well?

178 Q. I think so. Just briefly, I just want to show, I suppose, how this was working in practice. You apprehended a real issue here but rather than just record it you put it onto the agenda of the top table 14:32
and we can see that if we go to WIT-100059. This is you writing as Chair of the Performance Committee a day or two after the meeting we have just looked at. You're telling Eileen Mullan, in her capacity as Chair of the Board and Mrs. O'Kane, who I think by this stage is 14:33
Interim Chief Executive?

A. Yes, she is.

179 Q. It's late 2022. So, you're enclosing, it's on the next page - and we needn't bring you to it - but a synopsis

of what was discussed at the meeting. You are indicating that you have agreed to escalate the main issue regarding protected beds and a second cardiac cath lab for more urgent consideration with the full support of the committee. 14:34

A second example that you draw our attention to in your witness statement is in relation to stroke services. That was an issue that came up before your committee in March 2022 and if we just go to the escalation, it's WIT-100084, just down the page. So you're explaining that, at your Performance Committee the day before, that would have been 12th of March, you had a presentation from a Dr. McCormick in relation to, I'm not sure if you'll know what the abbreviation means, SSNAP. Stroke services? 14:34 14:35

A. Stroke services.

180 Q. You wanted to escalate the concern you explain. You go on towards your concluding remarks to say that you feel strongly, that we need to be keeping a close eye on this service and giving stroke services more priority. You make the point in your statement that, if we go to WIT-99785, just at the bottom of the page. Yes, we pick up on the cardiology and stroke services issue again. You're explaining that, as a NED, clear policies and procedure for escalating concerns around governance issues to the Board as a matter of urgency, they didn't appear to be there, or you didn't appear to have clarity around how to do that, that is why you 14:35 14:36

were emailing, is that right?

A. Well maybe if I can give some context to this. I didn't pick these two areas out of the ether. Both these areas, stroke and cardiology, were brought to me by Melanie McClements, who was the Acute Director. So it was, you know, a discussion that went on in the Committee, and that was the proper way to do it. So certainly when the issues were escalated, they were escalated to a very open and receptive Chair and Chief Executive. The Chief Executive would have had a lot more knowledge of this. So I felt that these issues were going to be very well received and that they would act on them. So I think that was the change in culture there for me in terms of escalating issues. But since that we have got, I think last September the Chair drew up, the present Chair drew up an escalation template for Committee Chairs. But prior to this, Committee Chairs did a report, anything that you were concerned about you could put in that report and send it up to the Chair and Chief Executive. 14:37 14:37 14:38 14:38

181 Q. Yes. But there is now a template to specifically allow for that. You could have done it anyway informally by email as you have illustrated, but there is now a Committee Chair template which we can see at WIT-105933, and that was appended to your most recent statement. So, just help us to better understand that. If you as a Committee Chair realise or apprehend that something needs urgent consideration by the Board, you put the details onto this and it's flagged for urgent 14:39

consideration at the Board meeting, is that right?

A. That's the process now.

182 Q. We know that concerns around urology waiting lists and the performance of the Trust in the management of urology services was the subject of consideration in performance reports and appeared on the Trust agenda from time to time or the Board agenda from time to time. We can, I suppose, most conveniently see this in Mrs. Mullan's statement, if we go to WIT-100488. Apologies that we didn't place this material on your witness disclosure bundle, but I hope that you will be able to fairly deal with the point with me. 14:40 14:40

We can see, as I say this is November '17, if we scroll down and maybe take you to a particular example, if we get to January 2019. So in January '19 it's being reported by the Director of Performance and Reform, right-hand column, that in various specialities, including urology, there is an increasing trend in waits. Over 52 weeks continues to be demonstrated and there is a paper speaking to this. 14:41 14:42

If we go down to May of that year and it's explaining that, again the Director of Performance and Reform is explaining that, at the end of March 2019, 2700 people were waiting across nine specialities over one year, and in urology there are waits of up to 2069 weeks; these kinds of performance issues would have been considered by your Performance Committee when it formed 14:42

in 2019?

A. Well, as you say I have not seen this until today, so I suppose my limited answer would be that some of these discussions were in an hour at Trust Board meeting which gives you very limited opportunity to drill down. 14:43
Also, it's not just urology, you're also looking at a number of other areas where there were pressures. But certainly, I think the difficulty with some of the reporting, particularly when it was on Trust Board, was that they were isolated, it was isolated reporting. 14:43
Sometimes when you put all of these things together, as I said before, you look at the situation over a year, you're looking at where they've come, where they are at at the present, and what the forecast is. So then you are able to make more sense of the evidence and the 14:44
data to understand the depth of the issue.

183 Q. Yes. I was struck by your statement, you seem to indicate that the MHPS issue in urology was drawn to your attention in 2017, you're just in the door and then it goes away again and it's not until August 2020 14:44
or thereabouts that urology comes on to your radar again. And I'm just wondering whether that is right? Were these - and you correctly make the point that urology is one of a number of specialties that is suffering service performance issues - but is it fair 14:45
to say that you and your colleagues were appreciative of these performance issues across a number of the services, whether they were considered in your Performance Committee or elsewhere?

A. I think there was obviously -- I mean, I haven't seen this. I mean, are some of these meetings Trust Board and some Performance Committee?

184 Q. These are Trust Board meetings.

A. These are Trust Board meetings. I mean, I think an hour to discuss all of those issues was far too limited which is the reason why we took performance out of Trust Board and put it into Performance Committee. 14:45

185 Q. But I've seen, if I can put it in these terms and hopefully not unfairly to you: Clearly there are, by any marker, significant backlogs in urology, it is well known that it has been a problem area amongst other problem areas. Can you recall any initiative on the part of the Board to look at urology and urology performance issues in your time as a NED? 14:45 14:46

A. Other than looking at the performance in the overall sense, I can't think of a particularly detailed discussion on urology performance.

186 Q. You refer in your witness statement, this is paragraph 13.2, about a concept called deep dives, the Performance Committee performs deep dives to provide assurance to the Trust Board. What do they involve and is there scope potentially to use those to try to get to grips with performance issues in any particular service such as urology? 14:47 14:47

A. Well, urology would have benefitted from a deep dive, I don't think there is any question about that. In my role as chair of performance I would have looked at the program for the year, I would have talked to the staff

and we would have picked out maybe four areas. I think one of them was children and young people, unallocated cases. We had cancer services. Maternity was a particular issue that probably we will visit again in governance. The deep dive, you take that area. 14:48
Usually we would invite the Director to put together a small team who would present evidence of some data, some description of how the service was doing and then we would interrogate that and look at any issues. And I think, you know, from a NED point of view, sometimes 14:48
it was looking at an area with fresh eyes or different eyes to see if there was any concerns that could be addressed in a different way. Quite often the staff themselves would have action plans and it's a matter of looking at what the action plan was. Then occasionally 14:49
I would usually ask them to come back to performance with the action plan maybe in six or nine months to see what progress had been made.

187 Q. So a deep dive is a way of taking a standalone issue and interrogating it, pulling it apart, looking at its 14:49
constituent elements and trying to assess where the problems are perhaps and whether things can be done better or differently?

A. Yes.

188 Q. Just looking at the agendas for your Performance 14:49
Committee, there is many examples on your witness disclosure bundle. You receive reports from your various directors, isn't that right, nursing, medical, children and young persons, you get a report from the

Director of Performance and Reform. You receive reports on the service delivery plan. You receive a performance report, which looks at things like patient flow, access times, correspondence with targets, that kind of thing. It should have been relatively straightforward to see problems in areas such as urology? 14:50

A. I mean there is problems in all the areas. I don't think it was just urology, there is huge challenges around waiting lists. Our biggest concern over the last year has been delayed discharge. But certainly the performance of different directorates would have come across the corporate scorecard. The Director of Performance would have been the person who would have brought the risks and concerns to the group. 14:50 14:51

But Performance Committee is also about improvement, you know. I didn't want people coming to the committee feeling that they were going to be blamed. Certainly that was not the culture that I would have encouraged. So when we looked at a lot of the performance issues I would have encouraged directors and their assistant directors to come with solutions or action plans on how to improve their own areas. But certainly urology would have been one of the areas in that. 14:51 14:51

189 Q. There no doubt was general recognition because it was obvious before the Board that there were these waiting times, there were these targets, for example, for cancer that are quite often missed. But when you say

there was some recognition of the problems in urology, I can't and nor have we received evidence of any particular initiative, whether through your Performance Committee or Governance or anywhere else that sought to do, if you like, a deep dive with the subject, to recognise that the patient, that these were real patient safety issues and try to see if things could be done differently, that just doesn't seem to have been done as a specific exercise for this service? 14:52

A. With the benefit of hindsight I wish we had done a deep dive in urology. 14:53

190 Q. Could I ask you about the Governance Committee briefly. You refer to the Governance Committee, this is paragraph 9.1 of your statement, as being the key, perhaps the key committee to assessing assurance for effective risk management and escalating risks to the Trust Board. So that's the committee which is, I suppose, the fulcrum for bringing risk to the attention of the Board. Within that committee you rely upon a report, a number of reports, but the key report I think that you've highlighted in your witness statement is the CSCG report that comes to you quarterly, is that right? 14:53 14:54

A. That's correct.

191 Q. And if we look at an example of this report, it is WIT-99962. This is the kind of report that you have in mind. I think you reflect positively on this development before I think Mrs. O'Kane came into office. You suggest you were receiving information, if 14:54

not so much piecemeal but in a fashion that was difficult for you as a NED and perhaps amongst your NED colleagues difficult to grapple with the information, it was disparate and didn't join up or triangulate in the way that would have been most useful, is that right? 14:55

A. Well in my view governance is a dynamic process, I mean you're always looking at improving, it changes all the time. Certainly the June Champion Report was a significant improvement, in my opinion, in how we did our business around governance. Certainly we did have governance reports before that, but in my opinion they were almost in silos. I think what this report does is bring all those areas together so that you can triangulate the data. It also included additional reporting on Managing High Professional Standards. I had asked for judicial reviews to be included because I think that's a very good indicator of what the issues are, certainly for our service users. We get much more detailed reporting in SAIs, on complaints, on clinical audit. So when all those reports are brought together and there is analysis done, mostly by the Medical Director I have to say, that gives you a much more comprehensive understanding of where the pressures and the risks are. 14:55 14:56 14:56 14:57

192 Q. Try to think back to a time before this service was available to you, before this kind of reporting was available to you. So in those early years in your role as a NED, is it possible to describe, I suppose, the

lack of clarity in the governance picture and how was that detrimental to how you did your job?

A. I wouldn't so much characterise it as lack of clarity, we had those reports but they didn't come together, they weren't cross-referenced. We weren't able to see the trends and the patterns. You know, it's useful to see all those reports brought into one because then you can start to analyse the data to see where particular issues or concerns are recurring and coming up. 14:57

193 Q. Well, we can see, let's examine the purpose of this report, a couple of pages in, if we go to WIT-99964. Its purpose is described as containing -- sorry, it's described as providing information to the Trust governance team using performance indicators agreed by the Trust senior management team across those four areas. The report analyses activity for the last or the third quarter of the previous year with the exception of patient safety and quality measures which are for the second quarter of the year. It explains that incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident or a near miss, no matter the level of harm is the first step in learning to reduce the risk of recurrence. 14:58 14:59 14:59

So instant reporting, I suppose whether or not it develops into a Serious Adverse Incident review is seen as a very important tool. Again is that something that you realised as time went on in your role as a NED or

was it always something that you had an appreciation of?

A. I suppose with my background I would have understood that, you know SAIs are very, very important, I think the information that was provided to governance was more around numbers. Now there is a much fuller description of what the issue is, the progress that is being made and what the outcome is so that you are able to understand. One example is the high incidents of, in terms of litigation in maternity and obstetrics, so we looked at that in particular, what was causing that. I mean, a lot of it is historical, it's delay. Some of these families have had to wait nearly 20 years to get these cases resolved. So I think in terms of that sort of information and data that you're given, it is very helpful to understand that, particularly around that issue, that it just didn't happen in one year. 15:00 15:00 15:01

194 Q. One of the things that the Inquiry has been somewhat exercised with as a result of hearing evidence, and we'll look at one of these cases in a short time, is the apparent delay in moving an incident report through the various stages, if it is screened in for Serious Adverse Incident Review, moving it from start to finish and beginning to learn lessons and implement actions from the recommendations and findings. This report, and I don't have the reference to bring you to the page number, but you will have seen this, I hope, it shows whether the Trust is in compliance or out of compliance with expected timelines or time limits for SAI 15:01 15:02

reporting; is that something you felt able to challenge or at least explore and get answers to?

A. Yeah, I mean we have had a lot of discussion about SAIs. SAIs I think probably needs -- I think it is being revisited now by the Department. There is a difficulty there in terms of -- my understanding is getting people to chair SAIs. They are incredibly intensive. They are a lot of work. They need really experienced people to be able to chair that process. Also you need people independent of the Trust and other areas to move around, to undertake those investigations. So I don't think it's just an issue for the Southern Trust, I think it's an issue for all of the trusts in terms of keeping to the timelines and progressing the cases. Because, obviously, as you've said, the most important thing that comes out of SAI is learning for our services and how we can do things better and differently.

15:02 15:03 15:03

195 Q. Can I just pick up one example of how you appear to use this report and it's perhaps an example of no specific relevance to the Inquiry's Terms of Reference but I suppose it's a tool of governance for you. This report is discussed at the governance meeting of the same month, February 2022, and it's presented by the Medical Director, Dr. Gormley by this time. And if we go to WIT-99947 and just scrolling down. So Dr. Gormley is explaining the report. If we go over the page then to, I think we need to jump forward to WIT-99978. Sorry, I've done that in the wrong order,

15:03 15:04

if we go back to WIT-99947. So here we are. You are referring to this particular incident, it is an incident arising out of what you describe as staff attitude in relation to an area of concern that's arisen in the integrated maternity and women's health unit. We'll look at the incident in a moment but it's an incident concerning perinatal mortality. You are asking about this. Dr. Gormley noted that the information from these various sources would highlight any significant trends in relation to staff attitudes in that unit. And the Chair, I think that's Ms. Mullan, "spoke of the importance of triangulation of data". 15:05 15:06

Perhaps you don't maybe remember this specifically, but can you help us to understand how you were using the tool of the report to challenge the Medical Director to provide an explanation? 15:06

A. Yeah, well...

196 Q. If I can bring you, sorry just to help you, to the incident itself, it's at WIT-99978. That's the incident, it is an instance of perinatal mortality? 15:07

A. Yeah, I think what concerned me there was that they felt that there could have been a quicker response, but that may not address attitudes. But that's about culture. 15:07

197 Q. Yes. Just to put this in the round: Dr. Gormley is bringing his Clinical and Social Care Governance report and you, as a member of the committee, are reading

through the report, you pick up on this issue which points to a potential problem with staff attitudes within the unit, that's the lesson that needs to be, I suppose, further interrogated, and you challenge Dr. Gormley to provide greater clarity on it? 15:08

A. I mean, her opinion would be the experience of the service user, how obviously that mother experienced, you know, her treatment in the hospital. The Datix is about what the staff, did they do it well, did they not do it well. Datix is just the ordinary reporting of 15:09 incidents. But it's very important to look at those sorts of incidents in the round from a number of different angles. Because procedurally it might just look like a clinical issue, a technical thing, they didn't get there quick enough. But when you see 15:09 comments about attitudes, for me that would raise an alarm. Certainly that was classed as a potential miss, so it was agreed for a level one SAI, which was the proper thing to do, and then the learning from that was that the staff had to be reminded about the policies 15:10 and procedures and they have to attend mandatory training. But, you know, it is important that you just don't treat these incidents as a technicality. We've got to understand the patient's experience. It is so important, I think we get so much value out of 15:10 listening to patients and what their experience is in our service in terms of how we can improve the next patient's journey.

198 Q. Yes. The reason I picked up on this example is because

you're anxious within your statement to describe, if you like, something of a transformation in the approach to governance. You say, at paragraph 16.1, that hitherto the Trust's attitude to risk and risk management was one dimensional and that has changed you think. Is this kind of approach of bringing everything within one report, allowing the NEDs, and others, obviously the other members, the operational or the executive members of the Board, to pour over this information in a more meaningful way, is that what you have in mind when you're saying it's now become a more multifaceted rather than a one dimensional approach? 15:11 15:11

A. It has been a huge improvement. You're not looking at isolated cases, maybe in the SAI process. You're also looking at what were the complaints from service users. You know, litigation certainly highlighted the maternity issues for us, very, very important. I know I keep going back to judicial reviews, but they also highlight areas of concern that we should be looking at as well as clinical audit. All of those areas give a much more rounded view of what's happening, what the patient's experience is, as well as the clinicians, what the pressures for the clinicians are. I just think culturally that's a much safer place for patients because systems protect patients but systems also protect our staff. 15:12 15:12 15:12

MR. WOLFE: Would now be a convenient point for a short break?

CHAIR: Yes, we'll come back again at 3.30.

THE HEARING ADJOURNED FOR A SHORT PERIOD

CHAIR: Thank you everyone. Mr. Wolfe?

199 Q. MR. WOLFE: You've been reflecting somewhat positively, Mrs. Leeson, about the developments in the approach to governance which you've observed in your time as a NED with the Southern Trust. You have, however, remarked in your witness statement that, when we consider how the issues within urology, and here I'm speaking specifically about the performance issues in association with Mr. O'Brien's practice, when we reflect upon how they were dealt with, you highlight, I think I'm right in judging, the shortfall in the information that came to the Board, the timeliness of reporting the difficulties to the Board and in particular to you and your colleagues, the non-executive directors, is that fair? 15:30 15:30 15:31 15:31

A. I think there's two issues there. There's the reporting of performance which is about the Directorate as a general.

200 Q. Yes.

A. Then I think there is the specific issue about Mr. O'Brien's practice.

201 Q. Yes, and it is that second limb that I am now moving to focus on. If we look at your witness statement, to better explain what I meant by my opening remarks just now, if we go to paragraph 21.1 at WIT-99786. You are asked: 15:32

"Are the issues of concern and risk identified in urology services of the type the Board would be expected to have been informed about at an early stage. Was the Board informed of concerns regarding urology and Mr. O'Brien, in particular, at the appropriate time, and, if not, what should have happened, when and why did it not?"

You say that the issues of concern and risk identified in urology services are the type that the Board would be expected to have been informed about at an early stage when there is clear evidence of potential patient harm. You reflect the fact that you were first informed about a consultant, you didn't know the name at the time, you now know it to be Mr. O'Brien, in January 2017, that was the first time that you were made aware of concerns about his practice, albeit his name wasn't known to you, no issues regarding SAIs were brought to the Board connected to this matter. Then you were told of further concerns in August 2020 in relation to a number of SAIs.

If we think of those as two temporal pillars, there is an awful lot that occurred within the period January '17 through August 2020 which wasn't drawn to the Board's attention at a time that you would have expected it to be brought to the Board's attention, is that fair?

A. I think that's fair.

202 Q. And we'll look at some aspects of that. Can I just, having obtained your answer in that respect, you say at paragraph 25.1, if we just pull it up, WIT-99789, 25.1, you say that once the Board was alerted to concerns in relation to SAIs in August 2020, and by SAIs I think you mean there the generality of concerns relating to Mr. O'Brien which had emerged by that point in time which were encapsulated but weren't limited to the SAIs, is that fair? 15:35

A. Yes, yes. 15:35

203 Q. And you say:

"Once the Board was aware of these concerns we could monitor progress on actions taken in relation to the concerns about Mr. O'Brien and his practice." 15:35

You say: "In my view I felt the updates given to us by the Trust Board."

Sorry: "I thought the updates gave us as Trust Board greater clarity and assurance that effective actions were being taken in terms of greater involvement of the families affected, the progress of the lookback review for patients and progress on SAIs." 15:35

15:36

It is just your first answer then you say, yes, once the Board was alerted we were able to be effective. Do you think, looking back on things, that if you had received information about Mr. O'Brien and his practice

and the concerns which the Trust had, as well as the concerns about management at various levels, which is reflected in the report of Dr. Chada and in the report we recently sent you from Dr. Khan, if you had that information earlier could the Board have been more effective in turning these matters around and in addressing them more effectively or at an earlier point?

A. Yeah, I think right from 2017, if we had have been given fuller information rather than just a verbal report, I think that we would have grasped the seriousness of the matter. After that we should have been given regular updates. In the present process that we have those updates would have come to us in governance every quarter so we would be able to see what the delay was, what the drift was and why the case was taking so long. 15:36 15:37 15:37

204 Q. Yes. Well let's work through some of those particular aspects and may I ask you similar but different questions about different parts of the process and take your view on it. Let's start with 27th January 2017, it's your first Board meeting. We can see from the minutes, TRU-112983, so this is the minutes of that first meeting for you, you're present. If we scroll down to item 6 on the agenda at page 8-5 in the series, two pages further down, and item 6: 15:38 15:38

"Mrs. Toal is reported as advising that under the MHPS framework there is a requirement to report to the Trust

Board any medical staff who have been excluded from practice. She reported that one Consultant Urologist was immediately excluded from practice from 30th December 2016 for a four week period. Mrs. Toal reported that the immediate exclusion has now been lifted and the consultant is now able to return to work with a number of controls in place."

15:39

Dr. Wright then explained the investigation process, that Dr. Khan has been appointed as the Case Manager and Mr. Weir as the Case Investigator. Mr. John Wilkinson is the nominated Non-Executive Director and Dr. Wright confirmed that an Early Alert, as he called it, had been forwarded to the Department, the GMC and NCAS have also been advised.

15:39

15:40

You have explained in your witness statement that there was a lot of information that you weren't told, you weren't told, for example, the controls that were in place in relation to Mr. O'Brien, or the consultant as we should maybe call it for present purposes, to facilitate his return to work. There is nothing there about the particulars of the concerns that had occasioned this process and there's no mention there of the Serious Adverse Incident report. Well there was one index report of which you are now aware and then there was the makings at that time of a further Serious Adverse Incident concerning five patients. So some information but not all of the information that was

15:40

15:40

available to the Medical Director's office and the Director of Human Resources. Do you believe you were given sufficient information at that time?

A. No.

205 Q. Knowing what you do know now, what additional or what kind of information should you have been provided and why should you have been provided with it? 15:41

A. Well, we should have been told that there was an SAI, we weren't told. I think we should have been given a written report on it, not a verbal report, setting out what the issue was. We didn't need to know the name of the clinician, we needed to know what the issue was, who was the Investigator, who was managing it. Obviously we were told that and that John Wilkinson was the Non-Executive Director. We should have been sent the Early Alert. Certainly for me the SAI would have been a red flag for me in terms of looking at this case and then we should have been brought regular updates on progress, if there had been a determination made, what was the outcome. 15:42 15:42

206 Q. We all recognise, I think, that the minutes of meetings, even of significant Board meetings, are perhaps not the best vehicle to record everything that might have been said at a meeting. But certainly there's no suggestion from any of the evidence that we have received whether Mrs. Toal or Dr. Wright were exposed to a curious Board asking them the kinds of questions or seeking the kinds of information that you now think would have been essential. Is it fair to say 15:43

that this Trust Board did not go seeking further information from Dr. Wright or Mrs. Toal either at that meeting or subsequently?

A. Well, I think there is two points that I'd like to make in relation to that, it's accurate. None of us asked questions. No one asked any questions about this, including myself, at this stage. But the other factor is that there wasn't a procedure whereby this was captured and brought to Governance Committee. So I think that impeded our ability to be more curious and to ask for further updates. 15:44 15:44

207 Q. How is that the case? Can I put it in these terms: On the face of it, it looks serious, a clinician has been excluded, albeit he is returning to work, that doesn't happen every day. You have the Medical Director before you indicating that some senior members of staff are now becoming involved in this and there is to be an investigation. I quite take your point that there isn't a specific process of the kind that you now have in place that would perhaps give more focused consideration to this, but these are senior personnel who appeared before the Board bimonthly, did the Non-Executive Directors not think to reflect we need to keep an eye on this, if we haven't asked questions in January we should probably ask them in March and if we don't get progress there is then the next meeting or the next meeting? 15:44 15:45 15:45

A. That's what should have happened and it didn't happen. It's no excuse, it was my first meeting, I didn't

understand what the process was. But you're quite right, I think when I read the transcripts now I can see that Mr. O'Brien was actually returning to work the day before this reporting. I suppose the other thing is that, you know, you have to put trust in your senior staff that they are reporting the events accurately and you have to trust that they are going to deal with it, but we should have asked more questions and we should have asked for an update. 15:46

208 Q. Yes. I think you have recorded in your statement that Mrs. Brownlee had come out of the meeting at this point, at the point of agenda item 6. Did you or were you party to any conversation with her as to why she had left the meeting or did she declare why she left the meeting? 15:46 15:47

A. Do you know, I honestly can't remember if she declared a conflict of interest or not.

209 Q. We know from your evidence and the evidence of others that, as we've said several times today, this matter works its way through the system. It essentially becomes an 18 month, two year process before it reaches a conclusion. Mr. Wilkinson was being kept abreast of developments, he was obviously a fellow Non-Executive Director. I think you allude to the fact that you were aware that he was involved in a complex MHPS investigation and that he was driving the need for further training at various points. But he wasn't a source for updates to the Board during any of this? 15:47 15:48

A. I think when you're the NED attached to one of these

cases there is a big issue around confidentiality. Really what the system should have provided was transparency and assurance that it was being dealt with in an appropriate manner, not just left to the individual concerned. 15:49

210 Q. Is it not fair to suggest that it wouldn't be a breach of confidentiality for the designated NED to come back to the Board to say about that MHPS investigation which you all know about from January 2017, it hasn't moved significantly forward 12 months later or 15 months later or whatever the timeframe is, that would be a reasonable use of the designated NED? 15:49

A. I think that there wasn't a forum for that. In the present procedure that we have all of these cases are updated and presented on a quarterly basis where you obviously would see the NED, but that system wasn't in place. And I think, to be fair to Mr. Wilkinson, he was very minded that he had to protect the confidentiality of the clinician involved and to some extent the process as well. 15:49 15:50

211 Q. Leave Mr. Wilkinson aside and the specific facts of this case to the side, where you have a NED appointed designated to the process, do you consider that it would be an appropriate use of that resource, where he or she finds that the process isn't moving forward as efficiently as he or she would like, that it should be reported in and concerns should be raised by that NED at Board level to say this isn't moving forward and I'm concerned? 15:50

A. Well I think the first port of call would have been the Medical Director and then the Chief Executive and then the Chair when there wasn't a clear procedure in place to bring this into governance.

212 Q. Yes. By the June of 2020 Mr. O'Brien had run into a difficulty with the Trust. He wished to retire, to claim his retirement benefits and return on a part-time basis in early August. You and your fellow NEDs were advised of a dispute between Mr. O'Brien and the Trust in connection with his intentions, in other words the Trust had decided that he couldn't return and he objected to the Trust stance and correspondence in respect of that was brought to your attention, isn't that correct? 15:51 15:52

A. That's correct. 15:52

213 Q. Is it fair to say that that is the next time the affairs of Mr. O'Brien reach your desk and the desk of your fellow NEDs to the best of your understanding?

A. Yeah, that's correct.

214 Q. And we can see, if we go to WIT-100341, that Mrs. Brownlee circulates the correspondence that she receives from Mr. O'Brien through to you and your fellow NEDs. Just take a brief look at Mr. O'Brien's correspondence. If we scroll down the page then to WIT-100343, so he is, on 10th June, writing to Mrs. Brownlee attaching correspondence that he has already sent to Mrs. Toal and to Mr. Devlin, so there's essentially three letters in the mix. He summarises, just to work through this letter, the dispute that he 15:52 15:54

has now reached with the Trust in relation to his desire to return on a part-time basis. The nub of the problem is set out in the last lines of the second paragraph there, in that he was told that he would not be permitted to return to part-time employment in August 2020 due to the Trust's practice of not re-engaging people with ongoing HR processes. And the ongoing HR processes which he describes, scrolling down a little bit, is that there has been this MHPS process which he explains commenced on 30th December 2016, completed on 1st October 2018 and a formal grievance and an appeal of the outcome of the formal investigation was launched by him and the appeal has not been addressed 20 months later. All of this is new to you, isn't it? 15:55 15:55 15:56

A. Yes, it is, yeah.

215 Q. This is the first time you're hearing that there had been a completed MHPS investigation, that it had been the subject of an appeal. We are now in 2020 and the appeal hasn't been addressed and it is being used in Mr. O'Brien's view as an obstacle to prevent him from returning to work. And he submits, if we can go over the page, he writes to say, he is asking Mrs. Brownlee to bring these issues to the attention of her non-executive colleagues. He is doing so because he considers that, as he describes it, the severity of the lack of the Trust's compliance with its own policies and procedures, the severity of the impact of that on him and its consequential impact on the delivery of 15:56 15:57

services is something that merits your consideration and the consideration of your fellow NEDs. Do you remember receiving this conversation?

A. Yes, I do.

216 Q. I'm not going to bring you in the interests of brevity to the other two letters but they are similar in content and tone. You remember receiving them? 15:57

A. Yes, I do, yes.

217 Q. Did you discuss the contents of the letters with any of your NED colleagues? 15:58

A. Well, first of all, I'd just like to say that any staff member or service user is welcome to write to the Board. Whether or not that's considered appropriate to be discussed by the Board is a different issue. I didn't, no I didn't discuss this with the other NEDs. 15:58 I thought myself that it was inappropriate that something that is mainly a HR issue is being discussed in Trust Board. There is a process, Mr. O'Brien has been a staff member for many many years, he would presumably have understood the HR. But just in terms 15:59 of the formal investigation, is that in relation to his grievance or his MHPS because I don't think that process was concluded then, was it?

218 Q. What was concluded was the MHPS investigation. It had concluded in or about the summer of 2018 leading to a 15:59 determination by Dr. Khan in October 2018 and it was then the subject of an appeal by Mr. O'Brien and an associated grievance. Those two latter aspects had not been concluded by the time he wrote the letter.

He draws attention in the correspondence to a breach of procedures on the part of the executive directors of the Trust and in particular in association with the failure to address his appeal and grievance some 20 months on leading on to a situation where he can't be returned to work. Your responsibility as a NED is to hold executive directors to account. If there has been delays of these magnitudes in contravention of the Trust's procedures, is it not entirely appropriate that he draws your attention to them and seeks your support in holding the executives to account for their failures, if they be failures? 16:00 16:01

A. I suppose my reading of the correspondence from Mr. O'Brien was that he had been involved in a HR process and that needed to be concluded. I thought it was very unusual correspondence to be sent to us as non-executive directors. There is a very clear procedure in HR that deals with these sorts of issues, so I thought that's where it should rest. 16:01

219 Q. Well leaving aside his own, if you like, personal employment related or HR-related interest in this, is there not, did you not read in the letter a, I suppose, wider series of concerns in terms of procedural failures on the part of the Trust executives. For example, you're being told here that it took until well into 2018 to complete the MHPS investigation, you as a NED had not been told anything about this, you hadn't been told about the delay, you hadn't been told about the outcome, there is now an appeal in respect of that 16:02 16:02

and you, as a NED, none the wiser about that until Mr. O'Brien's correspondence told you; were those not the kinds of issues that attracted your curiosity and should they have?

A. I read this correspondence was about Mr. O'Brien's opinion, about his situation in relation to his employment and I thought that that should rest within HR. 16:03

220 Q. It didn't on the other hand attract any inquiry from you about the MHPS process itself, what it found and what you as a Board ought to know about it? 16:03

A. I suppose the context is that we heard nothing about this from 2017 and then we get correspondence in June 2020.

221 Q. Well that's my very point? 16:04

A. Yeah, yeah, yeah. I mean, my reading of that, that was because Mr. O'Brien felt aggrieved that he wasn't being asked to return to employment because of the determination.

222 Q. But was it also your reading of it that, regardless of the outcome of this MHPS investigation, it's none of our business, I'm a NED, I don't need to know about it, I don't need to know about the findings, I don't need to know whether there are any patient safety issues or wider issues that need to be explored by us as a Board? 16:04 16:04

A. Well, I don't think Mr. O'Brien raises any patient safety issues in this correspondence.

223 Q. You're missing my point. He has raised the fact that the MHPS process has concluded, it's the subject of an

appeal, you as a Board were told about it in January 2017 and have raised no issue in relation to it. Does this correspondence not encourage you to open your mind to the fact that, whatever has happened over there has been hidden from you? 16:05

A. I didn't read this as relating directly to the MHPS process. Mr. O'Brien mentions a formal grievance, there is no other connection mentioned to that process in there.

224 Q. Well he mentions the MHPS, doesn't he? 16:06

A. Where does he mention that?

225 Q. If you go to -- if we scroll back up please.

CHAIR: I think, Mr. Wolfe, he talks about a formal investigation but it doesn't actually use the MHPS terminology as such, unless I have missed it too. 16:06

MR. WOLFE: Sorry, he refers to a formal investigation, fair enough. So this didn't trigger any interest on your part to ask questions?

A. My honest reading of this was that he was aggrieved, and he does say that in the letter, that he is not being to be re-employed. 16:07

226 Q. Yes.

A. So I considered that to be a HR issue.

227 Q. The issues remain unexplored or uninterrogated until August 2020 and on 27th August you are attending a virtual workshop and if I can bring up on the screen TRU-158990, that's just the cover page of it. If we could drop through to TRU-158997. So it is said that the Chair, that's Mrs. Brownlee, left the meeting at 16:07

this point. And then Dr. O'Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired Consultant Urologist. The members asked that this matter be discussed at the confidential Trust Board meeting following the workshop and the Chair returned to the meeting at this point. So, this was done in steps then. There was an attempt to broach the subject at the workshop and the view was it should be discussed as part of the Trust Board meeting? 16:09

A. Well it wasn't on the agenda which is why it came under AOB.

228 Q. Yes.

A. So I do remember that Mrs. Brownlee left at that point very abruptly. She didn't declare a conflict of interest and one of the other NEDs stepped in to chair then. 16:09

229 Q. Yes. We then have the Board meeting itself. If we go to TRU-130799 and just at the bottom of the page under, "Any other business". It's largely the same words that were used at the workshop, Mrs. O'Kane again bringing to the Board's attention that SAI investigations into concerns involving a recently retired Consultant Urologist. Members requested a written update for the next confidential Trust Board meeting. I think that's the end of it, if we just scroll over the page, yes. So on the basis of that note it wouldn't appear that you were told about the name of the consultant? 16:10 16:10

A. No, we weren't.

230 Q. Yes. It wouldn't appear that you were told that there had been an MHPS investigation in respect of whoever we were talking about here and a determination?
A. No, we weren't, we were just told that there were a number of SAI investigations. 16:11
231 Q. It wouldn't appear that you were told that these issues had come to the attention of the Trust in June leading to an Early Alert being issued to the Department on 31st July?
A. We weren't told about and we didn't see the Early Alert. 16:11
232 Q. Yes. When you think about things now, do you understand whether there was good reason to be keeping information flow to the Non-Executive Directors at a low level of detail and what would appear to be with some delay as opposed to telling you about things as they were happening? 16:12
A. Well I suppose now on reflection I would be wondering why Dr. O'Kane didn't put it on the agenda, why did she feel that it had to come under AOB, but that's a question for Dr. O'Kane. 16:12
233 Q. If we go back to the events earlier that summer, if we start with the Early Alert. If we go to DOH-00666. This is, I think we received an explanation in the mists of time as to why there is an Early Alert dated 31st July and also one dated 1st August, but the explanation hasn't been carried well in my memory. But this is the one dated 1st August, the content is the same. So this is four weeks before your workshop and 16:13

Board meeting of the end of August. Dr. O'Kane is telling the Department of Health about the events which initially came to the Trust's attention in June and obviously there was a process of investigation, including an informal lookback until further information was gathered.

Plainly within this document there is significant information about the extent of the problem as the Trust saw it. Mr. O'Brien has, in his evidence, given an account which suggests that aspects of the original concern are without foundation and are inaccurate and it's important to bear that in mind. But what I am putting before you at this stage is the significant amount of information that the Trust felt it needed to share outside of its structures to the Department. You didn't see this Early Alert? 16:14 16:15 16:15

A. No, we didn't see this Early Alert. An Early Alert is a process where the Trust has to inform the Department primarily, usually it's a phone call and then it's a written form but, no. But this was shared with Mrs. Brownlee as Chair. 16:16

234 Q. Yes.

A. All of the Early Alerts went to Mrs. Brownlee.

235 Q. Yes. It was shared several days later with Mrs. Brownlee. If we go to WIT-101964, and Stephen Wallace sends it to her on 3rd August. He describes it and he says: 16:16

"Please note, given the sensitivities and ongoing processes surrounding this issue, the internal circulation list has been limited and we ask that this is not shared wider at this stage."

16:17

So, Mr. Wallace is telling Mrs. Brownlee not to disseminate it further. Can you think of any good reason why Non-Executive Directors of the Trust deployed for the purposes of holding Executive Directors to account would be excluded from this kind of information? 16:17

A. I can't and my own opinion is that it should have been circulated to NEDs. But the context of Early Alerts at this stage was that they went to Mrs. Brownlee and they were disseminated at her discretion. And in fact, until Mrs. Brownlee was completing her term we didn't see Early Alerts, only in the last couple of months before she left. Now the procedure is that we see all the Early Alerts. For me that's a really important part of the clinical and social governance piece because Early Alerts give you a lot of information about what issues are coming up of concern and they complement the data and the information that you get from SAIs and complaints. 16:17 16:18

236 Q. Yes. I'll come back to what you've said about what was your experience of Early Alerts by this point and how things may have changed. But, certainly on the face of this document Mr. Wallace is - looking at these words - suggesting to Mrs. Brownlee that, noting the 16:18

sensitivities, this should not be shared beyond the current group at this stage. Just so that I'm sure of your answer, do you think you should have seen it at this stage?

A. I think it would have been very helpful for us to have seen it. 16:19

237 Q. Well it's more than helpful, isn't it? There is no reason why you, given your governance responsibilities and your fellow NEDs, given their responsibilities, should not see the Early Alert if it is being sent to others outside of the structures? 16:19

A. Yeah, I agree with you. I suppose the context for this is that Early Alerts were not shared with us.

238 Q. Is that quite right? I've seen material tending to suggest that they are sent to Mrs. Brownlee and her secretary in the first instance but she has on occasions then recirculated then to her fellow Non-Executive Directors, isn't that right? Can you remember experience of that? 16:20

A. Yeah, occasional Early Alerts came to us but only in the last couple of months before Mrs. Brownlee left. 16:20

239 Q. Certainly there is some in --

A. Maybe in the last year.

240 Q. At least one in July that caught my eye in preparation for this today. But, would you be prepared to accept that - I'm not saying it, I'll take your view on it - but are you prepared to accept that Mrs. Brownlee did circulate Early Alerts? 16:20

A. She did circulate occasional Early Alerts.

241 Q. The position as it now stands appears to be set out in a Trust policy of July 2022, if we go to the policy, it's at WIT-100301. Just give the whole page. So it's dated 28th July 2022, it's the policy for reporting of Early Alerts to the Department of Health. If we can scroll down to Appendix 1 at WIT-100310 and paragraph 2.8 does refer to a report. Just scroll back. I think the word "report" is used interchangeably with the word "alert": 16:21 16:22

"The report will be issued simultaneously by the Corporate and Clinical Social Care Governance Office to the Chief Executive, the Chair, Directors, Non-Executive Directors, the relevant Assistant Director." 16:22

Et cetera. Is it now your experience that you receive Early Alerts as soon as they issue or as part of this communication trail?

A. As soon as the current Chair came in we saw all the Early Alerts. 16:22

242 Q. Yes. There are many reasons for issuing Early Alerts and the content of an alert may refer to issues that are important but reasonably benign and don't require any action through to potential controversies that require NED input and involvement as soon as may be, is that fair? 16:23

A. Yeah, that's fair.

243 Q. And if you're being kept out of the Early Alert loop

for whatever reason, and here you still didn't know about the Early Alert by the end of August, these issues having been generated in June, that's a serious communication failing, would you agree?

A. Yeah, we should have seen it. 16:24

CHAIR: Mr. Wolfe, I wonder if that's an appropriate time to rise for the day?

MR. WOLFE: Yes, I agree. Convene at 10 o'clock tomorrow?

CHAIR: 10 o'clock in the morning, ladies and gentlemen. 16:24

THE HEARING STANDS ADJOURNED TO THURSDAY, 11TH JANUARY 2024 AT 10

16:24