Urology Services Inquiry

# Oral Hearing

## Day 81– Wednesday, 17th 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 AT 10:00 A.M. ON WEDNESDAY, 17TH JANUARY 2024 AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Wolfe.

MR. WOLFE KC: Good morning, Chair. Your witness this morning is Mrs. Brownlee. 10:05

ROBERTA BROWNLEE, HAVING BEEN SWORN, WAS QUESTIONED BY MR. WOLFE KC AS FOLLOWS:

10:05

1 Q. MR. WOLFE KC: Good morning, Mrs. Brownlee.

A. Good morning, Mr. Wolfe.

2 Q. Thank you for coming to the Urology Inquiry. I want to begin by bringing up on the screen your witness statement, followed by a couple of addendum witness statements which we've received in the course of the last 48 hours or so, and I'll ask you whether you wish to adopt those statements as part of your evidence to the Inquiry. 10:06

10:06

So, commencing with your primary response to the Inquiry's Section 21 notice. We received it on 29th November 2022. If we go to WIT-90846, and that's the first page. If we go to the last page at WIT-90911, and that's your signature? 10:07

A. Yes.

3 Q. And you recognise that statement or that response as yours. Subject to the corrections contained in your addendum statements, do you wish to adopt this document

as part of your evidence to the Inquiry?
A. Yes, I do.
4 Q. Thank you. Then on Monday of this week, we received an addendum from you. It's to be found at WIT-105947. As you can see at the bottom of the page, it's a one-page document, it's unsigned and undated. That is a document endorsed by you; is that right? 10:07
A. Yes, that's correct.
5 Q. It deals with some corrections to the timeline in respect of your dealings with Mr. Pengelly? 10:08
A. Yes.
6 Q. We'll look at those in some detail later in your evidence. Can I ask you this: There's a second supplementary or addendum statement, which I'll put up on the screen now. WIT-106615, and this is signed by you. Over the page it contains an attachment, which is a phone record concerning a telephone call with Mr. Pengelly on 26th October 2020. Taken together, both of those documents, the first addendum and the second addendum, do you wish to adopt those as part of your evidence to the Inquiry? 10:08 10:09
A. Yes. Yes, I do.
7 Q. Thank you. Now, the importance of your evidence, Mrs. Brownlee, is or arises out of the fact that you were Chair of the Southern Trust from 2011 through to November 2020, which was obviously a pivotal period in terms of the issues which this Inquiry has to consider. Do you understand that? 10:09
A. Yes.

8 Q. If we could just bring up on the screen something of your background. If we go, first of all, to WIT-90848, we can see your academic and professional qualifications. You are a nurse and a midwife by profession?

A. Yes.

9 Q. We can see that you have post graduate qualifications in nursing as well as in management or leadership. You have a Masters in Executive Leadership, which was gained in the period 1996 to 1998 before you took up your role, 10 years before you took up your role on the Southern Trust Board; isn't that right?

A. Yes. Yes.

10 Q. Taken together, do those qualifications or did those qualifications assist you in your role as Chair of the Southern Trust Board?

A. Absolutely. As a registered nurse, they assisted me to understand a lot of the clinical and nursing background. All of my years that I had worked in health and social care in the independent sector, I had held senior positions in the largest privately owned health care organisation in the UK. We had a private hospital and we had 42 nursing homes, both in England, Scotland and in Northern Ireland, so I had a vast experience. Of course then my academic Masters in Executive Leadership added to that by giving me additional tools to be equipped. So yes, absolutely.

11 Q. Just if we go up the page to WIT-90846. Just go to the top of that page. We can see your professional roles

set out. Back in the mists of time, registered nurse was your first occupation; various employers; midwifery, ward manager. Then just scrolling down, moving into the private nursing home sector. You've described your role with -- was it Tamaris or Sandown you are describing as the largest nursing home provider?

A. I started my career in the Sandown Group and then it was bought over, and then I was joined into the Tamaris Healthcare UK but it had a subsidiary in Northern Ireland, so it became the largest because we brought together quite a number of the groups there. We had the 42 homes across a range of services. We also, in my previous employment, had the private hospital as well. 10:13

12 Q. Yes. We can then see in or about 1998, your first steps into, I suppose we could describe it as public service, as a Non-Executive Director for the then Armagh and Dungannon Health and Social Care Trust. As we scroll down, we see that that public service has continued in a significant number of roles since that time and continues to this date; isn't that right? 10:14

A. Yes, that's correct.

13 Q. So just looking at that, you became a Non-Executive Director in the Southern Trust for the first time in 2007, moving on to become Chair of that organisation, as I've said already, from 2011 through to 2020. Setting aside those roles, you were also occupying other Board memberships in other public bodies. 10:14

Southern Education and Library Board; you are still a member a lay panel member of the Care tribunal?

A. Yes.

14 Q. Over the page, Chair of Macmillan Cancer. Described yourself as a cofounder of CURE, the Craigavon Urological Research and Education charity. I want to come later in your evidence to ask you about the background to the formation of that charitable company. You were a cofounder with whom; who were the other cofounders? 10:15

A. We'll probably come to it later on but I had been very sick and I was a patient in Craigavon in the Urology Department, and the ward sister then was a lady called Eileen O'Hagan, who was the ward manager but an absolutely amazing person. Because of some of the deficits that I found as the need for my care, I mean, Eileen and I, along with many others, but Eileen and others were the cofounders of this CURE charity.

15 Q. As I say, we'll come in more detail to that later in your evidence. Membership of a number of Board of Governors. You are a board member of AFBI, the Agri-Food and Biosciences Institute. That is an Arms Length Body from the Department of Agriculture; isn't that right? 10:16

A. Yes. Yes. 10:16

16 Q. I think, just scrolling down, a Board member of the Prison Service Pay Review Board, and external assessor for performance on the Education Authority. As well as all of that, a director and owner of a nursing home, as

we can see there. It's, I suppose, worth pointing out that at the same time as serving as Chair of the Southern Trust, you had the Prison Service Pay Review Board role; you had the AFBI role, as well as managing or owning your own nursing home; that's a significant set of responsibilities. Was it?

A. Sorry, just the AFBI Board member was towards the end of my term as the Southern Trust Chair. But yes, it was.

10:17

17 Q. Yes, we can see it there --

10:17

A. Yes.

18 Q. -- your Southern Trust role ended in 2020. You appear to have had four years as a Board member at AFBI when you were still with the Southern Trust; is that right?

A. Yes, yes. I mean, it was a busy life, I would be a busy person. I enjoy my work. I am totally committed to health and social care and I believe I had a lot of experience that I could bring to assist. I loved education. I was very committed to the voluntary sector as well. So yes, it was busy but I had excellent support at home and I managed it, I believe well. If one was to look at my record of attendance both in the Southern Trust at meetings and indeed in other Board appointments, I think I rarely missed a meeting, but it takes organisational skills and good support. But I enjoyed it and I loved everywhere that I have worked and assisted to improve any additionality to services.

10:18

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10:18

19 Q. I think Mr. Pengelly yesterday reflected on the

importance of people coming forward to give of their time in public service in these kinds of roles. What was your motivation for not only coming into such a role way back in the early part of 2000s, but then taking on additional roles and staying in those roles over a lengthy period of time?

A. Well, just like you refer, the public appointments attracting younger people who have an interest and can give of their time is jolly hard work. At the time I was doing my executive leadership, there was a part of that programme about public service, so I was very interested. I was much younger then. So in that year, despite holding a Senior Chief Executive's position in the independent sector, my boss and Board were very supportive of me taking on a role in then the Armagh and Dungannon Health and Social Care Trust. So it was probably that I believe I had a lot of skills and I could contribute much to the Board. I also was very committed to community and voluntary work, and I believed if there was anything I could do to enhance that, I would. It was something I did then and to date, I've loved it. That's why.

20 Q. Very good. In terms of the Southern Trust role, I spent some time focusing on that, your initial impressions of it, how you did the job and the kinds of challenges you faced and, if you overcame them, how they were overcome. You succeeded Mrs. Balmer as Chair?

A. Yes.

21 Q. And that was 2011?
A. Yes.
22 Q. As I've noted already, you served two terms but with an extension towards the end when ultimately Mrs. Mullan, or Ms. Mullan, succeeded you? 10:21
A. Yes.
23 Q. What was the difficulty, if any, as you understood it, in delaying your successor's appointment, or what was the reason for the delay?
A. I completed my two terms and I was ready to go, and 10:21
Mr. Pengelly had phoned me to discuss just -- I mean, you would have been constantly in touch with them about the replacement. It was always quite a long drawn-out process to recruit Non-Executive Directors and indeed chairs. I understand the complexity around that all. 10:22
But at that time, my post, when my term was up after the eight years, hadn't even been advertised.

Also at that time, there was a lot going on within the Trust, and a lot of, you know, changes. I suppose for 10:22
stability, I was asked to stay on for a short period, for less than a year, and for the continuity of that. Also, to be able to do that, you would have to have had a successful track record and successful appraisals, and I did say I would stay on until someone was 10:23
appointed, with the intention hoping that it would go to press and there would be a successful applicant. So it was just due to instability probably at chief executive level, the appointment process hadn't taken

place. There was many other chairs' posts coming up at the same time to be vacant. No other reason than that, I believe.

24 Q. I suppose Covid became a factor, perhaps, in early 2020? 10:23

A. Yes. Yes.

25 Q. And undoubtedly, as you reflect in your witness statement, that may have had some impact?

A. Yes.

26 Q. Interestingly you make the point that your second term, the clock on it would have stopped at some point in 2019. You make the point that even as the clock stopped on that period, they hadn't yet gone to press to advertise for your replacement. 10:23

10:24

Can I ask you this: Mrs. Mullan, in her evidence last week, I suppose bemoaned what she saw as a lack of attention to succession planning, both on the Executive Director side as well as with regard to Non-Executive Directors. Focusing on that latter part, is that something you would share a concern about, that the Department wasn't as focused on succession planning as it ought to have been? 10:24

A. Well, certainly it would have been something I would have brought up at my annual appraisal. I also had been selected by the Commissioner of Public Appointments as a reflection for all of my years of service how to attract other younger people into this. So, I would have been bringing up to the Department, 10:24

and indeed I remember speaking at that time for the same reason. I'm not sure there was a lack of focus. I mean, they knew it needed to be done but other departments or other areas became a priority. So it could have been another Trust or the Northern Ireland Ambulance Service, there was always somewhere else got the Chair first. So yes, it could have been better organised, but I suppose I always say the pressures that everyone was under. But most of the Non-Executives that I have worked with in my years all had extensions. Mrs. Balmer that you referred to was an excellent Chair, an excellent role model in every aspect, and trained her Non-Executives to the highest standard in preparedness for all that a Board requires. She went off quite quickly towards the end due to illness, so another Non-Executive Director stepped in to act up in that role before the appointment was made to myself. So, there was no planning for Mrs. Balmer going, to be fair, because of illness. 10:25 10:25 10:26

27 Q. Could I draw your attention to something you've said about the renewal of your first term in office. If we go to WIT-90848. Towards the end of that first paragraph - sorry, it's the second paragraph - you say: 10:26

"It's important to note that I was asked to stay on as there was no permanent Chief Executive in post from early March 2015 until Shane Devlin was appointed in March 2018". 10:27

In the way that you've expressed that, you're seeming to suggest that you were asked to enter a second term, a second four years as Chair because there was no permanent Chief Executive; is that correct, Mrs. Brownlee? 10:27

A. It was one of the contributory factors, yes, for stability. At the time when Mrs. McAlinden left in March 2015, we knew she was going and had her three months' notice and we talked quite a lot. I can remember the meeting in the Department because it was 10:28 just Christmas Eve of the previous year when we were talking to Mr. Pengelly about that appointment. At that time, to be fair to Mr. Pengelly, there was other Chief Executive posts vacant. I remember the Belfast Trust was vacant and the Western Health and Social Care 10:28 Trust was vacant. I mean, he asked if I didn't mind that the Southern Trust waited in the pecking order for advertisement for the Chief Executive posts until those posts were filled. 10:28

Chief Executive posts in the health and social care family are not very attractive, for whatever reason. You wouldn't have many applicants, and sometimes none. I mean, these other two Trusts, he believed, were more of a priority. I remember him saying we had a very 10:29 stable senior management team, an excellent senior management team, very competent, well-experienced and many in post for years, and also my track record was pretty good. It was a Trust that really hadn't much

trouble. The Southern Trust was renowned during my tenure as a Trust that had outstanding performance and had achieved many rewards under the leadership of Mrs. McAlinden. I mean, it was very stable. I remember other Trusts had some difficulties at that time. So, that would have been a contributing factor to it, my reappointment. But I also said I was willing to. You're asked at your appraisal are you willing to be considered for another term, which I was.

28 Q. Yes. 10:29

A. And I hadn't to be interviewed. Apart from my appraisal, you didn't have to reapply for a second term.

29 Q. To summarise on that, you were very keen to stay on for a second term -- 10:30

A. Yes.

30 Q. -- but from a Departmental perspective, losing the stability provided by Mrs. McAlinden rendered it, I suppose, even more important that continuity, in the form as you as the Chair, was realised during that 10:30 period?

A. Yes.

31 Q. Thank you. We have noted from your evidence, I'm not sure if it is - yes, it's just as you've said it there - during the three-year period following 10:30 Mrs. McAlinden's stepping down until the appointment of Mr. Devlin in the spring of 2018, that was a period of, I suppose, some instability given the lack of leadership at executive level; is that fair?

A. I wouldn't like to say it was unstable. Mrs. McAlinden in her time left an excellent Trust. I mean, it was in very good arrangements in relation to governance and lots of other performance and outcomes; it was very good. So the people that acted up into those interim role, the first one was the lady, Mrs. Paula Clarke, who came in '15/'16. She had been the Director of Performance for some time; a very capable, competent person, so I didn't see any instability at that time. To me, I describe it as a vehicle that the tank was well-filled and we were in very good position, and I was proud, and rightly so, to be proud of that Trust. 10:31 10:31

So when Mrs. Clarke came in, it was very stable. The person acting up into her role as an assistant director again had been at that level for some time. 10:32
Mrs. Clarke then was appointed to a position, a senior position, in England and moved, and then we had another interim. Remember, during this time I would have been keeping very good contact with Mr. Pengelly. I mean, I had an excellent working relationship with him. I had his phone number, I could have phoned him at any time. I still understood the priorities of the other two Trusts and we all worked very collectively together. 10:32 10:32

In came then Mr. Francis Rice. Again, he was a highly experienced Director, having been in Mental Health. He was a former Acting Chief Nurse of the Department. Again, the Trust was in a very safe position. He had a

lot of very good deputies at his level that acted up. Regrettably, Mr. Rice, during the time he was there from '16 to 2018, [redacted] and he was back and in and out. But again we had Mr. Stephen McNally, who was the Director of Finance and had been for many years, and a very competent, capable person who took over. So no, I would disagree that it was unstable. 10:33

I mean, it was the same in the Acute Directorate which I have heard before the Inquiry. The Acute Directorate in the Southern Trust had Assistant Directors who were there a very long time, had moved around within the Trust. I think there was five or six of them, and they have been before the Inquiry. I mean, very experienced people. So I wouldn't agree that it was a time of instability. I provided a stability but I had a superb Board of senior managers at that level. My Non-Executive Directors that I had, yes, some may have changed but those that left, we missed them of course, their skills and expertise, but those that came in were equally very skilled, and I was privileged to have the Board I had during my tenure. All of my Non-Executive Directors and Board of Directors were very competent, capable. I mean, it was a really good Board. 10:33 10:33 10:33 10:34

I have heard also - we'll come back, no doubt, about the culture - but during my time, the culture was one we had invested in heavily through Mrs. Balmer when the

Trust was formed; we spent many times in workshops looking at culture, duty of candour, how could we improve ourselves, how do we perform together, we were very reflective practitioners in our own right. Whilst I have heard other comments, I can just tell you, Mr. Wolfe, during my time the Trust was very stable. We would, of course, have liked a Chief Executive of a permanent post and we did advertise. I think we had maybe one applicant, or two, but an appointment wasn't made until Mr. Devlin came in 2018. 10:34

32 Q. Others might consider that having such a turnover of interims at the Chief Executive level before you had a permanent isn't ideal, and perhaps you would accept that?

A. Yes. 10:35

33 Q. It wasn't ideal. Did you not detect any adverse implications of such a turnover?

A. Mr. Wolfe, I didn't, no.

34 Q. You didn't?

A. I mean, I would agree with you, you would have liked a permanent but I had to respect -- I don't think the Belfast Trust appointment was too quick either because of succession and getting the right person, and the same in the Western Trust. My post didn't go to press until they were filled. So absolutely, everyone would want their own permanent Chief Executive, the accounting officer, but I wasn't in a position to push that any greater than with Mr. Pengelly who was looking at the totality of the region. 10:35 10:35

35 Q. In terms of your role during that period of flux, do you consider that you had to involve yourselves in activities, perhaps on operational side to some extent, that wouldn't normally come with the role of the Chair?

A. No. No. Paula Clarke, when she came in, hit the ground running and fulfilled that role to a very high standard, and the same with those that came after. My style of leadership and my performance as a Chair never changed from Mrs. McAlinden until Mr. Devlin arrived. I didn't do anything different. I was a well-known Chair. I believe a Chair should be visible and I was out in the Trust a lot, both in the primary community settings as well as the secondary care, so I would have been well-known. It might be perceived by others that I was meddling or getting into whatever, but I never was involved in the engine room in any aspect. I never attended any operational meetings of any kind but I certainly would have been out a lot in the canteen; I was very involved in the leadership walks. It was Mrs. McAlinden and I who initiated those, no doubt we will come to talk about those later, but I never seen myself as a Chief Executive. 10:36 10:36 10:37 10:37

Of course, you provide continuity and the conduit when there's people in and out because Mr Rice went off quite suddenly. I remember the time he came in [redacted], and he needed to go that day. Then you were bringing in, say, Mr. McNally, who you knew well but you had to use the knowledge that you had 10:37

for a hand over, so that could be perceived. But I certainly was never out and operationally involved in any Chief Executive role.

36 Q. You have reflected a short time ago on the success, as I think you view it, of the Board during your tenure. It's right to reflect that, as set out in your statement, you had been commended with an MBE for your services to the Trust and your commitment to charity work in Northern Ireland; isn't that right? 10:37

A. Yes. 10:38

37 Q. That came your way in the 2019 New Year Honour's List?

A. Yes.

38 Q. Additionally, you've achieved a lifetime achievement award from the Royal College of Nursing for, I think the citation was "Outstanding Contribution to Health and Social Care". Isn't that correct? 10:38

A. Yes. I think one of the reasons for that probably was I was the first nurse, I understand, in the United Kingdom to be ever to bring in models of excellence that could be measured in relation to quality outcomes for patients. We used a recognised company in the UK, Goldsmith it was at that time. But the forward thinking to know to do that in the independent sector, many of that started some of the quality standards within the health and social care families. 10:39 10:39

39 Q. Let me talk a little more about your role as Chair of the Southern Trust Board. You describe in your witness statement - if we can bring it up on the screen, please, WIT-90849 - your responsibilities, you say,

were substantial, and you explain that you were accountable for the performance management of the Trust in its broadest sense, and you further explain that in that paragraph.

As you took up the role and at various points along the way, the Department would issue reminders in relation to what is expected of a Trust Chair. For example, in 2017 it reminded Chairs of the importance of practising with integrity and taking steps to avoid conflicts of interest; isn't that right? 10:40

A. Yes.

40 Q. One of the documents that would have been sent your way, I hope I'm right in saying, is the Code of Accountability. If we could look at that, it's TRU-113442. This is, I suppose, a standard explanation that went to Non-Executive Directors, including Trust Chairs, to set out the basic values of the role, and the responsibilities. Could I bring you to paragraph 6, if we could scroll down, please. It explains the role of the Chief Executive Officer as compared with that of Chair. Middle of the paragraph: 10:40 10:41

"There is a clear division of responsibility between the Chair and the Chief Executive". The Chair's role and the Board functions are set out below. "The Chief Executive is directly accountable to the Chair and Non-Executive members of the Board for the operation of the organisation and for implementing the Board's 10:42

decisions". It explains that: "Boards are required to meet regularly and to retain full and effective control over the organisation".

Does that adequately, I suppose, explain the difference between the two senior roles? On the one hand you have the Chief Executive and, on the other hand, the Chair of the Board. You are, as Mr. Pengelly memorably put it yesterday, in addition to your Non-Executive Directors, responsible for holding the Executive's feet to the fire is how he put it, maybe a little inelegantly, but it is about constructive challenge in holding to account; isn't that right? 10:42 10:43

A. Yes. Yes, that's correct.

41 Q. The role of the Chair is further explained in more detail, just if we scroll down to paragraphs 9 and 10. The role of the Chair, almost by way of a job description. You didn't have a separate job description, did you? 10:43

A. Whenever you made an application for the public appointment, you got a pack. 10:43

42 Q. Yes.

A. And it was an application and of course then two/three documents, one of which you've referred to, and definitely a document similar to this explaining your role. 10:43

43 Q. Yes.

A. And the remuneration and all that was expected of you. So, you got a broadened example of a job description.

44 Q. Yes. Paragraphs 9 and 10 very much casts the Chair's position into the mould of a leadership role. You were expected to be, I suppose, very much the leader of the Board and to be, I suppose, the public-facing representative of the Board. It is set out and explained at paragraph 10 across a number of particular tasks or duties. Just scrolling down, I think it continues onto the top of the next page. Just briefly, does that appear to adequately reflect the kinds of responsibilities that you held? 10:44 10:45

A. Yes. Yes.

45 Q. At paragraph 11, it speaks to the importance of a complementary relationship between the Chair and the Chief Executive as being important. I mean, I suppose that's self-evident, you needed to work closely with your Chief Executive and you needed to function in a complementary fashion. 10:45

We'll come on and talk about some tensions which Mr. Devlin believed punctuated your relationship with him or his relationship with you. I know that you have a particular view to express on that; that comes as some surprise to you in the round. We'll come to that in a moment. In general, do you feel that over the course of your tenure that your relationships with the various Chief Executives worked well and were, in fact, complementary? 10:45 10:46

A. Absolutely. I always remember when the Trust was formed in 2007 with Mrs. Balmer then as the Chair, I

mean we had time away, and it will always last in my memory how she described the relationship between a Chair and a Chief Executive: It should be a good, working relationship, good communications and good relationships but there should always be the blue water. There should be a clear knowledge of how you are separate to it. So I mean, all of the Chief Executives I worked with from Mr. Donaghy to Mrs. McAlinden, right through those in the interim posts, Mrs. Clarke, Mr. Rice and Mr. McNally, were excellent, and I should say they were excellent with Mr. Devlin. I was not aware Mr. Devlin had any concerns about me in any aspects of my work interprofessionally or personally until I read much of the Inquiry. So I had no problem with any of my Chief Executives, not none ever brought any to my attention of that. We had a very good working relationship, which you had to have. We were dealing with some of the most complex issues on a day-to-day basis and the fast pace of change. So I have never had any problem with anyone in the Trust that I am aware of, or indeed in anywhere I have worked. 10:46 10:47 10:47 10:47

46 Q. We're obviously sitting in a Public Inquiry which will consider through your evidence, and obviously through the evidence of others, some alleged shortcomings in how the Trust has functioned in a particular sphere. Viewed from that perspective and what you know of the Inquiry, its reasons for being and its work, have you any reason or cause to reflect that things with Chief 10:48

Executives over a period of time might have been better approached or better handled so that we are not here scrutinising these issues?

A. Well, a lot that is before the Inquiry I have been reading and been informed for the very first time. I can assure you many times to Trust Board, under all of those different Chief Executives that I have referred to, we dealt with information that came to us in a very structured, in a very challenging, and indeed we were very clear on governance and reporting lines through a variety of subcommittees. Yes, I'm not disagreeing with you what has come before the Inquiry now is shocking to me, but I can assure you much of it I didn't know. I believe if Mrs. McAlinden and those that followed her had known any of this, and had come to Trust Board, we would have taken immediate corrective action. I am disappointed about that, but the flow of information or what we needed to know did not come. 10:49 10:49 10:49

47 Q. Yes. We'll have an opportunity obviously to explore that in greater detail but thank you for that for now. 10:49

Your witness statement and the evidence of others has looked at the training needs of the Non-Executive Directors. Can I just open your statement in this respect? WIT-90852. You explain that in terms of training, you attended numerous training sessions during your tenure: 10:50

"As an experienced Non-Executive Director across a variety of sectors, both in the private, public and voluntary sectors, I gained a broad breadth of skills, knowledge and experience".

10:51

You also had senior executive positions spanning 25 years. You also refer to the training that you received in the academic sphere of Queens' University and elsewhere.

10:51

Do you consider that in terms of the training and support more generally that was available to you, whether through the Trust or through the Department or through other HSC bodies and supporting mechanisms, was it adequate? Did you feel well-supported and equipped to do your job? 10:51

A. Yes. Yes, I believed I was well-trained, very well-supported and it was adequate. During the time of the formation the Trust from 2007 with Mrs. Balmer, we had a lot of training because it was the formation of different Trusts coming together, so we had a lot of ground work done then. I couldn't tell you how many times I have attended the onboard training, which I'm sure others have referred to, which is really a department training that you go on. I have attended that on numerous occasions with different public bodies I've sat on. So we were well prepared to be a Non-Executive Director during the early years. When Mrs. Balmer left and then Mrs. Mahood acted up for 10:52 10:52

a period of time, I took over from her. No, I didn't have any formal training to move into the role. Mrs. Mahood gave me a very good hand over. I myself believe my breadth of experience at Chief Executive level, I worked to banks in London and I was held very 10:52
accountable to boards there. Be assured, Mr. Wolfe, you were very accountable so you knew what that was. We had a lot of governance training in relation to finance and other performance, which you transfer your skills from your practical work into these roles. At 10:53
that time, it was Mr. Andrew McCormick when I took over was the Permanent Secretary. I mean, he would have talked to me, he was very available at the end of a phone. He then moved, I think, departments, and Mr. Pengelly; I had him for the rest of my time. 10:53

To be fair to Mr. Pengelly and all of his deputies, there was never none of them I couldn't have approached at any time. Through my own appraisal, and if there was anything you weren't sure of with your own 10:53
self-reflection and reviews, if you were weak in an area or something you didn't know, the onus was also on you to be trained up for that. To be fair to colleagues before and who I worked with in the Department and others, I believe I was well-supported. 10:53

I didn't have any induction but I'm not just sure what induction you would give to someone coming into a Health and Social Care Board, at whatever level. Yes,

I think you can have more, maybe on governance and risk management, but it is doing the job. It is when you get in and see the volume of work and what's coming across your path every day, it is where you have to actually reflect and take cognisance of where you may have came across this before. You have to be very shrewd, you've to be very detached, you're very accountable, you've to hold others to account, and you have to challenge. So, if you didn't know something that I was dealing with, it would be very remiss of me not to have made inquiries through senior colleagues or indeed other Chairs. We had a Chairs forum, and that network and all was important. I don't believe I could have been any better trained. I trained a lot myself and a lot of my past experiences, wherever I worked, I mean I brought those with me. So I wouldn't be critical of that. I learnt a lot on the job. 10:54 10:54 10:54

48 Q. Yes. You make the point that you probably have lost count of the number of training for boards that you have attended with the Department. I'm sure it wasn't like a broken record, that training. What new material was offered to you through such training? I'm thinking in particular that the Health Service in Northern Ireland is clearly an organisation, a large organisation that is subject to expressions of concern and criticism from time to time. We've had major public inquiries before this one, notably, for example, the Hyponatraemia Inquiry. 10:55 10:55

A. Yes.

49 Q. The training that was being offered by the Department, was it cognisant of lessons learned, whether through that inquiry or otherwise, or did the training more or less stay the same?

A. No, the training was variable to meet the needs. For example, if I can use, stepping out of health, when you went to education to the Board, you know you had a different type of onboard training. A lot of it was around governance, accountability, risk management. It was the same in health; the onboard training was tailored to what was happening at that particular time. We would have used -- I mean, it was a one day. So, you would have used the afternoon on examples of lessons learned, bring it in the Boardroom to actually other specifics. 10:56

I came into Hyponatraemia and the outcome of the public inquiry. I can remember that well. We tried, despite the number of recommendations, we tried at local level in our workshops to look at specific strands because, from memory if I go back, I think that was to do with the standard and guideline that came out and came across the desk of, say, a Chief Executive and how did it filter through the organisation so that effective management of fluids took place. I mean, therefore if you were going to learn any lessons, you wanted to make sure any new standards and guidelines came out, any new alerts from the Department or from RQIA or any other regional -- a lot came from the region like Mid 10:56 10:57 10:57

Staffordshire. I mean, a lot of those came. It was one thing I was paramount in reading those, even executive summary, and I always asked the question - and I'm sure there are records and minutes to see - could that have happened here, could it happen again, and what was the immediate learning.

Yes, the training may not have gone into a lot of detail in an eight-hour day, but the morning would have been about the theoretical and the afternoon was always practical. It was changed regularly. It was the same company did it, from memory, in health. You know, it changed to meet the needs of a resolving health and social care environment.

10:57

10:58

50 Q. Could I ask you about the training that was provided to new or incoming Non-Executive Directors. You pick-up on this in your witness statement at WIT-90851. Under question 4 or just below that, you've said that, four lines down:

10:58

"All new NEDs had an induction which included a buddy system, manual of information on Board assurance documents, visits to every directorate for onsite learning with each Director, ongoing meetings with myself, the Board Assurance Manager and the Chief Executive as needs arose".

10:59

You were responsible for the NEDs' training needs, you explained, and the senior management team which flowed

from their appraisal system and their monthly performance meetings with the Chief Executive. I should have read the first couple of lines as well.

"The Board Assurance Manager would have notes of the training records but there was training for risk management and appetite for risk". 10:59

I want to ask you some questions about the training for NEDs. Just on the last point I have raised, risk management, what was the angle taken there, if you can remember? What were your Non-Executive Directors, through their training, encouraged to think about in terms of risk? 11:00

A. Well, would you allow me just to go back to explain about the Board Assurance Manager and the induction. So, the Non-Executive -- 11:00

51 Q. I will come to that.

A. Sorry.

52 Q. Because there is a particular concern that has been raised about that which I want to deal with. 11:00

A. Okay.

53 Q. Can I deal with that specific point in terms of risk.

A. You mean the risk management and how they were inducted to that; is that what you're asking me? 11:00

54 Q. What was the angle? How was that training around risk directed at? What was it directed to?

A. Well, if we were training Non-Executive Directors, they would have been told about a risk register. I mean,

again all the Non-Executive Directors who came under my watch were experienced, very competent people in their own particular field so they would have known about risks wherever they worked. We would have been explaining to them when you come into health and social 11:01
care, honestly the risks are enormous every hour of the day. So we would have been talking to them about risks, how we manage risks, the reporting mechanism through, in my time, corporate governance, and the risk register was held in each directorate and fed up into 11:01
the corporate risk register. I mean, we would have possibly shown them -- and I know Sandra Judt, the Board Assurance Manager, the folder of evidence that she would have given a Non-Executive Director was comprehensive. We would have been showing them what a 11:01
risk register was and maybe some examples. You know, you would maybe have picked one out of what a risk was and how you managed the risk. The risk could have been as great as not filling a consultant's position to actually a suicide in the hospital. You know, lots of 11:02
risks. So, you would have maybe taken one. I do remember workshops that we would have used, risk management and how do you manage risk. The ability to take a risk and to manage risk, and what were the structures you put in place and the framework around 11:02
risks to allow you to take the risks because many days would you have been taking risks.

It would have been quite a light touch, to be fair. I

don't want to be unfair to the Inquiry. I'm sorry, I'm coming back to the induction. You Would have been explaining to them that at the centre of all that we do in health and social care, it is about people; it's about where patients enter the service, whether it be in primary care right through to their end delivery whether they come into secondary care. So, the greatest thing we do every day was to look after people. Therefore, you were explaining to them the risks that come with that, and the importance of quality outcomes and patients' experience. So, it would have been quite a light touch, yes. 11:02 11:03

Non-Executive Directors are very busy people in their own field. They are employed to do possibly a day or two per month, or whatever. So their induction, you were trying to get a day to suit them all. That didn't work. You never got the six or seven people together in the one day. I mean, you were also looking to see the amount of information you gave them, was it overwhelming? I introduced the buddy system because when I and my former colleagues were Non-Executive Directors, we didn't have that so we thought it was good that when you came in, you got a buddy system to one who was maybe more experienced. Then we also introduced that going out to the directorate, to meet the Director and see what was going on. That was very beneficial and we had a programme for that. That also showed them the risk when they were out for them to ask 11:03 11:03 11:03

questions.

55 Q. Just put a marker down, we'll come on later in your evidence to consider issues around the risk to patients, particularly in the urology sphere associated with the lengthy waiting lists which the Trust experienced, which may have been a factor of resources issues and the ability to bring appropriate staffing resources into place at the appropriate time. We'll look at that in a little detail later. 11:04

Listening to what you're saying about risk and what your Non-Executive Directors were, I suppose, told or counselled about during their training, training was light touch in order not to overwhelm - there was a lot of information to take on Board - but you appear confident that at least in their training, there was enough information being given out, enough signals about the importance of taking risk issues on Board and equipping yourself with the knowledge so that you can raise challenging questions? 11:05

A. Absolutely. A Non-Executive Director, when they are appointed, just like a Chair, you start the next day. So once you get your letter, you're in. You could just be arriving on the day of the Board meeting or it could be a few days later. It certainly would have been my job, which I did, I would have given them a brief overview of the Board and the agendas and what was on, but be assured I would have talked a lot about the patients' experience, the quality outcomes and the 11:05

importance of safety. Absolutely.

56 Q. Mrs. Leeson, if I could bring up what she has said about induction training. WIT-99776. You will recall that she was appointed as a Non-Executive Director from in and about January 2017, and she still serves on the Board. She describes her experience here of the induction training. She describes it as being basic. I don't know if that word aligns with your description or your understanding of it. She goes on to talk specifically about MHPS training, saying that it did not sufficiently inform or support her to fulfil the role as a non-medical person, just by way of example, I think. Your sense of the training - and we do have the programme, it rolled over a period of months perhaps so as not to overfeed a new Non-Executive Director with too much information too quickly - you wouldn't appear to describe it as basic? 11:06 11:07 11:07

A. No, and with respect to Mrs. Leeson, who was an excellent Non-Executive Director and one I held in the highest regard, I wouldn't say it was basic. I believe that Sandra Judt was the Board Assurance Manager, and along with my personal assistant, Jennifer Comac, they were my ears and eyes, and they were excellent and I couldn't have done my job without them. Sandra Judt would have put together a very comprehensive pack all around Board etiquette, Board performance, Board accountability and governance, along with all of the other packs that was necessary around Board assurance and risk, I mean, and you took that to read. 11:08 11:08

Absolutely it would have been overwhelming. Then we sent you out on these visits. I'll come back to the Maintaining Higher Professional Standards, if you don't mind, in a minute. I wouldn't have called it basic. I would respect what Mrs. Leeson says, and I believe having heard from Mrs. Mullan it is going to be much better. One of the problems you have with a Non-Executive Director, they are still working possibly in other jobs; their commitment and time to do more training - I can remember that vividly from them all at their annual appraisal and maybe when we would have been talking about training needs analysis - they couldn't have committed much more but I'm always looking to see improvement. So if the Department and someone else can make a better induction for a Non-Executive Director, then that's healthy. 11:09 11:09 11:09

In relation to Maintaining Higher Professional Standards, in all of my years as a Non-Executive Director and as a Chair, I never remember any Non-Executive Director liking this process. We rarely had one in my time, whether it was in a former Trust or not. You may have had only one Maintaining Higher Professional Standards in a year or every 18 months, so you weren't seeing one every month. It is like anything, if you are not familiar doing it, you don't become as competent. I had probably the training at least four times, and it wouldn't have been a maintaining higher professional standard training we 11:09 11:10

would have put in your induction because you may not have been doing all of those for some time. But when we did have the training, and I have listened to the Inquiry about this, my understanding and interpretation of that is somewhat different. I have in my time, when I was a non-exec, completed two. I was always told at the training, which was always done by DLS, my role was a supportive role to begin with. It was a role of one to support the clinician in question, to make sure you were like a conduit to them, that if there was anything that they need or help. It was like a pastoral role, in inverted commas. Plus then the other important part of your role was the timeliness, to make sure that it kept momentum going and that it was meeting its timeframes. 11:10 11:10 11:11

I would say most times consultants didn't accept the Non-Executive Director because they saw it quite as a complicated role, you weren't really independent. I can remember one, maybe two, even phoning me because they couldn't understand if you were the Non-Executive Director, why did you feed back into the Director of HR or Human Resources, and they were the ones wrote you the letter. So, they didn't see you as independent. So whilst I respect -- 11:11 11:11

57 Q. Was that a trust issue?

A. Sorry?

58 Q. It was a small "t" trust issue?

A. Yes, it was a trust. Certainly the ones that came

across, it would have been less in number at the time. So whilst I respect what Mrs. Leeson was saying, it wouldn't have been part of their induction training; maybe again it should. But even if you had had it in your first three or four months, unless you went in to do one, you wouldn't really have been involved in that, but that is what the training was. I should add that, at that time, we had a Non-Executive Director who was ready to retire in the coming years who was also involved in a very complex case, who would have discussed it with me, brought it to the Board and even talked to the Chief Executive about it. I know that's not relevant to this but it's in, I'm sure, past minutes. So whilst I maybe criticised for not the training or it, any training I have been on with respect to DLS, it was good, it was informative. But my understanding of a role, and that never changed during all of my time - however I have heard different from the inquiry -- 11:12 11:12 11:12

59 Q. Yes. 11:12

A. -- but I mean -- and the Non-Executive Directors that are in at that time, and I think most are still there, I would think had training on Maintaining Higher Professional Standards at least four, if not five times. After the one I was speaking of with the other Non-Executive Director in a complicated process, we had training and we had training again during the time of Mr. Wilkinson. So, we had a lot of training, but did it help you to be effective in what you were doing? I 11:12

am just explaining to you what my understanding was when I did them and also my understanding of them when I was the Chair.

60 Q. You reflect in your statement that there were opportunities for your Non-Executive Directors to reflect on their training needs and there were other processes through which, I suppose, training needs or training blind spots could be identified and rectified. You refer in particular at page - I'll not bring it up on the screen - WIT-90850, that there was an annual audit of Board members which permitted self-reflection and then a meeting with you. Then, secondly, the Department of Health had an annual Board effectiveness audit, which addressed how effective the Board was. Again, both of those processes would have allowed training needs, whether as a group of Non-Executive Directors or as individuals to be identified; is that fair? 11:13 11:13 11:14

A. Absolutely. Am I allowed to answer the two parts?

61 Q. Yes. 11:14

A. Okay.

62 Q. In terms of an analysis of training needs, how did that work, in your view? Did it work effectively?

A. Absolutely. If I think of the Board effectiveness, we were the first Board that was selected to do that. I mean, that was a very comprehensive document. You were sent it out in very good notice. The way that I did it -- it wasn't done about with my predecessor, this was a new document. Something tells me it was around 11:14

'12, '13, '13/'14 year that that came out, and we pioneered that. The way I did it under my watch was I asked each Non-Executive Director on their own to complete that assessment tool. It wasn't a tick box, which I have heard. It was an excellent tool to reflect how you individually performed, how collectively the Board did, and the learning and the outcomes. You did that individually as a Non-Executive Director. The Chief Executive did the same process with each of his executive team on the senior Board, and they did it individually. Then the Chief Executive, collectively together with the senior management meeting, brought theirs together. As I did, I then brought the Non-Executive Directors back. We talked about it, what were their scores and what had they recorded. So we had now, at my desk, my completed draft one and I mean the Chief Executive had theirs. Then we actually had a Board workshop to bring that together to finalise it. I mean, then it came to the Board for approval. It was very comprehensive. Actually at the end we were asked to give a lessons learnt, an example within the Trust of learning, and I think if I'm right, we always had someone externally to review it. 11:15 11:15 11:16 11:16

63 Q. Yes.

A. I may be wrong here but I'm fairly sure Ms. Mullan, Eileen Mullan, who wasn't then a Non-Executive Director, was the independent person who came to audit it. We always then had every three years an audit of

that. The audit was completed I think in '15/'16 year by the BSO, the Business Service Organisation. So that was that one. If I could come on --

64 Q. Could I interpose on that the Board effectiveness report for 2018-2019, just on the issue of training and what was picked up on that. WIT-101650 under the heading of "Building and Developing the Board." Let me jump to the third paragraph, interesting in light of Mrs. Leeson's evidence. It says: 11:17

"Whilst NEDs were generally content with Board induction and annual performance assessment processes, it was executive directors who generally did not feel that they had appropriate Board induction and annual assessment of performance on the Board". 11:17

So that's the results of the survey, if you like, or that analysis across both the executive and Non-Executive teams with regard to induction.

A. I remember this. Part of the learning, we accepted that of course, and then we always had action plans. I mean part of that learning was then that I, as the Chair, would meet the executive directors - I'm not talking about the Chief Executive, they had a different appraisal - I would meet the executive directors who sat on the Board annually. I think that happened sometime around -- would it have been the summer of '19 - I don't think it was '20 - the summer of '19. My diary will confirm that each one of those executive 11:18 11:18

directors I met on a one-to-one to actually see how are they getting on, what are some of the risks that they are dealing With, what are some of the pressures that they find. I wouldn't disagree with that, that was the BSO independent audit, that they didn't feel an appropriate induction and annual assessment. But remember the Chief Executive was also appraising his executive team. We didn't get into that but one of the learning points was that I, as the Chair, should have been meeting with them. 11:19

65 Q. Let me move on to examining, I suppose in a bit more depth, your approach to your role. If I can bring up WIT-90853. You explain, just scrolling down, that you were in your office approximately four days per week from early morning to late afternoon. You would have seen the Chief Executive most days. You met with the Chief Executive formally usually once per month, but this was subject to change obviously with busy work schedules. 11:19

11:20

"However most days if myself and the Chief Executive were both in the office, we would have had informal chats and indeed had many cups of coffee together informally for updates".

11:20

Is that intended as a general reflection of your approach throughout your tenure and not particular to one Chief Executive, or is that --

A. No, that would be them all. I'm sure the Inquiry has

been told that the Southern Trust headquarters is located in the old nurses' home building, so it's quite an old building that has been beautifully refurbished but the corridors are still narrow. So if you can imagine my office was in a corridor, a long corridor, I had an interconnecting door with my personal assistant, and next door to me was the Chief Executive's office who had the same interconnecting. Opposite my door would have been the Medical Director, the Director of HR. As I came down the corridor each day, there was the Director of Performance. So you had an open door policy for most of my time there to maybe the latter stages. 11:20 11:21

I would have been in early every morning; I would have been in there as the needs of the job required. I would have had very, very regular meetings with the Chief Executives, all of them formally, but if they were in the office and I was there, they would have popped in to me or I would have went into them, I mean if time allowed; certainly under Mrs. McAlinden's watch and those that followed. I'm sure you are aware, Mr. Wolfe, that every Chief Executive has different styles of leadership. Whilst Mr. Rice was very good with the coffee and had his own coffee machine and the coffee cups always out, someone coming after him may not have had that same style. That is not a criticism, it is just personalities. Certainly in Mrs. McAlinden's time, we would have walked the walk 11:21 11:21 11:22

together to the canteen and around, the same with those that followed, and indeed with Mr. Devlin. But circumstances change in workloads. I mean, Mr. Devlin may not have just been in the office as much but any day he was there, he would have popped in to see me and vice versa, and if time allowed we would have had that cup of coffee. So there would have been no difference how I worked with chiefs. 11:22

66 Q. In terms of your own style, we can catch it just at the bottom of the page there - I think you've said it already in evidence - that your style of management was as a people's persons. 11:22

"If the door were open of a Director office, I would have spoken in to say even a hello; this was well known as my style. The same to all admin and office support staff who shared the same corridor. I walked the walk as well as talking the talk". 11:22

You were a visible Chair. You liked to meet all grades of staff and made time to stop and have a brief chat. 11:23

Just before we come to the next bit, your reflection is different Chief Executives have different personalities, different styles. I suppose the sense of what you're saying there is that you're frequently in the office? 11:23

A. Absolutely.

67 Q. You weren't invisible; you put in long hours?

A. Yeah.

68 Q. You had your own dedicated office which was situated proximate to other senior members of the team. Are you by implication, I suppose, putting across the point that if there were issues of concern, you were there and available to discuss them, and indeed you were always keen to ask questions about what was going on within the organisation? 11:24

A. Absolutely. I would never have passed, as I came in in the morning, an open door. It might have been 7.30/8.00 in the morning, sometimes some of the directors were in at that time; you would never have passed that open door without saying good morning, how's things today, what has happened; much? It wasn't that you were getting involved in the engine room, it was just actually interpersonal skills to me and how you form relationships and communications are the essence of success and that's how I have built my life so therefore that was just normal to me. Absolutely any Director or any Chief Executive that I have worked with, all of them including Mr. Devlin, could have approached me at any time. I mean, I had one phone and I was always, because of my other work, 24 hours a day on-call. 11:24 11:24

Just to give you an example. In Mrs. McAlinden's time, I can remember five to twelve at night, she rang me to say we were going to have one 12-hour breach in the Emergency Department. I remember it well. She took 11:25

her work extremely seriously and would have phoned me and I was always at the end of a phone. One can see from evidence and indeed listening to media that 12-hour breaches now, there is maybe 500, 600 per day. But I can tell you that every Chief Executive that I had would have phoned me about any serious concern - and I could list you numerous ones but time doesn't allow - I had no problem with that. Indeed, a Director would have phoned me as well if the chief wasn't there. So I was very approachable, I was very visible and I was always contactable. Always. 11:25 11:26

69 Q. You go on as part of your description of your role to reflect, I suppose, in the negative:

"I never", "I never formally or informally discussed Urology Services or Mr. O'Brien with any member of SMT". 11:26

Just dealing with the first part of that, I suppose, why is it the case that you never informally or formally discussed Urology Services with any member of SMT? 11:26

A. Because I don't recall ever any senior manager - and the only ones that could have been talking about Urology or Mr. O'Brien would have been the Acute Director or maybe the Medical Director or whatever - but I never remember any senior manager, and we're talking about the executive team, talking to me either on the phone or informally to discuss Urology Services 11:27

or any concerns about Mr. O'Brien.

70 Q. Maybe you had intended to connect the two, I am asking you about Urology Services generally.

A. Never. Never.

71 Q. We'll come on this morning to look at how the circumstances and the challenges of Urology Services featured on the corporate risk register from time to time, how it was the subject of performance reports from time to time, and there were obviously serious adverse incidents arising out of Urology. 11:27

A. Yes.

72 Q. Leaving aside Mr. O'Brien in that sentence, is it really the case that Urology Services in general was never the subject of conversation between you and senior management? 11:28

A. Just to correct, I was taking that about me as a one-to-one with. Of course Urology Services, along with many other aspects of service delivery, came to the Trust Board through performance reporting and on the risk register. My apologies. I'm taking that that 11:28 I never formally discussed on a one-to-one Urology Services but it definitely came on a performance report. To give you an example as well, until my last maybe 18 months, I chaired every appointment for a consultant; I didn't miss any, I don't think. Then I 11:28 introduced Non-Executive Directors to start learning because I knew I was going out in the latter stages. I mean, I would have sat on so many interviews, that's where I collected what I call my soft information. I

mean you met so many people normally. The Medical Director I would have chaired them, they would have been on, not all of them attended but in their absence would have been the Associate Director, Clinical Director and then maybe one or two consultants from that speciality. I mean, you would have talked to those kind of people, not only about be it urology or indeed what other the specialism was. I'm referring there I don't recall individually anybody coming to talk to me about Urology, but definitely it came in the performance reports and through other means. 11:29 11:29

73 Q. Yes. We'll look in due course at what that looked like. Just to complete the sentence, no discussion regarding Mr. O'Brien with any member of the senior management team. Just on that, I wonder if that is quite correct. We'll look in due course at whether you had even passing discussion with Dr. Wright, with Mr. Rice, with Mr. Devlin, with Mrs. Toal about Mr. O'Brien and processes that were about to be put in train or were in train in relation to his practice. We'll come to that in some detail later. 11:29 11:30

Isn't it fair to say that you were, from time to time, kept in the picture about developments in respect of Mr. O'Brien, even if those conversations may not have descended into an awful lot of detail? 11:30

A. Oh, yes. I mean, when Dr. Wright first came to tell me, I did have that conversation. That was under the watch, I think Mr. Rice was the Interim Chief Executive

then. He would briefly have mentioned it. You know, that was informal coming to tell me.

74 Q. But that's the point I'm making. That sentence isn't just quite right when you reflect upon it. There were, and we can examine later the extent to which those conversations were sufficiently detailed or whatever the view might be, but some conversations did take place with regards to Mr. O'Brien over the years? 11:31

A. Oh yes, with the Medical Director and the appropriate Chief Executive. 11:31

75 Q. You have explained that in terms of the work that you did as Chair, you had an annual appraisal every year and at no time did the Chief Executive, senior management team, Non-Executive Directors or indeed Permanent Secretary ever raise any concerns about the performance of your duties; is that fair? 11:32

A. Absolutely, never. You know, I did complete a comprehensive process for my appraisal. I mean, you would have been notified by the Department. Over my years I would have changed the -- I introduced for myself a 360 degree asking staff that worked to me what did they think of me basically, and it covered a lot of areas. I mean, I asked them to complete that. Most of them did. I don't remember many whatever didn't have them back. I used that to reply. You complete -- it is quite a comprehensive document, the appraisal for the Chair. Then it was sent into the Department and then you had a formal meeting. 11:32 11:32

76 Q. Yes. We'll come on in a moment to look at some of

that.

Mr. Devlin and your relationship with him is perhaps important in terms of the work of the Inquiry because he was the Chief Executive in place and you were the Chair in place when the issues of concern to the Inquiry flared up. If I could bring you to his witness statement, WIT-00095. Just at the top of the page, he says that in terms of his work with the Board: 11:33

"One weakness from a personal reflection is that during my early tenure the relationships between me and the Chair, Roberta Brownlee, were not as strong as they could have been. Outside of public Trust Board meetings, we had clashed a small number of times on the difference between the roles of a Chief Executive and a Chair. In my opinion, given the lack of consistency of personnel in the Chief Executive post prior to my tenure, the Chair had understandably become more involved in the operational delivery of the Trust. As the new Chief Executive, I found her approach overreaching and in many cases unhelpful. On reflection, I know that this imperfect relationship may have had an impact on the functioning of the Board and I know, through discussion, that some members of the senior management team found the relationship with the Chair difficult at times". 11:34 11:34 11:35

Your reflections on hearing that have been set out to

some extent in your own witness statement where you described a good relationship, and that you say never clashed to the best of your understanding or recollection?

A. I mean, this was a real surprise to me. Shane and I got on very well. I note what he says. I was not aware, nor never did he make me aware, or indeed any other senior manager mention anything to me about the relationship. I find that actually quite hurtful and stressful that other members of the senior management team found the relationship with the Chair difficult at times. I never was aware of that and it was never brought to my attention. Certainly I'm sure you've got many copies from all of the executive team their reflection on me, because those would have been held in my office by my assistant. I don't remember any clashes. It's how you describe "clashes". I don't remember that. 11:35 11:35 11:36

I think if I've read somewhere - I hope I'm correct - he named one of those was a visit of the Permanent Secretary to a quality improvement, or something he mentioned. If I would be allowed to explain that. I probably, with my Non-Executive Directors, attended many functions within the Trust on quality improvement and innovations; excellent, some really excellent stuff. I remember there was one in Dungannon in a venue and myself and two or three others would have attended. We would have attended just to see and 11:36 11:36

learn, we weren't participating. During that time, the Permanent Secretary arrived. Now, Mr. Wolfe, I didn't know he was coming nor did I meet him on that occasion. I did remember saying to Shane afterwards it would have been good to know he was coming. I do think out of courtesy, if Non-Executive Directors and I have gone to the trouble to go to an event like that, if someone had even said by the way, Richard Pengelly is coming, you have no role to play with him but he will be there, we were learning that both during the event and after. I do remember saying that to him. I don't think I was very critical of it but I just said I would liked to have known. Going by previous Chief Executives, that would never have happened, never have happened. I think that may have been one that he clashed or that he refers to. I think the other one, no doubt you are going to come to anyhow, was around governance and the review of clinical and social care governance, so I'll not go into that. 11:37 11:37 11:37

77 Q. We will come to that very shortly. Do you accept that viewed from your perspective, Mr. Devlin's approach to initiating a clinical and social care governance review, which was conducted by Mrs. Champion from the Leadership Centre, his approach to that was a matter of concern to you and in a sense you clashed with him by telling him about your unhappiness? 11:38 11:38

A. Yeah. Well, probably clash isn't a word that I would often use in my vocabulary, but I would respect it if that's what he called it. Every Chief Executive in a

substantive post, Mr. Donnelly and indeed Mrs. McAlinden, Mrs. McAlinden did a major piece of work in relation to clinical and social governance review and governance, corporate governance; a huge piece of work, and a lot of implementation of new changes and structures that were put in place. But she would have discussed that with me and with the Non-Executive Directors, the terms of reference would have come to the Board and we would have had a discussion of all that involved. I think the Inquiry has before them lots of emails to'ing and fro'ing regarding this. I mean, I wasn't aware that we were having a clinical and social care governance review. I mean, that's --

78 Q. I don't wish to stop you unfairly, we are going to come to that after the break. Just let me finish this section and we can look at the context in which that CSCG review commenced. Just to elaborate on what Mr. Devlin said in order to explain his experience of working with you, he suggested in his oral evidence - this is TRA-01094 - that you had, as he described it, huge authority and power in the organisation. He said he couldn't ask a Non-Executive Director - this is line 19 - he couldn't ask a Non-Executive Director for help - I'm paraphrasing here - without getting permission from you, yet you could walk into and speak to an executive Director without issue. Is that the way you organised?

A. No, I wouldn't have seen it like that. We're talking

about walking into the office. Not all of the directors were in that corridor. For example, the Director of Social Work and Young Peoples' Services as well as the Director for Mental Health weren't on our site so I wouldn't have been able to walk into their office. I mean, I do think it's good practice if a Chief Executive wants to engage. There was no harm in talking to them, I'm sure he talked to them often and I wouldn't have known. I do think it's good practice, and we would have had that, that if you were going to use the services of a Non-Executive Director, for whatever it might have been to be part of... I remember Eileen Mullan was involved in a part of a risk management review, and that was discussed and it was nominated that she, because of her experience, would do that. Of course that happened. But it was good to know if he needed a Non-Executive Director, for whatever role he wanted them, that I should be informed. It wasn't, Mr. Wolfe, that I didn't allow him, as is maybe being perceived, to talk to them. 11:41 11:41 11:41

79 Q. It was a sense that he had to formally request permission of you is how he put it?

A. Well, I wouldn't agree with that. Yes, it would have come through an email, or indeed it maybe came up as an action point from a Board meeting or the governance meeting or one of the other sub-committees if a Non-Executive was to be involved in, say, one of the subcommittees under the Medical Director area, and then you would have formulated which one will do that, I 11:42

mean through an email, if he calls that formally asked. But, I mean, I don't really understand what that means, to be honest.

It sounds actually quite harsh that I didn't allow him. I mean, I know Ms. Mullan and Mr. Devlin, and rightly so, would have had a lot of conversations together around governance and risk when I wouldn't have been there and I didn't know about them, and that's fine, it wasn't that kind of relationship. But what he is describing there I think isn't just as balanced, I mean about me walking into an office. I would never have asked a Director to do anything without having gone through the Chief's office on any occasion. 11:42 11:42

80 Q. I think within your witness statement you point to the review of your performance conducted by Mr. Devlin as indicative of a more positive view that he held of you than he has perhaps allowed for in his evidence. If we just look at that specifically, WIT-90934. You can see the period in play here, April '18 to March '19, so roughly his first year in post as Chief Executive. The scorings are 1 for very effective and 2 for effective. If we scroll down the various indicators or qualities, it's all ones and twos, so effective or very effective. 11:42 11:43 11:44

He explains in his evidence, Mrs. Brownlee, that he hoped that this document would be an opportunity for a conversation to improve your relationship with him. He said he found it -- this is TRA-01798. Just look at

the detail of that. If you can see what he said. He had hoped that this document would be an opportunity for us to have a conversation about how we could improve the relationship. I put the point to him that most of the assessment of you was very effective or effective, and he agreed with that. Scrolling just down to the next section, he was seeming to suggest that, as we can see at the last section there, he was regarding a score of two as not being overwhelmingly positive. He says: 11:45 11:45

"I had hoped that by calling out a small number of twos, there would be a point of conversation that we could have had around those to explore why I felt it wasn't the top mark". 11:45

He went on to say he found it very difficult to give feedback to you because feedback was often not accepted in the way that it was meant. Is that a fair comment, that you were somewhat prickly around any form of criticism even if that criticism was intended to be constructive? 11:46

A. Absolutely not. I mean, first of all about this tool, this was a tool I was asking others to complete. I didn't expect to get the top mark in each box. This was a learning and this was for me to set my objectives with the Department for another year and I would have used that, so I didn't expect that. It wasn't a tool that I also, when I see what Shane writes here of an 11:46

opportunity to come back -- I'll come back to the criticism that he says in a few minutes. Shane was a very competent, capable, confident Chief Executive who I met very often. I did his setting his objectives. I mean, we had many conversations. So honestly, 11:47
Mr. Wolfe, if Shane had a problem with me, I would believe he could have told me and should have told me. I don't recall him ever being critical of me, I mean personally or professionally. I don't remember him ever bringing that to my attention, or indeed anyone. 11:47
If he means within the Boardroom and setting agendas, he, along with the Board Assurance Manager and myself, set the agendas, and I believe I afforded him every opportunity at that to talk and to do whatever. So I don't know where he is referring to that he couldn't 11:47
approach me or, when he did be critical of me, that I didn't respond well. If he could give me examples of -- maybe it's too late to ask that but I would have liked to have known give me an example of where you are critical of me and I didn't respond well. I have not 11:48
read that in any of the documents that has come before me, but I don't recall ever having a criticism.

Look, we agree to differ, all Chief Executives, that's a healthy environment, but I had the greatest respect 11:48
for Shane Devlin and I gave him that respect. Him and I did a lot together and he did a lot of work. I knew a lot about his family, we exchanged gifts. I mean, when I was leaving if this guy didn't think much of me,

why did he write and send me this? I can't understand this, Mr. Wolfe.

It was the same when we come to the senior management team. When I was leaving, I wanted no farewell or any gifts or anything, but the letters I got via my personal assistant are commendable, from the senior management team at levels, and indeed from Mr. Devlin. So I just want to put on record that I had no recollection of any time Mr. Devlin and I not working well together. 11:48

81 Q. I know I am pushing my luck with the break but if I can put one final in this section to you, and, subject to the Chair, we can have a break. 11:49

If we go back to WIT-90881, which is your witness statement again, and the third paragraph. You say:

"As Shane rightly says, there has been some lack of consistency in personnel in the Chief Executive post and associated instability. I felt that my position as a longstanding Chair provided much needed stability for the NEDs and I had built a very good professional relationships with them. This is what Shane was unsettled by". 11:49 11:50

Could you help us understand that. Is this your rationalisation thinking back and taking into account what Mr. Devlin has said about your relationship, or

had you some sense as you worked with him that he was unsettled and perhaps intimidated by the strong relationships that you say you had built with your fellow NEDs?

A. That's probably what I believed whenever he was in for a while, Mr. Wolfe. Shane would have seen, when I went to the canteen, the number of staff that would have come over to talk to me, or even the ladies serving the tea. I mean the leading cleaning the corridor, et cetera, I had a very good relationship with. He would have known I had a very good relationship, and I did have until I left, with the Non-Executive Directors, absolutely, and the same with the senior management team. It was the same, when I would have been out for a walk or in the main canteen, I was well known, people came to talk to me. You know, it was only maybe a sense he probably felt that I knew a lot of people and it will take him time. I had never worked with Mr. Devlin before, he had never worked in my time in the Southern Trust, so it takes time to build. 11:50 11:51 11:51 11:51

Another point, and it might be soft information, maybe I am fairly wrong, but during all previous Chief Executives, Director's doors would have been open and you could have went in. I mean, then they were closed of course for when they would have been doing their business. Maybe not relevant at all but I noticed from when Mr. Devlin came, over a period of time, doors were closed and there was a much more closed approach. Now, 11:51

that's a personal observation. I would have thought my years of experience and how my style was with people - you used the word "intimidating" - it probably may have -- he may have thought it was too much. I mean but sorry, that's my style and I would have known my staff at every level. I did visits to the laundry. I mean, you just knew your staff well. Remember, that's how you are going to get feedback. When we introduced leadership walks, if you are approachable and you meet people out, they will say to you, you know, something. That's probably what I meant and I don't think he particularly liked that but, I mean, that's not an unfair criticism of him. 11:52 11:52

As far as I am concerned, during all of my time with Shane we had an excellent working relationship. We worked well together as a Chief. I gave him his place, I kept the blue water between us as best I could. Whilst he calls them clashes, that wouldn't be a word I would often use. I can only think of those examples. I don't call it a clash. It's regrettable but it was regrettable to me as an experienced Chair and someone who is totally committed to their role to read through an inquiry that the Chief Executive had a problem with me, and indeed he refers to others -- 11:52 11:53 11:53

82 Q. Yes.

A. -- whenever we did a lot of reflective in-practice. We did a lot -- I mean, if you look at the evidence in 2018 and '19, we did a lot of work on the values within

the Trust, and the culture. We were really committed to that. Again, I am amazed when people say the culture.

83 Q. We'll come to that. Thank you for that answer. Subject to you, Chair? 11:53

CHAIR: We are going to come back, ladies and gentlemen, at 12.10. Thank you.

THE HEARING BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 12:18

CHAIR: Thank you, everyone. Mr. Wolfe.

MR. WOLFE: I want to move on, Mrs. Brownlee, to explore with you how, during your time, you experienced the area or the Trust's approach to the area of clinical and social care governance. Let me start by what you said in your own statement. WIT-90856. You say: 12:18

"As Chair, I regularly assess the systems through internal audit, external audit, Board assurance, framework, performance reports, Board committee minutes, serious adverse incidents, Medical Director and Director of Nursing reports to the Board, patient safety and quality of care reports to the Board, corporate risk register, and the management statement signed by the accounting officer". 12:19 12:19

That's governance in general but aspects of that are clinical and social care governance. You go on to say

that:

"Each Chief Executive that I worked with undertook a clinical and social care governance review as well as the high level overarching governance reviews generally".

We'll come on to look at some particular aspects of how you looked at governance, or how you used governance tools yourself, later. Help me with this: Various Chief Executives do their own review; by the time Mr. Devlin came into post in April 2018, how would you characterise the state of clinical and social care governance within the Trust? 12:19 12:20

A. Probably, Mr. Wolfe, what I meant there was each substantive Chief Executive, it wasn't any interim reviewed, did a formal review. Certainly during Mrs. McAlinden's term, there was an extensive review of clinical and social care governance and corporate governance at the highest level. At that time when that review took place, she brought the mechanism to the Chief Executive's office, if you know what I mean. She was the lead for that. There was an extensive review then. I may not remember all of the detail but it resulted in each directorate - and that was the same in community care as well - had their own risk register and their own teams of people reporting into that. Then she would have had regular senior management team meetings with her Executive Directors and would have 12:20 12:21 12:21

looked at the governance within each directorate. The Chief Executive also would have met with her Directors very often for formal meetings and one-to-one meetings, and at least half of that time would have been on the individual corporate risk register in that directorate, 12:21
so there was time spent on that. There was, I mean, a different emphasis during her time put on governance, overarching we'll call it. I mean, there were structures put in place and different people changed roles. So as far as I am concerned, under her skilled 12:22
management and leadership the governance arrangements in the Southern Trust were as good as they could have been with all of the information flow that should have come.

12:22

We had a Board Assurance Manager, Sandra Judt, who was separate to me and the Board. She had a huge responsibility in relation to Board assurance, standards and guidelines, and was really independent really to the rest of the team, and would have been 12:22
very well informed and kept me informed as well. So I would have been very satisfied when Mrs. McAlinden left, I use the analogy, that the engine was well-oiled, it had been very well reviewed, she put in excellent processes around. For example, if I take, 12:23
say, nursing and medicine, the Medical Director, what was reporting in on his report all around re-validation; doctor that was failing, or GMC; I mean, health care acquired illnesses, to serious adverse

incidents, lots of different feeding into that triage of work. The same in clinical indicators as well, and the same in nursing. I mean, they had their quality nursing standards,and all that came in about workforce and all et cetera was in that. So, Mrs. McAlinden left 12:23
a legacy of a very firm, integrated governance system within the Southern Trust, and it was never -- I was never aware we hadn't enough staff, I mean to manage that all. Let's be honest together, we never have enough staff anywhere in health and social care but 12:24
nobody, or Mrs. McAlinden, brought it to my attention. The new structures she put in place were very effective and worked well.

84 Q. Very well.

A. Therefore the Chief Executives followed her followed 12:24
that per se. Nothing changed there, there was a lot of fuel and it went. Yes, when Mr. Devlin came in, as I would have expected, his overview with the Medical Director, et cetera, he wanted to do a clinical and social care governance review. 12:24

Certainly I never had any concerns about the reporting mechanism of clinical and social care governance to any of the Board committees and how it was reported in to us. You are aware of the subcommittees -- 12:24

85 Q. Just to be clear, you're characterising the clinical and social care governance structures and environment in fairly positive terms?

A. Yes. Yes.

86 Q. You appear to have had a high degree of confidence in it?

A. Yes.

87 Q. Just to be clear, if I can put this in broad terms, the Inquiry has received evidence that because of budgetary pressures perhaps, perhaps also because of the cultural issues, clinical and social care governance wasn't in a good place by 2018. Take, for example, the area of audit. Audit - perhaps I exaggerate slightly - had collapsed, there wasn't the money to resource posts. People were moved out of audit into other posts. That had an effect within, for example, within the patient safety environment in that we have heard that the clinicians who led on the Morbidity and Mortality Committee witnessed an environment where audit was not well pursued, not well organised and not well supported. Did that kind of thing reach your ears? 12:25 12:25 12:26

A. You mean clinical audit in the Medical Directorate?

88 Q. Yes.

A. I am not aware of the Medical Director's report ever informing us that there was changes in clinical audit because of workforce issues. I mean, that is from memory and in my recollection I don't remember that. I believe that the staffing that was in clinical and social care governance, right people were in the right place, I mean. Clinical audit or nursing audits are only as good as the tool that you have and the people doing it. So therefore I believe that audit, whatever way you talk about audit, can and should be done 12:26 12:26

regularly, there should be a tool that completes it. When it's not being done, there should be Early Alerts or letting us know through a flow of information. I would have expected that to have come not only through the Medical Directorate but even in an Acute directorate, if audits weren't being undertaken, say in relation to infection control or tissue viability or whatever some of these things were, I would have expected that to come through the audit and say we are not achieving that. 12:27

Remember our leadership walks when we went out, and maybe we weren't there enough, but nobody raised any concerns with me that audit wasn't being completed, and certainly I wasn't aware. I knew about the M&M meetings, sometimes the attendance wasn't as good again due to pressures of work, but I wasn't aware that it was because of clinical audit not being done. It certainly didn't reach my level. I don't recall ever reading that on a medical director's report. 12:27 12:28

89 Q. Let me put it to you so that I can have your comments on where Mr. Devlin saw it when he came into post. If we go to his statement at WIT-00036, and just at the bottom of the page. He reports that in 2019 he commissioned two reviews to provide assurances around clinical governance processes. He says: 12:28

"Having worked in other Trusts, I was concerned that the assurance processes were not as robust as I had

been used to. In particular, the importance of a completely integrated governance system was not as explicit and, in my experience, felt underresourced".

Therefore, he progressed with two reviews. First of all he refers to a Trust Board development workshop and, secondly, he deployed the Health and Social Care Leadership Centre to undertake an independent review of clinical and social care governance within the Trust. 12:29
If we go over the page, please, he reports that that review led to 48 recommendations, and we'll come to that in a moment.

Just on down to the bottom of this page again where he further explains the concerns that he observed and 12:30
which led him to initiate this review. He was concerned that the system was disjointed and not operating as he had experienced in other HSC organisations. He makes the following additional points: "The level of expenditure on the governance 12:30
functions felt light", and he refers to funding concerns in SAI management, complaints, as well as standards and guidelines. He says there was little evidence of systematic and dynamic flow of clinical and social care information to the senior management team 12:30
on a regular basis. His concern, he goes on to say, was that the evidence that was raised was based on a push system, as he called it, from the directorates without a regular systematic review process.

Thirdly, he says that the level of data and statistical evidence being brought to the SMT in respect of quality and safety was lower than what he was used to in other organisations.

First of all, that, in light of what you reflected on a moment or two ago, would appear to jar with your experience?

A. Certainly that wasn't what I had found or been reported to me or noted missing. However, I respect what Shane is saying here. He was the New Chief, he is the Accounting Officer, he had a breadth of experience of working in other places. Of course, any new Chief or leader brings with them a breadth of knowledge and experience to introduce new things. So, I mean some of this I would not have known because they are operational, I mean in relation to what comes to the Board. If he was identifying this with the senior management team and the flow not coming, he was absolutely right to do something about it and that's what he was assessing there.

That wouldn't have been what I had found previous to that because all I can say is the reports coming through from, say, the Nursing Directorate or indeed the Medical Directorate covered, you know, serious adverse incidents, complaints, any Early Alerts. I'm just thinking of the medical at this time. Infection

control, shortages of workforce. I mean it would also have identified -- I remember, I think it was Dr. Wright's report of '15/'16 year, where he was reporting then out of the four years of five of free validation and appraisal, we were at 100%. We had all of that flowing in to that. So I wouldn't, from my experience, have thought there was anything wrong with that, unless someone else. 12:33

I mean in the governance leads in each as they were feeding in, I would have expected them to identify weaknesses as well. You had the same then in nursing and of course in social work, et cetera. I didn't identify that from my experience. Also, I wouldn't disagree with him when it comes to budgetary restraints. I mean everywhere in the Trust, you know there was no lucrative money or else anything extra. You know, the budgets were tight, there is no doubt. The delivery of health and social care is extremely expensive and the demand and capacity was enormous. So, if he had found that it wasn't properly funded to be able to do the SAIs or complaints, or to manage standards and guidelines, we were really strict about those and how those reported in to the Board assurance framework and through the control standards, how many did it receive; I'm just using it as an example. I mean standards and guidelines, there was huge numbers that came in from both the Department, maybe from RQIA, the Public Health Agency. You know, the assurance of 12:33 12:34 12:34

knowing when they came in, how they disseminated and of course appropriately what action was taken.

90 Q. But we have also seen in the evidence how the Trust was struggling with those as well. I suppose the point perhaps by way of explanation is this: You didn't appear to realise that there were the kinds of problems that he, perhaps with more of an expert or specific operational eye, was able to identify. 12:34

We started this morning, I was asking you about whether there were any problems created by the absence of a dedicated Chief Executive for a number of years. Isn't this the kind of thing that can happen when you don't have a permanent Chief Executive taking a comprehensive overview of his organisation. With all due respect to the three or four incumbents who held the reins temporarily, this is the kind of area that requires a degree of dedicated focus; isn't that right? 12:35 12:35

A. Oh, yes, yes. A permanent person coming in is looking at all aspects of the business. I would have expected a Chief Executive to look at all areas, and especially governance. I don't remember Shane ever bringing that to my attention but I wouldn't have expected him, those are operational issues. If he, with his team, wanted to make changes on that to improve services and better outcomes, of course. 12:35 12:36

91 Q. Before we look at what Mrs. Champion found, could I just look at your response to Mr. Devlin when the report from Mrs. Champion was available. If we go to

the Board minutes for 27th February 2020. They are to be found at WIT-00583. Mrs. Champion's draft report was available at the tail end of 2019, and the report was the subject of discussion at this Board meeting. If we just scroll down a little; there we are. Sorry, just scroll up slightly. 12:37

You're recorded as saying that you felt very offended by the report in how it was written in relation to the Trust Board. You say, for example, you were named as a contributor when, in fact, you had not been involved and only met the author at the final draft stage. You say whilst you agreed with the Chief Executive that he can undertake a review at any time, you understood that it was a review specific to clinical and social care governance, yet it went wider than its terms of reference and strayed into corporate governance, which you felt should have involved yourself and the Non-Executive Directors. You made the point that the Trust Board has a responsibility to ensure that the Trust has effective systems in place for governance and therefore it was important for the Trust Board to have a discussion on the report and agree a way forward. 12:37 12:38 12:38

It is the case that in the summer of 2019 when the report was still being developed by Mrs. Champion, she spoke to you and interviewed three of your Non-Executive Directors? 12:38

A. Yes. Can I go back a little before that, sorry?

92 Q. Yes.
A. I mean, I had absolutely no problem with the Chief Executive doing a review of clinical and social care governance and its importance to make sure around the quality and safety for patients. I had no problem at all with that. My point was we didn't know, myself and the Non-Executive Directors. Therefore, I felt that the Chief Executive should have at least sent to me in an email 'I am going to look at clinical and social care governance, I am engaging with lady June Champion', et cetera, and that would have been fine. But we never saw the terms of reference. So, Mr. Wolfe, at the time the Board Assurance Manager, Sandra Judt, always would have met with me meticulously to have gone through preparation for the Board, what reports were coming, and a draft agenda. When I met her, this is the first I heard of it. She said there is the draft report, the Champion Report, coming, and I said what's report is that? She is said that's the governance report. I said goodness, you know we hadn't been involved in it at all. 12:39 12:39 12:39 12:40

We'll move on then quite a bit of time. Then when I spoke to Shane about it, he did say that -- and when I looked at the report, Mrs. Champion's draft report talked about the Trust Board; it talked about myself. I had never been a contributor to it, none of my Non-Execs. I would have thought, right, Roberta, you might have missed something. I said to Sandra, what 12:40

was this all about. She explained - she was excellent in her role around governance - what all was happening. I said well, had he met, say, Eileen Mullan -- has the lady met Eileen Mullan, the Chair of Governance, or any of the non-execs, and she hadn't. So I said to Shane I was concerned that a report was coming to the Board in draft form naming myself and others, and we weren't contributors to it; I hadn't been informed we were looking at the overarching governance, not about clinical governance, and I said would it be possible for me to meet June Champion. I should also add, Mr. Wolfe, that the Champion Report and outcomes came in at the very latter stages of my tenure so I wasn't involved in the embedding of them. 12:40 12:40

12:41

Anyhow, I did meet with June and, yes, it was around summer time. I mean, June did tell me have you seen the terms of reference and I said no. She said the terms of reference have now been expanded to look at -- and she was apologetic. I said to her I did think it important if we were going to look at the totality of governance, that she would need to have been meeting possibly with myself but certainly with the Chair of Governance. That's whenever I started a flow of emails, which I think is before the Inquiry -- 12:41 12:41

93 Q. They are. They are.

A. -- about asking. And even Eileen Mullan, who was the Chair and an excellent Chair of Governance, I mean you will see she wasn't aware of it, and indeed expressed

concerns about what was written at the end of it, and had asked others. I think Mr. McDonagh was asked. We had an excellent other Non-Executive Director in Governance, Siobhan Rooney, and Siobhan had already brought to my attention that she was concerned about the content. So that's how that all began, so yes --

94 Q. Those emails that you referred to, they are of course before the Inquiry.

A. So that was --

12:42

95 Q. And they date from primarily August 2019. The final draft of the report wasn't produced until later in the year, so while you have certainly concerns, and we've heard from Mr. Devlin that he, upon reflection, has taken on Board those concerns in terms of the way he handled it, and he said in his evidence that "In hindsight I could have done a lot more with the Chair and non-executives in advance to warm them up to the report". This is TRA-01653.

12:42

A. With respect, he didn't involve us at all.

96 Q. Is it not fair to say that by the -- and you're certainly -- your evidence would appear to be correct that until you raised concerns, arrangements weren't made to speak to the non-execs but the non-execs were spoken to in advance of the completion of the process?

12:42

A. Yes. The report was pulled back then and June agreed to see three non-execs. It was the summer months, which is extremely difficult to get a sample of non-execs from the Governance Committee. I think we picked Eileen, of course, because she was the Chair, I

12:43

think Siobhan Rooney was one and I think Martin McDonagh was the other to try and see her.

97 Q. That's right.

A. And then I had a time with her. That was all good, that is all about collecting evidence from different areas. Then so that naturally pushed the report back and then the report did come back then at a different time. I suppose what the minute is trying to say, be it clumsy or otherwise, that we were expressing concerns about not the clinical and social care governance review, it was the overarching review that involved the Board and named the Board and yet the Board as such didn't contribute. 12:43 12:44

98 Q. Now, that's a problem of process and we have your evidence on that. Let me move to the substantive findings or recommendations of the report, of the review, and let me have your views on that. 12:44

The executive summary of the review is to be found at WIT-00509. If we just go three-quarters of the way down, the report provides analysis and recommendations throughout Section 4, and we'll look at some of those. Mrs. Champion explains: 12:44

"Good governance is based on robust systems and processes by which the organisation directs and controls their functions in order to achieve organisational objectives". 12:45

The Trust, she says, has in place the required elements of good governance framework, and she sets some of the key aspects of that framework out. What she then goes on to say is:

12:45

"The Trust Board subcommittee structure is less well defined and requires revision. Senior stakeholders identified a lack of connectivity across the existing governance structure and a lack of a robust assurance and accountability framework which added to the 12:45
perception that the core elements of integrated governance were being delivered in silos with various reporting lines, corporate, directorate, professional and expert advisory committee. The proposed revised good governance structure will provide the Trust with 12:46
an assurance and accountability framework which will also address the concerns expressed in respect of existing accountability and reporting lines to the Trust".

12:46

When you read that, Mrs. Brownlee, coming towards I suppose the end of your time as Chair, did that disappoint you, that here was a person experienced in governance arrangements reporting back to the organisation that all was not well? 12:46

A. Certainly when I read that, it was important to note that and I was delighted that June Champion had identified that. That's what you would have expected in a governance review, someone independent coming in,

looking at how we were doing our business and identifying weaknesses. That's healthy. I mean, it was disappointing, and I am assuming the senior stakeholders were, of course, contributors like the Non-Executive Directors. Again, the three people that would have been contributing from their background would have had a wealth of experience in that. So, it didn't disappoint me or indeed shock me that I was offended, if you know what I mean. It was actually good to know and healthy that the Chief Executive, here we are now, here's the findings and this is going to get better, you know. So it wasn't that I was offended because I was there and it hadn't been picked up. I mean this is all about teamwork and therefore someone independent identifying the lack of connectivity and governance processes that could be improved, you know, is just to be encouraged and healthy and let's get on with it. So it didn't -- it caused me, yes, concern that we hadn't identified it sooner; good we'd a Chief Executive in, good June had found this, now let's see the report and now let's see the action plan and the flow from that. 12:47 12:47 12:48 12:48

99 Q. You say it was good that it was spotted, we hadn't spotted it sooner. What do you put that down to?

A. Well, I just put that down to actually again people not informing us. Was this not telling us what wasn't as good or was this opinions of others? You know, I think governance and audit is very individual and is very personal and everyone has an interpretation of it in a 12:48

different way. I mean not unlike when you come to talk about my leadership walks with my Chiefs, those were the pillars of governance I believed and why we had those headings. So therefore, I'm disappointed that the Directors who were the post holder and the accountable person who we held to account in each directorate through their structures hadn't identified some of these weaknesses. That's what I would have expected, be it in the Medical Directorate, the Acute Directorate or wherever. If your governance processes are working well and you're doing your audits and you're having the clinical outcomes expected and the quality indicators, I mean if that's all flowing and working well, good. But I wouldn't, or my non-execs, have known if it wasn't informed to us through means of reporting what was being reported to the Board. 12:49 12:49 12:49

100 Q. Let's look at one or two of the specific recommendations that Mrs. Champion made. As I said, there was some 48 or so. I understand that the recommendations regarding the Board were not taken forward, that's certainly Mr. Devlin's evidence; certainly not taken forward at that time. That may have been a casualty of your concern that the Non-Executive Directors were not properly, in your view, engaged in the process. Is that correct, is that your understanding? 12:50 12:50

A. Well, I respect what you say but I wasn't aware of that detail of what he is saying that the Trust Board didn't do. I mean, where I see the subcommittee and the

governance committee of the Board and the audit committees is where you feed this all into.

101 Q. Yes.

A. And therefore if any of my Non-Executive Directors, being the Chair or otherwise, hadn't identified these, or indeed when they were identified, we didn't take action, then of course it's a weakness. But I didn't see it that way. 12:50

102 Q. The recommendations, let me look at them briefly. If we go to WIT-00560. There's recommendations around good governance structures, including specifically Board governance. The question I was putting to you - I'm not sure you picked it up correctly - Mr. Devlin's evidence was that it was agreed that these recommendations wouldn't be taken forward at that time, and I was asking you is that your recollection and was that as a result of your concerns about how the processed been handled? 12:51 12:51

A. No, definitely not, I mean why they wouldn't be taken forward. I do remember this now this is before me. Like, for example, the Chair of Governance Committee should be involved in the development of the agenda and the cycle of reports. Well, with respect to Eileen, she was a very skilled governance person, and Eileen would have been involved in the development of the agenda with the Board Assurance Manager, I mean before -- 12:52 12:52

103 Q. Sorry, I don't wish... It is beyond the scope of your evidence to unpick all of these. I suppose what I'm

asking you is, just to repeat, these Board governance recommendations were held back, according to Mr. Devlin?

A. Well, I am not aware of them being held back. Definitely not. 12:52

104 Q. There were recommendations across 14 other areas. Let me take you to clinical audit. If we go down to WIT-00563. At the bottom of the page, the recommendation is set out as follows: 12:53

"The 2018 clinical audit strategy and action plan should be reviewed and updated. The Clinical Audit Committee should be reinstated and the reporting arrangements considered in the review of the Trust Board committee structure". 12:53

What lies behind that recommendation would appear, as I put it perhaps earlier, the audit arrangements had to some extent fallen by the wayside. I used the word "collapsed", and maybe that's too strong. If we go 12:53 into Mrs. Champion's report. WIT-00544. As regards clinical audit, she explains that. This is the second paragraph.

"Senior stakeholders advised that internal audit had 12:54 provided clinical audit with a limited assurance level."

She goes on. If we go down to WIT-00554, she says,

scrolling down, having set out her findings, "clinical audit is back on the radar" with her recommendations.

A. Sorry, I am just trying to find where that is. "Clinical audit including M&M", is that the paragraph you're on? 12:55

105 Q. Yes. Before that she goes on to say clinical audit is back on the radar, the implication being that from a position of low assurance with regards to clinical audit, with the recommendations that she is putting forward in place, "clinical audit back on the radar". 12:55 The implication is that audit has come from a pretty poor place and it needed the scrutiny of this review and the recommendations that follow to bring it back to health. Did you appreciate that in terms of the information coming to the Board through audit processes 12:56 was not as it should have been?

A. Well, I certainly remember the limited assurance because that would have come through the audit -- in through the Audit Committee and Governance and also it had been one of the standards. So I do remember the 12:56 limited assurance, and the action and the acceptance of the priority ones; I do remember that.

I mean, I would have to look back. I have no recollection on clinical audit and benchmarking against 12:56 clinical standards would have been an agenda point on the Medical Director's reports coming to the Board. Mr. Wolfe, I can't remember specifically anything in any of the Medical Director's report in that recent

time there that was indicating they weren't doing them, but that's my recollection. But I don't remember seeing that jumping out at me in the report, that clinical audit wasn't being completed to the highest standard like it was previously. I just can't remember that. 12:57

106 Q. Can I bring you to another example. Recommendations were made in relation to Datix; you know the system for recording and reporting upon incidents?

A. Yes. 12:57

107 Q. If we go to WIT-00564, and scrolling down. As regards the governance information management systems, or Datix, the recommendation at 44.1 is that the Trust consider that the information management systems and administrative support required to support the implementation of the governance review recommendations, and, secondly: 12:58

"To ensure that the Trust maximises the potential for the use of patient safety software, it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present". 12:58

Again, one of these critical tools for good governance, the need for high quality data to be provided through, for example the Datix system, had fallen into disrepair or wasn't adequate. Again in terms of your understanding, sitting as the Chair over a lengthy 12:58

period of time, did you not see that kind of deficit in the material that was brought forward to you?

A. No. Definitely the Datix system, I wouldn't have been aware that software wasn't meeting the needs and it was inadequate. I definitely wouldn't have noticed that. 12:59

108 Q. Sorry, you would or you wouldn't?

A. I wouldn't have noticed the software deficit. I would have expected that to come through from informatics and that department. I do remember all of the Datix information that would go on, and that is in relation 12:59 to all accidents, incidents, complaints, untoward events, near misses. All of that went onto the Datix system and that would have been fed in. But that system, whether it needed upgraded or not, is only as good as the reporting in. I do remember a whole area i 13:00 that around domiciliary care services and indeed independent providers not feeding into that system. So therefore we could have been getting - think of falls as an example - the number of falls; you got it from the hospitals but you didn't get it from the community 13:00 settings. Was that a fault? I would see that as a fault of those feeding in the information rather than actually the actual software.

But I wouldn't have been aware that there was 13:00 inadequate information coming through because it hadn't been reported and we hadn't picked it up on the Datix, apart from that example.

109 Q. As I say, recommendations across 15 areas in total,

Mrs. Brownlee. When you saw that report and reflected upon it, were you broadly in agreement with the need for the kind of structural change that it identified --

A. Absolutely.

110 Q. -- as well as the need for improvements, if you like, in the tools that were being used to feed into the structures? 13:01

A. Oh absolutely, absolutely. I mean if you have engaged an independent person with expertise in governance and they have given you a report like this where there needs to be improvement, significant improvement and some sooner than others, I mean it would have been remiss of us not to address that, and I would have expected that to start to roll out. I can't remember the actual date this came to the Board; was it late '19? 13:01

111 Q. It was February for the first time, 2020.

A. Yeah, yeah. February 2020 this was coming to the Board. I do remember it.

112 Q. When you saw it and thought about it, Mrs. Brownlee, did you have any reflections about your own role as a leader in terms of the state that governance had been in and the journey that was going to be required to improve it? Did you reflect in terms of could we have been doing better to spot these problems? 13:02

A. Yes. Well, to just answer your first question, I don't remember having sort of a light bulb experience of thinking 'gosh, this has been terrible' and 'you've missed this'. I'm sorry, Mr. Wolfe, I don't remember

that.

But secondly, again I keep bringing this back to those who we hold to account through the Chief Executive and the Directors. Some of this, we would not have been 13:03
aware of; we didn't identify it in the information flow. Of course I was very pleased that someone had identified this, and would have supported the implementation of the changes as a matter of urgency, but it didn't come across that oh gosh, your Trust is 13:03
not in a good state. Now, I mean I remember February 2020, and I think that year that was all the Covid and many other things. But what I must stress is still, in all of wherever this negativity and the learning was, we were having some really good reporting in on 13:03
different areas. I think back to during that time, I mean the endoscope, for example, is one example that came to the Trust Board of an alert of picking up through governance. I mean, there is many others around Radiology. 13:04

Whilst I totally respect -- but the report and the need to change, and would have of course supported that, I don't remember anything when I read the report other than it's good to know this and let's start making the 13:04
changes. But it came at a very busy time in the Trust with lots of other things ongoing. I would have expected it now at this stage to be well-embedded and has made significant change. But it didn't, to answer

your question, come to me that your governance wasn't in a safe place, because we were seeing quite large numbers of serious adverse incidents, Early Alerts, I mean other learning, which would have come up through governance, and I think there is emails to prove that. What we were picking up was maybe the slowness of reporting serious adverse incidents or Early Alerts, and indeed the learning from it. So that was still working well in the Trust, but I mean it didn't come across to me that you've real concerns here. 13:04 13:05

113 Q. Thank you. It's 1.05.

CHAIR: We'll come back, it's almost 10 past according to that clock, so we'll come back at 2.10.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:05

CHAIR: Thank you, everyone. Just before we start, Mr. Wolfe, I just want everyone to know that we are going to sit tomorrow but not before 11 o'clock, so that will hopefully allow people sufficient time to get in here safely, those who are coming. Anyone who doesn't want to risk it, then certainly follow online. But I think it's better that you know we will be sitting tomorrow. 14:11

MR. WOLFE: Thank you, Chair. 14:11

114 Q. We were discussing just before the lunch break the review of clinical and social care governance. Your evidence was to the effect to some extent you were unsighted on the kinds of concerns that Mrs. Champion

identified, but you saw such a review as a positive development in that it shone the lights on difficulties and offered a pathway to progress and move forward.

Could I come to your witness statement and take your evidence on the quality of the Board and its work overall, perhaps with a particular eye to its work in the governance field. If we go to WIT-90852. You describe under answer 6, which is down the page, that you considered that you were an effective Board, used as a role model. Members had a broad range of expertise and experience. 14:12 14:13

"We completed yearly individual assessments on our own skills and weaknesses. Training needs were identified and training was provided. We were a forward-thinking Board and had innovative initiatives in place". 14:13

You go on then to specify a specific initiative, that is leadership walks to improve the governance arrangements. I want to touch on a couple of the tools of governance which were used or which you had sight of. 14:13

In terms of being a role model, where does that thought emerge from? Who were you a role model to, and who told you that the Southern Trust Board was identified as a role model? 14:14

A. Well, I remember - I think I referenced it earlier -

when we completed the first Board assessment that was sent through from the Department, we were the first Board, I believe, to do that, because I do remember the Northern Ireland Ambulance Service were much later than us and they sought our advice how to complete it. We did work through that thoroughly, like I've described earlier without repeating it. That went back to the Department. I remember the Department confirming to us they were very pleased, not only to be completed in time, but the outcomes and what we had recorded. So it was the Department that self assessment went back to. 14:14 14:15

115 Q. Yes. Can I bring you to the Board effectiveness model which was applied in the period 2018-2019. This was performed by the BSO --

A. Yes. 14:15

116 Q. -- internal audit section. We can see it at WIT-101640. I'll say that again, 101640. If we go down that two pages to 42, we can get an understanding of the scope of the assignment. If we just move down, it's explained as follows: 14:16

"The Northern Ireland Audit Office Board Effectiveness Good Practice Guide was used as a basis on which to conduct this assignment".

14:16

It set out how that assignment was performed, including the use of surveys, the observation of committee meetings, the review of Board minutes and papers, and a review of some of your key strategic and operational

papers. The results of the survey were presented to a Board workshop held on 21st February 2019. This piece of work was, I suppose, finishing just as Mrs. Champion's work in relation to clinical and social care governance was commencing, and we can see reference to her work within this assessment.

If we go then to the results of this assessment just over the page. It's described under "Level of Assurance". 14:17

"Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives". 14:17

That, in terms of their scorecard, as I understand it, was the top rank. "Satisfactory" is, I suppose, as good as it gets in terms of the language that they use?

A. Yeah. 14:18

117 Q. Under "Executive Summary", some positive remarks made including, for example, at bullet point 2:

"From observation of a Trust Board meeting and review of Board minutes, there is evidence of effective challenge by Non-Executive Directors". 14:18

Nevertheless, there are some remarks within this assessment that perhaps don't paint a wholly positive

picture, and again I am anxious to take your views on that.

If we go to WIT-101646, we can see that with respect to Board minutes - just scrolling down we can see it - in its entirety, again some positive remarks made about Board participation and levels of scrutiny. One of the problems, I suppose, identified were heavy Trust Board agendas and lengthy Board meetings which could potentially impact on effectiveness; absence of guidance on how to deal with members of the public; issues at Board meetings creates uncertainty. 14:19 14:20

Does that surprise you, or perhaps you were well aware of the heaviness of the Board meeting workload? 14:20

A. That didn't surprise me. The agenda at the meetings were heavy. We would have started around 8:30 in a morning, where we would have met the Non-Executive Directors, and I would have met with the Chief Executive to discuss matters of confidentiality, or serious matters that we may want to bring us up-to-date on or indeed that we had concerns about. So your meeting started 8:30, and then sometime around 9:15/9:30 you had a break and then you started the confidential section. We only brought the confidential which was really confidential, we tried to keep as much as possible to the main meeting. So, your meeting probably was starting around 10:30 and we aimed to finish it at 3:30. I know from feedback from reviews 14:20 14:20

and Board development we tried to bring it back even to before 3:00, and it was difficult. The agendas were heavy because you had a lot of reports. After we did the initial welcome, et cetera, we always started the Board meeting with maybe a lessons learnt model or an improvement, a quality improvement. We tried to bring frontline staff and middle managers to the Board to be familiar with who we were and also just to test and hear some of the good news stories. So we tried to allow about half an hour for that and then we would have got into approval of Board minutes. We always had maybe strategic as the first agenda item, or we alternated the next month with quality and patient safety and patient outcomes. 14:21 14:21

So, if you think of patient safety and quality outcomes, under that heading would have been the Medical Director's report; you would have had the Director of Nursing's report, the Director of Social Services; anything to do with patient quality, patient experience, any outcomes. Now, that did take quite a bit of time. 14:22 14:22

The strategic overview; you might have had the strategic plan for whatever or a new strategic issue that was being worked through, maybe in imaging or something. The big area then would have been another performance report. I mean, I wouldn't be the first to say that the performance report was extremely heavy and 14:22

to get it through it in the time. Then you would have heard from other, and indeed maybe later on from myself, that we decided that to really have a deeper look at some of the performance issues that we had, we would create another subcommittee of the Board, which was really just getting embedded when I was leaving. So you did have heavy agendas but what we tried to do was we did always have a time at the end of every Board meeting to reflect and see what did we really do today, what decisions did we make, what did we learn together and what were some of the salient messages. 14:22 14:23

We also at the very end always had a question to the Executive Directors of Nursing, Social Work, and indeed the Medical Director, is there anything else that hasn't been on today's agenda that you believe as the responsible officer that you should be bringing to the Board's attention. I introduced that sometime before that. Another area to try to improve it was we did a summary sheet at the front. That was very important. It was what was the paper about, who was its author, how was it linked to the strategic overview and the clinical standards, you know, where was it linked to. Then I called it the front page was what keeps you awake at night, what are the risks and concerns that you have that you need to report to us as the Board. Yes, we all should be reading our papers but it meant if you read the summary sheet, it gave you some idea what the depth of the paper behind was. 14:23 14:23

Now, we tried to lessen that by giving you links as we went on with better IT that you could look it up online, but that summary sheet was the opportunity for the Chief Executive, but definitely the author which was also the Director, to tell us what is it that you believe we should be talking about today. What, as I say -- and remember these reports were approved by the Chief Executive and the Directors. They were cleared, as we'll call it, at the senior management meeting. 14:24

118 Q. Just looking at this in light of the point made here about lengthy agendas, clearly a lot of the heavy lifting would be done in subcommittee?

A. Yes. Yes.

119 Q. You've talked in your statement about the importance of the Governance Committee and then the formation of a Performance Committee at some point, I think in 2019. No doubt it was helpful for reports to Board to be tilted in the direction of what you really needed to know, with summary sheets and that kind of thing. Is there any sense in this concern expressed here that such was the weight of the work before the Board that you as members, as Non-Executive Directors, weren't afforded adequate time to focus on the difficult questions, the issues you really needed to explore with executives to get to the heart of issues? 14:24 14:25 14:25

A. No. I believe we explored those to the best of our ability. I mean, the Non-Executive Directors would have asked a lot of challenging questions. One of the

criticisms may have been the Directors didn't always ask a lot of questions of each other; could that have been of time or because they would have said they already really been through these in detail at their senior meeting. I never got the impression we didn't have enough time. Certainly I would have asked at the end of the meeting did people feel that we had had adequate time to discuss; was there something more that needed to be discussed that we weren't in detail with. Sometimes we maybe, you know, weren't able to get all done, you know a paper that was coming of maybe something that we wanted to learn. I think one of those that jumps out at me, one of the local GPs who had a link into respiratory, around cancer and lung cancer, you know you may have moved that back to the next meeting, because definitely the Non-Executive Directors, not as familiar as the Executive Directors, would have found the day quite exhausting. You know, it just depends on your level of energy. If you were in from 8:30 in the morning, we always had break for lunch, certainly by 3:00 or 3:30 you were becoming maybe not as alert as you should have been. But I believe there was adequate time. 14:26 14:26 14:26 14:27 14:27

120 Q. Yes. This assessment went on to look at governance structures, if we just take a quick look at that. WIT-101654. It is three pages further forward. Just maybe go back so we can see it in its full. Sorry, just scroll down, please. There is some discussion of the Hyponatraemia Inquiry recommendations, and over the

page there is discussion of governance structures. It says as a finding:

"Clinical governance structures could be further developed and strengthened as reflected in the discussions with NEDs in recent internal audit reports".

The implications of this finding were weaknesses in the assurance processes to Governance Committee and ultimately Trust Board. The recommendation is:

"The Trust should review its clinical governance structures with a view to further developing and strengthening current arrangements". 14:28 14:28 14:29

So, management action is recorded as being accepted. This is, I think, the reference to the Champion Report, "an independent review of clinical and social care governance has been commissioned". 14:29

This review would seem to give credence to Mr. Devlin's concern that all wasn't as it should be in clinical and social care governance, there was a need to review clinical governance structures, and, as appears here, that independent examination had already been commissioned. Again, this seems to be coming, at least in part in terms of the evidence, from discussions with Non-Executive Directors. Just your comment on that 14:29

set against the evidence you gave earlier, you didn't seem to recognise the concern but some of your NEDs did?

A. Well, none of the Non-Executive Directors brought anything to my attention. I didn't attend the Governance Committee or any subcommittees of the Board like audit unless invited because there was a presentation or something. But definitely none of the Non-Executive Directors brought to my attention any concerns. Certainly I knew about the lengthy agendas and we talked a lot about how we could restructure that. 14:30 14:30

The other thing to remember, Mr. Wolfe, is after every subcommittee, to help the loop of governance the Chair of, say, audit or governance, presented, brought a report along with the Board Assurance Manager to meet with the Chief Executive and I, and that had been going on for a number of years. That would have happened, say, within normally 10 days my personal assistant would have, in advance, been preparing after the schedule of meetings when we would meet that. So, every Non-Executive Directors, especially every Chair of a subcommittee, had opportunities to say on those one-to-ones, as I would call them, they was giving us feedback on the high level of the meeting and then, remember, it still came again to the Board meeting. I never had no Non-Executive Directors saying to me they had concerns around reporting, information sharing, 14:30 14:31 14:31

what was coming.

I mean, we would have often said when we would have been asking challenging questions, you know, this is a different type of paper we want, or we need more detail on this. That would have come up quite regularly at a meeting; you know, don't give us so much of the narrative, give us more of... You know, the non-execs would have been exceptionally good at doing that. But no one specifically, even at their performance review when they came to meet me at a one-to-one and planning their own training needs, ever said to me I have concerns about the committee I sit on or I would like to see changes there, because that was the opportunity to do it there. Also, the feedback meetings. 14:31 14:32 14:32

We also had quite a number of away days. And our Board development day every November was an excellent forum of where we looked at ourselves critically as a Board, how were we performing. We invited people in to speak, we talked about committees, heavy agendas, who should move, what else we could do. This was a very open work away day, a team building day, whatever one wants to call it. We had lots of opportunities for that. But I don't recall any Non-Executive Director ever specifically saying to me about concerns they had. We were always looking to see what to do to improve performance. 14:32 14:32

121 Q. I want to bring you to some of the evidence before the

Inquiry from other of the Non-Executive Directors, but just a final footnote on this report. If we can go through to Appendix A. Sorry, I don't have a page reference in front of me. If you scroll down, I'll tell you when to stop. Thank you. The survey that was 14:33
placed across the Board members as part of this exercise asked for views around whether the organisation has strong leadership and appropriate culture. The footnote, if you like, to the right-hand margin states: 14:34

"Discussion with Non-Executive Directors indicated that this largely due to the Trust having 4 Interim CEOs and other acting Directors for approximately three years and this weakened leadership and culture in the 14:34
Trust".

That's reflecting on, if you like, the breakdown in the results there. If we can scroll up to the top. In terms of the strength of leadership and appropriate 14:35
culture, more than 50% tend to agree or strongly agree but there's a significant number in the middle, Mrs. Brownlee. As I say, that's reflected in the comment expressing reservations about the culture and the strengthen of the leadership. 14:35

Just scrolling down, to finish. It's also recorded, however, those surveyed presumably felt that now the CEO and Director posts were substantive, there was

clear evidence of improvement in this, and there to be Board workshops on culture and vision in the current year for improving this aspect.

Any observations to make on that, this sense among your team that leadership and culture within the Trust had not been as strong or as optimal as it should have been because of the, I suppose, the impasse in putting a substantive post holder in place? 14:36

A. Sorry, I didn't have the last page up but it's fine, I remember what you've said there. Getting back to the organisation, strong leadership and appropriate culture. Yes, it has 11%; is that one or two people of percentage. I mean, did everybody return? I do recognise what is said. I note that senior team thought the Chief Executive not being substantive was a weak area. I mean absolutely, I think we've covered this before, that having a permanent Chief Executive is the ideal and we would have liked to have had that. But what I was trying to say all along was those that we did have were experienced, there was a good hand over. I mean, many of these Non-Executive Directors coming in at this time in 2017 -- 14:36 14:36 14:37

122 Q. This report is dated 2019.

A. Yes. 14:37

123 Q. February 2019.

A. Yes, but at the time when they would have been looking back, they only had -- you know, they came in in 2017, the greater majority of them, they never worked

actually with a permanent Chief Executive, to be fair to them, they had the interims until Mr. Devlin came. But I note what was said, and we talked about that quite a bit. We would have Non-Executive Director meetings quarterly and I would have listened to them about that. I did try very regularly through to Mr. Pengelly, he was my first contact, about trying to get the post advertised, but I was in that situation. But I did hear what they say and we would have talked about that. 14:37 14:38

The various types of leaders too. You know, when one comes in and one goes off sick, you know, and they have all different styles. It wasn't that I didn't listen to them, I did understand that. And it wasn't a surprise to me, you know, when you do a questionnaire like this here that you'll have, rightly so, one or two or whatever who are very strong in their opinions, which I respect -- 14:38

124 Q. Yes. 14:38

A. -- that that is what...

In relation to the culture, I mean, we worked extensively on culture and had a lot of time out of the boardroom to look at culture and our behaviours. But you'll maybe want to come back to that. 14:38

125 Q. I wonder whether, and we look at some of the remarks of your Non-Executive Directors now --

A. Okay.

126 Q. -- I wonder whether this was a watershed moment in some respects, that the appointment of Mr. Devlin and the removal or the ending of that unsettling period where you didn't have a substantive figure at the head of the organisation, and indeed the appointment of Dr. O'Kane, there having been difficulties in securing a substantive medical Director for a period of time with Dr. Wright's illness and Dr. Khan coming in to sit on that Chair for a period of time. I wonder would you agree with me that those difficulties, contrary to perhaps what you said earlier this morning, were a really difficult period for the Trust, and key work, particularly in the governance field, wasn't developed, wasn't pursued, leaving gaps which were, from a patient safety perspective perhaps, relatively dangerous gaps? 14:39 14:39 14:40

A. Well, Mr. Wolfe, I wasn't aware that we had dangerous gaps or that there was weaknesses there. As far as I'm concerned, I still continued to do my work and attend and be at work like I should have been. As did those Interim Chief Executives, they definitely were very able, very skilled, I mean very experienced. I mean they devoted a lot of time to it. 14:40

The backfill, yes, while it is a weakness with people stepping up, they were very experienced people. These weren't people who were coming out of a department not with experience, but I didn't see that, or during the interim, any dangerous or really concerning areas under my watch at that time. 14:40

127 Q. Yes. Let me take you to what Mrs. Mullan has said in her statement to the Inquiry, starting at WIT-100544. At paragraph 46.1, just scrolling down, she is asked "Do you think overall the governance arrangements within the Trust were fit for purpose, and did you have concerns about the governance arrangements and did you raise these concerns with anyone?" She is saying:

"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".

She goes on to say:

"At the centre of this unfitness is what appears to me to have been a lack of triangulation of information and or a culture of working in silos", and she cites separate processes were being undertaken with no joining up of the intelligence. She points out the unhealthy churn in key executive positions in that period which didn't help matters.

I think I should have started with this at 45.4, if we just go back to that. She says:

"In my view knowing what I know now, the Trust Board and the governance were not kept appropriately informed in the period 2016 to 2020. This included explicitly

detailing the patient safety risk arising as a result of the demand capacity mismatch".

She goes on to explain that:

"Since Dr. O'Kane raised matters at the Trust Board in August 2020, I believe that the Trust Board and the Governance Committee has been kept appropriately informed". 14:43

Mrs. Mullan, to summarise from a position of retrospectivity, is recognising that the information flow into the governance system during that period of four years was not good, that there was information that ought to have come to the Board and to the Governance Committee that didn't come. She includes within that concerns about the impact of the demand capacity mismatch. 14:44

Do you concur with her thinking? 14:44

A. First of all, the first reference that was made --

128 Q. Yes.

A. -- where she believed as an individual the Board, it was not fit for purpose, I would disagree with that. At that time I believe I had no concerns about it. 14:44

In relation to the patient safety arising as a result of demand and capacity, we did know that the demand was great and the capacity to fulfil quite a number, not

just Urology, quite a number unscheduled care, scopes, I think of those, trauma and orthopaedics, so there was quite a number where we knew the demand was outstripping that. We did see that at Trust Board and we worked very hard to see what was that telling us, how long were people waiting, how was the feedback to that. We also would have asked a lot of questions. I attended and went -- because of the waiting lists, I attended with the Chief Executive to the Health and Social Care Board and the Department to try and influence to get additionality. 14:45 14:45

One of the problems with the demand and capacity, Mr. Wolfe, the Craigavon site, I think, was built in the late '60s, early '70s. It was the last hospital, and still is, in Northern Ireland not to have anything new. If you look throughout the province, without going into detail, all of the new hospitals are there. So this was quite an aged hospital. Even if we think back to the C-difficile and we think back to COVID, our complexities we dealt with was we had very few single rooms for infection control; we were sharing toilets. This was an old hospital and we didn't have enough theatre space. 14:45 14:45

If we look at just trauma and orthopaedics. You could have had a list of orthopaedics today with consultants to do hip replacements, knee or whatever; you only needed one road traffic accident during the night or 14:46

one big catastrophic event that became the trauma list for the next day. All of those patients, they may even have been in hospital, would have had to be sent home. We were dealing with actually very often. Many of the consultants across different areas of speciality would have brought this up. I am not making that as an excuse, I am just saying we were aware of the capacity and demand. If you look from when I started, even in Urology the referrals to when I was leaving to now and they are huge. That is the same in many specialities. 14:46

129 Q. I want to -- sorry to cut across you. I will ask in due course, I don't want to deal with it now, I want to ask you in due course what was done with the knowledge that you had.

A. Okay. 14:47

130 Q. Just on the issue, as Ms. Mullan puts it, of not being appropriately informed. You see no...

A. Well, the way I would look at that, Mr. Wolfe, is if I am not being appropriately informed and I am a Chair of a subcommittee or a Non-Executive Director, then you need to ask for the appropriate information to come. I respect what Eileen says, she was saying she didn't get adequate information, there wasn't the flow of information informing them of governance concerns. I mean, when was that identified? I mean, that -- 14:47

131 Q. Just to be clear, she is looking at it with the benefit of the hindsight and the information that she has now.

Mrs. Leeson, she maintains, so far as I understand her

evidence, that the governance arrangements were fit for purpose, but she puts something of a caveat on that, so far as again I understand her evidence. If we go to WIT-99779, and at paragraph 10.2. She explains that she thinks there is a more robust system around clinical and social governance since Dr. O'Kane commissioned the review in 2019. I'm not sure whether it was Dr. O'Kane or Mr. Devlin who formally commissioned the June Champion review. She says: 14:48 14:49

"Prior to 2019, since my appointment in January 2017, in my view there was a less developed approach to governance where there were separate reports to the Governance Committee on specific areas". 14:49

She goes on to say:

"Governance is, however, a dynamic process where there needs to be continuous improvement and I think it has become more effective with the introduction of the CSCG report to the Governance Committee which brings all this information together in a summary report". 14:49

I think elsewhere in her evidence she talks about the greater opportunity for triangulation of all of the information, and that in turn improves the process of doing governance. It opens the pathway for Non-Executive Directors to better understand the trends, the connections between various discrete pieces 14:49

of data, and helps to build a better and more comprehensive picture of what is going on from a governance perspective.

Now, conscious that your term in office didn't go beyond November 2020, did you see any notable improvements in how the Board was able to interact with the changed governance structures and what appears to have been a better flow of information after June Champion's work had been endorsed? 14:50

A. Just first of all... sorry, I've lost my school of thought. June Champion's work came in and the report in 2019. 2019 was a horrific year, and the last six months of my term. I think we all in this room will know what the Covid pandemic did to health and social care, and indeed to our community. For example, in 2019, February on, we had a hospital that I've said before isn't fit for the capacity and demand. Just to give you an example, our canteen -- 14:51

CHAIR: Sorry to interrupt. I think you mean 2020, wouldn't it be? Covid was 2020, the first lockdown. March 2020 we were in lockdown. 14:51

A. Okay. Sorry, my apologies. Going back to the June Champion's report, it came in yes, in my last six months. We were starting to see that embedded. I do remember seeing new staff and structures being put in, but, to be honest, and sorry what I was going to say at the start was would I have read all of the governance papers before -- I didn't attend governance but I got 14:52

the papers. Certainly they were hefty documents. I would have been able to -- you could see the number of serious adverse incidents reported in a year; you could see the litigation; you could see the falls bundle; you could see the infection control. There was a lot being 14:52
fed into that committee. I mean, I can't remember very many changes that were made. Now, that's not a criticism, I just honestly can't remember of a lot of changes that happened from her report when it was started to be embedded into the organisation because 14:52
that would have started to take time and momentum of getting -- putting extra allocation of money and then, you know, quite a number of staff moving to work in governance. So, that all takes time. So I don't remember seeing a very different flow of information to 14:53
the Trust Board or to any of the subcommittees of a huge difference to what it was before.

132 Q. MR. WOLFE KC: Yes. Let me take a particular example of what some have described as an information shortcoming in terms of sharing with the Board. 14:53
Mr. O'Brien is the subject of an MHPS investigation in 2017. It stretched into January 2018 and there was no determination in respect of that process until October of 2018. The Board was told about the process and the commencement of the process at the very beginning in 14:54
January of 2017 but it didn't hear anything more about it, anything more about it until the chaos of the late summer of 2020 when an Early Alert went to the Department.

Maybe it's unfair to focus on one example but is that a shortcoming, in your view? Should the Board have been updated on progress and early findings and ultimate findings in that exercise, particularly where it touched upon patient safety issues or where it touched upon management issues? 14:54

A. If I could just say before I get into that one, Maintaining Higher Professional Standards, after it was notified to the Board generally, never came back to the Board again unless the Medical Director had concerns. I do hear from Eileen that now that has changed significantly and better reporting, and that's to be commended. Just to mention that they didn't come back. Certainly in relation -- 14:55

133 Q. I suppose the point I am making is whether it is specifically this case or whether it's the generality of MHPS cases, should the Trust Board, allowing for the confidentiality of the clinician and his name or her name needn't be communicated to the Board, but where there are concerns identified during the process that touch upon patient safety, that touch upon management failures, are they not the very kinds of things that the Trust Board, and particularly the Non-Executive cadre of the Trust Board, should be expected to be told about? 14:55 14:56

A. Absolutely. Absolutely. Those concerns should have been raised very early in the process through the Medical Director or through the Acute Director.

Absolutely. If they believed, through an investigation, the findings were around patient safety or inadequacies or under-performance, absolutely should have come back. What I was saying, sorry, at the beginning was normally they didn't come back because they were managed by the Medical Director. But if there any concerns, you would have expected them to come back for anyone else as well as this particular case.

134 Q. But through your nine years in this post, you are seeming to suggest that as regards MHPS, information in terms of the outcomes or the findings, that didn't come to you, didn't come to the Board? 14:56

A. I remember one where I referred to earlier where another Non-Executive Director was working on a complex one, it coming to the Board. But we didn't have them routinely coming, no. We could have a year where maybe there was none. 14:57

135 Q. Well, why not? Why, for example --

A. Well, we mightn't even have known. 14:57

136 Q. You knew about the commencement of MHPS, didn't you, in the majority of cases?

A. Oh sorry. Yes, if it was reported to the Board. We hope it was. We were dependant on the HR Director informing us. I am just saying -- 14:57

137 Q. But you used the word too dependent" and this perhaps goes to the culture of the Board that you chaired. You are dependent obviously on the executives carrying out their duties but can you not, as the Chair of the

Board, direct the Executives to improve the information flow to you so that you are better positioned to understand the risks facing the organisation and the changes that might need to be made?

A. Oh, absolutely. I mean, we could have asked for any information at any time as extra. What I was saying was if there wasn't a reporting in of a maintaining higher professional standard investigation, we wouldn't have known. I was very dependent, and the Board, of hearing that through the Director of HR or the Medical Director. I mean, there wasn't one very often now that I can think of. They would have been reported definitely if there was one, but sometimes, you know, you could have had six/eight months, maybe a year, none reported. I just can't be specific as I look back. 14:58 14:58 14:59

But definitely I would have expected if there was any consultant going through a Maintaining Higher Professional Standards, it should have been reported in to the Board through the Medical Director's report. Also, if there was any concerns at all in relation to that, that should have been reported back through the Board. We could have asked for that information. I'm not sure if you want me to expand on the one you're referring to in January. 14:59 14:59

138 Q. No, we'll come to that in due course. You speak in your witness statement about the specifics of some of the governance tools that were available to the Trust; for example, Serious Adverse Incident reporting. You

say that that was something the Board always wished to learn and follow up on, including near misses and any issues that flow from that.

If I could draw your attention to an email you sent to Mr. Devlin on 1st February 2019. WIT-103218, and just scrolling down. I put this in front of the Panel in light of the questions I have just asked you. In all fairness, there is clear evidence here of the Board and the Non-Executive Directors expressing concern about an aspect of governance, and let's see how that concern emerged. You are working through the governance papers for a meeting the following week. You say to Mr. Devlin: 15:00 15:00 15:01

"You have probably noted, as I have mentioned before under litigation, the number listed under maternity and women's health".

You go on to say that you are noting the SAIs reported between January 2018 and 31st December 2018, that the high graph "blue" shows 10 to 60 days or more. "I appreciate this area is under discussion". Then you go on to cite a particular example of a tragic maternal death, and you are recalling that Eileen - Mullan, assumedly - and the Trust Board NEDs were especially concerned about the length of time for reporting the incident, and who and how escalated that to the Chief Executive. That was back in Stephen's time as Chief 15:01 15:01

Executive. You are asking has the reporting mechanism improved since that Trust Board meeting.

So, that's a concern that where incidents arise, there is, judged by an example that you were pointing to, a delay in reporting them in to the incident reporting review system; is that right? 15:02

A. Yes, yes. This was me reading the governance papers, and I had come on the maternity and women's health issue. I say it would have been one that was on quite regularly. Quite a large number, I think from memory then it was eight or nine, were listed under the litigation report, and I had seen that before. I was also pointing out that the SAIs, and remember the SAIs had had a lookback exercise in Northern Ireland, I think in 2015, '16 by the then minister, looking at the numbers and how those were being actioned, and I mean the time and the reporting. So, I'm looking at the SAIs reported for that year that were going to governance, and here was still evidence showing that they weren't being reported in 10 days or less, which was the standard, and some were going as far as 60 days. So I was sending an email into Eileen as the Chair and copying Shane in to say look, Eileen, because he was new, Shane, remember we have discussed this before in Stephen McNally's time, the length of time reporting, has this improved because from me reading the papers, it doesn't appear to have improved much, mindful that I didn't go to the governance. I can't 15:03 15:03 15:03

remember, sorry, the reply.

139 Q. The reply from Mr. Devlin above I think recognises the problem and states that this will be discussed at committee as he isn't content with this area. February 2019. 15:04

Did you follow this through and pursue it? Was there any change for the better that you noted?

A. I've followed that through. From memory, again I attended governance meeting and again one in 20; I attended one where I was saying I want to talk, if I'm allowed, a few minutes about some of these pressing matters. Some of them would have been around SAI reporting and the timeframe, because I couldn't see a change in the improvement of the 10 days or less. So I did follow it up. Eileen didn't reply to me there but because the Chief had said it's already on their radar, they are looking at it at the SMT, he was too was concerned or wasn't as content as he would like to be. 15:04 15:05 15:05

Governance met quarterly. That was me saying that to Eileen. I can't remember if that was the meeting -- if I did attend that meeting. I think the governance meeting was maybe on 9th February. Anyhow, I didn't see a big improvement for when I went back to another one. 15:05

To me, SAIs is not only so important to report them so that everyone knows what has happened, but for the

immediate learning of lessons and to sharing them throughout the region. It's a requirement after a lookback exercise. I think it was in that year I've mentioned, and the Coroner. I think, I mean, we were asked to be really diligent in that area. Of course there was that the problem within women, you know, in maternity services and the number as well, because it had been showing for quite a while, the litigation report for maternity services and indeed I think into the next year, I mean around that. So, I did follow that up. 15:06 15:06

140 Q. We asked you in your witness statement to provide us an indication of how you might be expected to be made aware of concerns regarding patient safety and risk. I just want to bring you to your answer. It's at WIT-90584. No, it's not. Thank you. 15:06

That's the question we posed. You explain:

"Normally concerns regarding patient safety and risk would be brought to the attention of the Board via the Chief Executive or relevant SMT member to the confidential governance meeting or the confidential Board meeting. The Governance Committee is a subcommittee delegated schemes to subcommittees of the Board and chaired by a NED. Meetings were held every three months". 15:07 15:07

Is that an explanation around concerns about individual

patient safety or risk to individuals arising out of care or treatment?

A. Well, I would have been replying in that way, that normally concerns regarding patient safety, be it an individual or a lessons learnt model or a risk, would have come. It could have been individual patient or a group. I mean, I could give you an example about the endoscopes and the scopes and the problems around that. It could have been in the wider organisation and it could have been the individual. You know, I would have been informed if a maternal death, or whatever like that, which is an awful tragedy and you are always looking to see the immediate learning. 15:08

But definitely any Chief Executive I worked with would always have phoned me, if it was in between meetings, about any patient safety risk that they were concerned about, definitely. But if it was near, you know, if it was coming to the governance meeting, it would have gone there too. But we would never have sat on patient safety risk that I would have been aware of, nor would the Chief Executives. 15:08 15:09

141 Q. You explain in your witness statement that obviously by 2019, there was a Performance Committee. The Director For Performance would have provided a report into that committee and that report then with the Chair of the Committee -- sorry, the Chair of the committee would then provide a follow-up report and probably meet with you in advance of the Board meeting. Is that how it 15:09

worked?

A. Yes. After every subcommittee meeting, it would have been in the schedule of a calendar that the committee Chair would have prepared a paper, alongside the Board Assurance Manager who was pivotal to this all, and they would have come and met with the Chief Executive, the Chief Executive and I on every occasion. There was always a feedback meeting and a high level paper prepared. 15:10

142 Q. Yes. You comment in your witness statement - this is at WIT-90862 - that no clinical concerns are reported on the performance report. We'll come to look at this specifically in the context of Urology in a moment, but when you get a performance report and it is showing significant waits, missed targets, is that not indicative of clinical problems or likely clinical problems for those who are not being seen? In other words, with extensive waiting lists you are likely to have significant morbidities and risk to health. Was that how you viewed it? 15:10 15:11

A. Well, the Medical Director, I should say, would also have brought if there were any clinical indicators that weren't being met. In relation to the performance report, we would have seen some areas that were very good and we honestly didn't always talk about those because they were meeting their targets. But we would have looked very specifically and would have been highlighted red areas on the report that needed attention, and why. We would have looked at how long 15:11

some people were waiting, not just in Urology but in other specialities. We would have asked a lot of questions - how are these people being followed up, have they gone back to their GP? The Director of Performance I think was nearly always the same person in my tenure, maybe two when they moved, but they would have been reporting into the Health and Social Care Board, the Commissioner, and also the Chief Executive. The Director of Performance and the Chief Executive would have had at least a three-monthly meeting with the Health and Social Care Board. I mean, so we would have been asking why. A lot of these reasons could have been because of workforce; we maybe just didn't have the consultants to see. We maybe didn't have the capacity for either theatre or outpatient clinics. We were also trying to look at newer ways of working to see -- we had moved -- like, dermatology is one that comes out high in the numbers that they had there. Was there any other way and we got into looking at, you know, maybe doing online remote dermatology. 15:11 15:12 15:12 15:12

Definitely, we would have seen those numbers high. We asked a lot of questions about them. We got pretty good answers, to be fair, around when we wanted to know the deep reasons why. At times we did get -- I mean, I think of some of the extra theatres that were modular, the modular theatres, so we would have worked very hard to get extra money to be able to meet the capacity. A lot of this was not only workforce, it was the 15:13

financial end, so you had to prepare and present papers and a commissioning plan why you needed it. I can remember we got quite a number of modular theatres to be able to reduce waiting lists for theatres. I mean, going to the Department on numerous occasions about funding gaps and capacity. Also, you would have been looking to the rest of the region.

For example, if I was allowed, I always remember breast screening. Now a lot of this is from memory but breast screening from you visit your doctor to you are referred to the system, you're meant to be seen in 14 days. In the Southern Trust during my time, we were rarely not at 100%, 98%. We were seeing people fairly quickly, and rightly so. Tragically, we had the loss of our two consultant radiologists all within a space of about 14 days. Honestly, Mr. Wolfe, our waiting lists in where we were high performer dropped to, I think from memory, 14%.

That was an alert to us fairly quickly, what are we going to do about that. We engaged very quickly with the Commissioner. We triaged and looked at patients with their GPs. We talked to the Department and to the region, as I call it, the other Trusts to see could they help us so that if you were in the Northern Trust, you weren't being seen greater than being seen in the Southern Trust. We would have noticed that very quickly.

But in some areas that I've used already, trauma and orthopaedics, and the waits for routine hip, knee, whatever, some of those people were waiting far in excess of their times, and I have given you the reason why. I mean, the reporting on plain x-rays is another one that jumps out at me because of the shortage of radiologists. These are not excuses I am making, I am just saying to you when the performance report came to us, we did go through it in detail in preparation for the meeting, had our questions ready, and my Non-Executive colleagues asked many questions and we were looking to hear back from the Director and Chief Executive who were held to account, what are you doing about this, these are people at the end of this line and waiting. 15:15 15:15 15:15

Definitely, I would have attended - which would have been outside my remit - I would have attended the Health and Social Care Board, meeting the Chief Executive and their Director of Planning and the Department around concerns I had about our waiting lists. We did in some cases get extra money, and we then moved into share in the region some areas, and we got modular theatres; we maybe changed the profile of the hospital around. But our hospital was absolutely chockablock with mobiles and lots of things. 15:15 15:16

We did look at the performance report. We did

always -- I remember non-execs would have said at the end of that, that's a patient waiting five years or three years. We did take this very seriously, but we were needing to really put the pushback to the Health and Social Care Board and as well to the Department. I'm not sure, I didn't hear Mr. Pengelly yesterday, but a lot of that going back to the Department and the Commissioner was every Trust doing it, we weren't the only one. 15:16

143 Q. Let me come back to that external discussion in a bit more detail in the context of Urology in a moment. Can I ask you about a particular initiative that you pursued in the governance context, and that was the introduction of the leadership walks. If we go to WIT-90855. You explain that you introduced leadership walks, which were performed by Non-Executive Directors, to all areas across the Trust looking for evidence that what we heard in the Board was happening on the frontline. These leadership walks, you explain, enabled testing of the systems and an opportunity to meet all grades of staff, listen, and be a visible Board. You say this further completed the circle of governance. 15:16 15:17 15:18

Can you clarify who amongst your team participated in these walks? 15:18

A. The leadership walk was introduced by Mrs. McAlinden and I after her big governance review. We wanted to complete the loop of what we heard in the boardroom

that we actually saw at first-hand out. So, Mrs. McAlinden put together with her senior team the pillars of governance and what she believed was necessary to ask. A lot of this came from her leadership. Then her and I discussed it, and we had an excellent tool of about - I'm sure it is before the Inquiry - maybe 15 questions. So, I discussed it with the Non-Executive Directors, who also were involved at that time when they were introduced, of what we would do. 15:18 15:19

The leadership walks were undertaken by myself and all of the Non-Executive Directors. I do believe the Chief Executive at that time had their leadership walks, but we did these ones. I probably did the most because I was there maybe more, but the Non-Executive Directors would like to do at least three/four a year. I found that an excellent tool. I heard before the Inquiry that this was an inspection; I did not see that as an inspection. It was very welcomed by then the senior management team, and the Chief Executive introduced it initially. 15:19 15:19

Also, when we went out to different areas, it was a great opportunity to see frontline staff. We would have not only visited the facility, we would have looked around it to see what the estates were like, thinking of infection control, thinking of they always had a safety dashboard in the wards, so we were able to 15:19

see first-hand the safety dashboard around falls, infection control, staffing. You know, you saw so much when you went out on a visit, Mr. Wolfe.

144 Q. Sorry to cut across you. In terms of its arrangement, was it by way of a surprise visit or was it formally arranged with the relevant service provider? 15:20

A. Yes, it was. I mean, my personal assistant, Jennifer Comac, along with Sandra, the Board Assurance Manager, we worked out a programme of when we would visit and who should have the visit. We would try to have went for development areas to the Non-Executive Director, but we also would have went to an area that we believed was a bit troubled or were going through difficulties, should it have been staffing. 15:20

15:21

So, it was very structured. We asked the Non-Executive Directors for their diaries, when they would be free. That was so important because it was normally a good half-day and you might have had to travel to Daisy Hill or South Tyrone Hospital; our Trust was very widespread. So the Non-Executive Directors gave in their diary and availability, and then Jennifer, my assistant, would have worked with the particular directorate, the Director. Also, we did try to make sure the Assistant Director or Head of Service was also available. They could join us if they wanted. Towards the end of my tenure, we were trying to move towards if we could maybe do it with a Director. That was just becoming impossible because of getting diary dates to 15:21 15:21

suit a Director, to suit a Non-Executive Director.

They were very structured, they were planned. Also before we would have went, say it was a ward, we went to the ward sister the tool that we were going to be looking at the different areas so that she could see. Most of them had their work very well prepared before you went so that, to save time maybe, their audits and some of their innovative practices and their concerns. If you look, which I know you have some before the Inquiry, I think it is questions from 11 to 14, but certainly question 11 does ask you - because I so remember it - tell us in your ward what are your greatest risks are you dealing with, what are your concerns. So it wasn't a tick box exercise, you spent quite a lot of time there. And I always -- 15:21 15:22 15:22

145 Q. Sorry to cut across you. We'll maybe look at the two Urology leadership walks of which we are aware. You performed one in 2012, isn't that right?

A. Yeah. 15:22

146 Q. If we can bring that up on the screen, or the report that flows from it. WIT-19178. That's the cover sheet. You are going to the Thorndale Unit on the 23rd, I should say, May 2012. The person accompanying you is the Urology specialist nurse, Kate O'Neill. 15:23

Is it fair to say that nurse, Ms. O'Neill, was the key informant during your walk, and nobody else?

A. Oh no, you would have met -- and I can't remember this

one, but if we scroll through it you will maybe see what other staff did I talk to, because normally we'd have recorded if you had talked to a consultant or if you had talked to nurses or if you talked to administration staff; you just didn't dive in and talk to the nursing staff. I mean, Kate O'Neill, from memory, was one of the Urology specialist nurses. When we would have booked that, or Jennifer, she would have tried to make sure the most senior ward manager - or indeed if you were going to the day centre or wherever, the person in charge was on - so that you were meeting the person but also they could give you all of the information. But Kate O'Neill was very senior and a very experienced Urology specialist nurse. I think there was another girl, maybe Jenny or someone was there. I can't remember all but I do think -- 15:23 15:24 15:24

147 Q. We'll go through it, but before we do was there any particular reason in selecting Urology as the place to visit at that time? You said earlier we sometimes directed our attention on areas in difficulty, or had particularly special reasons or particular reasons for doing a walk in that area. Was there anything coming to your attention in Urology by 2012 that drew your attention? 15:24

A. Not that I'm aware of. One of the reasons also we would have looked back to see where didn't have a visit. 15:25

148 Q. Yes.

A. What we tried to do, and I think we got through most of

them during my time to get around all of the sites, we're talking about the laundry, the kitchen, the pharmacy, all of these places had a visit. From memory, the Thorndale Unit hadn't had a visit. I sometimes would have filled in the gap because some of the Non-Executive Directors, it was extremely busy, their workload and they mightn't have got it done. It would have been Jennifer in the office with Sandra who would have been looking to see where a visit was due. 15:25

149 Q. Let's just scroll through it and if any particular issue catches our eye, we'll deal with it. I assume that you are not walking around clipboard-like asking questions and recording answers, but you have a conversation, is it, that embraces all of these questions or is it the formal working through the list? 15:25 15:26

A. The way I would have done them - and everyone had their own style - we used the same tool, of course, and the Department would have got a copy, as I have said, in advance. Normally when I would have arrived, I would have went to a quiet area to meet with the lead person, to take them through the form and to explain to them this is what we are trying to gain at the end. I also would have explained to them that when this tool is completed by myself, I will spend it back to you, being the lead, to make sure that there is no inaccuracies or if I have recorded something wrong. Once they sent it back to me, then the triangle of this was it went to the Chief Executive. It was then the Chief Executive who dealt with it with the Director. Normally you 15:26 15:26

would have got a response. Now, I'm assuming as I read this here --

150 Q. It starts off with a positive, what works well. It is set out in terns of the effectiveness of the team, its skills; it points to the specific nurses who lead in different areas. Then there is an area of what doesn't work well. We can see that it's pointing to shortfalls in staffing resources, particularly around middle grade doctors; limitations in the size of the building; the size of the team being small, so it's not responsive to accidents such as illness, and a more practical issue around car parking. 15:27 15:27

Just scrolling through it and we'll pick-up on the questions -- 15:27

A. Sorry. I'm sure you are aware, Mr. Wolfe, that is me listing in the black what I have been told as on my walk around, not with a clipboard. Then this is the response in red from the relevant lead in the department or indeed from the Director. The red is not my recording, mine would have been in the black. But when you sent it in and were getting it back for clarity, you would have seen this is just what way it was recorded. The red is very much the response from the -- 15:28 15:28

151 Q. From the staff member?

A. Yes, and indeed their team. You know, their Head of Service or whatever would have been involved in this.

152 Q. Yes. Then questions around what would you like to

change. It focuses on expansion of the team. That's explained, that there is a process in train.

Just working through it; I'm not in the time available to us going to stop at every point. Just keep on working through this. Obviously that's a reflection in terms of improvements. The one-stop clinic was a recent development which we've heard some evidence about. Scrolling down. This particular example seems to be very nurse-specific, it's the view from the perspective of a nurse; is that fair? 15:28 15:29

A. Yes, but I'm just surprised I haven't yet come to anywhere else that I met other staff because it would be very rare you just spoke to one staff member. But yes, this was what the leader, the team leader, was telling us. But it is a small area, from memory. The Thorndale Unit was one of the modular buildings that was placed beside the Cancer Unit, so it was small. It was a small select accommodation, and indeed select staffing. It was very specialised. 15:30 15:30

153 Q. Just continue to the end then. You were drawing your attention to the importance of questions, I think you said 10 to 14?

A. I'm sorry. Just from memory I remember there was always a question that you asked, the areas of concern. 15:31

154 Q. Yes.

A. So that you didn't leave the building having asked a lot of maybe soft questions and yet here was a team leader who had real risks they were trying to manage

and she didn't have an opportunity to tell you. That was why, when we were putting this tool together, I remember Mairead McAlinden, we looked at the pillars then of governance and doing what we were doing. We would have always asked, you know, what are the concerns, what are some of the big issues that you are dealing with, because that married then through to the front reporting sheet of the performance report.

155 Q. Sure. Then just bringing us through to the end, comments on the excellence of the facility. Then there is an issue about a potential move, which, as I understand, at least in terms of the Thorndale Unit itself, didn't come to pass. There had been an earlier move of the Urology ward which caused some disgruntlement amongst the team. Just continuing on.

A. Yes. At one time it was in 2 South, a full ward, and then moved to there.

156 Q. That's the first of the walks. Geraldine Donaghy, who was one of your Non-Executive Directors, she performed a further leadership walk some six years later in 2018.

Should there have been a repetition of the exercise long before 2018, particularly in the context of a service which, I'll demonstrate in a moment, was well known to you and your fellow Board members to be struggling in terms of its capacity? Does it not strike you, thinking back on it, that you really should have been directing somebody back to do another leadership walk to better understand what was actually

going on on the ground?

A. Yes. I wouldn't disagree with you, Mr. Wolfe, but remember we had many sites to visit from the Clougher Valley, which is quite a distance away, right through to Kilkeel, to Coalisland. Our geographical spread of the Trust was huge, and therefore we were trying to get round all sites. It would have been difficult to do many more visits above what we had done. However, coupled with this, remember, was the head of services visit; you had a governance lead in there as well that you would have expected to be visiting; you had an assistant Director. This is in the operational end. You had a clinical Director. Also the Chief Executive would have been out walking as well. I can't say if was reported into the Trust Board where they went on their walks, so I just can't remember. I mean, during that period did any Chief Executive visit there or indeed the reporting in of an assistant Director. 15:33 15:34 15:34

But no, as a Non-Executive Director, we didn't go back again but I do remember Geraldine's visit in '18. 15:34

157 Q. Isn't it fair to say that the Non-Executives are performing the walk for perhaps different reasons than the executives? The Non-Executives are the challenge function, you need to gather the information so that you can challenge the Chief Executive and his or her team as to what's going on on the ground. To say there were other people walking that walk isn't a useful substitution for the work that your Non-Executive team 15:35

should be doing?

A. Yes, and I respect your opinion on that. However, it would have been difficult to ask the Non-Executive Directors to do many more visits. If you look in their schedule of work that they did for the overall Trust as well as those walks, at least two of them were struggling to get those visits completed. I think that came up on an audit somewhere, an internal audit. But that wasn't because of not a willingness, it was just time pressures on their other work. 15:35

158 Q. Yes.

A. So I take that criticism but it would have been difficult to fit in many more visits. Remember, we were visiting other sites.

159 Q. Yes, I take that point. Geraldine Donaghy's visit on 5th March 2018, we can see that at WIT-26631. She is accompanied by Jenny McMahon, who is another Urology nurse specialist. We'll not walk through every aspect of this form, the Panel can read it, unless you have any particular observations to make. 15:36

Can I bring you directly to the question about what doesn't work well, and we can find that at 26632, just a couple of pages in. There we go. In the last paragraph it explains that workforce issues are generally stable, albeit with an ever increasing workload so that additional staff are needed. Incidences of prostate and renal cancers have resulted in a case being made for an additional nurse to do 15:37

follow-up, and the reporter was hopeful that this will happen.

"Currently there is a consultant urologist vacancy and ongoing dependency on locum consultants continues". 15:38

Then, over the page, the question is asked what would you like to change or see different? An explanation is given about the need to discuss further opportunities for nursing development, improvement of flexible 15:38 cystoscopy and improved succession planning for the service.

In terms of challenges then, difficulties remain in meeting the cancer targets for first appointment and 15:38 first definitive treatment. Lengthy waiting time for what are considered to be non-urgent urological surgery. However, many of these patients are experiencing significant impact on their quality of life while awaiting procedures. 15:39

I suppose by contrast with the picture that was referred to you six years earlier, here is a clear articulation of the pressures facing the service in terms of its ability to manage capacity and the impact 15:39 that this is having on patients. These reports and the information contained within them, they go to the Chief Executive?

A. Yes. They go back after they are initially written up

by the Non-Executive Director or myself; went back to the Department within maybe 10 days to allow them to check the accuracy, and then they came back and then they went to the Chief Executive, and then they would have discussed it on a one-to-one for the Director responsible for that area. Then, remember, they also went to governance; they went quarterly to the Governance Committee. 15:40

160 Q. Through the Chair, we will hopefully take a short break in a moment. When we come back, we will look at the kinds of information the Boards was receiving by this point in relation to the pressures facing Urology service. I suppose the question I'll ultimately be asking you to think about is to what extent did the Board adequately grapple with the concerns that were coming through to you from Urology about the capacity issue. So if we can pick that up maybe after the break. 15:40

A. Sorry, could I just?

CHAIR: Go ahead. 15:41

A. I was going to say isn't this the report - and again this is from memory - that Geraldine had the opportunity - I didn't, there was no consultant on during my visit - isn't this the report that Geraldine had the opportunity to speak to Mr. Haynes? 15:41

161 Q. MR. WOLFE KC: I'll just check through that during the break. I think that's right.

A. She spoke to a consultant and others, I think. On the day of my visit, the two clinical nurses were on and

the admin staff, but Mr. Haynes was there on that day and she had quite a conversation with him on a one-to-one because I can remember her bringing back and showing me this and telling me about a new consultant, or I think he was new. But maybe it is a different report but just checking if --

162 Q. I think he was five years new by this stage.

A. But there was something about then... Maybe a different report.

163 Q. We will come back to that after the break. 15:42

CHAIR: We will come back at four o'clock, ladies and gentlemen.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 15:59

CHAIR: Thank you, everyone.

MR. WOLFE: If we could go back to the page we were at, the leadership walk, to tie up a few loose ends. WIT-26633. It's under the question of what challenges do you face. We were looking, Mrs. Brownlee, to see if 15:59 there was any mention of engagement with Mr. Haynes during this exercise. Certainly my eye hasn't picked up on anything. You will be coming back to give evidence tomorrow; if you have a recollection to better bottom out that point, then feel free to bring it to 16:00 our attention.

I just want to deal with the utility of these walks and how they were used. You've explained that -- I'll just

let you make your note.

A. Sorry.

164 Q. No, no problem. You have explained that these reports, as the product of the walk, would end up with the Chief Executive and go to the Governance Committee. Did I hear you right? 16:00

A. Yes. Yes.

165 Q. Would you have expected any form of action or response when they were passed to those people or committees?

A. Yes. Well, to be fair to the Chief Executive and indeed the Director, they always did respond. That's I think at an earlier one we saw the red writing. It was always -- I would honestly say always the Director would have replied. If there was anything highlighted on it, definitely. If it went to governance, I can't recall what would happen then. They went as a block for a particular quarter if they were reported maybe every three/four monthly into Governance. But definitely the Chief Executive would have discussed it on the one-to-one or sent it to the Director. 16:01 16:01

I have many, many recollections of the Chief Executive sending it back then with the comments from the Director, and action points. Definitely they did.

166 Q. Yes. I am going to move to look at some of the occasions when the Board or the Performance Committee was directly referred to concerns about the pressures facing Urology. But just looking at the content of this walk, for those, I suppose with a focus on this, 16:02

they would have seen the real expression of concern about the impact of lengthy waiting times on the quality of life of patients. I mean, that could probably be written up in a variety of ways but it does point to risk to patients, doesn't it? 16:02

A. Yes. Yes.

167 Q. Would you agree with me that passing this to the Chief Executive, passing it to the Governance Committee, is not enough of itself? It might be a useful first step but in order to get to grips with I suppose big ticket 16:03 issues such as not meeting cancer targets, coming up with solutions for lengthy waits, particularly where it is impacting on or risking the quality of life of a patient, it requires a rather more well thought out and considered and developmental response than it just 16:03 going to one person?

A. Yes. But I keep using this one as an example, I do remember Geraldine Donaghy was a very strong Non-Executive Director who was very challenging, I remember her bringing that up under performance around 16:03 her visit at that time, and I'm sure it's in a minute. So it wasn't just written up, went to the Chief Executive and a Director replied to you. We did try a lot of these, if you put them under headings, we knew we had a capacity and demand issue in many areas. We 16:04 knew ourselves about the cancer targets on the performance report that we weren't meeting. You're absolutely right, I mean, this shouldn't have been a surprise to the Director or line management in Urology

as an example, because a Head of Service would have known this and an Assistant Director would have known this and certainly the Clinical Director, so this wouldn't have been surprises.

I mean, what did we do about it? Are the actions flowed then from governance into the Board and the asking of questions.

168 Q. Yes. Let's look at this in a bit more detail. I'm going to bring you to a minute of a Board towards the very start of your tenure. In 2009 you were not yet Chair, you were a Non-Executive Director. Mr. Beech will help me with the date. If we go to WIT-90860. Sorry, I'll bring you to a different reference, sorry. TRU-105665. So, TRU-105665, halfway down the page. 16:04 16:05 16:05

Mrs. Clarke, was she Director For Performance?

A. Yes. At that time, yes.

169 Q. This is 24th September 2009, if I haven't said it already. 16:06

A. Sorry, what date was this again, sorry?

170 Q. I'm not sure if I've said it three times now, 24th September 2009. Let just orientate ourselves by bringing you to the first page of the minute. TRU-105658. There you go. It is being held at the Dungannon Council offices. Mrs. Balmer is in the Chair and you are there as Non-Executive Director; Mrs. McAlinden being the acting Chief Executive. As we can see, jumping back to TRU-105665, Mrs. Clarke is 16:06

reporting on a number of risk areas. Number 1 is described as "in-patient day case access target". In the next sentence, we realise that number 1 is referring to Urology because she says:

16:07

"In relation to 1, Mrs. Ewart advised that a trusted undertaken a review of Urology services and this had highlighted a capacity gap".

That issue of capacity gap would have been something you were aware of from the earliest times in your career with the Trust. You've said in your witness statement, this is WIT-90860, just in the second paragraph: 16:07

16:08

"Along with other services like Radiology, Endoscopy and Unscheduled Care, to name a few, Urology came to the attention of the Board as a service under pressure. I do not remember Urology ever coming to the Board as a single agenda item. We did know of the long waiting lists as this was referenced on the performance reports along with many other specialities". 16:08

So, you are aware of the problem and perhaps features of the cause of the problem, as we'll see when I take you to the references. The executives, you are suggesting there, didn't bring forward to the Board for discussion Urology as a standalone item to be discussed and grappled with and for solutions, perhaps, to be 16:09

worked through. Is that what you mean by that?

A. What I mean, as a single item --

171 Q. Yes.

A. -- Urology didn't come, say, separate to Radiology, Unscheduled Care, et cetera, there was many others. That's what I meant when I was preparing my Section 21. 16:09

172 Q. Yes.

A. It didn't come because it came in a group with other services under pressure. There is no doubt we had many areas at that time that you are speaking of. We had a lot of reconfiguration of Trust sites, of both South Tyrone Hospital, at Daisy Hill Hospital, and even on the Armagh site as well as Craigavon, to try and deal with the pressures on any specialities, not only Urology. 16:10 16:10

Can I just say that when you did and could have got additional money, it wasn't always about getting extra money. Some of the difficulties was on the site, whereas we could have put in a building. Very importantly, it was we may not have got the workforce to manage that. That was a huge pressure that we were dealing with every day in relation to recruitment of consultants across most areas in both surgical, specialised, and indeed in medicine. 16:10 16:11

173 Q. The Trust was the subject of a regional -- I'll put it a different way. Urology was the subject of a regional review in 2009, which created three teams to provide Urology services across Northern Ireland. Team South

based in the Southern Trust was focused on the delivery of Urology services to many populations west of the Bann down as far as Kilkeel and into Newry.

Did you have any clear signs of how that regional review was supposed to work in Urology in the Southern Trust? 16:11

A. Again, some of what I have read in my bundle, the letter from Mr. Mullan, I think it was, and the review, I wouldn't have seen that before nor would I have 16:12 expected maybe to see it because they were operational. As a Board member, I wouldn't have been -- I don't remember any Non-Executive Directors involved in the regional review of Urology. I definitely know our Director of Performance, quite a number of her 16:12 clinicians in Urology, and indeed the Chief Executive, would have been involved in that region. Again, from memory, let me think, cystectomies was moved to Belfast.

174 Q. I suppose the question -- sorry to cut across you but 16:12 just to focus on where I want your views. The outworking of the regional review was supposed to focus, or better focus, resources on Urology need within your area, but you can quickly see in the years after the Urology review that this service in the 16:13 Southern Trust remained under significant pressures. For example, we have a performance report in August 2012. TRU-106597 is the cover page for this report, and it's dated August 2012. If we go through to

TRU-10660?
CHAIR: I think you left out a 5, Mr. Wolfe. It should be 106560.
MR. WOLFE: Yes, I think that is correct, Chair, 106560. 106600; that is another option. 16:14
CHAIR: Maths was never my strong point.
MR. WOLFE: TRU-106600. Under Urology for this performance report in August 2012, it's describing the performance risks in inpatients, day cases and urodynamics result from an established capacity gap for 16:15 which recurrent investment has been committed.

"Current in-house capacity is entirely absorbed in managing red flag referrals and urgent cases. The Trust has appointed three consultant urologists 16:15 starting in August, September and November. However, the impact of this capacity will not manifest until into Q3 and Q4, and so the independent sector has been considered. However, they are unable to provide all of the capacity required to achieve access standards". 16:16

So shortly after the implementation, or the commencement of the implementation of the regional review, recognition of the need to recruit more consultants, and that is taking some time. Meanwhile, 16:16 there is a need to reach across to the independent sector.

For the next several years, although recruitment does

take place, the service continues to experience significant pressures; isn't that right?

A. Yes.

175 Q. We can see, for example in 2013, towards the end of the year, Urology is identified as an area where there are significant risks so that they are reflected in the corporate risk register. If we go to that please. WIT-52912. Just there on the third bullet point, it is describing the largest volume of waits are in Urology and ENT, with the longest waits being Urology. 16:16 16:17

The position, as we understand it, remains largely unchanged, as I say notwithstanding recruitment, and in fact might be viewed as getting worse. If we look at the corporate risk register for February 2016 at WIT-53073, we can see that it's been reported that areas of risk highlighted to Health and Social Care Board formally include Urology and in particular its outpatient review backlog. 16:18 16:18

You have said in your evidence, I think, that on occasion, almost beyond your remit, you have directly engaged with the Health and Social Care Board. Can you remember particular examples of that and why you saw fit to engage with them directly? 16:19

A. Well, certainly from what you've shown here, we knew, despite the current funding, even the recruitment of consultants - and I'm not quite sure all of those three consultants did arrive, I may be wrong - that the

capacity was still great. It was coming to the Board and we were hearing back that the Director of Performance had been to the Board about additional funding and to get extra help from the region. I'll come back about the region that you talked about earlier. I mean, all of that was happening but as a Board we couldn't see progress or anything getting better. So I felt it important, as a Chair of the Trust, looking at the risks, that I should go with the Chief Executive. We would always have written a letter to the Chief Executive of the Health and Social Care Board, and through to the Department. 16:19 16:20

So I accompanied at least twice. I remember going. Mrs. Watts was definitely the Chief Executive on one occasion and going to Linenhall Street in Belfast for that, to talk about capacity and demand and Urology. I remember -- I am fairly sure I went with Mrs. McAlinden, and I also went once with Mr. Devlin - that's all from my recollection - to talk about capacity and demand and how we were going to manage this. To be fair to those departments we went to -- and I remember on top of that we were going to the accountability meeting where we talked about some of these pressures again with Mr. Pengelly, and there were other meetings at the Department but those were the meetings that I went to. There was always a sympathetic ear. To be fair, we were received well. They understood because they were seeing the report, 16:20 16:20 16:21

and our colleagues went before us to see what was it they could do to help us. It wasn't all just money. It was actually seeing, as you talked about in the region and the region south, that actually you would have thought helped us, but it involved our consultants travelling to the Southwest Hospital, the new Acute Southwest Hospital. Sometimes it's difficult maybe to explain the geography, but that was a consultant travelling in his time from the Craigavon site to the southwest and trying to deal with that. 16:21

So, it wasn't just getting extra money, we were looking the regional support, what was the region going do about Urology. Because it wasn't just in the Southern Trust, from memory the Western Trust had huge problems as well, and we know the Belfast Trust had huge Urology problems. The money was one thing, the capacity was another, but there is no question about it - recruiting skilled urologists was a problem. We were not able to recruit from the Republic of Ireland. I don't recall us ever recruiting a consultant urologist from within Northern Ireland, if you know what I mean, from another Trust. We would have been trying to recruit from the UK. Sometimes we had no applicants. Sometimes would you have had three/four and you would have tried to take the three or four. One may have been going off for a Fellowship to Australia, Canada, wherever it was. 16:21 16:22 16:22

Also, the pool of people that were applying, I mean the

Northern Trust could have been applying for urologists at that time, and possibly the West. If you understand how consultant interviews take place, I could have been interviewing on a Tuesday afternoon, the Northern Trust could have been interviewing on a Monday afternoon, and if they interviewed and selected that person, by the time you came to Tuesday, we already had two cancellations. So, I did visit. We spent considerable time on that. We didn't -- 16:22

176 Q. Sorry just to cut across you in the interests of time. If we go to another corporate risk register entry in August of 2016. If we go to WIT-102924. That's the front page; if we go to 102969. It explains that in terms of planned patient backlog - I assume this is a reference to elective patients - it is setting out the figures there and it is saying that the longest waiting patient dates back to October 2014 and relates to Urology. 16:23 16:23

Was there a recognition - it's written there in black and white - that Urology, albeit that there were other services and disciplines within the Trust that were also getting it hard and were under pressure, but Urology was really, in many of the services it wished to deliver, in a worse place than maybe any other service? 16:24 16:24

A. It certainly would have been one of the worst, yes. Maybe Radiology at that time was another. Yes, it was recognised. I mean, the like of that patient in

October '14, when that would have come to the Board, I definitely know a Non-Executive would have always asked that's a patient somewhere who is waiting a long time, who has been in touch with them? What type of letter have they had? Have they been back to see their GP? Can they be seen? We would have always thought of a number as a patient. It wasn't that there was a thousand and we didn't think these were people. All of these people in whatever speciality it was, and especially Urology, we knew these were patients awaiting a service, we were very concerned about this. Certainly patients were in the centre of all that we did. But it was extremely difficult to get all of these patients seen on site. We tried to do these outlying clinics. There was clinics held in a variety of places, but the Urology theatres were all in Craigavon site. 16:25 16:25

177 Q. But the problems, as they have been described to the Inquiry so far, include the recruitment issue?

A. Yes.

178 Q. And as well as that, capacity or access to theatres. You've said earlier that Urology didn't arrive on the Board's agenda as a single item at any point, it was always part of the mix of other services facing difficulty. When you think about it now, should the Board have given greater focus to Urology? Should it have become a single item for consideration given that, across some of the indices at least, it was a worst performing service, or a service that was least well able to deliver and was gathering the biggest waiting 16:26 16:26

lists?

A. Yes. With hindsight, it could have come as a single item but there would need to have been other specialities come as well, and it did get the focus of the Board. Did it get the outcomes we expected when we see the waiting lists still? It got lots of discussion, it had a lot of performance management reviews, there was a lot of meetings at the Board. When I say the Board, I mean the Health and Social Care Board. And also at accountability meetings through -- 16:27

179 Q. We've heard from time to time that there were waiting list initiatives and any capacity made available through that was snapped up by Urology clinicians to the extent that they were available, but we don't ever see any evidence of, I suppose, a focused plan on Urology, notwithstanding the fact that we've seen correspondence from the likes of Mr. Haynes writing in to the Acute Director and saying, listen, we are really concerned about this, patients are at risk, patients are in danger. Is that the kind of thing you and your Board appreciated? If so, was there any substantive action taken to try to address it? 16:27 16:28

A. We were very aware of that, definitely those discussions took place. We spent quite considerable time talking about long waiting lists, and Urology with particular reference. We knew how serious it was, we knew each one of these were patients -- 16:28

180 Q. Can you be specific, how was that manifested? How was that awareness of the risk to patient health manifested

in the actions that the Trust Board performed?

A. Again, we would have said back to the Director of Performance, and the Chief Executive as the accounting officer, you know, we need to go back, we need to see what more we can do. But, Mr. Wolfe, even by going to these others, the Commissioner and our department, they weren't able to help us fix this problem that we had. Now, we did go out to the independent sector. I mean, again we've quite a limited resource here in Northern Ireland for that. It was taken up quite quickly, the spaces, but it didn't reduce our lists very much because you are talking about they would have maybe done 30/40 people at a time, but it didn't bring down the numbers. What was important was those who were the longest wait; the patient with the longest wait would have been seen. 16:29 16:29 16:29

If we're saying Patient A was waiting from October '14, what we were saying was we wanted to see the action that that person was being made contact with, and when would they be seen by the independent clinic or wherever. It wasn't as if you took them off at random. Again, it was always urgent cases, you know, people who were a priority, red flags, whatever. I'm not sure what else we could have done than go and raise issues. We put it in writing to the Board, as did the Accounting Officer. We brought it up with the Department. We got sometimes extra consultants. Also in the regional review, we got the specialised nurses 16:30 16:30

to help to do with some of the urodynamics and the stone clinic, and also to assist.

To be fair, it didn't make a big impact because the referral through from GPs and emergencies was just outstretching our ability to do it. But definitely if there was an urgent case came in, we would have tried to look to the region to see, because it was a regional approach and we have tried that with many of our specialties. 16:31

181 Q. If we just look in conclusion this afternoon at some of the waiting lists which the Trust had to grapple with. As I said by way of preface earlier, you came into the Trust in or about I think it was 2007. 2009, we've seen from Mrs. Clarke's input at that August 2009 Board meeting, that already, in the development of Urology Service at a fairly early stage, already it was a service under pressure; throughout the period after the Urology review in 2009 it remained under pressure. 16:31 16:32

Looking at the waiting list for the category of first outpatient appointment, if we go to TRU-98238. This is the waiting list for May 2016. I am just remarking that TRU, for whatever reason, seems to be the slower of our documents to come up. It's not pointing the fingers at the Trust. I can see Mr. Lunny becoming unsettled by that remark. 16:33

CHAIR: I'm sure he isn't. Mr. Lunny is usually the one that gets the numbers on the pages right. Not like

the rest of us.

MR. WOLFE: I think the reference is right. Perhaps, more seriously, we need to look at this system and see if it can be improved in that respect.

16:33

What we see Mrs. Brownlee, is for number of patients on a consultant-led first appointment as of May 2016. There are a total of 2,743 waits, looking at the far right-hand column, across each of the consultants retained in the service. 420 are waiting more than a year. That figure was to increase significantly, so by April 2020 there were more than 2,000 waiting more than a year.

16:34

16:34

If we can bring you to, at the risk of a significant delay, TRU-98242. There we are. Albeit that there is probably a COVID element to these figures, we can see that there is a substantial jump both in terms of the overall number waiting, and those waiting more than 52 weeks is now sitting at more than 2,000.

16:35

Were these figures regularly brought to your attention?

A. Yes. Yes, those reports all came to the Trust Board. I use again as an example, colleagues would have been asking, say - I've lost a bit of my screen - but if, say, one waiting, tell me some of the people that are waiting 52 weeks plus, say, under a particular consultant, are these routine - I'm sorry, I don't particularly like that word - are these routine versus

16:35

a red flag? Hopefully not but there may have been some of those waiting a long time. So, we would asked about individual feedback from the Director presenting this. And that is where the Director of Performance would have been looking to the Director of Acute Services as well as the Medical Director to assist a lookback or a look in to see how long are they waiting, what is their condition, what is their follow-up like. So, they did come to the Board.

182 Q. To summarise your evidence, you appear to be telling us that the Trust Board were not strangers to this kind of information; the Trust Board regularly discussed pressures on services, not just in Urology but across several services. You appear to be saying that as a Board, you didn't lose track of the fact that patients could come, and possibly were coming, to harm, certainly at risk of harm while being on the waiting lists. But in terms of the initiatives that the Trust was able to take up to address such matters, you would maintain that you did your best through the Health and Social Care Board, with the Department, in making use of whatever resources that you had available to try to at least ameliorate matters?

A. Oh yes, definitely we did that in meetings. But also as well as trying to get behind some of these numbers, because we knew these were patients, we would have been looking to know about -- we would have always said the GP would have been the one who would have been referring them in again if it was urgent so that they

would have been seen. That was definitely happening.

The other thing, when you ask what else we should have been doing or could have been doing, we did try with our own consultant urologists to see about taking on extra work; I mean to do extra theatre lists. Our theatres were extremely busy. You know, there was rarely any time that the theatres weren't occupied by other services but if there was a gap, we did try and definitely extra theatre lists would have been put on. It didn't really make a big impact because we are talking about maybe only three/four that you could do in a day. Or a Saturday, I think there was Saturday and Sunday working. Other areas we tried to do through, as I say, the independent sector, as well as seeing could any of our other colleagues in the other regions could help.

But whilst all of those seem small when it came to reducing your number of 2,000, it didn't make a big impact because as you got more people coming in and being referred, it started at this side of the screen and pushed these people waiting longer. So we would have had a huge referral number through from GPs usually was the referral or through maybe another speciality of that. We had huge numbers. I suppose I think back to when you refer, Mr. Wolfe, to 2007, what consultants there was in post for Urology then and the numbers telling us -- I'm not sure, again this is from

memory when would I have been leaving, had we even our full capacities of consultants at that time, the six or seven. But even with the six and even with extra theatre and even with the independent sector, all of those extra resources and modular units, et cetera, whatever was happening, our waiting lists in Urology continued to rise.

183 Q. The point has been made to the Inquiry that the factoring which took place at the time of the Urology review in terms of the resources needed by the Southern Trust Urology Service would have been sufficient going forward, but when you added in the backlogs that existed at the point of the conclusion that of regional review, it was never going to be sufficient to enable the service to catch up. Which probably prompts the following question: You were there throughout this period, you've observed what Urology was able to do and what it couldn't do as manifested in the waiting lists. Is it fair to say that the Trust was never adequately resourced to meet the demand for urological care?

A. I absolutely agree with that. I mean, we weren't resourced for the demand of people that we had but it wasn't infinite resources. I'm sorry, I have just lost the screen a bit. I am interested to point out, Mr. Wolfe, if I am allowed, the consultant's name. I think is down the left. Sorry, thank you.

I suppose the point I would like to say when I look at this, and hopefully from memory, I think Brown is

Mr. Brown in Daisy Hill, who was a general surgeon, from memory, and all of that. What I used to ask after we made an appointment, and this is just my practical question rather than knowing the specialism, if you got a new consultant and you knew there was X number of patients waiting, I could never understand - and I did ask this at very senior level - why when they came in, even for just the first six months, why could they not have just dealt with those that were waiting the longest? To me it just seemed the practical -- rather than starting a new waiting list, why did a new consultant - and I'm sorry for picking out some of the ones that I may not know that are there longer - why did they not, as part of the business plan and the day-to-day operations, be allocated to look at the longest waits and try and reduce them. We would have brought that up quite a bit at the Board. 16:41 16:42 16:42

Also, like Mr. Brown is a general surgeon but sometimes, you know, he would have been involved in urological medicine as well. It's just a generality. 16:42

184 Q. Do you think, upon reflection, that engagement with the clinicians themselves might have been an unusual course to take? Obviously you had the opportunity with the leadership walks to engage with two of the nurses, but do you think, upon reflection, engaging with the clinicians to see where they saw the problems and potential solutions might have born dividends? 16:43

A. Certainly we, as a Board, Non-Executives, didn't engage

with the consultants unless on a leadership walk. I do remember coming to either the Patient and Client Experience Committee or else the start of a Board, Urology, the specialism, coming to hear some of the in-workings to try to reduce the waiting lists around urodynamics and what the specialised nurses were adding to in reducing waiting lists. I remember that coming to the Board. 16:43

There is no doubt talking to consultants per se is a wonderful experience, and that's why I found when I went out walking, should it have been to the canteen, I had probably more talks to the cardiologist, the dermatologist - these were people all with a big waiting lists - dermatology and also Obstetrics and Gynae, you would always have bumped into consultants. As I say, on the interview panels - and remember I met many of these people on interview panels - so I did have opportunities and I did hear their problems and I did try to bring them back on any concern. If anyone raised a concern with me around capacity demand or a risk about patients, Would I have always, even after 5:00, late evening, have talked to the Chief Executive about it. I always would. 16:43 16:44 16:44

Did we routinely talk to consultants? No, we didn't because there is that line between operational. But I would have talked to a lot of the consultants, not in Urology as such but --

185 Q. Did you ever speak to Mr. O'Brien about the capacity concerns that he would have had?

A. Mr. O'Brien, never. No, no.

186 Q. And why not?

A. Well, I don't remember Mr. O'Brien ever speaking to me about clinical issues in Urology or about his specific pressures. He never came to my office. He never - I can't remember, I may be proven wrong - was writing to me until the latter stages about that. Certainly when we have been doing interviews, and I would have interviewed many Urology consultants, and I think Michael Young was the clinical Director and I remember appointing Mr. Glackin -- 16:45 16:45

187 Q. He was clinical lead, just to be clear?

A. Sorry, clinical lead. So you would have picked up -- I, at an interview, you would have heard while you were maybe in between while waiting for candidates, but before we started the interview we always asked the Medical Director, and indeed the clinical lead or the associate Director, tell us about this post, tell us where the vacancy is, what is the speciality that you're looking for. Because a lot of consultants have their own specialism, you know, be it stone, to a tumour or whatever. We would have talked quite a bit about the speciality. So, definitely I didn't miss any of those opportunities and I would have talked to many of those consultants. 16:45 16:46 16:46

If I did bump into them out in the corridors of the

hospital or in the canteen, I mean these wouldn't have been a group that ever came over to me and said anything compared to maybe some other consultants.

188 Q. What you are saying, in conclusion, is they, as a group of consultant urologists, didn't engage with you about the specifics of the capacity problem and ways that they might have had in mind to address it or mitigate it? 16:46

A. No, well not me directly, but I would have heard that at an interview because we would have spent a morning, I mean, interviewing or waiting for candidates to come who maybe didn't turn up, and you would have heard a lot up. I call that the soft information that you would have gathered from consultants. So absolutely you would have heard from Mr. Young the pressures they were under, I won't deny that, I mean. But did someone come to me specifically, to my office or write to me about Urology pressures or Urology concerns? I may be proven wrong but I don't remember it. 16:47 16:47

189 Q. Yes. In any event, through the sources we have looked at, you were clearly aware of those pressures? 16:47

A. Absolutely.

190 Q. And you took the steps that you have described?

A. I believe I did to the best of my ability with my executive team, because I was tasked with that as well by the Board to do that, collectively that we should write, and I did write, and also I should go. I did all of that right to the end of my tenure. 16:47

MR WOLFE KC: Thank you. Chair?

CHAIR: It is ten to five, Mr. Wolfe, and it has been a long day for everyone.

We will start at 11 o'clock tomorrow, weather, gritting, non-gritting permitting. Hopefully see you safe and sound tomorrow morning. 16:48

THE INQUIRY ADJOURNED UNTIL 11.00 A.M. ON THURSDAY, 18TH JANUARY 2024