Urology Services Inquiry

Oral Hearing

Day 83 – Tuesday, 6th February 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

INDEX

THE HEARING COMMENCED ON TUESDAY,
6TH DAY OF FEBRUARY, 2024 AS FOLLOWS:

CHAIR: Good morning, everyone. Yes, Ms. McMahon.
MS. McMAHON: Good morning, Chair. The witness this morning is Mr. Aidan Dawson, Chief Executive of the Public Health Agency, and he is going to take the oath. 10:01

MR. AIDAN DAWSON, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS: 10:02

CHAIR: Mr. Dawson.

1 Q. MS. McMAHON: Mr. Dawson, thank you for coming along to give evidence to the Inquiry this morning. You have, helpfully, provided a Section 21 response to notices sent to you from the Inquiry, and I just want to take you to those at the start of your evidence. 10:02

The first Section 21 response can be found at WIT-61582, and you will see your name at the top of that page. And then if we go to WIT-61638 and, just at the end of that, we'll see a signature and a date of 24th October 2022, and do you recognise that as your signature? 10:02

A. I do. 10:03

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

A. I do.

3 Q. You sent us in a further addendum statement relating to

an issue we can deal with subsequently. That can be found at WIT-106837, and we'll see your name at the top of that, and this is the supplemental statement to your main Section 21, and just if we go to the end of that, it is just the next page, at WIT-106838. Just go down there, we should see a signature and your name and the date of 30th January 2024, and do you recognise that as your signature? 10:03

A. I do.

4 Q. And do you wish to adopt that as your statement also, evidence to the Inquiry? 10:04

A. I do.

5 Q. Thank you. Just, at this point, is there anything you would like to add or amend on either of those statements at this point? 10:04

A. Not at this time.

6 Q. Okay. Now, in relation to your evidence and the context for that today, you have provided a statement and extensive exhibits for the purposes of the Inquiry, for them to reflect on, and that evidence is now in, formally into -- before the Panel, so your oral evidence today will focus on some main points just that arise from those statements. In broad terms, the areas that I am going to cover, just to give you and others an idea of our roadmap for this morning, will be your role in the PHA, the role and responsibility and functions of the PHA, the PHA's relationship with other bodies, other arm's length bodies and others, and the relationship with Urology generally and specifically 10:04 10:04

within the Trust.

Then, we'll move on to look at some of the issues arising in Urology and PHA's knowledge of those issues and actions taken by them. We'll then look at SAIs, Serious Adverse Incidents, the reports, the role of the PHA and the PHA's knowledge of the SAIs around Urology, and then we'll generally just touch on the Early Alert System, the current review of SAIs in Northern Ireland and any reflections you have as to what you think went wrong or have the issues been resolved or, indeed, what the learning has been from the Public Health Agency's point of view. So, with that in mind, those are the areas that I will take you through. 10:05 10:05 10:06

Just at the outset, I wonder if you could give us a brief background to you and your career to date and your current role within the PHA?

A. Yes. I started in the health service as a management trainee back in the early '90s. I have held a number of roles over 30 years in my career, both at operational level at Trusts. I spent four years working in the community and voluntary sector, also. Then, turning to Green Park Trust, then Belfast Trust subsequently, where I left Belfast Trust in, sort of, '19/'21 to take a post as the Chief Executive, Public Health Agency. In the Trust, I spent 16 years as a Co-director and Director, before leaving to take up this post as Chief Executive of the Public Health 10:06 10:06

Agency. I report through to the Board of the Agency, who, in turn, report to the Minister and the Department of Health. I'm the financial accounting officer and, in that role, I report through to the Permanent Secretary for Health as well.

7 Q. Just give us the date that you took up post with the Public Health Agency?

A. Oh, gosh, it was 1st July '20, I think.

8 Q. 2020?

A. 2020.

9 Q. So a lot of the issues that are before the Panel are, the chronology would suggest that you came late in the day to some of the issues arising, but your staff provided you with some information, and you have provided that detail, if we just go to your statement at WIT-61586, at paragraph 20. We've asked you if you had to rely on others for assistance to complete the notice and asked you to identify them, and you set out -- at paragraph 20, you say the following:

"PHA staff involved in the completion of this notice have included Dr. Joanne McLean, Director of Public Health; Dr. Bríd Farrell, Deputy Director of Public Health; Dr. Diane Corrigan, Consultant in Public Health Medicine; Mr. Rodney Morton, Director of Nursing, Midwifery and Allied Health Professionals, Mrs. Denise Boulter, Assistant Director; Mr. Stephen Wilson, Director of Operations (Interim); and Ms. Karen Braithwaite, Senior Operations Manager (Delivery)."

So I presume they are individuals who form part of your Senior Management Team, senior roles within PHA?

A. The majority of them. We have three executive directors: Dr. McLean being the Director of Public Health; Mr. Stephen Wilson, the Interm Director of Operations; and Mrs. Heather Reid, the Director for Nursing in AHPs, that's the executive team.

10 Q. And the individuals you have listed at paragraph 20 were able to provide you with specific information that we had requested or that they and you found would be helpful to the Inquiry, given our terms of reference? 10:08 10:09

A. Yes.

11 Q. Now, I just want to give you a little bit of background around the Public Health Agency, and if we go to WIT-61589, and this is just some general background information, and I'll just read it out in summary form and then we'll just want to ask you a couple of questions around this. 10:09

10:09

So the Public Health Agency is a statutory body and it came into existence on 1st April 2009. The role and responsibility and the outworking of the Public Health Agency, and indeed other arm's length bodies, is derived from Section 13 of the Health and Social Care (Reform) Act 2009, which is then further extrapolated out into the Department's framework document, a document I think you will be familiar with? 10:10

A. Yes.

12 Q. Which was dated September 2011. And what that framework document does is explain and outline the systems, mechanisms and procedures for the PHA to comply with its statutory functions, and there are effectively three functions of the Public Health Agency: the first is the health improvement functions, then the health protection functions and then the strategic development, along with the Health and Social Care Board, which is now referred to as the Strategic Planning and Performance Group (SPPG) and the Panel will hear evidence from SPPG staff and personnel on Thursday. 10:10 10:10

So those general three broad themes of the PHA, could you just give us an idea of the way in which the PHA operates to fulfil those broad areas of their statutory remit? 10:11

A. Yes. I suppose the health protection one is probably very well known through Covid and we also have a responsibility in health protection for things like vaccination and screening and to identify risks to the public health and to mitigate against those risks, working with our partners across health and social care, the rest of, I suppose, the public sector and the community and voluntary sector, and indeed the population at large, so that there would be health protection. Health improvement and social well-being, we predominantly work with local communities and the community and voluntary sector to commission services 10:11 10:11

at a local level. They might be in such things as mental health or active travel, etc., so we arrange contracts in that area. We might also contract with, sort of, disability organisations as well, and the aim of that is to reduce inequalities and improve health at a local level, improving the resilience of local communities regarding their own health. Then, service development is where we work with the Health and Social Care Board - now SPPG - to provide professional advice into commissioning of health and social care services in the work that they carry out and which the SPPG lead on.

13 Q. We've seen from the list of individuals that you have called upon to help you fill in the Section 21, that you have clinicians and other allied healthcare professionals on your team?

A. Yes.

14 Q. Presumably, that is a deliberate strategy so that the Public Health Agency can take, perhaps, the lead, or at least inform decisions of other arm's length bodies, but also the SPPG and the Department, would that be a fair reflection of the reasoning behind that?

A. Yes. We do -- our public health consultants and our other professionals, such as nursing and AHPs which work for the Agency, would provide professional advice, predominantly on public health issues to SPPG around commissioning, but also to the Department on a wider - I mean, we provided a lot of advice on Covid during that period of time as well.

15 Q. And the Public Health Agency in that regard are probably uniquely placed within the other arm's length bodies, given that level of medical expertise in your senior team and in your directors?

A. Yes. If I can say, we're uniquely placed both as well across the UK because we're the only public health body which has an input directly into the commission of health and social care services. You don't have to -- maybe it's worth identifying that you don't have to be a qualified medic to be a public health consultant; that has changed in recent times, and we do have a number of public health consultants who would not be of a medical background. 10:13 10:14

16 Q. And when you say you're the only healthcare body that has direct involvement with commissioning, clearly that's within the structure of the legislative framework and the powers that the PHA have been given under that particular framework. Just from your perspective, do you consider that that is beneficial overall in the service delivery of the statutory functions of PHA? What's the advantage for us, in Northern Ireland, that you have that particular role that other public health agencies don't? 10:14 10:14

A. I think, for us, it allows us to link our work in -- as I said earlier, we work with community organisations to outline primary intervention and prevention around health and allows us to link that directly into what is also happening and have a consistent approach in the commissioning of secondary care, delivery of healthcare 10:14

services, to make sure that they are perhaps complementary to each other and not working against each other.

17 Q. Just at this point, I know you have mentioned Covid a couple of times, and I think it dovetailed almost with your taking up post, the commencement of that. We'll go on to look at some of the actions of PHA and others and the Panel will be aware of the timeframes. But just from your perspective, as regards staff concentration during that time when Covid emerged, what impact did it have on the Public Health Agency as a statutory body and indeed both you and your staff in service delivery? 10:15 10:15

A. It probably, at that time, when Covid arrived, all of our efforts, as an Agency, were deflected into Covid response. So, many of our staff - say, those that worked in health improvement, etc. - would have taken up posts in things such as contact-tracing or education cells, so the whole staff, and our staff grew temporarily during that period to have over 700. Normally, we sit around about 350. Our staff were under considerable pressure, we have a very small team, and an awful lot was expected of them during that period, and was, in fact, I believe, delivered as well. 10:16 10:16

18 Q. And was that also reflective of the fact that you do have that clinical expertise, that perhaps other arm's length bodies look to PHA to assist them in their decision-making? 10:16

A. Yes. And we would have provided a lot of information

through to the Department of Health and the Minister and the CMO to support decision-making at that time.

19 Q. And at that time - we'll look at decision-making across some of the bodies shortly - but, at that time, during Covid, we'll use that as an example, was it your view that the communication between the relevant bodies and indeed the collaboration and decision-making was something that was enhanced because of the nature of the emergency around Covid, or did you think that it was simply reflective of good communication that exists at all times? 10:17 10:17

A. I think it was enhanced, or certainly of a greater volume, with the Department of Health in the support that they needed from us at that time. It was perhaps lessened due to -- that all comes in under health protection within the organisation. So our links with other groups were probably diminished during that time. 10:17

20 Q. And the position now, have things settled down and relationships returned to what they may have been pre-Covid or has there been a benefit of the relationship-building that must have taken place during Covid? 10:18

A. I think there's benefit from the relationships built during Covid, especially with the Department of Health. I think things in health, while the system is under a great deal of pressure, especially in the absence of a government for a period of time as well, and we are moving into new commissioning arrangements, as well, under ICS, and the old commissioning arrangements have 10:18

been stepped down, they are still somewhat in development. But we work very closely with SPPG, we work closely with the Trusts and Councils as well, if I may say that, too.

21 Q. Just before we look at the commissioning issue on its own, just your relationship with the Department of Health, can you just set out briefly your level of engagement, the frequency of engagement with the Department of Health and the sort of issues you engage with them on, on a regular basis? 10:18 10:19

A. I suppose there is normal accountability; we have a sponsorship branch which comes in under Social Care and Population Health. The Department has recently undergone a restructuring, so from December of last year, the Population Health and Social Care Policy Group is our sponsorship group. Previous to that, it was the CMO group, and I would have met with the CMO once a month for an hour to go through issues. We would have accountability set at every six months and we would have ground-clearing as well before accountability meetings, again once every six months, in preparation for the accountability meetings. The accountability meetings themselves come with the Chair and the Permanent Secretary, with the sponsorship lead in attendance, but, having said all that, they are very much the formal arrangements. I would have frequent meetings with members of the Department of Health from across different departments, such as the CMO's office and the CMO's office on areas such as vaccination. To 10:19 10:19 10:20

give you a recent one, we were doing quite a bit of work with the department around measles, it's very topical at the minute; we've done a lot of work, usually during the winter, around flu vaccination as well, and other topics. So it's quite a regular thing, depending both on, sort of, normal sort of governance, assurance and accountability around how the organisation is running, but also, sort of, threats to the public health and addressing those and how that might be achieved. 10:20

22 Q. So there's regular contact with the Department, and then that can be enhanced, dependent on, as you say, a public health issue or something prevalent that needs further communication. You mentioned some information that seems very new and I don't think will be in your statement, about your sponsorship branch, so I just want to make sure we have the evidence on that and that I am clear on that. You previously said the sponsorship branch involved you directly not reporting to but liaising with the Chief Medical Officer? 10:21

A. That's correct.

23 Q. And that has changed just within the last couple of months?

A. In December of last month, that changed. The Department has undergone a restructuring or a review and therefore, as part of that, our sponsorship arrangements have changed. And I think some of the policy areas which previously sat under the CMO, now sit under that directorate of Social Care Policy and 10:21

Population Health, and equally, other bits sit under other policy leads within the Department.

24 Q. It's just a slightly longer name, so it sits under the sponsorship branch of Social Care Policy and Population? 10:22

A. Population Health, I think.

25 Q. Health. That's fine. Just so we know. Is that restructuring something that affected all arm's length bodies or do some still sit under the CMO? What's the position? 10:22

A. I wouldn't have that level of detail, I am sorry. I know the impact that it has upon us. I think the general principle was that the Department, the Permanent Secretary wanted the professional leads, such as the CMO and CNO, to be slightly separate from policy 10:22 leads or separate from policy leads and the majority of the policy to be developed through the civil service end rather than the professional end. I'm not really qualified to talk on that.

26 Q. That's fine, thank you for that. I know it's early 10:22 days in that new arrangement, but do you have any views or have you formed any view as to whether this movement is more beneficial for the Public Health Agency? Has it improved communications? Has it, in your view, taken away your direct clinic with the Chief Medical 10:23 Officer? Do you have any views on that at the moment?

A. It is very early days and it is hard to say. It has not reduced significantly our contact with the Chief Medical Officer at this time and I would still meet on

issues that are pertinent to meet with the Chief Medical Officer on, so there is no intent to reduce our contact, where appropriate, with the CMO's office in that. I think the relationship with the new policy leads are still developing. Our Chair will meet with the Deputy Secretary lead for that group, sort of, quarterly as well, I think at this stage, so I think it will enhance over time. But I think that's a relationship which is still very much in development. I have agreed that I will meet with the Deputy Secretary once a month as well to keep them informed of things that are happening within the Agency. 10:23 10:24

27 Q. Now, in relation to that restructuring - I know we have SPPG witnesses in on Thursday - is that something that was undertaken with consultation with other arm's length bodies, including the Public Health Agency, or is it a restructuring that you are informed about? 10:24

A. It is the Department's restructuring, so we weren't consulted on that, and I don't think I would have expected to be, either. 10:24

28 Q. It would seem to change the contours of the framework document from 2011, that there is now different processes, perhaps, in place and the way in which lines of accountability, perhaps, or communication at least, are reflected. Would you consider that the framework document is out of date in that regard? 10:24

A. The framework document, I think, is somewhat out of date. We know that it is -- it was last updated in 2011. That's the extant version that we're currently

working to. In discussions with the Department, a new one is to be developed and we have been told that we should perhaps see a draft of that within the next couple of months and that it should be finished in the financial year '24-'25 and communicated to us. We will be involved -- or consulted on what that final draft will look like. 10:25

29 Q. Is it normally the case - you have been in healthcare quite a while - is it normally the case that the changes happen before the document setting out the changes is published? Is that -- is it usually a process of evolution like that, or do we expect to know what's going to happen and then it happens? 10:25

A. I think, usually, things happen, sort of, and then the paperwork will follow afterwards. I think part of this is that we all work sort of very closely together and how we work day to day, operationally, doesn't really change that much. 10:26

30 Q. Well, just on that, on the point of whether, operationally, day-to-day things do change, on the issue of commissioning, the role of PHA is certainly very central, and has been, if we look back before this slight restructuring - before SPPG, in fact - the role of the PHA was fundamental to commissioning, hand in hand with what was then called the Health and Social Care Board. I know we'll fall into using acronyms, and I am conscious that we're on transcript and other people are listening who may not know them, so, between us, we will, hopefully, correct each other. But the 10:26

previous incumbent in the role of the SPPG, the HSCB - the Health and Social Care Board - you worked hand in hand with commissioning services?

A. Yes, and for a period of time the Chief Executive of the Health and Social Care Board, I think, acted as the Interim Chief Executive for the Public Health Agency for four or five years. 10:27

31 Q. And under the 2009 legislation, there was almost a dual mandate for the Public Health Agency and the Health and Social Care Board to agree on commissioning? 10:27

A. Yes, and it was in legislation that the commissioning plan had to be signed off by the Public Health Agency and, in that instance, it would have went through our board to be signed off.

32 Q. And what's the situation now in relation to commissioning; is that dual mandate still in place? 10:27

A. No, that changed. Obviously, the Health and Social Care Board has now been migrated into the Department of Health. Previously, they were an arm's length body as well. And the organisations, I would say, over the last couple of years, whilst they still work very much closely together, are probably slightly further apart, if I can say that. We do share the same building -- buildings across Northern Ireland as well, and our staff work very closely together, but within, sort of, the legislation for commissioning, that came back in, I think, in '22, with a new, sort of, Health and Social Care Act; I think section 6 or 7 or 5 and 6 have been removed around commissioning as we move to the ICS 10:28 10:28

model. The ICS model is still very much in development. There's legislation around area integrated partnership boards which have been developed, which are coterminous with our Trusts across Northern Ireland, as commissioning -- I think the idea is that commissioning becomes more locally or more locality-based and closer to communities.

33 Q. So, just to unpick some of that, and we'll get some of the detail from you, if we can, because it seems that it's fairly new and it's evolving all the time? 10:29

A. Yes.

34 Q. The commissioning model as envisaged under the 2009 Act - and correct me if I am wrong, I'm just listening to your evidence as well; we don't have that level of detail in the statement - the commissioning model as envisaged under the 2009 Act was that HSCB/SPPG and PHA would collaborate and agree, via your Board and via the HSCB Board which existed at the time, and you would both sign off on the commissioning --

A. Yes, that's correct. 10:29

35 Q. -- is that a fair summary of what the situation was previously?

A. Yes. And our dominant role in that was to provide professional advice to the Health and Social Care Board in the development of a commissioning plan. So it would have the Director of Commissioning working directly to -- the Director of Commissioning sat within the Health and Social Care Board and our professional officers would have provided advice in the development

of commissioning plans.

36 Q. So out of the, I think, the seven Arm's Length Bodies, and certainly for the purposes of the Inquiry the relevant bodies for our purposes are Public Health Agency, the Patient and Client Council, RQIA, formerly HSCB, they sat at one level and worked together, but the special relationship between HSCB and PHA, the clinical expertise within your organisation meant that you two worked together to commission services? 10:30

A. Yes, that's correct. 10:30

37 Q. And you were overseen by your individual boards --

A. Yes.

38 Q. -- who signed those off? So that was the position then. Now, you have mentioned that we're moving towards an ICS, or we're now in that landscape, which is Integrated Care Services -- System? 10:31

A. Integrated Care -- ICS, Integrated Care System.

39 Q. System. I couldn't remember if it was 'services' or 'system'. But the ICS effectively will replace the process of commissioning and be the way in which services are commissioned? 10:31

A. Yes.

40 Q. You mentioned legislation, that came in in 2022, and what that legislation does is, from your perspective, is, removes the requirement for the Public Health Agency to sign off and approve the commissioning under this new system? 10:31

A. That's correct.

41 Q. So your position is that your expertise still allows

you to engage with SPPG and for them to work with you to inform each other about what may be the best way to proceed under ICS?

A. Yes.

42 Q. But the actual previous mandate that you had of compulsory signing off commissioning, that no longer exists for the Public Health Agency? 10:32

A. That no longer exists. We do still work very closely with the Board and we also work with the AIPBs. Only one has been established to date in a pilot form in the Southern Trust area, and we have provided support to that since its inception, which I think was last summer. The timetable is to bring the other AIPBs, which will again sit within the other Trust boundaries, into place, I think, from April 2024, going forward, but they are still very much in development phase, and the pilot was a pilot to take learning on how commissioning might proceed into the future. 10:32 10:32

43 Q. In relation to the legislative change and the impact on the Public Health Agency's standing around commissioning, was that something that you were consulted on or part of discussions around the rationale as to why the Public Health Agency, the powers that they exercised around commissioning had been altered? 10:33 10:33

A. We weren't consulted on that, I think probably because, mostly, that was developed during Covid, and our -- obviously, our intentions were very much in responding to Covid during the period.

44 Q. So the position, just in summary then, that the SPPG is now the sole department or body that will sign off on ICS, in collaboration with other bodies as relevant, but the stamp of approval, as it were, lies with SPPG?

A. Yes, I think that's how it works, but we do work closely with them in that and we are working, at this point in time, to establish, perhaps, commissioning groups going forward in specialist areas such as Acute Services, Mental Health, etc., Cancer Care, so we would work very closely with them, but I think, ultimately, going forward, the AIPBs will be the commissioners, but that commissioning process will very much be led through SPPG. 10:34 10:34

45 Q. And do SPPG, do they have the board structure that the old HSCB had, or what's their line of accountability through to the Department? 10:34

A. SPPG have a Deputy Secretary, I understand, that responds through to the Permanent Secretary or reports through to the Permanent Secretary, and when the Health and Social Care Board was closed, the Board -- the body, the Board itself was closed down. Sorry, it's a bit confusing because it is Board, but, I mean, the corporate Board, if I can put it that way. 10:34

46 Q. I can explore that with the SPPG witnesses when they come on Thursday. The ICS system of commissioning, what difference do you think that will make around the commissioning process and help the PHA, if at all, fulfil their statutory duties? 10:35

A. I think the AIPB will bring commissioning close --

47 Q. Just tell us what that stands for.
A. Area Integrated Partnership Board and, if it helps, the pilot is chaired by the Chief Executive of the Southern Trust as it sits in their area and it is co-chaired by one of the GPs there. It also has representation from 10:35
a carer, a representation from the community and voluntary sector and representation from local councils - Armagh and Banbridge and Newry and Mourne, I think. I think there is three councils involved; sorry, I can't remember the third. So that constitutes 10:36
the area of partnership board, as it were. Both ourselves in PHA and representatives from SPPG will provide input into that, and our primary input is around the assessment of population health and needs.
48 Q. And these local boards, is that a way in which you 10:36
give, perhaps, power and authority back to local areas for identifying what their particular needs are, is that the idea behind this?
A. Yes, that is the intention of -- around this, is to bring commissioning closer to local communities. 10:36
I think one of the things that we are particularly keen on, as an Agency, is that they have a greater focus on early intervention and prevention going forward, working with community planning in tandem that sort of operated out of the Boards. 10:37
49 Q. Now, I know you've said that's operating in the Southern Trust area at the moment. That's a -- did you say it was a --
A. It's a pilot.

50 Q. Pilot, a pilot scheme. And the idea is that they gather information and provide that and that informs what services need commissioned, is that, in general terms, what the plan is?

A. Yes. And it is an -- it should also be evaluated as a test site to see if that sort of construct, in terms of who sits on the Board, how they are recruited to the Board, best represents, sort of, local communities as well and actually does, indeed, deliver what it is intended to deliver, and that will go through in a formal evaluation process. 10:37 10:37

51 Q. And they then get their information from where? What way do they operate in order to inform their decisions around requests for commissioning?

A. They would obviously have information which comes out of the Trust's own information systems and they would have information -- we would provide information from our outlook in terms of population health. We have created a dashboard which would give them a range of information pulled in from the likes of NISRA, from the Board, information systems themselves maybe around flu and things like that, but also the age profile of their population, etc., so -- but, again, that's very much in development and I would see that that would develop going forward as well in terms of the level of information that we can give them around their area. 10:37 10:38 10:38

52 Q. I know it's only a pilot scheme, but do you have a view at this stage whether the way in which it's been set up and operates is something that will enhance

communication or looks as if it may provide a solution to some of the commissioning issues?

A. I'm hopeful that it will actually bring us more focused to individual area needs as opposed to, perhaps, commissioning on a broader sort of Northern Ireland regional level. It should enhance the voice of local populations and I think it will do that over time. 10:39

53 Q. And those boards will be informed by information and data that's coming from the Trust?

A. Both. 10:39

54 Q. And other sources?

A. And other bodies as well. So all partners should have the ability to bring information to it.

55 Q. We took a slight detour but I'll come back to the plan. It is just that's information that's very up to date for the Inquiry, so it's very helpful to have that information but also your reflections from the PHA point of view. 10:39

A. I do accept that that sort of obviously has come in significantly after our statement. 10:40

56 Q. Yes.

A. If the Inquiry requires us to provide another written statement on that, I'm happy to do so.

57 Q. And no criticism meant of you in relation to that. It is -- the landscape has been changing during the currency of the Inquiry so it is just helpful for the Panel to know what's happening at the moment, and certainly we will be asking other witnesses after you just to give us their update. It's really -- what the 10:40

purpose of the evidence and those conversations, were to see what your reflections were as Chief Executive of the Public Health Agency, if there is anything that you think, from what you have seen, might be improved upon, that might inform any recommendations from the Panel, and that's the purpose of today, is for us to explore some of the issues and for you to say, 'well, you know, this works and this perhaps doesn't work and this might work'. You're in the driving seat of the Public Health Agency, so please feel free to comment or provide any of your expertise as you see fit, if I happen to miss a question. 10:40 10:40

A. Okay.

58 Q. Just in relation to your interaction with other public bodies, you have mentioned about the HSCB, the SPPG, and also the Trusts generally. Could I ask the level of engagement that you have with the Trusts, could you outline what, generally, the PHA does to speak to the Trusts and to find out what's happening and how that sits within your own functions and role? 10:41 10:41

A. I suppose one of the key things that we would do with Trusts is screening, so we directly commission screening, so we would have a range of services, say, around breast cancer screening or bowel screening, so we would meet with the Trusts and have a dialogue about the commissioning of those services directly. We would also meet with the Trusts around vaccination, so very much going back into our health protection role, and we would have information that comes in from the Trusts, 10:41

I suppose, in a surveillance role around, say, surgical-site infection rates or health-acquired HCAIs which would happen and their use of antimicrobial prescribing as well, so there is a range of data that we would get in from the Trusts that we would have conversations. As I say, the landscape is changing and I suppose pre-Covid we very much would have also sat in commissioning groups with SPP -- well, Health and Social Care Board would have regular sort of contract updates with Trusts around their service provision as well. 10:42 10:42

59 Q. And that involves their service frameworks. Were you the joint commissioning team, yourself and the Health and Social Care Board?

A. Yes. 10:42

60 Q. Would have been responsible for monitoring those frameworks?

A. That's correct.

61 Q. And also falls under your remit, I think, the implementation of any mandatory policy or guidance issued by the Department, subject to the caveat that any that are not subject to formal performance arrangements, such as you have mentioned, the pandemic and the flu plans and things like that -- 10:43

A. Yeah. 10:43

62 Q. But in the implementation of the mandatory policy or guidance issued by the Department, what way does that work for the Public Health Agency? What's your role in that and how is that done in relation to the Trusts?

A. Well, usually a letter would come in perhaps from the CMO's office to say 'Here's a new guidance which is coming in, this is the actions which we expect to take', SPPG, GPs, perhaps, PHA. Usually, our role would be perhaps in the monitoring of the implementation of that and to provide assurance back to the Department of Health that it has actually been enacted.

63 Q. And when you say about monitoring and the implementation, given that you're a statutory body and you are confined by the legislation as to what you can actually do, how do you reassure -- how is the PHA reassured that the guidance, the monitoring and implementation of that is effectively done by the Trusts? How does that operate in practice? 10:44

A. Generally through written communications with the Trusts to say that 'This was expected to go in to sort of normal procedures within the Trust on such a date, can you confirm that it has actually been enacted or if it hasn't been enacted and any barriers to taking it forward', and we would usually receive written communication that it has.

64 Q. So you rely on the Trust reassuring you?

A. Yes.

65 Q. And would it be fair to say that that reliance on the Trust, you're assuming that their processes and procedures in place are robust enough for them to be sure before they give you any statement on which you place reliance?

A. Yes. I mean, we wouldn't have the capacity to go and double-check that what we have been told is either correct or incorrect, so it is very much a Trust basis on which we operate; we're not auditors.

66 Q. Is it perhaps a little more than capacity, given that you have a certain role, and perhaps to encroach upon the internal operational workings of a Trust may be to extend yourself beyond your statutory role? 10:45

A. Yeah, we wouldn't wish to overstep our role. We do recognise that, so the implementation for the Trust sits within the Trust, their accountability arrangements and/or assurance structures are their own and report through to their Board and their Board, in return, are responsible to the Department of Health and Minister. 10:45

67 Q. In relation to decisions, by way of example, of the operation of powers, if I can use that term, in small letters, if a Trust wants to make a decision around purchasing equipment and want to use the resources in a certain way, does the Public Health Agency have any role in advising about industry standards or the suitability of certain equipment or reading across all of the Trusts and seeing what others are doing, is there any of that link-up, or is that purely an operational decision for the Trust? 10:46

A. That would purely be an operational decision for the Trust. I suppose where -- it would then obviously, perhaps, come back to SPPG because that's where the finance of any new equipment would come through.

68 Q. And the justification for that then would --
A. The justification for that would go through to the --
69 Q. Lead on to the finance, if appropriate?
A. Yes.
70 Q. Does that mean that each Trust has autonomy throughout Northern Ireland, as to what equipment they purchase, or is there an expected industry standard regionally? 10:46
A. I suppose all of the Trusts and indeed all the Health Service work through BSO procurement and there is quite rigorous, sort of, procurement legislation that sits around how they do that and, sort of, there is an awful a lot of standard contracts as well which have been set up under NHS and local frameworks as well for the purchase of equipment, so it is quite, sort of, regulated, but the decision of what equipment to purchase, make a case for that and how it will be used, sits within the Trust. 10:47 10:47
71 Q. Now, just, Mr. Pengelly gave evidence, and one of the statements he made, and I presume it's non-contentious but I will just put it to you anyway. He said: 10:47

"Normally, the development and evolution of clinical standards would be an issue that would sit with the Board and the Public Health Agency."

10:47

Is that something that you would agree with?
A. Sorry, could you repeat that?
72 Q. I'll just read it again, and just for everyone's note, it's at TRA-10370. He said:

"Normally --"

He was asked a question in relation to the way decisions are made, and he said: 10:48

"Normally, the development and evolution of clinical standards would be an issue that would sit with the Board and the Public Health Agency."

A. I don't know that we have -- I suppose clinical standards, a lot of those would come down from the likes of NICE and there's accepted clinical standards. Royal Colleges would also develop standards as well. I think more our role is the expectation of it -- sorry, the expectation from us is that the Trusts are adopting and adhering to those sort of national guidelines and standards which might be set down by the likes of NICE. I suppose what I am trying to say is, we don't generally set them; they would be there, but -- 10:48 10:48 10:49

73 Q. No, I don't think there is any suggestion, to be fair to Mr. Pengelly. I think it was more how they filter through and the way in which standards may become known to Trusts as well, and I don't think it's contentious. As you say, NICE and other guidelines, we have heard evidence around how they find their way to clinicians and medical practitioners. But from the Public Health Agency's point of view, would it be more the expectation that applicable standards would be met and 10:49

adhered to, would that be their role of looking at that and seeing if that happens?

A. Yes, yes. And more to seek an assurance at times, where it's relevant, that it is happening.

74 Q. In relation to oversight generally and risks that might arise in a Trust, just in general terms, and given that services have been commissioned specifically, if we look before this new arrangement that is very new under ICS, the old commissioning arrangement, are there any other ways that the PHA seek to assure themselves that risks arising are being dealt with properly by the Trust, whether they be through thematic risks or performance risks by an individual, is there any way in which the PHA engages with the Trust to perhaps look under the bonnet a bit more to find out if risks arising are being dealt with, just to reassure itself, or is it simply a matter that the Trust is asked to provide reassurance and, once that reassurance is given, then the PHA is satisfied by that? 10:49 10:50 10:50

A. More the latter. I mean, if risks come to our intention, we would seek reassurance that the Trust are aware of those, that they are taking appropriate steps to mitigate against them. We would not -- I think it would be overstepping our role and it is not to operationalise how they would deal with those risks. Each organisation has an incumbent responsibility within itself and through its Board to ensure that risks are identified and mitigated against and managed. The Health Service has many, many risks which it deals 10:51 10:51

with on a daily basis and it is never without risk, but, operationally, that is the responsibility of the Trust, to address those and minimise those to patients which they serve.

75 Q. We'll look at some of the ways in which some risks that might have emerged find their way to the Public Health Agency in a moment when we look at the SAIs, but, just in general terms, in relation to targets, does the PHA have any role in monitoring targets or outputs of Trusts? 10:51 10:52

A. Yes, we would have a role, I think I said earlier, in monitoring sort of antibiotic use, HCAIs, surgical site infection rates, report that backs to Trusts and ask them around what they are doing to address those issues. We would RAG-rate those, about whether or not they are, I suppose, RAG-rating, sort of, red, amber or green, and things like that. The other area which we do monitor is the uptake of flu vaccination in their healthcare workers as well. So there are specific things that we monitor. However, the service level agreement contracts are predominantly monitored in terms of performance via SPPG. 10:52 10:53

76 Q. And was it ever brought to Public Health Agency's attention that any of the targets or monitoring itself gave rise to risks for the Trusts, that they were having difficulty with targets, that there was issues around that from a PHA perspective? 10:53

A. No. Generally, that would come through SPPG.

77 Q. Now, the review of Urology that the Panel have heard

about in 2009, the 2008/2009/2010, just was around the same time as the Public Health Agency started, so they were in at the beginning, as it were. I know you weren't there, but the Agency certainly was the same age as the review now from this remove. But in relation to your engagement with Urology on a regional basis, PHA staff are members of the Northern Ireland Cancer Network Board; is that still the case? 10:54

A. NICaN - the Northern Ireland Cancer Network Board - I believe was stood down about 18 months ago. There is a new way of sort of reviewing the networking for Cancer Services; there is a cancer strategy. 10:54

78 Q. Yes.

A. There is a cancer steering group, but that sort of particular grouping doesn't exist anymore. 10:54

79 Q. And your staff still work within that, within the cancer --

A. Yes, very much. Our staff are part of those, sort of, steering groups and operational groups, and SAC, I think, is the term, and please don't ask me what that stands for, but it looks, sort of, at various cancer services. 10:54

80 Q. In relation to elective care commissioning and waiting lists generally, I know that falls under the SPPG, I think, more properly, but from a Public Health Agency perspective, are you called upon at all to provide any advice or information, given the expertise you have in your team in relation to dealing with waiting lists and the issues that are clearly very prevalent at the 10:55

moment?

A. We don't really get called to issues around -- operational issues around dealing with waiting lists, that would not be our issue. We would be more, I suppose, advise or provide advice in the realm of professional adherence to sort of national guidance and things like that, and they might come and ask 'This sort of service is being conducted and this sort of patient pathway; is that correct?' But in terms of the actual performance around money and activity, that would not be our area of expertise. 10:55 10:56

81 Q. And given some of the risks that are inherent in long waiting lists and difficulty with elective services and perhaps the prevalence now of dealing with red alerts rather than, perhaps, the day-to-day healthcare provision, do you think there is a role for the Public Health Agency in looking at that as a risk and looking to see if they can provide a different lens through which problems around that may be viewed? 10:56

A. I think one of the different lenses we would like to adopt is, one of our statutory responsibilities is to reduce health inequalities across Northern Ireland, and it is usually those who lived in the most deprived areas will wait longer, and I think the statistics provide that. I think that's more the direction that we would wish to have impact upon, is not just that everyone is treated equally, but everyone has equity within the system. 10:56 10:57

82 Q. And does that also reflect the possibility that people

on routine lists are potentially being ignored, given that the services are so constricted; the evidence might suggest that the focus is on the immediate rather than the routine, and is that a barrier to health development and something that the Public Health Agency perhaps should be involved in? 10:57

A. I think our advice, perhaps, should be sought in those areas to ensure that there is a focus and lens brought to the elective. However, given the pressure which our hospitals are often under, that turns into how we ensure that only those that really need to go to EDs arrive in the EDs, because quite often what happens is that elective care gets cancelled when people come in, get admitted to beds, and then there is no place to admit the elective patient into, and therefore, operations get postponed, which obviously leads to sort of downtime in theatre, which you do not wish to have because they are very expensive resources. 10:58 10:58

83 Q. And that insight and lens, as we have both referred to it as, is that something that's being sought or do you think it would be helpful if it was sought from you and your staff? 10:58

A. I think so, but, I mean, those issues are well-known as well right across the system. I think it's up to us to work with our partners to look at how we maintain people closer to their homes, provide advice and an input into how that might be best achieved, but I think one of the key things in that is, how far upstream do you start? One of the best things to do is to avoid 10:58

getting cancer and is to ensure that we have at a healthy population that is less reliant on secondary care service.

84 Q. And unlike some of the other arm's length bodies, the Public Health Agency is responsible both in the hospital, out in the community for planning for pandemics, for anticipating health vulnerabilities, both short- and long-term, so it would seem to be the case that any blockage in the system might impact your Agency significantly more than some others? 10:59

A. I think that's probably fair to say.

85 Q. And do you think that potential for your Agency to be impacted more significantly than others, is properly reflected in your conversations with the Department and, in fact, the position of PHA within that structure as it current evolves? 11:00

A. I think it's very much an evolving structure at the minute; that is to say; the Department of Health has recently restructured the ICS, which is the new way of commissioning, is still very much an evolution, and I think we'll know the answers to, perhaps, that as we work through the next couple of years, but we are involved -- I do sit on the regional group for the ICS, which is chaired by the Permanent Secretary, so we do have the opportunity to input as to how the ICS is developed and we do have a place on the sort of pilots as well, so I think it's incumbent on us as well to influence how that new commissioning apparatus, if we can put it like that, or operational model, is 11:00

developed over the next couple of years.

86 Q. The context of that question was really just for the Panel to understand if the right people are around the table, having the right conversations, and your view is that the landscape is evolving? 11:01

A. It is very much evolving. I mean, we've had -- as I say, I sit on the Regional Steering Group. I have also been involved in a number of meetings directly with Solace, which is the, sort of, Chief Executive of the Council's group as well, so -- and we are in the 11:01 process of developing a new 'Making Life Better' strategy for Northern Ireland, but again, that has, obviously -- public health has a reach right across how we develop public services and deliver public services and, therefore, it is very much welcomed that we have 11:01 an Assembly up and running again to get those things adopted.

87 Q. Thank you for that. I just want to move on to a specific example of the Public Health Agency's involvement with some of the issues that are before the 11:01 Inquiry. Now, this is before your time and this information that you have provided in your statement, based on correspondence, which you have also exhibited, and what I intend to do, given that you have no personal knowledge of this but you have been informed 11:02 about it and that the exhibits provide the evidence base for what you have put in your statement, and the detail here. I am just going to read in some of the paragraphs from your Section 21 so that it is formally

in the record of today.

If we go to WIT-61599 and we go to paragraph 91.

So what we have done in the Section 21 is provide you with some of the issues of concern that have arisen clinically and operationally within the Trust and asked what the PHA might have known about it and may have done about it, and we give you a list, and one of the items on it was the IV fluids and antibiotics issue. Now, the Panel has heard a lot of evidence about this, I don't need to rehearse the background to this, but I just want to use this as an example of PHA interaction with Trusts and perhaps the benefit of PHA staff being clinicians and having a different view on some issues and perhaps being able to spot things. 11:02 11:03 11:03

So I just want to read these paragraphs in. So, from paragraph 91. Just move down. Just, the second sentence of paragraph 91 is where I start and it is based on your reference to the correspondence that you have seen that informs what's to follow. So, you say, at paragraph 91: 11:03

"The correspondence demonstrates that management and clinical staff within the Trust had identified a treatment pathway within the specialty of Urology that appeared at odds with usual practice. Following a discussion with Dr. Corrigan..." 11:03

And just pausing there. That's Dr. Diane Corrigan from your team?

A. That is correct.

88 Q. "Following a discussion with Dr. Corrigan in April 2009, the Trust's Medical Director sought independent expert advice from a Consultant Urologist and a Consultant Microbiologist from GB on this matter. On 24th April 2009, Dr. Corrigan emailed Dr. Loughran..." 11:04

Just pausing there for the transcript, that's Dr. Patrick Loughran in the Trust.

"... with the contact details of a Consultant Urologist who had provided expert advice to the DoH review of Urology in 2008 as a potential source of independent advice to the Trust." 11:04

Then, move down, please. Paragraph 92: 11:04

"In April 2009, the initial concern expressed by the Trust Medical Director was that the procedure did not have a published evidence base and was potentially wasteful of resources as it required a patient to be admitted to receive IV fluids via a peripheral venous line, along with IV antibiotics, instead of having oral antibiotics as an outpatient. A draft report from Dr. Loughran, including the views of the independent 11:05

experts, was shared with Dr. Corrigan in January 2010 as it referred to her by name. The draft report was not supportive of the practice. Dr. Corrigan provided some suggested wording amendments. These included:

11:05

'I have discussed the above with Dr. D. Corrigan, the PHA advisor to the HSCB Southern Office. On the basis of the information provided, she has advised that it would not be appropriate for SHSCT to continue to provide a treatment for which there is neither a 11:05
published evidence base nor a supporting consensus of professional opinion outwith the Trust. If SHSCT Urologists feel strongly that this treatment is of value, they should participate in a recognised clinical trial with ethical committee approval. For those 11:06
patients already on this treatment regime, an orderly process should be agreed and implemented to move them on to alternative treatment regimes, with the support of medical microbiology. It will be important that the reasoning behind this decision is sensitively 11:06
communicated to this cohort of patients.'

The final report was not shared with Dr. Corrigan. She assumed that the Trust would now complete the process to bring the treatment to an end." 11:06

Paragraph 93:

"However, Dr. Corrigan become aware at a meeting in

July 2010 with the Trust, in respect of implementation of the Regional Review of Urology, that the practice of admission for IV fluids and antibiotics had not completely stopped and the two patients may, by then, have been receiving IV fluids via a central line. 11:07
Placement of a central line can result in significant short or longer-term complications. If a central line was not required as part of an accepted clinical pathway, this raised a safety concern." 11:07

Paragraph 94:

"In reviewing earlier correspondence on the issue, Dr. Corrigan re-read the draft report received in January 2010 and noted a comment in the appendix 11:07
stating that some of the patients having this treatment had had a cystectomy (removal of bladder) and an ileal conduit (creation of a new tube from a piece of small bowel into which both kidneys drain via the ureters and from which urine is diverted through a stoma on the 11:07
surface of the abdomen). One sentence read: 'Whether these patients have been well-served by the major bladder surgery they have undergone is difficult to say as the records do not include the original letters leading up to the surgery.' 11:08

In the context of the new concern about persisting use of the IV fluid treatment regime within the Urology specialty, despite an understanding that this had been

phased out by the Trust, Dr. Corrigan decided to seek data on the number of patients having cystectomy operations in NI hospitals for a five-year period from April 2005 to March 2010, to explore if practice in Southern Trust was in line with that elsewhere in NI. This information was obtained from the HSCB information team within the HSCB Performance Management and Service Improvement Directorate." 11:08

Now, just to whist up there for a moment. This is an example of engagement with one of the clinicians on your team on an issue that had arisen. She provided both signpost to perhaps an appropriate expert to look at the issue that had been identified, presumably so that an independent view could be taken. I presume your clinicians are experts in public health, but given that this is a very specific IV fluid and antibiotic issue, there was perhaps an appropriate signposting to someone who may know more on the issue? 11:08 11:09

A. Yes. 11:09

89 Q. Dr. Corrigan then received the draft report, took the view that a form of words should better reflect both her involvement and her understanding and the final report wasn't shared. Just on that point about the final report, was that something, in your view, that should have been shared with the Public Health Agency? 11:09

A. I think it would have been helpful, in hindsight, that they should have sent it to us. Having said that, I think Dr. Corrigan's actions are commendable in that

she has spotted an issue, she has followed it up, she has acted to give best-practice advice and advised Dr. Loughran to seek best-practice advice. I think that she has acted appropriately at that time.

90 Q. And in relation to the Trust then following through on the information that they had at that point, before we move on to the cystectomy issue, that the Trust had at that particular point, would it be PHA's understanding - I know I'm asking you about a time when you weren't there, but just generally from a strategic and operational perspective even now, would it be PHA's understanding that it would be for the Trust to inform their own Trust Board of this issue? 11:10 11:10

A. Yes. I mean, ultimately, the responsibility for governance sits with the Trust Board, and the safety and appropriateness of actions of clinicians sits with the Trust Board as well, so yes. 11:11

91 Q. Dr. Corrigan did get in touch again with Mr. Mackle. So we see at paragraph 95 that Dr. Corrigan took further steps on behalf of the PHA. And paragraph 95, the question is: 11:11

"Outline what, if any, action was taken to obtain any explanation or clarification of any trends identified or address any concerns which rose." 11:11

And your answer is:

"Dr. Corrigan emailed Mr. Eamon Mackle, Clinical

Director of Surgery in the Trust, on 9th August 2010, indicating a concern that IVT was ongoing and that some patients were receiving this via a central line. She suggested the Trust should establish a multidisciplinary team to address the issue. This email also stated that she planned to seek information on trends regionally in cystectomy operations."

Then, she says, next paragraph:

11:12

"Correspondence between Dr. Corrigan and the Medical Director of the Trust on 1st September 2010, copied to the Trust Director of Acute Services, Dr. Gillian Rankin, and Mr. Eamon Mackle, Clinical Director of Surgery, sought an assurance that the practice of admitting patients for IV fluids and antibiotics was being brought to an orderly end. Further actions were requested in respect of benign cystectomy in the same correspondence, which are set out in the next section..."

11:12

Which we will go on to.

"... in relation to the assurance that the practice of admitting patients for IV fluid and antibiotics was being brought to an orderly end."

11:12

Was that assurance forthcoming from the Trust?

A. I believe it was, yes.

92 Q. Now, as we have mentioned earlier in your evidence, do you feel that that is an example of where the edges of PHA and the start of the Trust meet as regards accountability and clinical best practice?

A. Yes, and I think PHA and Dr. Corrigan has, I think you said earlier, taken her responsibilities to where she felt they should be taken, and she has sought assurance from the appropriate level within the Trust, which is the Medical Director, the Clinical Director and the Director of Operations -- sorry, Director of Acute Services, and she has received assurance back that appropriate action was being taken and, as I said earlier, you trust in those assurances back because those individuals are also responsible through their own assurance through to their own sort of Chief Executive and Trust Board. 11:13 11:13 11:13

93 Q. Now, in relation to the benign cystectomies issue which you set out in your statement, that was something that was also pursued, and the Panel has heard evidence around the conclusions around that, but it was something pursued effectively by one of your staff, or Dr. Corrigan, who works for the PHA, and still does, she was the one who saw that as a potential issue and followed her nose on that from a footnote in the report. Is that an example of the benefit of having people of particular expertise accessing information provided by the Trust as opposed to just looking at the data? 11:14 11:14

A. Yes. I think that is the benefit of having public

health consultants, especially those qualified, as Dr. Corrigan, who is medically qualified, to be able to read and understand reports to a level but also know when to seek external advice in areas which are not their expertise, and I believe in that instance, in the benign cystectomies, Dr. Corrigan was under the understanding that that procedure should be conducted and centralised into the Belfast unit and, therefore, there should be no further patients undergoing cystectomies in the Southern Trust area. 11:15

94 Q. Now we have looked at an email that Dr. Corrigan referenced, 1st September, when she wrote to Gillian Rankin, if we just skip on to paragraph 102, just to finish off the further steps taken by Dr. Corrigan on this particular issue, and this refers to the same date, which is 1st September 2010: 11:15

"On the same date Dr. Corrigan emailed Beth Molloy, HSCB Assistant Director for Elective Care, who led on both Cancer Services commissioning and managed implementation of the 2008 Regional Review of Urology and Caroline Cullen, Senior Contracts Manager HSCB Southern Locality Commissioning Group, to check the commissioning position in respect of an expectation that benign cystectomies procedures should be done in Belfast." 11:16 11:16

Paragraph 103:

"Dr. Corrigan emailed Mrs. Lyn Donnelly, HSCB Assistant Director of Commissioning for the Southern Locality Commissioning Group on 3rd September 2010, copying the correspondence that had been sent to the Trust, to inform her of the issues. Mrs. Donnelly, in an email dated 8th September, stated that she had informed the HSCB Director of Commissioning Mr. Dean Sullivan."

Paragraph 104:

11:16

"Dr. Corrigan also forwarded an email to Mrs. Pat Cullen, Assistant Director of nursing, Quality and Safety on 7th September 2010. The same email was later shared on 2nd December 2010 with the HSCB Director of Performance Management and Service Improvement, Ms. Louise McMahon, who was leading implementation of the urology review, to provide context for a discussion on cystectomy which had taken place at a regional meeting."

11:16

11:17

And, finally, paragraph 105:

"The Trust Medical Director Dr. P. Loughran emailed a response to Dr. Corrigan's letter of 1st September 2010 on 16th September. This confirmed that: IVT had been ceased but plans to do so, including a weekly report on progress to him, were now agreed; a remit had been agreed for a review of the cystectomy operations for benign disease over the previous 10 years led by E.

11:17

Mackle; that there were definite arrangements to ensure that no further radical pelvic surgery cases would be done by the Trust. Dr. Loughran's email was forward to Dr. J. little and Mrs. L. Donnelly on 20th September 2010 for information." 11:18

When I said "finally" I lied slightly because I am going to read paragraph 106 where it says:

"On 11 March 2011 Dr. P. Loughran's office forwarded a letter to Dr. Corrigan providing an updated position and resolution of clinical matters within the Trust urology systems. This stated that: None of the original cohort of patients on IVT remained on this treatment; an internal, clinically-led review had taken place of benign cystectomy cases over a three year period (13 cases); the Trust had engaged an external specialist urologist as independent assessor who was expected to visit the Trust at the end of March 2011. This letter was forward to Lyn Donnelly (AD SLCG) on 29th March 2011 and letter. In a final email dated 28th July 2011 from Dr. Loughran to Dr. Corrigan he stated that the external review by Mr. Marcus Drake from Bristol was almost complete and that, having seen the interim report, there were no gross errors or faults and that overall he expected the final report would be supportive/indeterminate. He reiterated that this surgery was no longer being taken by the Southern Trust." 11:18 11:18 11:18 11:19

The Inquiry has heard evidence on that and also evidence on the date and the likelihood on which IV therapy did in fact finish and whether it exceeded this particular reassurance. But from your perspective, looking at that in the round, from the instigation or the identification of a potential concern by PHA staff through to final assurances given by the Trust, the Inquiry can take a view on the robustness of those, do you consider that to be a good example of PHA engagement both with the Trust, with the relevant staff, with other Arm's Length Bodies to lead to a satisfactory and at least clinically approved outcome? 11:19 11:19

A. Yes, I do.

MS. McMAHON: Chair, I wonder if that would be a convenient time to break just before I move on to another section? 11:20

CHAIR: I think we'll take a short break and come back at 25 to 12.

11:20

THE HEARING RESUMED AFTER THE SHORT BREAK AS FOLLOWS:

CHAIR: Thank you, everyone.

MS. McMAHON: Just before the break, we were discussing a specific issue that had come before the Inquiry, one of the clinical issues and the Public Health Agency's involvement in that. Now, some of the other issues had come to light for the PHA, but they weren't necessarily involved in those because they clearly would seem to 11:36

have suggested they were operational issues. One of the issues that didn't come near the PHA was the Bicalutamide issue; you had no awareness of that at all prior to the Early Alert. Untriaged referrals, the PHA became aware of these through the SAIs in 2017, and subsequently through to 2020 the SAIs identified that issue, and I think, in summary format, there was a reassurance given that e-triage had been introduced; is that right? 11:37

A. Yes, that's correct. Reassurance had been given because e-triage was seen as a fail-safe, and I think the public health consultant - forgive me, I can't remember which one - had sought assurance also from GP colleagues involved in that that it was a fail-safe. 11:37

95 Q. And just on that particular issue, one of the functions or the main function of SAIs, I suppose, from the Public Health Agency's point of view, is the identification of themes of concern that would allow for learning across all Trusts and all areas that fall under your remit and the triage issue is probably a good example of that, that learning could be fed across other Trusts, and I appreciate this is before and just leading up to your time when you took up post, but is it the case when an issue like triage is identified as a problem area and an electronic system is purported to resolve that and was going to be implemented by a Trust, is that something then that the PHA would share that learning with other Trusts or did each Trust just get to that stage independently? 11:38 11:38 11:38

A. I think the way the system would work if that was learning which would be applicable to be distributed across the region, then the Agency has a responsibility. Its main responsibility in SAIs is a distribution of learning across the region, ensuring good practice across the region to enhance sort of patient safety. So, yes, it wouldn't be left to, sort of, other Trusts to find it by themselves if it was appropriate, but I don't know the detail of whether or not e-triage was already in other Trusts and was just being introduced in the Southern Trust, or whether or not it was being used, sort of, by a number or not. 11:39 11:39

96 Q. Now, the Panel are aware that SAIs come through HSCB/SPPG through the governance team, through the Health and Social Care Trust, they forward that information on and then there is a process by which they are designated a level and also a Review Officer, a DRO, a Designated Review Officer. From the Public Health Agency's perspective, what is your involvement in SAIs and is that currently changing? 11:40 11:40

A. Yes. Our responsibility is, as I say, to provide that sort of professional input. Usually, the DROs are professionals, so we would allocate one of those. Now, during my time, that has changed, so I think during the time of this it would have been an individual. Now, there is a sort of designated group, who look at them as a group to ensure that anyone's absence, etc., would ensure things don't fall between the cracks. Sorry, Ms. McMahon, can you repeat the rest of the question? 11:40

97 Q. I am afraid I can't, unfortunately.
A. Sorry.
98 Q. I am sure it was fabulous, but I just can't remember. I think it was what your PHA's involvement in SAIs is?
A. Sorry, it was. 11:41
99 Q. And I'll give you my trigger that I was looking at for my next question: that has changed since Covid?
A. Yes, it has.
100 Q. So if you could perhaps update us from that point?
A. So, as I say, the bit from Covid is that there is no 11:41
longer a designated response officer; I've probably just given that. It's now overseen by a group, which meets every week, to go through them as a multidisciplinary team, as opposed to leaving it to just one individual, because there is greater 11:41
safeguards, obviously, of a team looking at it, they bring a number of perspectives, so you might have a nurse, an AHP and a doctor reviewing that SAI. The Agency's responsibility then is to ensure that learning is distributed, and I think my second statement 11:42
particularly focused on how that learning is distributed. Pre-Covid, that would have been through workshops and letters, and now it's more through the ECHO programme, and that's sort of an online programme and it allows greater access into shared learning so 11:42
more members can join that than would previously have been able to join workshops, etc., and it is probably more accessible, and they are recorded, I believe, and held for people to view at a later date if need be.

And the SAI process itself is changing, subject to review. There was an RQIA review, which found that they weren't particularly fit for purpose on a number of levels, that, often, people asked to complete them were busy and they were doing it on top of their day job, that they quite often didn't meet patients' expectations in terms of the responses that they got out of them or the information they got out of them. They often overran their timeframes as well. And people, perhaps, were not trained in the way they should have been in sort of root cause analysis and in terms of their ability to undertake them. There is a review being undertaken now by the Department of Health; my team are feeding into that via the Director of Nursing and AHPs, Mrs. Heather Reid -- or Ms. Heather Reid and Denise Boulter, who is one of her Assistant Directors responsible for safety and quality. That group is due to report in 2024, in the next couple of months, I understand, and it will move away, I think, from SAIs to more focus on Patient Safety Events, with a view to a more open learning culture and compassion for all those that are involved in those Patient Safety Events. Sorry if that was too long.

11:42 11:43 11:43 11:43

101 Q. No, that just summarises your addendum statement very helpfully, where you have set out the new way in which SAIs are going to be viewed, approached as regards investigation, but also rolled out, hopefully. In relation to the Public Health Agency and this new, as you have said it is going to -- are they going to call

11:44

it Patient Safety Events, PSE, is that the new same for SAIs?

A. I don't know. I think that might be a working title --

102 Q. A working title.

A. -- but we'll see what they come out with, but it's certainly a move away from the term 'SAI' to 'Patient Safety Event', I think it's where the focus comes to it. 11:44

103 Q. Just for the Panel's note, that information could be found at WIT-106837, paragraph 4. Now, given the role - I know you have mentioned that several of your senior staff are involved in this process around looking at SAIs and perhaps coming up with a better approach to that, but in relation to the thematic learning and the responsibility of PHA to roll out learning and to inform people of best practice, if I can use that phrase, what way is that done under your stewardship? 11:44 11:45

A. As I say, pre-Covid, that would have been a number of workshops held each year where themes would have been sort of demonstrated and then the learning to be taken out of them was shared with audiences drawn from across the Trusts and other bodies. That has now changed, more or less, to an online learning event, which is run through, sort of, ECHO, Project ECHO. Please don't ask me what that stands for, I can't remember. I think it's in the statement. But it's much more online. I think what has led to that is that you can send out letters, which is what we did pre-Covid, and even sort 11:45 11:46

of post-Covid to an extent, but it's whether or not they were being read, taken up or adhered to, because you had no response back into that. And again, I think the workshops were very much where a limited number were attending. So the new approach is to ensure maximum reach, to be more interactive and to allow sort of a recording of that as well so as people can go back in and look at it.

104 Q. And you mentioned as well that these learning events have been overtaken by events, given Covid, so there is a focus now on distance learning for individuals and for people to join remotely? 11:46

A. Yes.

105 Q. And you say that these events have, to some extent, been superseded by the ECHO, which is an Extension of Community Healthcare Outcomes programme? 11:47

A. Yes.

106 Q. Is that a PHA?

A. No.

107 Q. It's a catchy title. 11:47

A. It's a catchy title. It sits within SPPG, or formerly the Boards, but it wasn't our programme. I think we were really just using the mechanism of that as a way of reaching people. It was very -- I think, during Covid, we learned that it was a very effective way of reaching large numbers of people at once, it was a good way of communicating information as well, and the feedback was generally positive about it, so that's why we've extended it. If it worked for learning during 11:47

Covid, it should work for learning coming out of Patient Safety Events as well.

108 Q. Now, there are two issues just as theme questions for me in relation to the SAIs from the Public Health Agency's point of view. The first one is, the anonymity issue around any clinician involved in a SAI, any member of staff, and perhaps, from this remove, there is a legitimate query as to whether that was a help or a hindrance in allowing people to identify a theme that may have otherwise been clear had that information not been anonymous. But from a Public Health Agency point of view, what's your understanding of the reason behind the anonymity and is it something that you think should persist? 11:48 11:48

A. I do think that the anonymity helps. SAIs, I think, originated by the work of Sir Liam Donaldson when he looked at the health and social care system in Northern Ireland with a view to creating a more open, safety-conscious system, part of that was to encourage people to come forward, and it's not a punitive system; it's a system based on learning and it is a system based on sort of system learning and developing themes. There are other mechanisms within Trusts to deal with clinicians which are not performing in the way that they should, especially for doctors where you have things like maintaining higher professional standards, plus the other HR issues. The SAI process is around identifying and sharing good practice and system learning and through the development of a safer patient 11:48 11:49 11:49

environment; it is not there to be punitive. And I think the risk of, where you start naming individuals, is that there be less people, perhaps less inclined to come forward and volunteer information and less open, if they are then conscious that it could lead to disciplinary action against them. So while the Agency is focused on the system, it is very much not focused on the individual and, if we're not focused on the individual, then we don't need the names. Now, you could say here's a series of events where one individual was at the heart of them; PHA doesn't need to know that, but surely, within the Trust, they would have known it was the same individual, especially at that operational level, who was at the heart of a number of those. So does that answer your question? 11:50

109 Q. Yes, it does. Just in relation to SAIs, and you've said about the thematic learning, it may readily be seen that if SAIs were coming in from various Trusts, or even one Trust, around, for example, the use of a new bed and potential damage or people falling on floors that hadn't been properly marked as being washed or a theme that may be applicable across all hospitals, there can be clear learning taken from that, all Trusts could be notified and that issue, in isolation, could be addressed that way. But I'm just following on from what you have said, PHA don't need to be notified if it is the same clinician, for example, or the name of a clinician or any healthcare practitioner, but if the theme is one that, arguably, is founded in culture or

behaviour which may be replicated across other Trusts, without it having bubbled up to the surface of SAI, would the revealing of some of the information around the clinician or practitioner involved allow for that theme to be properly identified as one of behaviour and culture that PHA could look at and, if the Trust wanted to look at other issues under MHPS or any disciplinary, they could do that also, is there not a potential for learning around that? 11:51

A. There possibly is. I suppose it comes back to, is it -- well, sorry, just to go back slightly further than that. In terms of beds, the SAIs are not the only mechanism by which sort of potential safety issues in the system can be identified. So, in the lack of beds, there is a sort of, I think it's called NIAC, which looks at medical equipment in particular, and safety alerts would be distributed throughout, but that is a separate sort of process. 11:52 11:52

In terms of cultures and behaviours, perhaps, across a specialty such as Urology across the region, would the naming of individuals be appropriate? I just wonder if there are other mechanisms such as peer audit, clinical audit, which might pick those things up and would be more appropriate as well. I would be concerned that taking the -- as I said previously, taking the anonymity out of the process may impact upon the process's ability to be open and just, and I think that's one of the key focuses of the Patient Safety 11:52 11:53

Event, is the change in SAIs, is to ensure that we have a very open culture, and I'm not sure putting names into that would help with that, but that's just a personal view.

110 Q. And just finally on the general point around SAIs, the progress that's being made or the plans for those, you say your staff are involved; are you content that the interrogation of that process and the likely outcomes of that, any learning that may come from that, are you content that they will be an improvement on what existed before and to help PHA fulfil its obligations? 11:53 11:54

A. I trust my staff, and I think those which are involved, in terms of Ms. Reid and Ms. Boulter, know the system well and will serve the review well. I can only trust, therefore, that we have had the appropriate input of our voices being heard and that the appropriate outcomes will make it a safer environment for patients and more open, as intended. 11:54

111 Q. One of the examples of PHA's involvement in an SAI relevant to the Inquiry involved Patient 95. You don't have patient details, and you don't need them for these purposes; you not only don't need them, but you weren't involved in this particular process or in PHA at the time, but this is for the Panel, the information in relation to this SAI can be found at WIT-61605. Paragraph 119, just move down just slightly for me. Thank you. We have asked you a question just in advance of paragraph 118: 11:54 11:55

"In the period prior to 2016, was the PHA made aware of any SAI and/or complaint (whether formal or informal) involving the care provided by or the conduct of Mr. Aidan O'Brien? If so, please provide full details." 11:55

And you, at paragraph 119 - I'm reading this out for the purposes of identifying PHA's involvement, and again it is Dr. Corrigan - at paragraph 119, it says: 11:56

"The PHA is aware of an additional SAI reference [redacted]..."

And for our purposes, that's Patient 95. 11:56

"... Involving the specialty of Urology in CAH prior to 2016. As is the case in all Trust RCA reports, individual staff members are not identified. This incident occurred on 7th July 2010 and was notified to the HSCB on 3rd September 2010. The incident was 11:56 reported as a retained swab after major urological cancer surgery. The DRO, Dr. Diane Corrigan, Consultant in Public Health Medicine, identified that the incident also involved a problem in respect of management of a radiology result. The emails and 11:56 reports which are held by PHA are included in the response to question 48."

If we just move down slightly, and this just sets out

the context of this, and this, again, is another example, and I want to ask you at the end if the possibility of this level of involvement and perhaps influence by PHA in the SAI outcomes and potential learning still exists and will exist under the new system. So, what happened then in 2010, paragraph 121: 11:57

"Dr. Diane Corrigan, Consultant in Public Health Medicine, PHA, the HSCB position report states that Dr. Corrigan was forwarded the SAI report on 7th January 2011. On 7th April 2011, Dr. Corrigan emailed Dr. C. McAllister..." 11:57

Who we know to be Charles McAllister, at the Trust.

"... the lead investigator for the SAI, seeking advice. The HSCB position report states, on 4th May 2011, that Dr. Corrigan was intending to meet the Trust about open SAIs that month to clarify outstanding issues. On 14th November 2011, Dr. Corrigan wrote to Mrs. Debbie Burns, Assistant Director of Clinical and Social Care Governance in SHSCT." 11:58

Then, if we move down again to paragraph 125, and we've asked: 11:58

"On receipt of the investigation or review reports, what action was taken by the DRO to quality-assure the adequacy of the investigation and to reduce the risk of

recurrence?"

And it says:

"The DRO felt that the SAI report, while comprehensive in respect of the issue of a revised process to avoid recurrence of a retained swab, had not addressed a more important issue. The patient was to have a CT scan some months after their operation and then to be reviewed at Out-Patients a short time later. The scan was done and the report indicated an abnormal finding. The differential diagnosis included a potential cancer recurrence; in fact, this abnormality was the retained swab. However, the result was filed, the patient was not reviewed as planned and the problem only came to light following hospital admission many months later. If the abnormality had been a cancer recurrence, the patient could have come to even greater harm. The DRO wrote to the Trust on 14th November 2011 asking that the issue of filing results without them being seen by a clinician was addressed." 11:58 11:59 11:59 11:59

Just move down, please. Paragraph 126:

"The DRO also suggested on 14th November 2011 that there was additional action that could be taken by the Trust to avoid a similar incident; in particular, that the Trust could develop a formal Trust policy for all specialities so that results of investigations were not 11:59

filed in patients' charts before they had been seen by a doctor."

Paragraph 127:

12:00

"The emails and letters between Dr. Corrigan and the Trust's Assistant Director for Clinical and Social Care Governance, Medical Director and Governance Manager indicate that her suggestion was not considered easy to implement. Alternative protocols were shared with 12:00
HSCB, but none appeared to address the underlying issue. However, it was confirmed on 17th December 2014 that the process was as follows: 'secretaries have confirmed that they do not file results without them first being viewed by the consultants. Consultants 12:00
mostly sign these and some then dictate a letter'."

Paragraph 128:

"Dr. Corrigan accepted this statement on 29th October 12:01
2015. As she did not know if there had been similar SAIs reported, she shared the Trust email with Ms. Lynne Charlton (PHA Head of Nursing, Quality, Safety and Patient Experience) who asked HSCB to run a Datix query in respect of SAIs filed away without 12:01
action. It was reported by HSCB staff on 16th January 2017 that it was not possible to undertake this search as this category of incident was not coded on Datix."

I just want to stop there, just for a moment. It is clear that the SAI had been exhausted, liaison with PHA allowed PHA staff to identify that, in fact, a further step needed to be taken to ring-fence the potential of this, perhaps, happening again, and that was that a report wasn't looked at in perhaps a timely way, and that was followed through again by Dr. Corrigan. Is that level of engagement - and we see correspondence with the HSCB, as well, in your bundle - is that level of engagement and interrogation of SAI outcomes by the PHA something that is still ongoing? 12:02 12:02

A. Yes.

112 Q. And when the PHA do identify, if they do, issues arising from SAIs and go back to the Trust, is that engagement welcomed by the Trust and acted upon? 12:02

A. I'm not sort of directly involved in that process, but I would say my experience of many years is that, and I did work in the Trust for many years, engagements with the DROs is always welcome and was acted upon because they were advising you how to keep your service safe, how to keep those involved in the service safe and, most importantly, how to keep patients safe, so, yes, I think anyone who wouldn't welcome advice and learning, because that is at the heart of what we do as an organisation, is to ensure that we have continuous improvement in learning and making our services as safe as we possibly can. 12:02 12:03

113 Q. It does seem from the correspondence in the chronology I have just read out from 2011 that it took quite a

long time, to 2014, to get a reassurance that, with respect to the Trust seeing something that was not costly at all to implement and, arguably, had a lot of common sense attached to it, that results aren't filed without someone signing them off. Would you agree that 12:03
that seems like a particularly protracted period of time?

A. It did, and I have had opportunity to discuss this with Dr. Corrigan, I think there was a degree of frustration at the time that they would write and ask for 12:04
reassurance and, quite often, the reassurance would come back around swab counting, missing the issue around the fact that the heart of this was the fact that the diagnostics results had not been considered by individuals and were -- that was the heart of what she 12:04
was looking for reassurance on, that that was implemented. She also felt at that time, from recollection, that there had been a number of changes in the governance team and the continuity had been lost as well. 12:04

114 Q. And the Inquiry has heard evidence around the issues leading up to this and whether the results -- what happened then and subsequent decision-making by the Trust to try and rectify that. But currently, and it may not be a problem if it has not reached you, but are 12:04
you aware of any issues around Trust's failure to engage with PHA when they are seeking to identify or help close a governance loophole?

A. No, not at this time. If there was a failure, my

expectation is it could be escalated to me to take up with appropriate people within the Trust, i.e. directly to their Chief Executive, if my team are aware -- if they do not feel that they are getting traction or being listened to, that will happen. 12:05

115 Q. And would that be on the basis both that you need to fulfil your statutory duties, but also inherent in any suggestion would be the potential to reduce or eliminate risk?

A. Yes. 12:05

116 Q. And enhance patient safety?

A. Yes.

117 Q. So, from your own staff's point of view, would they have a timeframe or a template in mind to say, okay, we have passed the point, we consider there is a risk 12:06 inherent in this and we need to escalate this. Does that -- it's something that is not operationally needed, you're saying, at the moment?

A. I don't think that anything has ever come to my desk which I feel didn't come in a timely manner, if I can 12:06 put it in that way, so it's not something that I would consider is needed. I have not been frustrated with my team either over-escalating or under-escalating things and I always think that they are very professional and act in the best interests of the patient. 12:06

118 Q. Just on the timely manner point that you have mentioned, the Panel has heard evidence that there is a backlog of SAIs that haven't been dealt with, that are dormant. I think, then, there is a difficulty of them

proceeding through to obtain the proper interrogation from your staff, given that they are sitting in the system; would you agree that that is an existing patient risk?

A. It is a patient risk because you don't know -- what you don't know, I suppose, is, sitting in that group, it hasn't come through to our professional group at this point in time. 12:07

119 Q. And is there anything the PHA can do to assist in addressing that or influencing either processes or conversations around that that may accelerate addressing that risk? 12:07

A. I would hope that our group working within this review will perhaps address that, going forward. So the existing review of SAIs and how they are handled and maybe there is a way of them dealing with the backlog coming out of that. 12:07

120 Q. And does the review, is it looking at the backlog as well as looking at how to prevent a future backlog? Are they two separate streams within the review? 12:07

A. I have to say, I'm not sure. I could check and I'd advise you of that, but I would hope that, coming out of that, there would be perhaps a way of ensuring that we don't hit such backlogs in the future, and then how we deal with current backlog is perhaps something that we perhaps deal with coming out of that review, but, as I say, I'm not aware of that. 12:08

121 Q. Now, neither SPPG or PHA follow up the implementations of SAI; that's a matter for the Trust --

A. For the Trust.
122 Q. -- operationally. Your remit is to carve out any thematic learning and ensure that that is shared at the appropriate level?
A. Yes. 12:08
123 Q. Are there any barriers to you fulfilling that sharing of information at the moment? Operationally, are there any difficulties with you being able to disseminate the information both in a way that's needed and to the proper audience? 12:09
A. Not -- no. I think the new ECHO programme is working well and will be subject to evaluation, as we do sort of most programmes that are introduced, and I would expect that, as that evaluation is completed, it will tell us whether or not it is working well or not, and 12:09 what we can do to improve it, but I think we should always be looking to improve how we disseminate that learning. As I have outlined, we have changed how we have done it. We've done the ECHO programmes. That is not to say that if there isn't an even better way of 12:09 doing it going forward, that we wouldn't adopt that.
124 Q. Given that you have said in your statement that there are -- since 2014, there have been three reports published in Northern Ireland relating to SAIs or governance processes, and you have included extracts of 12:09 what those reports say, and although the wording may be different, there are certainly thematic concerns that seem to run through all of those overviews of SAIs and potential improvements, how confident are you, given

the existing suggestions that perhaps weren't taken up, how confident are you that this current process will bring about the changes required in SAIs?

A. I suppose it's hard to say that when I haven't seen what the review might say, but what I can say is that I think there's been a review completed by the RQIA. I wouldn't disagree with what's in that, and, as long as the review considers those and addresses the issues, I am, I suppose, reasonably confident then that we should have a better process, but that is not to mean that we should then rest and not continue to look to improve upon that going forward. I don't think any of that should just be static. 12:10 12:10

125 Q. Given how central the SAIs are to a certain aspect of the work of the PHA, do you engage with your staff who are involved in the current review, to be assured that the direction of travel in that review satisfies you so that you are sure that progress is being made that will help PHA and also reduce patient risk? 12:11

A. I suppose, informally. I couldn't say that I have formally sat down and met with them, but I have spoken to Heather and I have spoken to Denise and they have provided me assurance that they think it is proceeding well. 12:11

126 Q. Just for the Panel's note, when I refer to three reports, the first one is 'Quality Assurance of the Review of the Handling of All Serious Adverse Incidents Reported Between 1st January 2009 and 31st December 2013', and that's actually the title of the report, and 12:11

it is at -- Mr. Dawson refers to it in his witness statement at WIT-61619, at paragraph 191.

The second of those reports is an extract from 'The Right Time, the Right Place', otherwise known as the Donaldson Report, in 2014, and Mr. Dawson refers to that at 192 of his statement. And at paragraph 193, he references the RQIA Report, 'Review of the Systems and Processes for Learning from SAIs in Northern Ireland', which I think had a date of June 2022. So that's the -- the outworking of that is what is currently -- 12:12 12:12

A. Yes, being considered.

127 Q. In train, is that right?

A. That's right.

128 Q. One of the other issues that arose from the overarching SAI, I just want to ask you about, just as an identification of themes, and the theme I want to ask you about is cancer MDTs as one of the issues that became involved, I think this is during your tenure, the overarching SAI, and if we go to WIT-61625. This is actions of the Trust following the issue of the Early Alert. On the Early Alert process itself, are you satisfied that the Trust dealt with the process of the Early Alert and the response thereafter, that that was done properly from the PHA perspective? 12:12 12:13 12:13

A. Yes. The Early Alert process is really there to identify to a Minister of issues of concern which may end up in the media or which become pressing or emerging issues, so I think, yes.

129 Q. I'll just go down to paragraph 218, and you say:

"The PHA's priority after the Early Alert was to ensure that measures were taken to ensure patients were on the correct treatment pathway and patients with a delayed review were seen in a timely manner." 12:14

As I say, this was after the overarching SAI report had been made available. You go on to say:

12:14

"PHA also clarified that Aidan O'Brien was not seeing patients and that the appropriate regulatory authorities, e.g. GMC and RQIA, were involved. As more patient reviews were completed, new issues emerged, e.g. suboptimal prescribing." 12:14

Paragraph 219:

"The PHA subsequently attended the meetings with SHSCT, where updates were provided. PHA did express concerns..." 12:15

And you have provided the dates of these meetings. For the transcript: 19/11/'20, 4/3/'21, 3/3/'22:

12:15

"PHA did express concerns at these meetings that more cases will need to be reviewed when the initial case note review of cases between 1/1/'19 and 30/6/'20 is completed. PHA also raised the issue that more support

was needed to be given to the clinician who was doing these reviews and that a more structured approach was needed for extracting information from case notes (see email from Dr. Farrell to Paul Kavanagh of 3rd December 2020 advising that minutes did not reflect the discussion on the need for structured pro forma for extracting information from case notes and reviewing the outcome of patient reviews)." 12:15

Paragraph 220: 12:16

"Actions of the SHSCT following receipt of the overarching SAI Report:

When the overarching SAI Report was received, Dr. Farrell emailed the Medical Director in SHSCT (4/3/'21) and the Director of Commissioning in HSCB/SPPG, giving a general comment about the report and raised concerns about the commentary relating to how urology cancer multidisciplinary teams operated and whether this way of working was happening in other cancer MDTs in the SHSCT. Following this, a meeting was arranged with the SHSCT and NICaN representatives to explore further and seek assurances that they were operating as effective MDMs." 12:16 12:16

So you would have some knowledge of that particular communication or query around the MDTs with the Trust, is that something you are aware of?

A. No, I was not aware.
130 Q. Given that it was after --
A. Sorry, can I go -- I actually think I came into post in July '21. I think I may have said earlier July '20. In July '21. 12:17
131 Q. That's fine, that's fine. So this was something that happen just before you?
A. It did.
132 Q. And there was learning identified as the way in which the process around MDTs was carried out. Now, do you have any knowledge of that, during your tenure, of what happened, whether that was rolled out and what the learning subsequently became and was it shared with other Trusts? 12:17
A. Sorry, I wouldn't -- I mean, it was obviously taken forward by NICaN. NICaN is where we work with sort of the expertise that sort of rests within the clinical team dealing with cancer across Northern Ireland, and therefore, that group brought that forward. Whilst we work with them, I wouldn't be -- it would be misleading to say I was aware of the detail of that. 12:17 12:18
133 Q. Is that something that your team would work out, they would deal with the outworking of that?
A. Yes.
134 Q. Is this a further example of a theme being identified through the SAI -- 12:18
A. Taking appropriate --
135 Q. -- the PHA has identified it as potentially broader learning and that has filtered it through?

A. Yes, and, I think, appropriately brought to NICaN, which is the appropriate place to look at that.

136 Q. In relation to the review and the Lookback Review and guidance, did you have any involvement with that as Chief Executive or are you aware of PHA's role in that? 12:18

A. I do sit in the, sort of, Urology Oversight Group, which is the chaired by the Permanent Secretary. The PHA's responsibility is to work with the Steering Group within the Trust, who have the overall responsibility for determining whether or not a lookback needs to take 12:19 place. We would also share with, sort of, other Trusts if there were issues coming out of that which needed to be addressed within those Trusts, and then we would support the, sort of, operational implementation team in the Trust in terms of their communication plans and 12:19 their, sort of, operational plan. I suppose how that would work, in reality, is that our officers would meet officers from the Trust to go through their implementation plan, their communication plan and provide quality assurance if they are satisfied that it 12:19 is taking appropriate measures in terms of the plan.

137 Q. And you have mentioned before that you can only know what you know, given the information that the Trust provides you with, you take that at face value?

A. Yes. 12:19

138 Q. A couple of incidents of extracts I was reading from your statement where there were examples of information being sought from Trust databases; for example, the suggestion that Datix should be searched to see if SAIs

reflected the particular administrative issue and that wasn't possible. Does the PHA have any view on the efficacy of the way in which the Trust keeps data or uses data or reports data, that -- you are shaking your head already. 12:20

A. I know.

139 Q. Does that mean that it's not something you get involved in?

A. No, not unless it is particular data that we've asked for, in which case we would provide definitions of how 12:20 we wanted that data looked for, go back to things like antimicrobial prescribing or surgical-site infection rates, so we would provide a definition of what we think that is, to come in to us, but the Trust information systems are not within our, sort of, 12:21 horizon to look at.

140 Q. And I ask you that question because the suggestion around the searching of the Datix to identify other queries in the system that are the same, seems to be one that -- a very sensible suggestion, in order, from 12:21 the PHA's perspective, to identify themes. Would you agree that that would also be helpful for the Trust to be able to do that sort of search, to identify their own themes, given the dominance of needing to keep patient risk at an absolute minimum? 12:21

A. Trusts do have access to their own Datix system, can search that, and actually, many years ago as an operational manager in a Trust, I underwent sort of rudimentary training in the use of Datix to be able to

go in and search it. I can't say that I did it that often, but it is something which you would have access to.

141 Q. So it is possible to search key words or to search particular phrases that then would bring up similar results that could show themes? 12:22

A. Yes, I mean, certainly -- can I go back to my experience in a Trust?

142 Q. Oh, yes, please, yes.

A. If there were things which I wanted searched - just to say, I was no expert in it - Datix is not the most easily intuitive and accessible system. You really have to know what you're doing with it because you can ask the question in a number of different ways to try and extract information out of it, but there are usually experts within the Trusts, within governance departments, etc., and if you explained to them what you're looking for, they should be able to search for that, get you information and provide it to you to consider, which I think is what our team were suggesting there. Obviously, Datix PHA officers have read-only access. The one that we have access to is obviously held within the Board, or what was the Board, now SPPG. Our teams have read-only access, but they could go into the administrative people in the Board, or SPPG, and ask for searches, if they so wished. 12:22 12:22 12:22 12:23

143 Q. That particular search that I read out was to look for SAIs that have been filed away without action, following your results not being looked at, and the

answer was that -- well, the answer from HSCB staff was that it was not possible to undertake this search as this category of incident was not coded on Datix. So are you limited by the coding on Datix, just in your other hat I'm asking you? 12:23

A. Yeah, you are limited in terms of how things are coded and what information goes in against them as well. As I say, it's not a wonderfully intuitive system to use and you do have to know what you are doing with it.

144 Q. Was your PHA involved in any of the structured judgment reviews or the SCRRs, was there any engagement directly with you on that? Or do you have a view on the appropriateness of the Trust instigating that? 12:23

A. No.

145 Q. So, in relation to what potentially went wrong, I just want to look at your statement at WIT-61635, paragraph 275, and we've asked you: 12:24

"From the information available to the PHA to date, what does it consider went wrong within the Trust's Urology Services and with regard to Trust governance procedures and arrangements? Has the PHA reached any view on how such issues may be prevented from occurring? Has the PHA taken any steps with a view to preventing the recurrence of such issues." 12:24 12:25

And I will just read out what you have said, paragraph 275:

"All HSC organisations are expected to meet extant DoH requirements, as set out in the relevant circulars, such as those on complaints, Early Alerts and Lookback Reviews. Trusts are also expected to adhere to HSCB/SPPG guidance on the management of SAIs. Individual Trusts have flexibility in establishing internal structures within certain parameters to manage Clinical Governance issues. They are also responsible for managing individual clinician performance issues. The PHA does not have an oversight role in this regard. Although senior PHA staff have participated in the HSCB and DoH groups established to oversee the process from 2020 onwards, PHA had no regular engagement with the Trust between January 2017 and the issuing of the Early Alert." 12:25 12:25 12:26

Paragraph 276:

"It follows that the PHA does not have a final view on this question but the following issues appear relevant." 12:26

Paragraph 277:

"The SAI process, although not designed to identify or manage failings in individual clinical practice, did, on this occasion, flag a problem in 2016 within Urology and, when asked, the Trust stated that this was in relation to one clinician. The HSCB/PHA process sought 12:26

and received assurances from the Trust that the issue had been resolved (primarily by the introduction of an e-triage system). The SAI system relies upon trust in communication between HSCB/PHA and Trusts. It is not resourced to test the veracity of Trust assurances." 12:26

Paragraph 278:

"The PHA is now aware that the Trust had been trying to address issues in Mr. O'Brien's practice from 2016. 12:26
The MHPS process was prolonged and, unfortunately, did not resolve the situation. It is noted that the majority of the issues identified appear to relate not to the clinician's technical competence as a surgeon, but instead to appropriate and timely triage of 12:27
referrals, ordering of diagnostic tests, action on results and MDT teamwork. It appears possible that governance systems are more focused on failings in clinician's technical competence and are less capable of managing poor practice in areas of 'patient 12:27
administration'. The latter are equally capable of causing patient harm and need to be given equal weight."

Paragraph 279: 12:27

"There needs to be a systematic approach within Trusts to identify and flag clinical or administrative issues meriting further exploration. In the submission from

Mr. Paul Kavanagh, HSCB Director of Commissioning, to Mrs. Sharon Gallagher, HSCB Chief Executive, in May 2021, it was noted that data infrastructure in the HSC makes routine audit of care across all pathways very challenging. However, Recommendations 5, 6, 8 and 9 in the submission address issues in cancer pathways which should prevent recurrence in this high-risk field of practice. These recommendations are supported by the PHA." 12:28

12:28

Paragraph 280:

"In addition, all measures described in Q40 need to be working effectively and efficiently to detect suboptimal practice and there needs to be a single oversight of all of these within a Trust." 12:28

Now, you have made some reference to some of the issues that would appear not to have been within the knowledge of PHA at the time, and you have mentioned Mr. O'Brien. Is the information that you have derived to inform those paragraphs, from information you have received from the Inquiry or from other sources? 12:28

A. From the Inquiry and, I suppose, as we've worked through this, our staff's recollection of events at the time. 12:29

146 Q. You would have no direct knowledge of any alleged harm coming to anyone as a result of care given by Mr. O'Brien --

A. No.
147 Q. That's not information that you would have any direct knowledge of?
A. No, and it would not be relevant for that to come to the Public Health Agency. 12:29
148 Q. Just generally in relation to commissioning overall, there may be some suggestion that the urology service from the outset was inadequately resourced and continued to be so in various regards, do you consider that, knowing what you know now given your information 12:30
from the Inquiry, that that was the case, that urology was inadequately resourced or that the commissioning plans for urology services weren't in fact properly implemented and resources were not forthcoming where they might have been needed? 12:30
A. I think many of the services, the Health Service in Northern Ireland has many constraints around resources. It would seem through coming out of the Inquiry that the service is inadequately resourced. But you can perhaps make that statement around a number of the 12:30
services which are currently being provided across Northern Ireland. I don't think urology would be unique in its lack of funding, and I think many clinical teams across Northern Ireland, if asked, would suggest that their services are underfunded. 12:30
149 Q. When you look at safety and quality in relation to commissioning, one would assume probably the dominant considerations in order to appropriately commission and allow a service to be commissioned by a provider,

beyond being told by the Trust that they can provide the service for which they are commissioned, are there any other sources of assurance or reassurance that the PHA seek or obtain around both safety and quality?

A. Other than the ones which I have outlined previously around sort of we would provide, carry out surveillance on specific areas, no. Mainly our assurance comes directly from the Trust, and I think it is the responsibility of the Trust to provide those assurances and be confident when they are given that their services are safe within the resource that they have got to provide them. I think the onus is within -- it is laid out in the framework document that the onus is on each Trust to ensure that it is financially secure, that it has appropriate corporate controls in place and that the safety and quality of its services are appropriate. 12:31 12:31 12:32

150 Q. And given what you now know, I know you gave the statement over a year and a half now, given what you now know and the evidence you have heard from other witnesses perhaps, is there anything else you would like to add around what you think may have gone wrong or what learning there may be from what the Panel have heard for the Public Health Agency? 12:32

A. I don't think there is anything else I would like to add. Only perhaps, I mean, as we have discussed and as it says in that, that the SAI process is not designed to do this. It has been perhaps the diligence of our team at times to identify issues which bring them into 12:32

another sphere. Perhaps going forward is there something additional needed when such events take place, is there a different process needed to identify sort of those incidents and deal with them? I'm perhaps not describing that very well, I do apologise. 12:33

151 Q. Is it the case that some of the evidence, including the evidence from PHA, might suggest that various bodies and individuals knew a piece of the jigsaw but no one had perhaps an view of the overall picture?

A. Yeah, perhaps that is what I am getting at. There needs to be a multiagency approach to triangulate and share the information that it has. I think that was also identified within the Neurology Inquiry report too, that agencies, as you say, certainly in Neurology GMC had information, Trusts had information et cetera, 12:33 12:34 and the triangulation of that was not there.

152 Q. From the recommendations from that Neurology Inquiry - I shouldn't say "that neurology" as though this is another one, from the Neurology Inquiry - has there been learning implemented by the PHA, has there been a 12:34 rollout of recommendations from that that might inform this Panel's recommendations as to what else needs to be done?

A. Obviously the Neurology Inquiry report is submitted to the Department of Health for them to consider the 12:34 recommendations and take forward. My understanding, there's a group within the Department now established which brings together the recommendations, the outworkings of the Hyponatraemia Inquiry and the

Neurology Inquiry to be considered. We await the implementation of those or sort of what we're advised to take forward from those inquiries.

153 Q. Mr. Dawson, I've tried to reflect the areas of particular interest possibly for the Panel, take those out of your statement and carve them out, is there any other part of your statement or issue that we haven't discussed that you think you need to address? 12:35

A. Not at this time, no.

MS. McMAHON: Chair, I have no further questions. 12:35

CHAIR: Thank you Ms. McMahon. Thank you very much, Mr. Dawson. I think we should have a few questions before we can let you go. Mr. Hanbury?

THE WITNESS WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS: 12:35

MR. HANBURY: Thank you very much for your evidence.

154 Q. I was interested in the role of the PHA with regards regional learning after SAIs and just briefly the triage, the results not being acted upon, the JJ stent problem and waiting list aspects. There was another case of a bleed following a nephrostomy, a tube going into the kidney, which didn't seem to go anywhere but maybe you have other views. 12:35 12:36

The process of SAIs being looked at by - the DRO, I think, was your acronym - that never seemed to arise into a forceful result, i.e. a strong letter to all the

urologists in the region, which is only 20 or so, I mean did you detect a problem, would you have a comment on that process in retrospect?

A. I think the Agency, its primary role is at the dissemination of learning, it's not to interact -- as you say issue strong letters. We don't tend to instruct, that would not be seen as our role. Our role is more the sharing and learning and creating a learning culture to move forward. As I say it's not a punitive thing. It is more coming out of Sir Liam Donaldson, the development of an open learning system and culture which is shared by everyone. I think if we got into the position perhaps of issuing strongly lettered statements, that people might back off, might be less open and that would be a concern for me. 12:36 12:37 12:37

155 Q. But are you content that your -- that new ways of doing it are actually activated by the clinicians?

A. I can trust in the system. I think the SAI system as we know and probably our actions within that are questioned over a period of time. I feel that we did what we were supposed to do during that period of time. Obviously the whole process is now under review. RQIA have identified that there were significant failings. Maybe they will come up with a suggestion similar to yours, that there should be more proactive and strongly worded statements demanding action. That was certainly, I don't think, the culture at that time. It was not the approach taken. We'll wait and see what the review comes out with to see if it does change 12:38 12:38

that. But that is certainly why the review is ongoing, because there is a recognition of the limitations of the SAI process. But, also, the SAI process clearly is not there to deal with an individual who is not performing appropriately. That clearly sits with the individual Trust Management Team, either in terms of, if it is a medic, the Medical Director, the Clinical Team and the sort of service area that it sits within. They have been maintaining higher professional standards to be able to do that. 12:38 12:39

So I suppose us telling the Trust where the issues need to be addressed, my expectation is that if strongly -- if there's a requirement change, then behaviours, that that is taken forward by the Trust and any strong interventions which they need to take with individuals to ensure compliance is at Trust level and within the management team of the Trust to take forward. 12:39

156 Q. Okay, thank you. Just moving on to a different subject, national audits. You mentioned in your witness statement the stroke audit and the fracture neck and femur audits which were helpful, but we are aware that Urology didn't really participate in national audits, of which there are in fact several, the national prostate cancer audits and the major surgery outcome audits; I mean was there any reason from your point of view that certain departments didn't? 12:39 12:39

A. No, sorry, not that I am aware of.

157 Q. The PHA wouldn't spot that as an index of non-participation and flag that up?

A. No. I think from the statement it's clear that we have at times supported and recommended through to Health and Social Care Board that certain audits do take place and we are supportive of that. Some audits require resource and need to be funded, and obviously funding will come through the Health and Social Care Board as well so we would work with that. But again we have had those discussions around the limitations of funding that we have. I suppose quite often it would be up to perhaps the clinical teams to come forward with 'we think this is an appropriate audit to do, we seek funding to do it, can we have the funding to do it' and then that would be assessed. But it wouldn't be a top-down approach, it would be more a bottom-up approach, I would say. 12:40 12:40 12:41

158 Q. Thank you. But you are not aware of being approached by the Urology Department of the Southern Trust especially for support for that? 12:41

A. No, I have to say I'm not aware of it, but that doesn't mean it never happened, just that I am not aware.

159 Q. Just, lastly, on the subject of prescribing, one of the problems with the Bicalutamide issue, which you are not necessarily familiar with, was that the hospital clinicians would prescribe and the prescription then went to community pharmacists so there was no oversight, as we are told by Tracey Boyce; did that surprise you or do you think now that there may be more 12:41

oversight from community pharmacies to flag up of script prescribing, shall we say?

A. I think the role of community pharmacists has evolved significantly over many years. We're now seeing sort of more prescribing. Indeed in recent weeks we have seen that they can prescribe for things such as sore throat and glue ear and things like that. I think that role will continue to deliver and that that is appropriate in a full multidisciplinary team working. So I think as that practice evolves and pharmacy evolves in working with secondary and primary care, you perhaps might see that in the future. It obviously wasn't in place during that time period. And I think during that time period pharmacists would have received the script and acted appropriately, that if that's what was recommended by the consultant then that's what would be administered. 12:42 12:42 12:42

160 Q. There seems to be a problem of lack of realisation that it was suboptimal, shall we say, in some cases and there was no challenge; I just wonder with your regional hat on whether there is an explanation for that? 12:43

A. I think in the history of things - because we often see consultants will prescribe things which are off licence, particularly perhaps for drugs which are used in an adult population perhaps being prescribed for children. So consultants have always had that clinical leeway that is part of their practice and is supported by the NHS generally. And, therefore, if someone sees 12:43

that as a pharmacist, they'll assume that that clinician is acting in the patient's best interests because that is their job to do that.

MR. HANBURY: Okay. Thank you very much. No more questions. 12:44

CHAIR: Thank you. Dr. Swart?

DR. SWART: Thank you. I found it quite difficult at times to understand exactly what agency does what.

A. Sorry.

161 Q. Something is whistling [background noise]. Can you hear me now? 12:44

A. Yes, sorry.

162 Q. So I found it a bit difficult to understand at times what agency does what with respect to setting the standards of quality and safety, so that's the background. So you have described your interface with the Health and Social Care Board to give advice up to a point in good things that might be commissioned, just to keep it very simple; how does the CMO fit into that in terms of their role in providing guidance for commissioning, how does that work? 12:44

A. The CMO in my opinion sort of sets -- previously would have set policy context, would have advised at departmental level what guidance should be followed, what patient pathways, things around NICE et cetera, so that would have flowed through them out to the wider system. I think I mentioned earlier that we would receive letters from the CMO's office and at times from the CNO's office saying for action and then it would 12:45

detail the action expected of various bodies throughout the system and what you were required to do.

163 Q. I have heard from one of the Medical Directors, for example, when asked a similar sort of question, they said well the CMO would send strong letters - back to Mr. Hanbury's point about strong letters - might come from the CMO's office, but when you're routinely having your commissioning planned for the year, do you have an interaction with the CMO to jointly impact, or did you, I know it's changing now? 12:45

A. I wasn't in that system, but it is my understanding, no, that wouldn't have happened.

164 Q. Right, okay. You are now going into a new system of the integrated care systems which has been in operational in the UK, well in England, for quite some time with variable results, I have to say, lots and lots of meetings and so on. Theoretically you have got an advantage with your integrated trusts here, what learning has been taken, what discussions have you had about learning from all the efforts made in England over the last ten years or so? 12:46

A. Sort of the regional body has support from, it's either a Chair or a Chief Executive from one of the integrated care systems in England. It also has a gentleman called Mike Farrah who is nominally known as a critical friend who has been involved in the development of ICSs in England. The purpose of that engagement is to do exactly that, to try and learn from the pitfalls. 12:46

PHA also back in July of last year brought the Chief Executives, who obviously would be co-chairs, to Wigan to meet with their council and ICS leads, again in a effort to bring learning from that.

165 Q. Because I think people would say in England 'NICE idea, what are we really doing with it?', and I just wondered how much of that real awareness was floating around, so what you are saying is quite a bit you think? 12:47

A. In April of this year I think the European conference in ICS is coming to Belfast, to hold in the Titanic, there is a number of, obviously submissions have gone in from my organisation and others about learning which will go into that as well. So I do think there is a degree of effort to try and learn from what's happening in England, learn from what's happening across Europe as well. We are different, inasmuch as our set-up, in Northern Ireland we have integrated Trusts; our public health is different, we still have a public health agency, whereas in England public health sits within councils. I'm guessing that's why councils in England have a significant role to play in ICS because public health still sits in them and they are a strong voice in that. But our set-up is different, so we won't and we shouldn't replicate exactly what is in England because our circumstances are different. 12:47 12:48 12:48

166 Q. No, I'm not suggesting you did, because it comes with a big problem as far as I can see it. And on a similar vein, I've got a personal interest in the patient safety agenda, there is a lot of learning on that from

what's been happening over the last 20 years in England, particularly the new way of looking at incidents, which I think is possibly being looked at as part of the group; where efforts have been made to kind of piggyback on to that, there is a lot of resource there to draw on and a lot more emphasis on patient safety at boards for a longer time, so has that been openly discussed?

A. Yeah. I mean, we would pick up sort of the inquiries that are in England, especially around maternity and things like that. We have our own sort of maternity and neonatal group at a regional level with CMO, CNO, ourselves, SPPG, directly looking into the outworkings of that. The name of the group doesn't immediately come to mind, but I suppose what I am trying to say is there is an effort to take those Inquiry reports --

167 Q. Not just the inquiries though. I mean, the national patient safety strategies, which are all about the kinds of things we've heard from people here in terms of the future, they are all about no blame, they are all about psychological safety, they are all about behaving properly, they are all about all about really putting safety at the top, do you think that's coming?

A. I think we have lifted some of those. I am trying to think, the big five disease groups and things like that. We have looked at it at CMO and I presented a paper back into the Health Service P10 which is the performance management team chaired by the Permanent Secretary as well about how we take some of that

learning around public health back into Northern Ireland as well.

168 Q. Your big advantage is you have got public health in a better position in my view here. So if you go back to the national audit question, for example, huge amount of work being done on that over many, many years, really important, it does have to be funded; who would be the person saying to the new commissioning functioners that set up 'these national audits really have to be bread and butter, every board should know the top three indicators from the top ten national audits as a matter of monitoring safety', who would do that? 12:50 12:51

A. It's hard to say because I don't think I have seen it previously in the past. If you're asking me where does that sit, I think it would be helpful to sit perhaps with the Department, and I mean that in the full term; they are the regional leads, they set the policy direction. 12:51

169 Q. So would that be the Chief Medical Officer feeding in that way, would it be Public Health Agency feeding in that way? 12:51

A. I think it's a multiagency approach to take it forward, if you really want to get traction. So when I say Department, that would mean CMO. I would also say the policy branches with responsibility for those things in public health. As I say we're in a new policy group, social policy and population health going forward. So I think it's working truly across the piece and SPPG, 12:51

which are now part of the Department as well, so bringing all of that together to work with ourselves, plus whatever other agencies would have a view on that at ALB level.

170 Q. Usually it has somebody who is responsible for driving this, this is why I'm asking this. I am just trying to understand what's happened before and where that's going in terms of responsibility for really driving quality and safety to where it needs to be, and I understand the funding issues here and everywhere actually. But, of course, unsafe care is more expensive care and there is a big cost effectiveness bit within this. So I think you are saying there would have to be sort of multidisciplinary subgroup advising the SPPG? 12:52

A. I think if you look at it, I would expect the CNO's office to be a big say in that because quality and safety for patients is a significant remit for the CNO as it is for the CMO. But it also depends, I mean if you are getting into dentistry, then the CDO. Then pharmacy safety, you have got a chief pharmaceutical officer, going back to the issues around community pharmacy. So it has to be in all of those agendas, I think, to drive that forward on that professional level. 12:53

171 Q. Coming back to the role of PHA in terms of its influence, you have described your unique role here, which I think is right, there isn't any other part of the UK that works quite like that, do you have enough

influence?

A. I think our influence is growing since Covid. I think that has offered us a higher profile than we previously had. I think we've had significant influence previously in years gone by working very closely with the Health and Social Care Board. I think at this point in time post Covid, post the new legislation, the Health Service economy, if you put it, system that way, is evolving, and I think it's up to us to make sure that we do have that influence going forward. We certainly have, I think there's opportunities provided by the Permanent Secretary. We do sit as part of P10, we do sit in the regional group for the development of ICS, we have regular meetings with CNO/CMO and we are involved in those discussions. I think it's how we use that window of opportunity going forward that will define whether or not we have had that appropriate influence. I think what we do need to do is drive forward, as I've said, the agenda for the reduction of inequality and better access for those which are most disadvantaged in our society and I'm not quite sure that we have done that to the greatest extent previously. 12:53 12:54 12:54 12:54

172 Q. In that context, though, as well, I mean if you look at cancer, for example, and perhaps 50% of cancers being preventible with lifestyle, this usually falls off the agenda somewhere, in my experience, wherever it's put, whether it's put with the council, but, actually, it is probably worse since it's been taken away from health; 12:55

is that being acknowledged and pushed forward in that sort of a way in terms of there is no healthcare without that as an arm?

A. The way I would like to see the AIPBs develop going forward is that their greatest focus is on that early intervention and prevention at local level, building the resilience of communities. I think that's where we're beginning to be heard. I think that yet has to be operationalised and how we do that will come in the next couple of years. But I do think we have an opportunity to influence it and drive that agenda more so in the past through those AIPBs. 12:55 12:56

173 Q. Just coming back to urology for a moment, you're part of the urology assurance group and implementation and all of that, and there are a wide range of governance and other lessons in that, it isn't really just about specific issues; what is your view on how that's been executed in terms of making changes and focussing on moving forward, have you got a view on whether it is causing some effective change or whether on the contrary it's just a big kind of diversion that's taking everybody's time and energy, is there a balance, can you give us any sort of idea? 12:56 12:56

A. I find it hard because I wasn't associated with urology up until then, it's not one of the services I ever managed. But I like to think, as I have sat through some of those meetings, that you can begin to see the change. I think you can begin to see where things are more centralised in terms of who appropriately comes 12:56

into Belfast for surgery etc. I think there is a greater development of that network going forward as well, and the development of a cancer strategy as well. So I do think changes are coming about and certainly the recommendations for those. It will come down to resourcing, ultimately, unfortunately too. But I think part of that is sometimes it's where we direct our resource as well to get better change.

174 Q. In terms of any kind of oversight, governance, focus on quality and safety that could be improved to assist matters - because this was urology, it could have been another service, another person, another day, couldn't it? 12:57

A. Yeah. I think things such as, going back, we have had the Hyponatraemia, we have had Neurology, we have now got Urology, I think there is a greater sense of awareness throughout the system and a greater sense of a person's responsibility to step forward and intervene is coming around as well. 12:57

175 Q. Can you see that through the meetings, what have you seen? 12:58

A. I suppose through meetings that I have been at, I think you can see where Trusts are taking their governance responsibilities to a higher level than they have previously been. Certainly, even in Belfast Trust before I left, we have talked about it there where different organisations knew different things and it wasn't joined up, certainly within the Trust that I worked at operationally before I left you can see 12:58

those arms of governance to pull things, triangulation perhaps, to triangulate complaints, to triangulate surgical outcomes, triangulation of activity, to pull more universal governance reports together, to ensure that you have better oversight of the complete picture, so that people who are in the same system aren't working in silos and are pooling information. I have certainly witnessed that at a Trust level before I came to work. 12:59

176 Q. You mentioned something today which was about standards and guidelines and assurance, this is something we've asked witnesses about. To simplify it, it seems to be there is a greater awareness that there are lots of standards and guidelines, some of them are very important, the Trust have a real job to try and even classify them, send them out, get comment on them and no mechanism really of assurance that people are following them, that is just to oversimplify. This is not because they don't think it's important particularly, it is because it is quite a big job to audit it regularly, it's not something that's regularly overseen, so it falls down to 'here it is, are you doing it, yes'. Now is PHA aware that it is like that, for example? I'm slightly oversimplifying. 12:59 13:00

A. Yeah. I suppose I'm aware because I have worked in that system for a very long time and you do trust a lot to people's word, that they have implemented, they have done it. There are -- I suppose you are reliant on things like clinical audit, you are reliant on activity 13:00

being measured, you are reliant on surveillance as well. There is only so much you can do in a limited resource. It is how much do we spend policing the system and how much do we devote to actually providing service and how do you get that balance right is probably the task which we are all sort of called to at this point in time.

177 Q. Is somebody taking that task on to develop an approach is really the question?

A. I'm not sure that I have seen sort of -- in that sort of overarching holistic approach. What I would say is, well the Department have pulled together that overarching learning group from the recommendations from all of the inquiries. So you would --

178 Q. It will sit there?

A. That would be the place for the outworkings to come.

DR. SWART: I'll stop torturing you. Thank you.

A. Thank you.

CHAIR: You will be relieved to hear I'm not going to torture you at all. Thank you very much, Mr. Dawson, it's been very helpful to hear from you this morning. I think -- is there anything else, Ms. McMahon, that you need to ask him?

MS. McMAHON: No.

CHAIR: Then that leaves us until tomorrow morning. So see you all again at ten o'clock, Ladies and Gentlemen. Thank you.

THE INQUIRY STANDS ADJOURNED TO WEDNESDAY, 7TH FEBRUARY 2024 AT 10 A.M.