Urology Services Inquiry

Oral Hearing

Day 90 – Wednesday, 13th March 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.

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THE INQUIRY RESUMED ON WEDNESDAY, 13TH MARCH 2024, AS FOLLOWS

CHAIR: Morning everyone. Mr. Wolfe.

CONTINUATION OF QUESTIONING BY MR. WOLFE

MR. WOLFE: Good morning, Dr. O'Kane.

A. Good morning.

1 Q. Just to recap. We finished yesterday by looking at aspects of the Board development, and in particular you finished by recognising, I suppose, a responsibility to support your Non-Executive Directors, recognising the benefit that they can bring through their curiosity and challenge function to the health of the organisation. I just want to finish that area by asking for your comments in terms of what has been done by way of helping the Non-Executive members to better understand what's going on in the organisation. 10:00 10:01

So we had Ms. Mullan's evidence, and she reflected in her witness statement, WIT-100545, that as Chair of the Governance Committee she sought improvements to reporting. 10:01

A. Mmm. 10:01

2 Q. And we have seen on the papers the - and we'll focus maybe a little later on it today - the wealth of information that now comes into Governance Committee. She also, I suppose by way of compliment to your

development of the organisation, explained that you brought significant changes to reporting and practice with the outworking of the Champion Review, and she remarked upon the, for example, the kinds of information the Governance Committee now gets in relation to standards and guidelines, SAI process, complaints, just to name several examples.

Do you wish to, can you expand on that for us? What, from your perspective, have you and your colleagues added to the body of information received by your Non-Executive Directors on a regular basis and what has driven this improvement?

A. Well, I think that the drive towards improvement certainly started with the Champion Review in relation to what was included there, and I think gave us an indication that potentially the structures weren't supporting the function of the organisation. So working through those 48 recommendations has helped us, I think, you know, now have a more robust approach to governance, and then within all of that what we've worked really hard to do is to improve the reporting structure and the quality of the information that goes there, because I think our concern was, when we looked at some of our committees, that actually there was very little opportunity to triangulate information and to understand the connectivity across the organisation in terms of what this might mean. So the increasing emphasis in recent times has been in making sure that

all of the right information is going to the right committees and that actually when it's there, it's discussed broadly, you know, within the context of the organisation rather than in parallel streams in isolation.

I think when we have brought forward that narrative, and Eileen has been instrumental in developing this, it is very much in terms of thinking about how we use that information, not just for one part of the organisation but for all of the organisation. So, I mean I'll use an example. We have - as you know, we have been concentrating our Serious Adverse Incident Review process. We have significant numbers, as has any organisation, that come through on an annual basis. We have been trying to address those in a timely fashion and, you know, we evidence improvement in relation to that. But within all of that process, you know, what we were mindful of was that, you know, when we brought forward Datix and the information that came from there or from other sources, that it was a very slow laborious process and actually getting the learning back into the system was very challenging.

So within all of that, mental health services, on the basis of the structured judgment review that we were using in relation to this Inquiry, developed what they call a safety early learning tool essentially, based on that, based on their experiences of serious adverse

incidents and the information that has been coming through, to really try and drive that process to an earlier stage in the organisation.

So, starting with that Directorate and now it's increasingly used in medicine and surgery and adult community services and paediatrics, we use the structured early learning tool to get feedback from the teams at an early stage with their recommendations on learning, and we move to implement that as early as we possibly can so that by the time we should now be getting to those Serious Adverse Incident reviews we have, you know, learned from that process and implemented some of the changes, and certainly the feedback we get in relation to that is that clinicians are much more engaged with serious adverse incidents, families find it really supportive, and we have developed, you know, a family liaison system, or officers in relation to that, they find that really supportive in terms of taking this information through. 10:06

CHAIR: Sorry, Dr. O'Kane, I'm going to have to ask you to slow down. I'm trying to get a note of this. So, please, if you could take it more slowly.

A. Sorry.

MR. WOLFE: Yes, and it is an area, specifically SAI is an area I'm going to touch on later. 10:07

A. Yes.

3 Q. And I had it in my note to come on to some of those specific improvements as we go on, but for now, thanks

for that. I just want -- in terms of, I'll just put it up on the screen just to illustrate the cycle of reporting that comes through the Board. We can see that at TRU-3050, sorry TRU-305091. And we can see, just scrolling through that, any observations you wish to make, but there's a - it's clear that the Board is organised in that these activities are preprogrammed into the business.

A. Mmm.

4 Q. Just scrolling down. And the members can anticipate when particular subject areas are going to come up for discussion, assuming - I assume that all of these subject areas are also the subject of reports and papers? 10:08

A. Yes, yeah, extensively, yes. 10:08

5 Q. And additionally looking at Board committees there, a body of work has been undertaken to reconstitute the Trust?

A. Yes.

6 Q. Trust Board committees and to strengthen them. If we can go to TRU-306029. And Ms. Mullan has taken the lead on this. And scrolling down to the next page, please, it describes the committees that have been reconstituted. Does reconstituted in this context simply mean repopulated with new members, or refreshed with new members, or does it mean that these, some of these committees have been designed and introduced for the first time? 10:09 10:09

A. Essentially it means that they have been strengthened

and internally reorganised. So the membership of some of them, you know, has changed. But in addition to that, the flow of information to them has changed and they are still partially an evolution. So, for example, when I look at the Finance and Performance Committee, we took a view that actually that needed strengthening to include workforce, so that's now Finance, Workforce and Performance Committee going forward.

7 Q. Sorry, I'm not stopping you, just let me scroll down and I think we can see that illustrated. 10:10

A. Yeah.

8 Q. So there's the areas of improvement I think is what you're talking to?

A. Yes. 10:10

9 Q. And there's a reference to finance. So part of the improvement, as described here, and maybe you could help us better understand why it's an improvement, membership of these committees has been strengthened to include Executive Directors, or perhaps more Executive Directors, or different Executive Directors, when they weren't in place previously, is that right? 10:11

A. Yes. I think there's a greater concentration on the Executive Directors, but also now that we have more Non-Executive Directors they are more readily available to populate these as well. One of the areas on the screen there, for example, that is up, is Strategic and Transformation Committee, that is a new committee and, again, that is to bring together the learning across 10:11

the organisation in the context of strategic development. So the learning, for example, that we are deriving from, you know, the process of being part of the Public Inquiry and from other areas within the Trust, come up through that to inform some of the strategic approach and transformation that we're, you know, we are implementing across the Trust.

10 Q. And there has been some development work in terms of helping Chairs of committees to better understand their role. If I could draw your attention and your comment on TRU-305105. So, there has been, as I understand it recently introduced, this description in definition and expectation of the role of the Chair. 10:12

A. Yes.

11 Q. If we scroll down through that. Again, is that a particularly new development? 10:12

A. Yes, over the last, over the last few months. And I think again this is borne out of the need to have really, you know, to improve clarity around roles and responsibilities, and also I think it brings with it the expectation that it will be well chaired and that people will be clear about the Terms of Reference, you know, I suppose the point of the committee, you know, and the understanding that actually it's not merely there to receive documentation but to process that and produce outcomes. So all of that is built into all of this in terms of responsibilities. 10:13 10:13

12 Q. Yes. You don't - do you occupy a position on any of the Board committees?

A. Nearly all of them.

13 Q. And do you attend as often as possible?

A. Yes, and we mentioned yesterday about my attendance at governance and audit, but certainly with this revised structure, I think as I intimated yesterday the timetable of this and the revised structure has been to take some of that into consideration so that attendance at these is easier. I think - I would need to double check - but I think I'm on five of these seven committees. 10:14

14 Q. And what is your sense of how they are functioning and whether there has been improvement, for example, in the scrutiny process or in the challenge process?

A. It's relatively early days with some of it, but the process for any of these committees is that the papers are processed through the Senior Leadership Team meeting before they come into the committee structure, so that we make sure that these are submitted in a timely fashion, that the Senior Leadership Team is familiar with them, but also that if there is any, you know, correction or change or challenge that needs to be involved in that, that that's put forward. And that, I think, also starts, you know in earnest, the consideration around how the information that comes through all of this is triangulated and then best presented to the actual committee with a view then to that being, you know, representative of Trust Board. So, we - it's realised I think in relation to the committee structure, but behind all of that what we've

also done is redesigned all of the feeder committees, all the subcommittees and the Terms of Reference, you know, the purpose of those, how they're chaired and the information is presented and triangulated, and then in addition to that we have changed our structure of Senior Leadership Team meetings to mirror this, but also to make sure that they are used to best effect in terms of feeding the committees for Trust Board. 10:15

So one of the areas, for example, is the - we have a risk and assurance meeting once a month over the last few months in the Senior Leadership Team, and basically that brings together a lot of the quality and safety concerns that are then brought into Governance Committee. So that again, based on the layers of feed that come up through the weekly governance reporting, the governance reports from the individual divisions and directorates into that meeting, and then to go to our monthly pull together essentially of all of our governance business within one large senior leadership team meeting, we then also feed this into the governance meeting of the Trust. 10:16 10:16 10:16

15 Q. Yes.

A. So everything has - in terms of Board to bed, it's about trying to get a line of sight either direction so that the information flows and that people have a good understanding of the business and the concerns. 10:17

16 Q. Yes. I think as we move on this morning we'll look at your clinical and social care governance reforms. We

can see the starting point for that, which is the weekly governance overview where the Senior Leadership Team attends and there's a weekly update. But what you're describing is, at least on your evidence, a fairly efficient programme of activity moving from the ward from the service?

A. Mm-hmm.

17 Q. Up to for scrutiny amongst the Senior Leadership Team, and then to the Board Committee, and they then report into the Board itself. I'm reminded, and just have it on the screen, that we do have a composition of the current committees, or at least as of September 2023, it's to be found at TRU-306032. And let me just scroll down through that. I think at the back of it we have the Chairs named there and those who are expected to attend. And just scrolling through it. Just while we're doing that, in terms of your contact, your contact or your Senior Leadership Team's contact with Chairs of Boards, do you get anything by way of feedback in terms of how they are fairing with their responsibilities? For example, do you get any requests for further support that you have or haven't been able to deliver for them?

A. No, I think the relationships between the Non-Executive Directors who Chair the Committees, and given that some of them have changed recently, but also based on previous experience, those relationships tended to be healthy, and certainly I would have had conversations with the, you know, the Executive and Non-Executive

Directors in relation to the participation there and, you know, how they were aiming to drive those committees forward. So, certainly I think the one where I noticed it most fulsomely is across Finance, Workforce and Performance because, by definition, the Chair of that committee has to be a Non-Executive Director who has finance background. So there's significant interface there. But, you know, also I will get feedback in relation to Governance, Patient and Service User Committee, all of them. And, you know, my sense, even at an early stage with some of the changes is that those are healthy. 10:20 10:20

18 Q. Yes. Thank you. A reminder of my road map. I am working through at the moment the leadership issues within the organisation. 10:20

A. Mmm.

19 Q. So dealt with the Board. I'm now going to move on and look at aspects of medical leadership. We won't have time, I suppose, to deal in any great depth with any of the other staff development issues you mentioned in passing yesterday, some of the work that's going on around administrative staff, some of the work that's going on around management, but let me focus on medical leadership for the next short while. 10:21 10:21

The evidence received by this Inquiry has, at least historically, suggested that all has not been well with medical leadership within the organisation?

A. Yep. Mm-hmm.

20 Q. And I suppose this is an opportunity to discuss whether some of the improvements which appear on paper have made any difference. I'm sure you have some familiarity with aspects of the problems as reported in to the Inquiry. So, for example, there was a whole set 10:22
of issues, I suppose, around the management of Mr. O'Brien. Were people failing to take responsibility? Was there a failure to communicate effectively within the different levels of medical management? Whose responsibility was it? Was it 10:22
medical management or was it operational management? We've had descriptions of difficulties on the part of managers, Mr. Haynes notably, a busy clinician, but also taking on leadership roles and whether it's feasible to exercise those roles in the way he would 10:23
like or in the way that the organisation would like. So, they're some of the issues that have been brought to the Inquiry.

I want to start, I suppose, by reference to some of the 10:23
material that is before us so that you can help the Inquiry to understand the journey that the Trust has been on in terms of trying to make improvements in medical leadership. Some of the themes would appear to be enhanced numbers or enhanced volume of medical 10:24
management, and efforts to better support them. But I wonder, and this is the question we'll explore in a moment, whether you feel, having regard to the job descriptions that Divisional Medical Directors and

Clinical Directors now hold, whether they are well equipped to discharge their responsibilities?

So the starting point, I suppose, there has been a number of medical leadership reviews undertaken during your time. Let me draw your attention to the March 2020 publication. It's to be found at WIT-79127. And it's described within the body of the report as being the first such review since 2011? 10:24

A. Mm-hmm. 10:25

21 Q. I think that's right. The context for the review is explained. If we go through the document to page 131 in the series, it's just, that's it, the next page. Thank you. And just picking up on a couple of things set out there in paragraphs 6 to 8, just to orientate you. 10:25

So it seems to be suggesting that over time there has been an erosion in the number and impact of these leadership roles, and here we're talking about primarily about what we used to call Associate Medical Director and Clinical Director, and impact on morale, recruitment and retention. 10:25

It's now time, it says, to revisit the form of medical leadership and their function and try to get to grips with how fit for purpose the roles are in a changing environment. 10:26

Can you help us - that's some of the context - what was, what from your perspective was behind such a review or driving such a review?

A. There were a few things. So I suppose in the course of my own training, you know, I was very struck, there was, you know, a very short period of time I spent training in the States, and I was always very struck by the fact that medical leaders there are identified at an early staged and given bespoke training to take on medical leadership roles in the expectation that they will become leaders within their organisation, and I think increasingly across the UK that is recognised, and is recognised through the way particularly Trusts in England are configured in having divisional structures, you know, run through a collective leadership function where, you know, essentially the oversight and leadership within each division is led by a divisional doctor, divisional nurse and divisional manager. We hadn't got that in the Southern Trust, and I had come from a system that had developed it recently and I could see the benefits of it having worked at different levels in it, and I think my sense within the Southern Trust when I arrived was the attitude towards medical management was at best ambivalent. Now, that - and certainly I was very fortunate that I had the support of the Chief Executive in realising that this was something that needed to change. So that was the...

22 Q. What was the source of the ambivalence? The post

holders themselves or those who they were supposed to manage?

A. I think both. I think that, you know, traditionally - and I think it has now changed, I think over the years there was an ambivalent attitude by medical staff towards medical management because, you know, away back in the early days it was seen as a dark art. I think that has progressed and improved, and I do think that people within medicine really do value that now. 10:28

23 Q. Mmm. 10:28

A. But, also, I think there was an ambivalent attitude towards medical management across the organisation in relation to managers who felt, you know, the sense - and I think this was, you know, part of the culture, that the doctors were there to see the patients and get on with it and actually all the management decisions should be left to other people. I think, and again I think that point that's made in 8 summaries is this, the point in having a collective approach to this is to bring, you know, the expertise and the knowledge and skills all together in the one place across the different disciplines, and I am very firmly of the view that doctors should be leaders in all of that. 10:29 10:29

So, on the back of this report in 2020, what we did was revised - the job descriptions as Clinical Director and Associate Medical Director did not lend themselves to supporting the medical leadership that was needed. So we, you know, we undertook a complete revision of all 10:29

of that, strengthened those roles, introduced an increased number of Clinical Directors and Divisional Medical Directors instead of Associate Medical Directors, increased - introduced Deputy Medical Directors and strengthened that function. All of the people who were selected were put through a fairly rigorous interview process and then have been given some support and training around that. 10:30

24 Q. Just - I'm sorry to cut across you.

A. Sorry. 10:30

25 Q. I want to look at the improvement as part of, if you like, the next stage of our exploration here. You've helpfully pointed out your impression of where medical management, medical leadership was at, and how it was viewed upon your, I suppose your arrival in the Trust. 10:30

A. Mmm.

26 Q. And there is within this report, I think helpfully in terms of the Inquiry's interest, a reflection through surveys of how medical management was viewed. So if we go to WIT-79142? I say this is helpful and it's perhaps obvious why, because the Inquiry is looking at a timeframe within which medical management on one view may not have been fairing particularly well, or reacting as one might have expected to some of the challenges it faced within Urology Services. So this - well it's not empirical, this survey and reflection of views perhaps gives an insight into maybe what was going on in medical management during that period. 10:31 10:31

So it's described as an independent survey of medical leaders carried out to identify barriers and enablers to achieving a robust medical leadership structure, et cetera, and then there's a summary of the findings. The full survey can be found in an appendix to the report. But - so we can see a series of positives and negatives set out in this summary of key things. Medical leaders say that there's a high level of motivation but - and there's an acknowledgment of their importance perhaps amongst colleagues, but there's also an acknowledgment that medical leadership is challenging and current leaders feel a sense of purpose and achievement in their roles. So there's, it points to a difficulty but also, I suppose, an opportunity to develop them. 10:32 10:32 10:33

A. Mm-hmm.

27 Q. In terms of those challenges there's a description of a lack of engagement. There's not an adequate PA allocation. And it goes on to say that they are often left out, that's Associate Medical Directors, often left out or feel that they're left out of decision making. And again, scrolling down, there's the problem we've heard through a number of witnesses of pressures on time. And scrolling down again. So, does that resonate, does some of those... 10:33 10:34

A. Yes.

28 Q. - descriptions resonate with you?

A. Yes, they do. Yes.

29 Q. And equally the report also contains a survey of

directors and some of their views on the medical leadership cadre are interesting as well. If we scroll down to the next page, 144 in the series, again a survey of Trust Directors and what they feel was needed to improve the medical leadership role. And, so, there's an important first theme, there's a need for clarification of roles and responsibilities of medical leaders and how they relate to operational management roles. Again, is that something that you had a sense of? 10:34 10:35

A. Yes. Yep.

30 Q. And we saw it through the evidence in relation to how Mr. O'Brien was managed, you had a Head of Service trying to deal with things on a day-to-day basis but - and while there was communication with the management leadership or, sorry, the medical leadership I should say, it often appeared, in terms of the evidence received by the Inquiry, that she was left, that is Mrs. Corrigan, left to deal with things, and it didn't really reach until quite late in the day with the eventual intervention of the Medical Director, at that time Dr. Wright, but it didn't seem to be - those issues didn't appear to be escalated through professional channels? 10:35 10:36

A. No, that's right, and I think again that came, you know, my sense is that it resonates with this in that the, you know, the roles and responsibility of the Clinical Director and Associate Medical Director I think weren't well enough defined within the job 10:36

description to capture what some of the roles should have been about, and also then I think the culture throughout the organisation was that the relationship between medical leaders and operational leaders wasn't a partnership, you know that - and I think it was borne out of a lack of understanding I think at times of what that partnership could actually bring, but also I think an anxiety about, you know, making appropriate demands on the relationship, because I do think - my sense is that the managers within the Southern Trust at a point in time I think felt that they were, you know, encroaching on even medical leaders to ask them for help, and then vice versa, I think often the medical leaders didn't automatically recognise it was their role to become involved. And, you know, the pattern at times seemed to be that when there was a clinical crisis of some description where they needed medical involvement then the doctors were asked for help, but usually outside of all of that it didn't seem to work as a partnership. 10:37 10:37 10:37 10:38

31 Q. Yes. And I think, if we just scroll down I think there's - yes, the integration point maybe echoes something of what you've just said. The role of Clinical Directors is less clear than that of Associate Medical Director, but there's clarification of the medical leadership roles with more structured engagement. It's this sense that the, at that point in time the state of the leadership arrangements, the management arrangements, could have benefitted from 10:38

greater definition and clarity around how the operational side and th medical or professional side was supposed to operate?

A. Mm-hmm.

32 Q. In terms of - so from what you're saying, you recognised the issues, you recognised the problems. Part of the solution, it would appear, was to throw more bodies at it, if I can use that inelegant expression, the recommendation coming through this report was for additional posts or realignment of posts at the same time. So the report goes on to propose three medical directors - sorry, three Medical Director posts at the level of Deputy Medical Director, isn't that right? 10:38 10:39

A. There were two at that point in time, and then a third was developed, but the increase was then in the Divisional Medical Directors to replace the Associate Medical Directors. 10:39

33 Q. Yes.

A. And then an increase in the number of Clinical Directors. 10:40

34 Q. Yes. Just scroll down to 147 in the series. Thank you. So this was a pitch for greater resources in some cases for more appointments. So we can see that. Ultimately this was pursued, as I understand it from your Section 21 evidence, it was pursued on a two-stage basis. So first of all it was focused on the divisional improvement on the Divisional Medical Director's side in 2021, moving on to 2022 to pursue 10:40

improvement on the Clinical Director's side. Could you summarise for us where that got to in terms of resourcing and in terms of numbers?

A. So there was - and the increased numbers was in recognition of having a wider spread of opportunities for medical leadership to develop, but also to share the workload, because the balance in all of this is always between the managerial time and the clinical time and, you know, from a service point of view we were very mindful that we did not want to strip out clinical expertise but we did need to bolster all of this. 10:41 10:41

So in relation to the different directorates, we went down each one individually and then increased the number of Divisional Medical Directors who were aligned to that and, you know, that has resulted in two in surgery. At a point in time there were two in medicine. We increased those then in relation to where that sat with bigger numbers of Clinical Directors then to support. So, for example, in Mental Health and Disability there continued to be an Associate Medical Director now replaced by a Divisional Medical Director, but instead of having one Clinical Director we now have three. So depending on what the needs were across each individual directorate the proposals were put forward in relation to that. 10:41 10:42 10:42

And then in relation to the Deputy Medical Director

posts, it was also about creating the opportunity for support to the Medical Director's office, but also having, you know, greater expertise and breadth and depth in terms of workforce and education, governance, and then more latterly appraisal, job planning and re-validation. So it was about bringing those elements together.

35 Q. Yes. And in terms of the problem which you observed, and which is highlighted in the survey evidence, how was the problem of relating to or integrating with the operational management, the director level staff, resolved, if at all? 10:42 10:43

A. There was - and certainly since I have become Chief Executive there has been an increased emphasis on Directors and Divisional Assistant Directors working with the Divisional Medical Directors and the Clinical Directors. So, you know, when we - in the past if there had been accountability meetings, the doctors weren't brought along to those. Now I have the expectation that they will be there, the same as everybody else, to take part. The same whenever there is oversight of certain situations or we need development in relation to certain areas. I certainly come to that, as do the Directors increasingly, that medical staff will be involved. So I think that culture of involvement has changed, but I do think it is still onerous for the doctors who undertake medical leadership roles, because they are still undertaking clinical responsibilities at the same time as they do 10:43 10:44 10:44

this and it is challenging, because part of the, you know, part of this role is in professionally managing their colleagues as well as contributing to the wider Trust, so there are a lot of demands made on their time. 10:44

I think - could I just say? I mean I think fundamentally medicine does not serve itself well in this respect. There is very little - when I look, for example, in comparison with the veterinary medicine 10:45 course across the UK, there's time and effort put into the development of leaders and, you know, an understanding of the business, and I appreciate that they're all - by and large veterinary medicine is a small business. 10:45

There's a lot - there's almost a third of the course in some areas put into developing leadership, you know, business acumen, all of that. We don't do that in medicine right from the point of medical student, and 10:45 the GMC at this point doesn't recognise medical management and leadership as something that merits a completion of specialist training. And, again, I think if those kind of supports were in the system right from the get-go, I think we would probably find it would be 10:45 much more straightforward then for people to be able to do these jobs, you know, more easily.

36 Q. There are a number of tensions, and the Southern Trust is undoubtedly not alone in this. You reflect that it

is important to have clinicians in medical management roles?

A. Yep. Yep.

37 Q. But at the same time you reflect on the burden carried by busy clinicians. 10:46

A. Yes.

38 Q. We see through your witness statement that as part of this development of medical leadership, it wasn't just about increasing numbers and different functions, it was also a part - it was also about adding or 10:46 redefining what was expected of them by addressing that through job descriptions. We can see you've said within one of your witness statement, WIT-45021, if we could have that up on the screen, please? You're highlighting here the elements that now feature in both 10:47 Divisional Medical Director and Clinical Director job descriptions. So across a wide range of governance issues, those medical leaders are expected to have or discharge a responsibility. We've seen it in a real situation with Mr. Haynes. He has taken up, I think 10:47 just under two years ago now, the Urology Improvement Divisional Medical Director role.

A. Mm-hmm.

39 Q. And again we can see this in his job description if we go to WIT-54012. So just - so the description makes 10:48 clear, as with all of the Divisional Medical Directors, they attract three PAs. The role is remunerated, just under £15,000.

A. Mmm.

40 Q. And the responsibilities then are set out over the page. So there's a set of main duties and responsibilities described, as per your witness statement. But, in essence, as it says there in the last bullet point, they're: 10:49

"Expected to lead all aspects of medical, professional, clinical and social care governance."

And then the specifics are set out. It's a massive range of responsibilities. 10:49

A. Yes.

41 Q. At least on paper. One might ask provocatively is this for real, is this serious? How could any clinician who has those responsibilities be expected to discharge these governance responsibilities with regard to their clients in any meaningful way? And then I come back to the realisation that undoubtedly Southern Trust isn't alone in terms of the model that it's adopted. 10:49

A. Yep. 10:50

42 Q. Is this - is there - is the premise of my question correct that really this isn't doable? It's not - we can't expect Divisional Medical Directors to attend to all of these responsibilities in any meaningful way?

A. I think even though, you know, this has been improved, I still think it's a significant ask. And, you know, in order to facilitate this, you know, the Divisional Medical Directors will rely very heavily on the information that comes from other parts of the system 10:50

to support them to do their job. So they will not necessarily operationally, for example, manage litigation and claims management, or even the, you know, education, training, and continuing professional development parts. You know, underneath all of that there will be people who will provide them with the information, but it is a significant ask. You know, we rely very often on people who have come through the system, you know, as trainees and junior medical staff before they become consultants to actually understand how all of this fits together and to be able to pull out the relevant bits, you know, as and when it's actually needed, but it is very broad based. But it's always about getting the balance between being able to do this and then maintaining their clinical skills, and also to some extent having clinical credibility with their colleagues, which is really important in all of this, you know. That's one of the aspects of this that carries them through. But also then that they have to be able to develop really robust relationships with their clinical colleagues so that, you know, if there are concerns or there are areas for development, that they're aware of it and they can support in either direction.

10:51
10:51
10:51
10:52

43 Q. We can see, and it should be said, that there are supports there. For example, within the Urology Service, each of the substantive clinicians have taken on a piece of the, if you like, the governance and/or managerial load. So we have Mr. O'Donaghue as patient

10:52

safety lead; Mr. Glackin, cancer MDT lead; Mr. Tyson, standards and guidance and quality improvement lead - two separate roles. Mr. Young, rota clinical lead. Mr. Haynes is obviously Divisional Medical Director and holds the NICaN Chair. And is it Ms. McAuley or Mr. McAuley is the educational lead? So there are supports there, and as you explain and we'll see in a moment, particularly around the medical professional governance, the roles occupied by your Deputy Medical Directors help to streamline and bring focus to some of the key professional governance issues that arise. But you seem to acknowledge that there is an element of looseness or weakness around the medical leadership responsibilities that fall to Clinical Directors and Divisional Medical Directors because they simply don't have the time to do it in as much depth as safety might require? 10:53 10:53 10:54

A. I think there are always particular challenges on their time. I mean one of the things that we did do was to double the amount of time that the Clinical Directors had. So when I came into the Trust, the Clinical Directors had four hours a week, and in some of those cases that was to manage scores of doctors and to try to be cognisant of, you know, patient safety issues and any areas for development. So we increased the number of those and doubled the time that was given to each post. But the - I mean that - the Clinical Director role is also really challenged in relation to doing this. 10:54 10:54

44 Q. They now receive two?
A. Two. Yes.
45 Q. Two PAs.
A. Yes.
46 Q. Yes. 10:55
A. So that's eight hours per week.
47 Q. You reflected in your evidence on the last occasion, just developing this theme a little further, just how preoccupied inevitably medical managers are and, indeed, clinicians in general are in terms of their 10:55 focus on their day job, their meeting the needs of patients. I just want to draw your attention to this and ask for your further comments.

If we go to TRA-01487, and at line 5, and this is your 10:55 answer:

"I think, you know, when you make reference to culture, my sense of the Southern Trust has been that they have been incredibly busy and that we ended up in situations 10:56 where doctors were seen purely as, not universally but at times I think because of the busyness, almost as technicians, that they had do their job, but the management and leadership bits were left to everybody else. In my experience it works well if doctors are 10:56 good leaders, because they have a lot of experience and training, and they also bring a system with them, and I think that bit had been lost. Part of the aspiration at the minute is to try to really develop that. Again,

I think that hadn't been around for a while, and I do think it was partly because of the busyness and demands on the system."

So it's the idea "I've got to keep my clinical eye on the clinical ball". 10:57

A. Mm-hmm.

48 Q. But there's a sense through some of the evidence on the part of the urology practitioners, was that there may well have been patient safety issues in association with one of our colleagues, but there were difficulties in trying to deal with that. 10:57

A. Mm-hmm.

49 Q. And in any event "I was very busy" appears to have been the refrain, and undoubtedly that is true, "very busy focusing on the needs of my patients". So - and that, I don't want to over-generalise, but that seems to have been the tenor of evidence, not just from medical leaders such as Mr. Haynes, and before him other medical leaders, and no doubt there were other issues including a so-called chill factor in not wanting or not feeling able to deal with some of the issues within urology. 10:57 10:58

With that preface, you seem to recognise within the answer on the screen that there is a need to address that, to give medical leaders and clinicians, perhaps in general, a better understanding and better equipment to be able to address patient safety issues where they 10:58

see them?

A. Yes, I think that's right, and that is borne out in what you described earlier in relation to the governance structure now, for example, within urology, in relation to each of the doctors having a leadership role in some aspect of that, you know. And I think, as I understand it within urology they will rotate that so that everyone at a point in time gets do each of those jobs and, you know, they propose to expand it, because we've recruited, we've internationally recruited three new consultant surgeons. So, again, as they come into the system and are developed, you know, they will be included in all of that, as are the SAS doctors, and as the juniors, and increasingly physician associates as they get registration. So all of that again I think depends on - I mean it can be a really powerful mechanism for coalescing a team around the core purpose and function of the business and allowing them then each to, you know, have an interest in a certain area and to bring that forward, you know, to the collective whole in terms of driving up patient safety, but that wasn't really there before. It was almost like it rested with, you know, if there was a clinical lead or, you know, someone who happened to be involved in something, along with a Clinical Director or Associate Medical Director. It wasn't particularly well developed, and I think now there is broader ownership of all of those.

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50 Q. I want to move slightly off the road of medical

leadership and segway into the developments that have taken place, and we touched upon them briefly yesterday, but the developments that have taken place in respect of medical professional governance. And here I want to explore with you issues including job planning, appraisal and re-validation, and steps that have been undertaken within the Trust to try to challenge and get to grips with what might be described as idiosyncratic clinical practice. 11:00

Starting with the general, I suppose. 11:01

I wonder do you acknowledge or see that the evidence before the Inquiry suggests that, at least in part, the medical professional governance system hasn't worked as effectively as it should have done historically. It might be said that in terms of appraisal, work planning, revalidation, there was often slippage. Perhaps the right ingredients or the right information wasn't being brought to bear and those valuable professional governance tools were left underdeveloped? 11:02

A. Yes, I agree with that. I think that there was - there's a very good electronic system in the Trust for job planning, but it requires the information to be put in, agreed, and then signed off. So certainly the mechanism for undertaking job planning was there, but I'm not sure that it was adhered to very seriously at times and, you know, that led to problems in terms of, you know, sign off, payments, understanding what people's roles and responsibilities were. 11:02

I also think that one of the shortcomings in job planning as it's constructed currently is that it focuses on activity rather than quality and safety, and that's a missing element of it. So I mean one of the things that I have been starting to think about recently, along with the Medical Director and others, is: How do you build quality and safety into a job plan, not just activity? That's really important. Because, you know, what should flow from that then is the appraisal system. And, again, in Southern Trust my sense was that on the face of it there was a system of appraisal in relation to, you know, and in particular good managers in there who ran the appraisal system, but actually in terms of the engagement of doctors with it and engaging with the spirit of it, I'm not sure that that was as fully engaged with as it needed to be. So it was difficult, I think, for people who hadn't got signed job plans, and particularly job plans that don't mention safety and quality, to then be appraised against that, when actually the four domains within appraisal concentrate on that mostly rather than, you know, activity which tends to be what the job plan is about. So the read across, regardless of Southern Trust, I think isn't robust, and then within all of that, in terms of how the appraisal system is used, I think was at times superficial. And the thing that...

11:03 11:03 11:04 11:04 11:04

51 Q. Just...

A. Sorry.

52 Q. Let's maybe just stick with job planning, sorry, just for the present?

A. Yep.

53 Q. So that's - what you've just outlined, the sense that job planning could be better utilised and join or gel better with what appears to be an overarching vision coming through the Trust's idea that it needs to prioritise quality and patient safety. So bringing that together within a job plan with specific expectations put on paper. 11:05

A. Yep.

54 Q. Is that a germ of an idea or is it at a relatively advanced stage of progressing into some concrete solutions?

A. We've had thoughts about it. I think what we would have to do now is pilot it to see how it would be pulled together, because for each there would be a lot of variation across specialities in relation to that. So in relation to the, you know, the outcomes that you would expect from that I think would have to be defined at a high level, but then within each of that I think there should be an expectation that - and I think it would be supportive to medical staff as well that, you know, the organisation has an interest in the quality of their work and not just the quantity of their work. So, you know, we've had the initial discussions but I do think - and, again, this would have to be agreed with the local negotiating committee, the BMA. 11:05 11:06 11:06

55 Q. Of course.

A. Yes.
56 Q. Of course.
A. But, again, in terms of thinking about this, I think broadly it could be, it could be helpful.
57 Q. Can you work through, and I appreciate it's not terribly advanced, but can you work through an example for us? I mean one way of approaching it might be to take a standard that's expected of a clinician when he or she carries out any particular element of their job plan, and of course you can be terribly high level or you could reduce it to triage, must be performed within a particular period of time because of the safety implications of not doing it. What do you have in mind specifically? 11:06 11:07
A. So if I think about the last clinical job I had, just to use that as an example. I would have been job planned against the time that I would have spent in direct clinical contact, and then within that the number of patients that I would have been expected to see. I think what would have enhanced that would have been, you know, a discussion or an agreement around either process measures or patient outcomes measures. Right. So if you think about process measures, you know some of the things that you're mentioning in relation to, you know, are you seeing patients in a timely fashion, you know, what does that look like? You know, the amount of time given to patients, all of that. Or is it actually, you know, are you, you know, are you sitting at 95% compliance with NICE guidance in 11:07 11:07 11:08

relation to personality disorder, which would have been my speciality, right, or self-harm, you know, guidelines. So something like that to guide the process a bit so that the Trust comes with the expectation this is not just about activity, it's also about quality.

58 Q. Yes.

A. And then potentially from the patient's perspective, you know, and again this is where, you know, service user involvement in this is really important, from their point of view - and there are some rudimentary but useful, you know measurement tools, in terms of giving, you know, user and carer feedback in relation to what actually a good clinician looks like in terms of, you know, did you communicate clearly, you know? So some process measures in there just to capture it. Then the appraisal could pick up in terms of saying, you know, if you're being appraised against your job plan it's not just about the activity but it's also about what was the quality of the job that you did and how could you see that that could be developed.

59 Q. Yes. Yes. Thank you for that. In terms of activity, I wonder whether you consider that the job planning process could be better tailored towards the demand capacity issues that the Trust is facing. Obviously Urology is a team of people, albeit with their different interests and different practices. Has there been any thought given to, for example, team job planning, whether Urology or more generally, to help

better target some of the capacity issues that you're facing?

A. Well, I think Urology does it as well as anywhere I have seen. Right. So they take their collective efforts, and not just across themselves, but they also bear in mind, you know, the skills and knowledge of the other disciplines they work with. So one of the examples, for example, in relation to this, and I think it was reported in the GIRFT Report, is that, you know, in consideration of some of the technical procedures, we now have our clinical nurse specialist trained up on that to take some of what was on the waiting list for the urologists, you know, on to their workload, but in order then to relieve the clinical nurse specialists what the urologists asked me to do, or asked us as a group to do, of managers, was to think about how to build in more admin support to allow the clinical work to flourish. 11:10 11:10 11:10

So, you know, on the basis of that, what came out of that discussion around capacity and demand and job planning, was actually a strengthening of the role of the nurses and an increase in the provision of admin time. So we doubled the amount of admin time that was available to the consultants so that the backlog of their dictation could be cleared up in a more timely fashion so that they could get the results and get to the patients more quickly, and then in addition to that we put administrative support in for the CNSs who 11:11 11:11

hadn't had that before so actually they could be freed up, you know, to get away from sitting in front of a computer to actually deliver care to patients. So that's the beauty of this when it actually works really well. 11:11

60 Q. We appreciate that recently, and I'm not sure how recently, a job planning steering group?

A. Yes.

61 Q. - has been established. Just if I can open the document at TRU-306106. It's led by your Medical Director, Mr. Austin. Dr. Austin. 11:12

A. Dr. Austin, yes, and Mrs. Toal the Director of HROD.

62 Q. Yes. And its roles and responsibilities are set out in this document. Again, is it fair to characterise this as a corporate working group which is designed to ensure that the practices of job planning are being implemented appropriately and to challenge, I suppose, where they see shortcomings? 11:12

A. Yes, I think, I think it was in reflection of that, and also I think, you know, it originally started out way back in the beginning because we had a concern about people who were carrying really heavy job plans with huge numbers of, you know, programmed activity on them. So it grew from that then in terms of thinking about actually the overall responsibilities within job planning and how that could be used, and this is as much about, you know, allowing doctors to work to, you know, the best of their ability in relation to the jobs that they do, but also being mindful of how we support 11:12 11:13

them to do that and at times protect them from excessive workload.

63 Q. Thank you for that. Appraisal and revalidation, we touched upon it briefly yesterday. If we can pull up your statement at WIT-45095, and I think we may have raised this particular page yesterday. 11:13

A. Mm-hmm.

64 Q. But in some respects it reflects and corroborates some of the observations which the Inquiry may have made already from consideration of the appraisal reports that were performed in respect of Mr. O'Brien. I'm conscious that appraisal of clinicians was really in its infancy and only began to get moving from about 2011/12 onwards, maybe even slightly later than that, and there was perhaps an uncertainty about where it's focus should best lie. I think the word that we have heard from some who have spoken to the purpose of appraisal was that it should be formative, it should be formative in the sense of helping the clinician to develop where development was required, rather than being used as any form of, if you like, quasi disciplinary or scolding mechanism. But at the same time I think what appears from an analysis of some of the appraisal reports that we have looked at, is that events happening within the practice of the clinician, and here I'm speaking about Mr. O'Brien, adverse events which are evident perhaps of shortcomings, were not often pulled into the appraisal discussion and didn't feature in terms of the formative or the support that 11:14 11:15 11:15 11:16

the clinician may have required. Is that something you acknowledge or - I know it was perhaps before your time, but is that a feature historically of appraisal that you understand and acknowledge?

A. I think that, and I think this stems from the GMC's relationship to appraisal. Right. I think at times it's neither fish nor flesh. So it was set up basically to be an opportunity for developmental learning for doctors and, you know, in its purist, in it's original purist days it was almost seen as something that was completely set apart that was only known to the appraisee and the appraiser, almost sat completely outside the system and didn't link. Now, as time has gone on I think - so it would have been seen as, you know, as an educational development tool, you know, in and around in the domains, the four domains that are within it. Increasingly the GMC has asked for evidence of it over the years and I think, you know, that gets used I think as an indication of the doctor's compliance with, you know, the willingness to understand their practice and develop, but also in terms of gaining their insight into their practice in terms of how they reflect and deal with their work. And I think - because it's called "appraisal" I think then it gets conflated with a performance management. Right. So I think that it gets seen in different ways in different places, when actually what we need is a job planning process, a performance management process that, you know, and performance in the widest sense in

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that it's not just activity it's also about quality, safety, you know, user experience, all of those things.

65 Q. Mmm.

A. And then the appraisal, you know, if it's going to sit outside all of that, should be a developmental tool in relation to what comes from these other systems then to support the doctors. 11:18

So, I think it gets used in different ways. But, you know, in more recent times, and I appreciate that this has been an evolution, in more recent times it is a go-to place in terms of, you know, recommending the doctor for revalidation with the GMC in relation, you know, to give an awareness of how the doctor relates to their work, but also, you know, if there are concerns about a doctor, or if the GMC is looking for evidence about a doctor, before they will even ask for the job plan they will very often come and ask for you to give a feedback in relation to the doctor's appraisal in terms of how they are. So I think that has permeated the system to some extent. 11:19 11:19

66 Q. Yes. Well from your perspective as the leader of the organisation trying to drive a quality and patient safety agenda, what, within your command, can you do with appraisal to help support that agenda, and is there any evidence that it is being used to support that mission or vision for the Trust? 11:20

A. Well, what we have done is we have tightened up the appraisal calendar. So, you know, we do come with the

expectation now that - the appraisals are run within a calendar year, right, so it's January to December, and we do come with the expectation that those will be completed in the first quarter of the following year, right, and that they're robustly done, you know, along the four domains of the appraisal, but supported by other information, and that has developed regionally over the years and it is a shared regional template. So there will be statements there about health, and probity and, you know, declaring interests, all of those things should go in there. 11:20 11:20

But the other part of it I think increasingly is the reflection, and there would be an expectation within each of the domains that there would be a reflection done, but I think also a reflection that if a doctor is in difficulty over something that actually there's a reflection done on that specifically, because what you're interested in knowing is if, for example, there has been a complaint about their performance in relation to quality and safety or, you know, there has been a complaint made by a patient, actually how they take then that information and used that as an opportunity for improvement? So how we're trying to support that is through appraisee and appraiser training. So it's done rigorously across the Trust. You know, we have quite a lot of appraisers in relation to that, and also then we have - in relation then to the step beyond that which is, you know, when these get 11:21 11:21

looked at by - or the overarching themes from them get looked at, not the actual conversations get looked at - then whenever the Medical Director brings together the Divisional Medical Directors on a monthly basis to consider the overall appraisal picture within the Trust, any concerns that have been raised in relation to appraisal or a doctor's relationship with appraisal within the Trust, whenever they're having their overarching monthly revalidation meeting, that gives an opportunity then for some of this to be quality assured in terms of having a shared learning around it. 11:22 11:22

67 Q. And I'm going to coming and look at some of those conversations that happen on a regular basis between your Deputy Medical Directors and medical leaders within the services, notably the Divisional Medical Director. 11:22

Just before we leave appraisal, you have - am I right to observe that you've tried to build a better infrastructure around appraisal? 11:22

A. Yes.

68 Q. I was a little unsure when I looked at materials. Is there a senior revalidation and appraisal manager?

A. Yes.

69 Q. And does he or she work with the Deputy Medical Director who has appraisal and revalidation as part of their job title? 11:23

A. Yes. So Ms. Davidson oversees that and she brings together not just the appraisal and revalidation for

medicine, she also manages it for nursing, which has been really helpful, because on the back of some of the work that has gone on in relation to this, and then the parallel process that has developed in relation to the oversight of doctors in difficulty, the Director of nursing and AHPs has developed a similar system for nursing, and social work is now in the process of developing that for social work. 11:23

So some of the systems and processes that have been put in place to strengthen all of this, together with the support system that has gone in, is increasingly being adopted across the Trust. 11:23

70 Q. Yes. And just further in terms of the infrastructure. There's now a Trust Appraisal and Revalidation Board? 11:24

A. Yes.

71 Q. It's due to meet for the first time this month, I understand?

A. Yeah. Yes.

72 Q. And I suppose there's greater visibility around appraisal. The Medical Director provides a report for the Trust Board in relation to medical appraisal. I think we can see it at TRU-306108. So that's relatively fresh off the press. This is Dr. Austin's report January of this year. 11:24 11:25

A. Mm-hmm.

73 Q. If we just go over the page and pick up some highlights. He sets out areas of improvement, including a new process agreed to standardise the

supporting information that comes into the appraisal process. I think there was perhaps some difficulty reflected on Mr. Young during the early stages of the appraisal process, in terms of his accessing all of the information that might have sounded on Mr. O'Brien's appraisal. There is a, I thought curiously within the appraisal materials, a process for dealing with paying and private practice. Why - I use the word "shoehorn", why is that shoehorned in there? 11:25

A. Well it takes us back to the 2017 Action Plan that came out of the Maintaining High Professional Standards Review in relation to Mr. O'Brien, and the concerns that were raised at that point in time about paying and private practice patients because, again, one of the things that we knew, and was subjected internally to an internal audit that we requested, was about the process of all of this and how private patients were dealt with across the Trust in terms of the interface between the private sector and the public sector. And, again, we did not have clear lines of sight in relation to all of that in terms of who had started off their journey as a private patient and who didn't, you know, in relation to Mr. O'Brien's practice at that point in time, and we were concerned that that was exposing medical staff in particular to probity issues. So, on the basis of all of that we now have a much more robust system in terms of picking those patients up, having them signed off by the Clinical Director and Head of Service as they come into the system, so that we know where they've started 11:26 11:26 11:27 11:27

their journey and we know that their information may not be within our system in terms of holding that together and making sure that they are not either prioritised or disadvantaged because they have started off in a private capacity. 11:27

74 Q. Thank you for that. So I'll leave appraisal now. 11:30, time for a short break?

CHAIR: Yes. We'll come back at a 11:45.

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS: 11:28

CHAIR: Thank you everyone. Mr. Wolfe.

75 Q. MR. WOLFE: Just continuing along the theme of the steps taken to enhance the ability on the part of, I suppose, the Senior Leadership Team to get to grips with what's going on with individual practitioners within the services generally from a medical professional governance perspective. Your witness statement, or one of them, reflects upon sort of initiatives that you either constructed or carried forward when you were a Medical Director in the Trust, and in particular you refer to fortnightly meetings with Divisional Medical Directors. 11:47 11:47

A. Mm-hmm. 11:48

76 Q. So that was the group of Medical Directors, or, sorry, the group of Divisional Medical Directors meeting with you, and then as Medical Director again scheduling monthly one-to-one meetings with each of the Divisional

Medical Directors, and you put that within the framework of giving you opportunity to scrutinise and challenge what was essentially going on within the services with regard to practitioners and their practices. Have those initiatives continued? You've obviously moved upstairs to the role of Chief Executive, but do those opportunities for close contact between Medical Director or his Deputy Medical Directors and the Associate Medical Directors, do they still take place? 11:48 11:49

A. Yes. So I've only moved across the corridor. But in relation to those, they happen more frequently now. So, what Dr. Austin did was reorganise that, so he meets with them now on a weekly basis for shorter periods of time, which I think is more effective, you know, I do think it keeps the whole medical leadership narrative flowing better, and then he has continued - now I know he has revamped the programme, but he has now continued to undertake the one-to-one meetings with the Divisional Medical Directors. 11:49 11:49

77 Q. Yes. And there was the development of what appears to be a fairly prescriptive format for these one-to-one meetings, and again I'll ask you to look at that and have your comments as to whether it still applies and what the purpose of it and what the benefit of it is? 11:50 So if we look at WIT-46754. So we have had this Divisional Medical Director review meeting, do they still take place monthly?

A. Yes.

78 Q. That's the one-to-one?
A. Yes. Yeah.
79 Q. And if we scroll down, one can see that there are a series of topics. It appears on my reading to be explored during these one-to-ones, I'm sure were applicable, and I suppose you don't slavishly stick to this, if the issue has been discussed last month and its not applicable this month. 11:51
A. Mm-hmm.
80 Q. But just it maybe helpful to see the kinds of issues that are canvassed. There we have job planning and medical appraisal, revalidation issues, professional performance management. What is that concept, professional performance? 11:51
A. It was - it's really a very broad term and, again, it's a broad definition of performance in relation to activity, quality and safety and user experience, but essentially anything that was coming out of that that was raising any concern or curiosity essentially for the Divisional Medical Director. Now, where I had hoped to get to before I finished as Medical Director was to more robust performance management reviews, you know, in relation to each directorate, but what I've done now is started to - we have reorganised our accountability meetings for each directorate. So what I'm hoping do in the course of this financial year is to bring this forward a bit more robustly into the overall accountability meetings with a feed then coming from the Divisional Medical Director when they turn up 11:51 11:52 11:52

for their directorate accountability meeting.

81 Q. Thank you. Then just continuing our scroll and we see what's covered. Yes. Medical workforce issues. I suppose that's recruitment type/vacancy type issues?

A. Yes. I mean this was useful, you know, in that I mean at a point in time we identified that we had 134 unfilled medical posts across the Trust, which is really quite significant, and that helped drive our international recruitment initiative last year. So, you know, this information gets used in different ways. But again I think fundamentally it was there to identify the challenges in relation to capacity and demand and, you know, how potentially beleaguered some of these posts could become if that wasn't being managed. 11:53

82 Q. Then as we scroll down, doctors and dentists oversight. Is that issues such as might arise out of MHPS or is it something different?

A. It's broader than that, but it includes maintaining high professional standards. So essentially now that we have started to develop the work around raising low level concerns, you know, if there are concerns about engagement with - and again reinforced by what has come out of the Neurology Inquiry - if there are concerns about engagement with appraisal, revalidation, you know, what we do is obviously have an oversight of that, you know, as well as, you know, any difficulties the doctors or dentists might be encountering in interpersonal relationships, or with workload, or with

health or probity or anything like that, it's brought into that meeting directorate by directorate. So the oversight in relation to that, it's led by the Medical Director supported by the Director of HROD, but for each of their individual directorates the directors attend along with the Divisional Medical Director, and all of this is then discussed in terms of having an awareness of any of the difficulties the doctors might be encountering. 11:54

83 Q. Mmm. 11:55

A. And, you know, we've tried to position this within a just and open culture so that, you know, the opportunity with all of this is to identify if there are things that we, as a system, can do at an early stage to try and support doctors so that it doesn't end up with a Maintaining High Professional Standards situation, in that, you know, we try and intervene at an early stage. And I have to say, you know, it has worked reasonably well, you know. 11:55

84 Q. Yes. It is of course important that you have a structure or a process in place where the Divisional Medical Director is, I hesitate to use the word "compelled", but it is in his or her diary to be at this meeting once a month and these issues are on the agenda? 11:55

A. Yes.

85 Q. But it's, I suppose, a cultural issue to ensure that the medical leader feels empowered or supported to - and sees that it is relevant to speak to issues which

are perhaps of low level concern?

A. Yep.

86 Q. We reflect back to the period before the MHPS in Mr. O'Brien's situation, four or fives years, perhaps longer, of putting up with and not escalating to the top table issues that might, at one point, have been categorised as low level concerns before the situation mushroomed? 11:56

A. Yes. I mean I think if this had been in place at the time, for example, there was the issue around the antibiotic prescribing, or the records going in the bin or, you know, some of the other issues that were around at an earlier stage, they would have been recognised and hopefully dealt with. I mean I think, I think the purpose of this is almost three-fold, it's about, you know, providing an opportunity to help and support people, but it is also, you know, as you have said, I think it gives, it gives medical leaders their place in the organisation. But also I think it helps the organisation take ownership of doctors in difficulty and all medical staff and, again, this is one of the processes then that has been replicated across the other directorates or the other professions in relation to, at this point in time, as I said nursing, AHP and social work, and then increasingly what we're thinking about is administrative staff, because there's something that we can do to try and support them as well. So it is a system that works well for us, and hopefully works well for the people who are there. 11:57 11:57 11:57

Anybody who is talked about on that, we make them aware, because we take the view it is not reasonable for them not to know, so they will be aware that we're having this discussion and hopefully that feels supportive. 11:58

87 Q. Yes. Clinical and social care governance issues are then explored I think over the page. We see a range of items that the Medical Director will expect to speak to the Divisional Medical Director about. Again, promoting a communication there, giving eyes on, or at 11:58 least an opportunity for eyes on in a timely fashion. So looking through some of the subjects covered; adverse incidents, SAIs, litigation I think, yes, and coronial matters, et cetera. I think it goes on to audit, patient safety, sign off, results. We needn't 11:59 scroll through it all. But how long - this system has been in for some years, this arrangement of regular meeting?

A. I introduced it I think at the, was it about 2020, end of 2020/2021 I think, and again I think it has become 11:59 more robust over time, because the challenge at the beginning was for the clinical and social care governance teams to populate these before the one-to-one with the Divisional Medical Director, so that actually that information could be captured and it 12:00 wasn't dependant on the Divisional Medical Director finding it. So that, you know, they and I were coming to this with the information in place and then we could discuss it. But, again, it was - some of it was to

explore further, but some of it was to stimulate other conversations around actually what might be causing this, but actually, more importantly, what can we do about it in terms of driving change?

88 Q. Mmm. Okay. Stepping outside of that format, but I assume an information flow between this kind of format and the doctors and dentists oversight group. This group was established, as I understand it, in 2021, and we can see its Terms of Reference set out at 47 - WIT-47266. So just over the page it's purpose is described. And if I can summarise? It acts as a support to the Medical Director in the discharge of his statutory responsibilities, for example, by ensuring that there is a process of review in any case where the doctor's conduct gives rise to a concern. It will regularly, as we see here, review all MHPS cases and will address delays in dealing with performance issues and ensure that there is support there for managers as well as the clinician. Again, observations on how that process is working and does it connect into the Board? 12:00 12:00 12:01 12:02

A. Yes, and the reports in relation to this - what gets discussed in that meeting and, again, this was derived out of the, you know, what we reflected on being the experiences of the organisation in the course of managing Mr. O'Brien largely, you know, but other situations as well. The content of what gets discussed in this meeting per se does not get passed to the Board, but actually what gets pulled from this are, you know, the numbers of cases in each directorate that are 12:02

being dealt with, you know, a classification around what some of the issues are there, and also then specifically a bit more information then in relation to MHPS and any doctor that's involved in that process.

89 Q. Yes. Your experiences, or The Trust's experiences of the MHPS, for example, in dealing with Mr. O'Brien's situation. 12:02

A. Mmm.

90 Q. Do you reflect upon that as not being a happy period in the sense that here you have an investigation, on the face of it not terribly complex in the sense that the issues were pretty clear at the outset, and yet it took 18 months to bring it to a conclusion in terms of the investigation phase, and then it never quite reached an end point in terms of the implementation of aspects of the determination because a grievance had been raised. 12:03 12:03

A. Mmm.

91 Q. What do you draw from your understanding of all of that?

A. I think if this process had been in place at that time I think it would have been dealt with more expediently. I think there was a lot left to the decisions made by the Medical Director at a point in time. But now, in the way this is set up, this, you know, the collective opinion comes forward from, you know, the Divisional Medical Director, the Medical Director, HROD's office and the Director's office in terms of having a broader approach, and then this information is passed back to me in relation to maintaining high professional 12:03 12:04

standards.

So at this point in time, for example, you know, if we have a doctor under investigation in relation to MHPS, either verbally and certainly in writing, on a monthly basis I will, you know, sometimes it can be verbally weekly, but on a monthly basis I will get a readout in terms of how that's progressing.

92 Q. Yes. And this Oversight Group, as one can see from its - the purpose of its - sorry, the description of its purpose, is there to drive MHPS investigations forward, or at least ask the hard questions if there appears to be problems along the road?

A. Yes. I mean its primary function is in, you know, supporting doctors in the course of all of this and protecting patients, you know, and that hopefully goes without saying. But, you know, increasingly what we're trying to do is intervene at an earlier stage so that it doesn't reach an MHPS process, but if it does reach that process then it's also about making sure that that's being, you know, stepped through in a very timely fashion to get both the doctor, the patients, and the service, you know, through all of that.

93 Q. Yes. I'll come to that area of work which suggests the Trust is trying to intervene at an earlier stage in a moment because I think it's important.

A. Mmm.

94 Q. Just on MHPS more generally. I'm conscious that we had a module dealing with MHPS. You didn't - you weren't

asked to give evidence to that. The Trust has invested in improving it's use of MHPS. I don't need to bring it up on the screen, but we have received evidence in relation to a more focused training plan across a range of interested parties, everybody from the designated member from the Board, through the investigator, case manager, et cetera, receive some element of bespoke training. And there's a tracker for MHPS cases. There's greater definition to some of the key concepts. A tool kit for clinical managers. So we've seen all of that. But from your perspective as a leader of a Trust, is MHPS fit for purpose? 12:06 12:07

A. I don't think so. I think it raises - I think parts of the process of it I think are helpful in terms of ensuring that, you know, information is gathered, reflected on and, you know, there's involvement at various stages of outside organisations as and when. But one of the things that really struck me after the MHPS process that was undertaken in relation to Mr. O'Brien was the - in terms of undertaking an investigation, that's not particularly well defined, you know, what that should actually involve, over what period of time, there are no timeframes set against it, the output from it isn't completely clear. And then when you get to that process, to the best of my knowledge at that point in time, when I didn't agree with the outcome in relation to Maintaining High Professional Standards, my only means of redress at that point in time, because it had finished, was either 12:07 12:07 12:08

to run it all again - and, you know, I wasn't clear how that was going to be done - or speak to the GMC. So I mean that's why I then went - partly why I went to the GMC at that point in time.

12:08

So, you know, it's not like other HR processes where there's appeals mechanisms and, you know, revisions and all of that. And, again, you know, increasingly within the Trust we've asked ourselves does it actually add any value or would we better managing all staff through the normal process in terms of appeal and consideration? So I think there's definitely room for improvement in relation to using it as a tool to identify and support doctors in terms of patient safety.

12:08

12:09

95 Q. You'll have to help me with this. I understand the Department commenced a review of the MHPS arrangements last year. Did the Trust contribute to that?

A. Yes. We were asked to give some feedback in relation to that, but they haven't - I don't think they're at the stage yet of publishing on it.

12:09

96 Q. I asked the question, and I got the answer from you: Is it fit for purpose? And you said no, in your view it isn't.

A. That's right.

12:09

97 Q. Is that the view that was communicated to the Department, can you remind me, on behalf of the Trust, or was it a more nuanced view?

A. I think we - I'm not sure that we specifically wrote

it's not fit for purpose, but I think we would have offered suggestions, but I will find it. Yeah.

98 Q. Okay. I'm obliged.

A. Yeah.

99 Q. You have touched upon the idea that there is much to commend an early intervention approach. 12:10

A. Mm-hmm.

100 Q. And one can see that some work has been done around identifying concerns when they're at a low level and responding perhaps proportionately before the issue potentially gets out of hand. In terms of that, let's bring up on the screen, please, TRU-305570. This indicates that there is now mandatory training in place for a cadre of medical leaders and operational leaders in this field. I think it may only be a product of a time lag. We can see, just scrolling down, that significant numbers have been trained. And scrolling down. But - I think Mr. Haynes's name is on this page. Dr. Tariq from cancer services, and Mr. McNaboe, haven't been trained to date, but it is part of a rolling programme of training, is that right? 12:10 12:11 12:12

A. Yes. It is, yes.

101 Q. And what, if you can expand on what you've just said a moment or two ago, what is the interest and the benefit for the Trust in engaging with concerns when they're at a low level, or might be regarded as being at a low level? I have in mind how in Mr. O'Brien's case there were issues at one point - let's take the triage issue - but they never - conversations happened informally, 12:12

emails were sent, but they never found their way into, if you like a process, until the MHPS process was raised. So it was at a higher level perhaps, and a more complex level, and you might consider not a terribly productive exercise? 12:13

A. Yep.

102 Q. - in terms of getting a solution. So why is there now this focus on low level concerns?

A. Well I think, you know, out of - there's an evidence base around this based on the Stanley Drucker work in relation to open and just culture and, again, in terms of our relationship with Mersey Care, who, you know, practice this and, you know, we've looked at their output in relation to the impact that taking this approach can have in an organisation, we think this is important because I think it creates a culture where people feel that they can speak up and not be punished for that, that actually, you know, we would be encouraging the system to approach this from a position of curiosity and helpfulness. So that, you know, if there are concerns about, you know, minor changes or aberrations of some description, that at least we can, you know, empower people with the understanding to try and, you know, manage that as quickly as possible and as expediently as possible, take the learning back into the system and hopefully prevent any deterioration, at the same time as improving, you know, these medical leaders' awareness of what can be done. 12:13 12:13 12:14 12:14

And I think, you know, creating a sense of - and I mean it is mainly concentrated on doctors - but creating a sense of psychological safety across the organisation that it's okay to speak up, and actually we want to hear you because that in the long-term will protect patients and help you. So that is the essence of this work.

I attended one of the sessions in the Canal Court in Newry and I have to say I was really encouraged by the level of engagement, you know. And, again, lots of, you know, lots of discussion about what was challenging people, and I think, you know, there is the explicit output of it which is around, you know, giving people a set of tools to deal with concerns, but actually what I also saw when I was there was that collective support among various people in terms of swapping ideas and thoughts about, you know, what in different circumstances might make a difference, and that was really encouraging, and I think it really did drive, or does drive the collective spirit.

103 Q. We can see from The Trust's MHPS trend analysis that low level concerns now occupy that space that they're being monitored, they're being logged, they're being the subject of some focus. Just to touch on that. TRU-305575.

So this is within a document that commences a page earlier. It is the MHPS Trend Analysis. So it shows

here in the top table a record of formal MHPS cases and informal or low level concerns. So that's the total numbers. Scrolling down. Then data in terms of the total number of active concerns. In terms of the process here, is there clarity around what is a low level concern, or is this more about creating an environment where the informant, the person with a concern about a colleague, feels enabled to bring that story forward, perhaps without fear that the Trust is going to go down an MHPS route, that it has the option as an employer of dealing with it perhaps more moderately or more - "sensitively" is perhaps the wrong word - but in a less antagonistic way? 12:17 12:17

A. Yes. I mean it is about creating - it's about helping the individual or individuals primarily, but it is also about creating that culture so that, as I say, people, you know, we don't have freedom to speak up guardians here. Although, you know, with the Department we've been one of the pilot sites in terms of driving that, you know to - and we are in the process of appointing a freedom to speak up guardian for the Trust. But, you know, in order to get to that position that all can't rest with one person eventually. We have to create a system where actually people come with the expectation that they should be able to speak up and they're supported to do that. So this is part of the work in relation to that. So, you know, some of this will not just involve doctors, this will also involve other practitioners as well, or other staff as well. So it 12:18 12:18

is about creating that culture,

104 Q. Mm-hmm. It's possibly something that isn't capable of being empirically measured, but if the impression of the Inquiry is, and it's obviously a matter for the Panel to say what their impression is, but if you had a - if there's a sense in the evidence that there was a reluctance on the part of colleagues, whether administrative, operational or clinical, to blow the whistle, to make a report, to raise a concern, that is part of the picture, how confident are you that that is a picture which is in the rearview mirror and is historical, and that the culture within the Trust has either moved on or is in the process of moving out of that and being more open and more candid when they do have concerns? 12:19 12:19 12:20

A. I think we're not there yet. So I do think that it is changing or I get a sense of that. And I view this a bit in the same as I do with Datix or IR1s, right. The picture that you want to see with your Datix reporting is that you get a lot of low level Datixes reported, so that people are sensitive to operations, you know, they're sensitive to the potential for concern in the system. But what you don't want to see is an increase in your major catastrophic incidents. Right. The equivalent of is this is the Maintaining High Professional Standards process right back through the system to the low level concerns. 12:20 12:20

So in my view, if we can increase the reporting in

relation to low level concerns, the hope and the aspiration is that we will reduce the likelihood of people having to progress to Maintaining High Professional Standards. So an increase in those numbers I would see is a good outcome actually because they're low level. If we had an increase in MHPS that would concern me more, but an increase in the low level concerns is good. 12:21

But, again, you know, we did the cultural survey that I mentioned yesterday pre-pandemic. You know, we would plan to do that over the next year and I would hope that in terms of looking at the comparison in relation to that and whether or not we've empowered people to be able to speak up safely, I would hope it would potentially come through in that questionnaire. 12:21

105 Q. Mm-hmm. Your evidence suggests, and the cataloguing of low level concerns suggests that these are issues that cannot be dismissed. Low level concerns are important, it's important to get to grips with them. 12:21

A. Mmm.

106 Q. I suppose as you reflected on the last occasion that concerns around Mr. O'Brien weren't adequately scrutinised, the deep dive didn't happen and, so, this was all regarded as not essentially relevant in patient safety terms, his behaviours, until you suddenly discovered, yes it was, and that brings us to the arena of cancer services and really the trigger for this Inquiry was what was discovered when the deeper dive 12:22

was performed, and the focus, as I say, was in how cancer services, and particularly at least first instance the urology aspect of cancer services was behaving and performing.

A. Mm-hmm.

107 Q. And obviously we had the Serious Adverse Incident Reviews performed by Dr. Hughes and his team, and one can see from the material supplied to the Inquiry that the Trust has engaged in significant work and devoted significant resources to improving cancer services pursuant to the recommendations that came through those SAI reviews, isn't that right?

A. That's right, yes. Yeah.

108 Q. And a decision was made at a fairly early stage of looking at these recommendations that consideration should be given to cancer services across the Trust Board, if you like?

A. Yeah.

109 Q. Across the board. There are eight, as I understand it, cancer services, or eight areas where cancer features as a service delivered by the Trust?

A. Yes.

110 Q. And if we can put up on the screen - we've had several updates from the Trust - I was going to say unhelpfully, at least in terms of my preparation - but we're are now, as of I think Monday of this week, in possession of the most recent update, and we can find that at TRU-306489. That's the cover page. The title speaks for itself. It's an update on the action plan,

it's in response to the Hughes' SAI recommendations, and then if we go down one page, please, and we'll observe the format.

The format, as I say, has changed over the course of the past week. Now removed from the document are the managers who took forward each of the actions in relation to the recommendations, but we have their names through earlier iterations of the same document. So what we see at the top of the page is the recommendation, of which there were 11, and then the fine detail in italics of each recommendation. And then what we have is on the left-hand margin, the steps taken, or the focus of the Trust's approach to addressing each part of the recommendation, and some of the recommendations have been broken down into, if you like, a series of tasks, in order to serve the whole. 12:25 12:25 12:26 12:26 12:27

A. Mmm.

111 Q. And then on the, if you like, the middle. The middle section is the update in terms of where the Trust is with the recommendation, and then that's subject to a RAG status score. And the far right margin provides evidence references, and we have - the Inquiry has in its possession many of those back documents which support the process.

So with that summary, could you help us, Dr. O'Kane, in getting a better understanding of the impact on the Trust of having to go through that process? We'll

touch on some of the specific recommendations in a moment, but can you explain to us the process, the seriousness with which it was regarded, and some of, if you like even on a high level, the steps that your team had to walk through in order to bring the task to what I understand is to be at a nearly completed point? 12:28

A. Well, firstly, could I apologise that we got the document to you and I realised we had sent previous iterations but that it was so late in the process. I mean it has been a fairly dynamic process in terms of collecting this and keeping it live, and I think we were very keen that it was accurate whenever it was submitted to the Inquiry, but I do apologise for the shortness of time. 12:28

112 Q. No apologies required. I mean it is a living document, as I would describe it? 12:28

A. Yes. Yeah. Yeah.

113 Q. So it's helpful to get the up-to-date version.

A. Yeah. So I mean, essentially after Dr. Dermot Hughes undertook the Serious Adverse Incidents Reviews and then published - there were 68 recommendations came out of those nine SAIs, and there were overlaps in terms of the recommendations across the nine reports, and those were then streamlined into these 11 areas with subtitles. So that work was taken on and, again, this has moved around the system a bit because of changes in personnel. So that was led - it started off at a point in time when Melanie McClements was Director. Then obviously beyond that we had split the directorate and 12:28 12:29

for a year - we have two Mrs. Reids who are Directors in the Trust. So Trudy Reid was Director throughout 2022, and then - she was Interim Director - and then Catherine Reid has been Director since January 2023. And as we approached the Inquiry at the outset we had three strands of work. So there was management of the overall Inquiry process and making sure that we provided timely and accurate information to the Inquiry itself and that, you know, the process of managing the Section 21s were managed, and that was managed down one work stream, and that sat with Jane McKimm. The part then in relation to the Lookback Review, which was the review of over 2,000 patients, sat with Margaret O'Hagan in relation to running that process. And then the operationalisation of the recommendations that came out of Dermot Hughes' Report sat with the operational team, because we felt very strongly that this should belong to operations rather than sit separately, because the learning needed to be embedded in the system. Right. 12:29 12:30 12:30 12:30

Now, what that has suffered from then is that even though the people on the ground were working their way through it, the management of it has changed. So that's why you will see, you know, in the serial reports you'll see different names against it. But this has been a work in progress. Much of it has sat with the cancer division, because within the Surgery and Cancer Directorate it's effectively split into

three divisions; so maternity and gynae is in one division, cancer services are in another division, and surgery sits in the third division. So most of the work has been undertaken by the cancer division in relation to this but relating back to the urology or the surgery division within the same directorate. And, again, it has taken a lot of effort I think in relation to really reviewing systems and processes and understanding what's required. 12:31

So, for example, in the first one there in relation to the multi-disciplinary team, as the audits showed there were points in time in the past when throughout extended periods of time the multi-disciplinary team in cancer services wasn't quorate. So there wasn't always - and some of these services are provided between ourselves and the Belfast Trust, which is the regional centre for cancer. So we did not always - and it was due to staff shortages - we did not always have Radiology present from Belfast and sometimes from ourselves. Medical Oncology and Clinical Oncology, which are two different specialities, were not always present. And the reporting systems within all of this were not straightforward. 12:31 12:32 12:32

So, you know, in his later versions of - in a later appraisal, and I can't remember whether it's 2017 or 2018, Mr. O'Brien makes reference to going to an MDM, right, but actually at that point in time the MDM may

not have been quorate and he may have found himself in a position of chairing his own MDM. So you can begin to see how all of that is not robust practice in terms of presenting challenge and passing back information.

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So they have taken all of this apart. They've looked at the process in relation to it. So as we stand in relation to MDMs, there is an escalation within the directorate if the MDM is not quorate. The MDMs are chaired, and we have MDM Chairs now. They have - 12:33
they're given four hours per week to Chair the MDMs. They deal with huge volumes of activity, and certainly, you know, on a weekly basis, for example in relation to one of the groups, they process 38 referrals a week, which is a lot to get through in a short period of 12:33
time, and out of that then these days what will happen is, you know, they will be checking always that the patient is meeting the 31 and 62 day requirements of the cancer strategy. We put additional funding against the MDM in relation to not just the job planning 12:34
process but also increasing the number of CNSs who take part in all of that, making sure that there is medical presence there, and also then we invested in trackers, so that when a patient comes through this process now the tracker picks them up and makes sure that there is 12:34
no gaps in terms of, you know, the outcome of the MDM being followed through. So if that specialist team is requesting more blood investigations or radiological investigations, the tracker will make sure that those

are done through to the end and will liaise with the consultant team, and the secretary, and the booking office, if necessary, to make sure all of those things are done.

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That is then audited on a regular basis, and they will take - out of samples of 38 they will take 5 cases and make sure, based on that sample size, which is, you know, in and around 12%, they'll do that on a regular basis to make sure that there aren't any patients falling through the gaps. Right.

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Now the other - so that captures the 31 and the 62 day patients. That's done at risk. So we've done that within the Trust. I think the concern that we have, and this is not funded, is for patients who may have come back into that process again who wouldn't have been coming through that as part of a primary cancer journey. So, again, what they have been trying do is capture some of the patients who may be coming through the MDM with metastatic disease, to make sure that information is also fed back in to the teams who are looking after them so that those outcomes aren't lost as well. So all of that work is in progress. And then the other side of that within the surgical side, to make sure that any of the new patients who are coming through and referred are being picked up for both cancer - because the weight of all of this is on cancer, right. Half of the patients who come through -

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no, sorry, three quarters of the patients who come through the Urology Service aren't cancer patients, so we were also keen to make sure that they don't get lost in the service as well.

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So on the surgical non-cancer side, what we've done is, in addition to putting more administrative support around that, we've also employed a booker, basically, so that they make sure that those patients who come through, that they successfully get into clinics and 12:36 that their treatment is managed as effectively as possible. But all of those things are done at risk. They're not part of what's described as the commission service. And, again, what they're constantly doing is looking for ways to improve that so that they can get 12:37 those patients safely through the system.

114 Q. Thank you for that. Let's step back a stage to what Dr. Hughes found and compare that with where you are now.

A. Mm-hmm. 12:37

115 Q. It appears at least on the papers to be a chalk and cheese situation. Can I ask you to reflect, because it's important that the Inquiry has your perspective on why this Trust was at such a low level of performance with regard to its cancer MDMs, not just Urology, it 12:37 would appear to be short in critical respects across the cancer environment. So how do you account, or what's your perspective on why this organisation was so short that this extensive rebuilding exercise has had

to take place?

A. Well, I think just to start with the MDM process to begin with. I mean there were concerns I think throughout raised about quoracy, but I think they didn't go beyond a certain level in the organisation. 12:38
And then, you know, some of those who were involved from the Belfast Trust who raised concerns at points in time, I think, as I understood it, they had particular concerns in relation to some of the practices there and wrote to the consultant involved, but I think probably 12:38
didn't know how to access our medical management structure, or we didn't make it explicit in terms of how that was actually done. So that kept all of those concerns at a certain level in the organisation and I think weren't addressed, and I think there was a kind 12:39
of a hopelessness around it, which was, "well, this has been going on for a long time. It has never been sorted out. You know, we've complained about it before and it hasn't been dealt with", right, and I think that bred complacency. 12:39

Then I think what compounded all of this, because, you know, the other consultants who were working in that system, you know, they saw their patients through from start to finish, they kept a running score on where 12:39
they were in the system, so that if they were concerned about them and, you know, if they needed CTs, MRIs, whatever, they got them followed through, they brought them back to their secretaries. They automatically

followed through on any of the recommendations that came out of the MDM, and they made sure that all of their patients that they were worried about went into the MDM.

12:40

I think the difference in relation to Mr. O'Brien was, if he wasn't taking the patients to the MDM in the first place, then the MDM didn't know about them. And if the MDM was reporting on improvements or investigations to be done and he wasn't following through on those himself, then they weren't getting done.

12:40

So the enhancement in all of this - and that applies to all of those patients who were there on the cancer side. So the enhancement from the patient's point of view is that this does not solely rely on a consultant being aware. There is a safeguard in place now with the trackers. So they will pick this up and make sure that it goes back in. And the MDM itself is alive to the possibility that these patients need to go back into a system to be further investigated.

12:40

116 Q. To take one example of many problems, but we heard from Dr. Hughes, we heard from Mr. Gilbert, and it was - my words, and others may have a different interpretation - there seemed to be a sense of bewilderment that basic safety standards that accompany other MDMs in these islands simply didn't exist here in the Southern Trust.

12:41

A. Mm-hmm.

117 Q. And clearly you can't have a system dealing with this kind of medicine which is vulnerable to the behaviours of one clinician. The system needs to be arranged to pick that idiosyncratic practice up, challenge it and provide solutions. 12:41

So what is the explanation for that not, those basic systems not being there? What is the Inquiry to write into its report by way of an explanation for that low base? 12:42

A. I think there was a failure to recognise the complexity of the systems that we're dealing with, you know. These systems, I mean the level of referral into cancer services goes up. I think it's gone up by 50% in the last five years, so it's rising exponentially, and the 12:42 spend around that hasn't increased in keeping with that, in terms of, you know, commissioning a service. But also, the complexity of the care has increased over time as well. You know, there are treatments available today that wouldn't have been available two or three 12:42 years ago. So I mean that's constantly an evolution and it is incredibly dynamic.

So I think we failed as a system to appreciate the complexity of all of this, the fact that, you know, 12:42 where there are many points of change in a process that they are always vulnerable to things going wrong. So every time you change a treatment, or you add something in or take something away, it's vulnerable to not being

followed through, and we really need to heavily manage all of those stages. And, you know, to enable us to do that, the team needs to be robust and we need to have someone, other than the clinicians, basically managing all of that and doing that. So, you know, we're not perfect, but we're definitely stronger than we were in that regard.

118 Q. Let me just leave this document for a moment and we'll return to it. I just want to get a measure on the extent of progress in terms of the recommendations. The BSO, the Business Services Organisation, conducted an audit in respect of the Trust's work late last year. 12:43

A. Mm-hmm.

119 Q. If we could turn to TRU-305875? And that is the cover page. And if we go down to 878 in the series, the audit objectives are set out, and the limitation of the scope is set out, and the level of assurance - in other words the key conclusion from the audit, at least on a high level, is that the level of assurance provided is satisfactory, which is obviously a strength or a positive. 12:44 12:44

If we scroll down to the next page - see if I can pick this up. Scroll down, please. So it - this is part of the Executive Summary. It says, as we've seen from the earlier document, there is a total of 11 recommendations in the Urology SAI, resulting in what it describes as 26 actions. As of November 2023, 65% or 17 of those 26 actions were deemed to be fully 12:45

implemented by the Trust, and the remaining nine actions are deemed to be partially implemented, with work ongoing across the teams to ensure compliance. That was late last year, November. Is that the current position or have things moved on beyond that, in your view? 12:46

A. I haven't counted them up in the latest report, but, no, that has moved on. Yep. Yep. So I mean overall I think nine out of the 11 recommendations, I think when they reviewed it they put green against it. How that measures up specifically about the action - in relation to the actions, I haven't counted that. 12:46

120 Q. That was my difficulty in trying to interpret that.

A. Yes. Yes.

121 Q. But are you satisfied with the pace of improvement around this, or disappointed that it's taken, I suppose, into the third year since Dr. Hughes reported to get to where you are now? 12:46

A. I mean, I will always want things done quicker, but I think I've got to be realistic. I mean this is also a team that was trying to rebuild the surgical services and cancer services post, well not completely post-pandemic because - well I think we are post-pandemic now - but, you know, in the midst of all of that trying to get these services up and running and get systems and processes in place. And, you know, across the two teams it was the same individuals that, you know, were trying to manage all of that as we're trying to develop all of this at the same time. 12:46 12:47

And then, you know, the other part that had to be developed in the midst of all of this was, you know, the move of emergency surgery from the Daisy Hill site and the reconfiguration of Daisy Hill as an elective surgical centre locally, and increasingly for the region. So there was a lot of other work going on at the same time. But having said that, I think they have worked their way consistently through this, and I think have been very cognisant of the seriousness of all of this and have progressed the work. 12:47

Barry Conway did a presentation to Senior Leadership Team last year June, and then to Trust Board in relation to this and, you know, each time I see this presented it has incrementally moved forward. So I know that the progress has been steady. 12:48

122 Q. Yes. If we - time doesn't allow us to go through each of the recommendations. The Inquiry has the paper and can judge for itself where the progress has been made and whether, from governance perspective whether it's satisfactory. 12:48

Let's return to the document. Again, just to remind yourselves, it is to be found at WIT-306501. Sorry, TRU. Thank you. TRU-306501. And we'll pick up on a number of the recommendations and pull the highlights, if you like, from it. 12:48

Just if we go back a page, please? Thank you. Just scroll back, please, for me. Let's focus on - sorry, I am at the wrong page again. If we go back to 306490? I want to look at Recommendation 1. 490. Thank you.

12:50

So what we can identify from Recommendation 1 on the left-hand margin, are the tasks which were focused on in order to further this recommendation. We remind ourselves that the recommendation at a high level was that the Trust was expected to provide high quality 12:50 urological cancer care for all patients, and that is broken down to ensuring that there is support for patients and their families through diagnosis, treatment, planning, completion, and survivorship, as well as assurance using a pathway audit to superintend 12:51 that process.

So the work that was undertaken appears to have been several-fold. We have work undertaken in relation to conducting a baseline assessment, and that's looking at 12:51 all of the material that was available to define the purposes, the purpose of an MDT working arrangements, and we can see that in that middle section, the work that was undertaken to follow that through. And then if we scroll down, feedback was sought from urology 12:52 patients and, again, an explanation of the actual work in the middle section. And then a third stage, or a third portion of the work, there was data mapping for each patient pathway or each condition pathway. One

can see that that has a yellow rating. Some of the work in urology and I think in renal services isn't yet complete. We can see in the middle paragraph:

"The immediate work needed to be delivered in relation to Urology has been completed but the Trust is adopting an ongoing improvement focus across all cancer pathways supported by the cancer service improvement league." 12:53

So the RAG status for this sub-action is therefore yellow, it's ongoing work. 12:53

A. Mm-hmm.

123 Q. Are you satisfied or are you in a position to be satisfied or assured that this aspect of the recommendation is in a good place, has been appropriately conducted and applied? 12:53

A. I think I would have liked it closed out, but I know that they are working on the aspects of this. To try - for the parts of this that haven't been delivered on yet, this will now - I mentioned yesterday about the External Reference Group and about how we're now moving the programme for improvement within the Trust completely, so that will be overseen by the Director of Transformation and Improvement in terms of ensuring and, you know, holding to account essentially the directorate in relation to making sure that these are delivered on over the next few months. So, I mean, we would all like it to be green, but I am confident that, you know, as this works gets underway that we will have 12:54 12:54

this done.

124 Q. Yes. Let me move through this quite quickly. If we go to Recommendation 5, which we can find at 306501. It's TRU. Sorry, yes, TRU-306501, and bottom of the page.

12:54

And so, the Inquiry Panel will recall the concern expressed by Dr. Hughes about the gross limitations in the tracking ability of the Urology Cancer MDT, and that's reflected in a recommendation that says that the Trust must ensure that MDT meetings are resourced to 12:55 provide appropriate tracking. And just scrolling down. And it's explained in the middle box just what has been undertaken. So the Trust - this is up-to-date as of a week or so ago:

12:55

"The Trust track patients from referral to first definitive treatment."

And that's what you're resourced for. But in addition to that: 12:56

"Cancer services monitor tracking monthly to ensure this is kept up-to-date to support escalation of delays. The Trust has been commended by the SPPG for keeping cancer tracking up-to-date. All patients with 12:56 a new cancer diagnosis are discussed at a cancer MDM. All patients will be allocated a Cancer Nurse Specialist as their key worker and a monthly report is produced by cancer services to evidence that patients

are being allocated a key worker."

And then:

"Monthly snapshots are completed for all local cancer MDMs to check that the plan agreed at MDM is implemented." 12:56

So some significant progress there. Is that your view?

A. Yes, and we increased - as I say we employed cancer trackers and we've employed more CNS to support this, and it is working, and I've seen the results of the audits and that supports that, yeah. 12:57

125 Q. Yes. If we could just briefly touch on those audits by way of some examples. If we go, just jumping out of this document briefly -- I'm looking at the clock, it's 1:00 o'clock. Maybe we'll start there after lunch? 12:57

CHAIR: Yes. 2:00 o'clock, ladies and gentlemen.

LUNCHEON ADJOURNMENT 12:57

THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS

CHAIR: Thank you everyone, Mr. Wolfe.

MR. WOLFE: We were examining, just before the break Dr. O'Kane, the content of Recommendation 5, I think it was, of the outworking from the SAI recommendations, which provided for and appears to have embedded some form of auditing across a number of the concerns that Dr. Hughes had. You mentioned, and just before we go to the evidence for the auditing, you mentioned in part of your answer that this system of auditing might have the potential to pick up on failure to refer into the MDT process, and if I picked up your answer correctly, you seem to suggest that with regards to Mr. O'Brien there was information, or it was your belief perhaps, that he had a history of failing to refer patients into the Urology MDT. Is that your understanding? 13:58 13:59 13:59

A. Yes. Certainly from the Lookback Review in relation to the 10 questions that we have undertaken in reviewing all of that, there's a suggestion that patients came through the system, had a diagnosis of cancer, and weren't always referred to the MDT. And for others, were referred to the MDT but may not have had their results enacted. 14:00

126 Q. Yes. Certainly - we can look at that, we can look again at the lookback as regards the first part of your answer. Certainly there is indication through the Dr. Hughes's SAIs, if I can call them that, that patients having come through the MDT didn't get their 14:00

referral, and I'm thinking in particular Patient 1, didn't get their referral in a timely fashion to Oncology, and there were other situations where, for example, with disease progression, or where there was difficulty perhaps around implementing the recommendation, the case didn't come back to the MDT. But on the first point, you believe there's evidence or a suggestion within the lookback that there were cases that didn't actually go to the MDT at all? 14:00

A. And I think, you know, the extension of that is that the normal cancer pathway would be that there would be a linkage with a CNS in terms of providing all of the peripheral support in relation to - but very important support - in relation to signposting patients into different services, providing them, and to some extent their families, with psychological support and practical support. And those patients, you know, who then didn't come through the process of being referred to other members of the MDM, then certainly didn't get access to that. 14:01 14:01

127 Q. Yes. Well we can pick up on that. I just wanted to illustrate for the Panel your point about the auditing, and I suppose the attempt to get to grips with a variety of issues, including quoracy, the allocation of key workers, and the need for pathology in particular to provide a link into the MDT, all of those matters are the subject of audit. 14:02

So let's look at some of that. If we go to TRU-305635.

And here we find across all of the cancer sites a record of the quoracy for meetings January through May 2023. So that indicates a good eye has been kept on attendance of the key practitioners at the MDT, and it would appear that in the main, certainly insofar as breast, colorectal - scrolling down, I think over the page as well, maybe not, yep - and including urology, that the main cause of lack of quoracy has been the non-attendance of a clinical urologist. In one case in urology in April, no clinical urologist or consultant radiologist. 14:03 14:03

As regards the oncology contribution to an MDT, is the Southern Trust still, if you like, beholding to the region to supply oncology support into the MDT? 14:04

A. Yes. So as you point out, it has been the availability of the clinical oncologists at those meetings that has been the challenge. And, again, I think, you know, when the team has been down through this, you know, there were links made with Altnagelvin, the Belfast Trust, Dublin, they also then pursued this with, you know, nationally in relation to thinking about the Royal Marsden and other places to see if this could be provided virtually, but there's a huge shortage of clinical oncologists. Now that said, once the patient gets through the system in relation to being identified for treatment, they should be able to get access to the relevant specialist then to prescribe the treatment. But in terms of availability at these MDM meetings, 14:04 14:04

certainly Clinical Oncology is one of the areas that they're really struggling to cover.

128 Q. Yes. If we just scroll back? I think it was over the period - yeah. So it's not every month where there is a difficulty, certainly not every week where there's a difficulty. So in January, four out of four meetings had a quorum. February, one meeting was short. Similarly in March and April. But May there was a full attendance. 14:05 14:06

Let's look at some of the other issues that are the subject of monitoring or auditing. If we go to TRU-305637. And this is the so-called snapshot audit, which I think you described earlier, it's described in the recommendations. 14:06

So for Urology it's - for Urology, lower GI, upper GI, gynae, auditing commenced April 2023. Is that how to read that? No. Ongoing from January 2022 for urology, but for the others specialties it commenced later. And what appears to be going on here is that a snapshot, a certain percentage, as you referred to earlier, of MDM discussions are examined for the purposes of determining whether recommendation from MDM had been, had been followed through. Is that what this is about? 14:06 14:07

A. Yes. They take approximately five a week and audit them against the process standards to determine whether those patients have been appropriately processed essentially.

129 Q. Yes. And Mr. Haynes spoke in some detail, he obviously had perhaps more familiarity with it than you. But this is designed to meet Dr. Hughes's concern that patients were being discussed in MDM, and then what happened to them thereafter was - and I don't mean this to sound as harsh as it sounds, but anybody's guess, because it wasn't being followed up and monitored at the time when the SAIs arose which concerned Dr. Hughes? 14:08

A. Yes, that's right. So this makes sure that the patients, you know, we have sight of the patient in the system, yeah. 14:08

130 Q. Yes. Going over the page to 638 in the series, there is built into the recommendations was a need to connect pathology to the MDT and, again, that is the subject of an audit and it's outworking is described here. Again, do you have any sense of how well that is working? 14:08

A. I certainly haven't had any concerns raised with me about this, and I get the sense that the flow of information in relation to this and the pickup seems to be robust, yeah. 14:09

131 Q. Again, a reference to a key worker audit, I think maybe I oversold it earlier. There is a problem around that, as it is explained here. It has been set up but not working properly, so has been escalated to the BSO by the information team. Because we'll see when we go back to the recommendation report in a moment, there was an issue around the CaaPS system? 14:09

A. Yes.

132 Q. In terms of how functional it is for the purposes of recording the appointment of key workers?
A. Yes. My understanding is that this is better now than it was, because that email was sent on the 6/6/2023. We can double check the figures, but my understanding is that that has improved, but the CaaPS system is still a problem for us.
133 Q. So that's an illustration of what has been done. But just before I go back to the report, or the recommendations report itself, just a couple of other points to highlight in terms of background documents or supporting documents. Work has been done to ensure that the role of the Cancer MDT Chair is better defined and that the responsibilities of that Chair are well understood, isn't that right? 14:10 14:11
A. Yes. The role of the MD - I think this is where we confuse the language in our paperwork as well. The MDM Chairs the multi-disciplinary team meeting, whereas, you know, the MDT is obviously the wider team that would be dealing with the patients on a regular basis, but I don't think we have made that clear in the paperwork. But, yes, the role of the MDM Chair has been defined, yes. 14:11
134 Q. Yes.
A. Yeah. 14:11
135 Q. And a job description to that effect?
A. Yes.
136 Q. - can be found at TRU-305846. There is also a protocol to support the safe and effective care for cancer

patients, if we can just briefly look at that. It is to be found at TRU-305850. And in the context section at the top, it is intended that this document is to address early learning from this Inquiry.

14:12

"Cancer services division are establishing systems and process audits..."

- as we've seen:

14:12

"...to ensure patients are managed safely through the local cancer MDTs."

And the purpose of this, of the protocol, is to clarify a number of things. First of all, that there is a process in place for MDT members to raise concerns either about the functioning of the MDT or the management of patients discussed at the MDT. And at the back of this document - I'm not going to bring you to it - are the pathways to be followed in the event of either of those two issues arising as a problem.

14:12

14:13

And then there is at No.2, a process for escalating issues flagged by the cancer division which arise by reference to the system of audits and, again, there is a pathway to support that.

14:13

In terms of the - and we saw it a moment or two ago, or before lunch in relation to the extra Human Resources

that have been brought into the cancer services mix. Obviously they're needed to support the kinds of activities that we have just worked through. I see reference to the fact that those additional Human Resources are employed at risk?

A. Yes.

137 Q. They are funded at risk is maybe a better way to put it?

A. Yes.

138 Q. Does that mean essentially they're not commissioned, or that the Trust has to find the money for their employment through it's budget, as opposed to being formally commissioned?

A. Yes. And, you know, in keeping with every other Trust across Northern Ireland, the Southern Trust had a significant deficit at the end of this financial year. So all the Trusts for ordinary business are sitting with a deficit of about £20-22 million each, and some of the funding that has gone into supporting this is adding to that deficit.

139 Q. Yes.

A. And that's not a sustainable position, unless this is commissioned.

140 Q. Yes. Plainly, the people who you have brought in to these roles, one from recollection is to support the auditing process?

A. Mm-hmm.

141 Q. There's another who sits with an oversight of the entire MDT operation, and I suppose is the go-to when

things are going wrong or, indeed, has to take initiatives to ensure that things don't go wrong. Is it - and, sorry, I forget their job titles - is it fair to say that the Trust regards that resource as essential to the safe operation of its MDTs? 14:15

A. Well, certainly since they have been employed we can see a fluency to all of this that we didn't see before. So there are the trackers who are involved in the cancer side of the house, and then there is the booker who is employed in relation to the non-cancerous work 14:16 that comes through, the 3,000 patients that are sitting on a waiting list, out of a total of 4,000 patients sitting on a waiting list, you know, that person obviously books all of those patients on and keeps an eye that their process is fluid as well. So if we lose 14:16 these people to the system, we're back to square one. And, you know, the context of this of course is not just the Southern Trust, but Northern Ireland has, you know, some of the worst cancer outcomes across the UK. So this is really important work. 14:16

142 Q. Can I just return to the Recommendation Implementation Report? If we go to TRU-306495. And just scroll back one, please? Go back one more, sorry. So this is Recommendation 2, and on my reading of the document it's the only recommendation that has an amber RAG 14:17 score. This is the recommendation that all patients of the Trust undergoing cancer care should be appropriately supported and informed about their care, and this should meet the standard set out in the

Regional and National Guidance, and some comments about your inability to meet all of the expectations around that are set out in the document.

So, if we scroll down. So sharing the - let me just go over the page as well to check I'm at the right place. So the first concern that is raised is the one I alluded to a moment or two ago. It concerns the allocation of a key worker, and the Trust is not currently in a position to stand over in every case that those allocations are taking place. It records here: 14:18 14:19

"As the new CaaPS functionality is not yet available which will allow monitoring of this and other KPIs, and given that sample audits have been undertaken for Urology, we have a level of assurance on this. However, we cannot fully sign the recommendation off as being green." 14:19

So there's that frailty in the system whereby you don't currently have a methodology to stand over appointments of key workers and compliance with their key performance indicators in every case, is that right?

A. We have - we do it manually, you know, in terms of trying to keep a running score to make sure that the patients are aligned and there's a monthly feedback in relation to that. But in terms of it being recorded on the system robustly and signed off by the CNSs, they're 14:19

not able to do that. And CaaPS is one of a number of pieces of software, you know, that functions across the NHS at the minute that is awaiting the implementation of Encompass. That rollout of Encompass regionally started with the Southeastern Trust in November last year. The Southern Trust will get to this in April 2025. So this is going to take at least another year/18 months. 14:20

143 Q. Yes. Just scrolling down. There's another couple of features of this recommendation that you're still working through. Just further down. Again, I think that alludes to something of the same problem. It's the key performance indicators audit for CNS. Working down through it again, is there - this refers to the staffing complement for CNS across all tumour sites. 14:20 14:21

A. Mm-hmm.

144 Q. And is the problem as recorded here that as of September you're still awaiting allocation of funding to support all that you would like to have?

A. Yes, that's right. These are at risk, yeah. Yeah. 14:21

145 Q. And scrolling down. So targeted non-recurrent investment has been made in urology, upper GI and gynae. More recently SPPG have indicated they will support additional funding for two whole time equivalent - is that key workers for skin? 14:22

A. Yes.

146 Q. So more work to do there with your Commissioner. But your concern is that this is all non-recurrent funding, is that right?

A. Yes, I mean it's fragile as a result of all of that. So, you know, we now have people embedded in the system who have been trained to undertake these roles but, you know, given that we're facing significant financial pressure in the next year, maintaining these is going to be challenging in the face of everything else.

147 Q. Yes. The work that's been undertaken in relation to cancer services has relatives in other areas of your patient safety work. So when this issue blew up in urology in the summer of 2020, you obviously conducted a lookback review? 14:23

A. Yes.

148 Q. The Royal College of Surgeons were commissioned to look at a sample of files or patient notes, and they have produced conclusions which are also the subject of an action plan? 14:24

A. Yes.

149 Q. And the Inquiry can see that at TRU-304948. Is there anything you wish to add which isn't obvious from the content of both the lookback and the Royal College output that you think would assist the Inquiry to better understand the state of play in urology, whether in terms of the patients who have been the subject of these processes, or in terms of the improvement or the lessons learned by the Trust, having gone through those processes? 14:24 14:25

A. I think one of the things that stands out for me is that the work that was undertaken by the Royal College of Surgeons, and they reported on 96 patients over a

period of time, I think it was in and around 2010 to 2015, triangulates the findings that we had discovered in relation to our own lookback review in cohorts 1 and 2. So in terms of adding assurance to the robustness of our process, I thought that was helpful, because essentially they had similar findings, and I think there is certainly an overlap in terms of approach to the outworkings of, you know, what has come out of the nine Hughes's SAIs, you know, what we've learned in terms of our own internal lookback process and then what has resulted from the Royal College of Surgeons document. 14:25 14:26

150 Q. And the work, as we've seen in the area of cancer services, has really led to some quite significant systems redesign? 14:26

A. Yes.

151 Q. And the allocation of additional resources at risk. Has the Royal College Report, or the Lookback Report, added any further layers into the system that are relevant from a patient safety perspective? 14:26

A. In terms of the overlaps of all of those reports I think what the lookback - and was triangulated through some of the work - what the lookback and the others revealed was in relation to Bicalutamide prescribing, the use of the multi-disciplinary meeting and the wider multi-disciplinary team, it looked, obviously, at the delays in process in relation to, you know, patients being managed through the system, how private patients, you know, came - partially how private patients came 14:27

into the system and then how they were processed through that, and also then some of the outworkings of this in relation to a lot of the cancer work that has been done in terms of tracking patients back and forth through the system. So most of what we have discussed certainly today I think has been picked up in that. The other area obviously was the Bicalutamide prescribing and just in terms of how that was done.

152 Q. Mmm.

A. And I suppose the review, you know, the snapshot review that was done at a point in time that identified that, you know, regionally there was inappropriate Bicalutamide prescribing, and I think it was 31 of those patients - out of the 32 or 33 patients, I think 31 of them belonged to Mr. O'Brien.

153 Q. Yes.

A. So it has been useful from that point of view, yes.

154 Q. Yes. I know some of the Royal College findings touched upon the issue of consent?

A. Yes. Sorry, yes, as well. Yes.

155 Q. And we can see that perhaps pursuant to that the Trust adopted a new consent policy in January 2023, and that's to be found at TRU-304951. I don't wish to spend any further time on those three processes. I want to - those processes, just to be clear in my mind and perhaps you would confirm this, these are processes designed to ensure that so far as the Trust is able to secure it, patient safety and the quality of care is being placed on a better footing?

A. Yes. I mean you mentioned about consent. Consent is intimately tied in with pre-operative assessment.

156 Q. Of course.

A. And we do know that that's another area of concern and that we have done some work around but, you know, we've subjected it to internal audit to look at what the improvements need to be there. That is going to need more investment, I think, to get on a footing to where we really need it to be. So we're about to undertake a quality improvement project around that identifying how that can be managed better. But, again, that's going to require, you know, more money. 14:29 14:30

The other area I think in relation to cancer services that it's important to think about is, you know in recent times we've had the cancer strategy and, again, the outworkings of that through the cancer steering group and the oversight of the process of delivery of cancer is, you know, mostly through the clinical reference groups which tie in to NICaN and the work that it does. Now, I think that in the midst of all of that change the role of NICaN is not particularly clear. So we know that the, you know, the cancer oversight steering group that's there is very much focused on activity and productivity, but NICaN has always been there as the quality assurance in the whole process. So I know that one of the anxieties throughout the system has been about the diminution of the role of NICaN and also then how that impacts in 14:30 14:30 14:30

terms of the clinical Chairs, and the clinical reference group, and the number of clinical Chairs. So, again, I think that's an area that's - there was a Shaklee Report that was done a couple of years ago that certainly recommended that NICaN should be strengthened. But, again, that hasn't been invested in either.

157 Q. Yes. Okay. So I want to broaden this quality and safety discussion out into I suppose what might be described as the means by which clinical - sorry, the means by which quality and safety of patients can be maintained on an ongoing basis. So you have these occasional flare-ups requiring a response to the SAI reviews, you have the response to the Royal College, but what is the mainstay for keeping the care at a sufficient level of quality and patients safe? I think the answer is to be found in having robust clinical and social care governance arrangements, isn't that right?

A. That's right. And I think built into that then are the second and third line assurances that have to go along with that, you know.

158 Q. Yes.

A. So to some extent, although, you know, it is not fully their remit, NICaN would have offered some level of assurance in relation to, you know, ensuring that clinicians, you know, kept with the correct evidence base, you know, respectfully challenged all of that, in the same way the Department of Health through SPPG will do something similar, but in relation to productivity.

14:31 14:31 14:32 14:32 14:32

Then the other part in relation to bolstering all of this then is the third line assurance, which is all of the national clinical audits that take place.

159 Q. Yes.

A. And, again, I think as Mr. Haynes probably outlined, Northern Ireland is slightly held back by the limitations of GDPR in terms of how information can be transmitted outside the system. Now there are some local workarounds in relation to that, but in order to not just deliver the system but to ensure the system is working to a high standard, it usually, you know, it would require all of those, those three levels of assurance to be in place. 14:33 14:33

160 Q. Yes. Well I want to spend probably the rest of the afternoon looking at the developments in clinical and social care governance and some of the, if you like, the tools that have been improved and deployed to make clinical and social care governance stronger within the Trust. 14:33

14:34

I want to start perhaps by exploring, and we've done it to some extent in bits and pieces through your evidence so far, I want to explore the journey that the Trust has been on, and then begin to look at some of those tools that are deployed, such as audit, such as serious adverse incidents, such as the complaints arrangements, leadership walks, that kind of material. 14:34

Let's revisit the Champion Report. We know that it

reported in November 2019.

A. Mm-hmm.

161 Q. We have from the Trust, helpfully, as of 5th March this year, an update looking at where the recommendations sit. If we can go to TRU-306233. This document, as I say, you can see the date in the right-hand corner, 5th March of this year, and it sets out in this tabular form the 48 recommendations that June Champion handed down, and we can see on the right-hand margin whether the recommendation is implemented and complete or not. 14:35

If we scroll down to item 12, I think it's several pages down. There it is there. So just to take that one by way of example.

14:36

"The integrated governance framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders."

14:36

It's also recommended that the framework provides electronic links to key corporate Trust strategies and policies and guidance. And, so, that's something that's in progress I think or not completed? It's in progress. 14:36

So there are a number, and I don't intend to take you to them all, I raise that by way of example. Why is it taking several years to move through all of what you

want do with the Champion Report?

A. I think for a number of reasons. Now, I - from memory, I think our last integrated governance framework was developed in and around the time of this, and when we've looked at it we don't feel that it's fit for purpose because it doesn't have, it doesn't take into consideration now all of the new subcommittees and structures that are in place. And, also, one of the other areas that we have to develop yet is the Board Assurance Framework. But, again, in order to develop - it's like a domino effect. 14:37 14:37

162 Q. Mm-hmm.

A. In order to develop the Board Assurance Framework what we have to do is settle on the corporate strategy and plan so that the Board Assurance Framework falls out of that. So all of these are interrelated. So once, once we get to the point of having our corporate strategy we can start to get these finalised. And I suppose what we've done is spent the time looking at really good examples of integrated governance frameworks elsewhere. We've identified what we want to do, but we've got to have these other parts in place to be able to implement this. 14:37 14:38

163 Q. Mm-hmm. This document is obviously 2024, and it shows the work in progress. 14:38

A. Mmm.

164 Q. It's clear that having received the Champion Report that you began a process of putting together, I suppose, the resources necessary, and the energy

necessary, or the support necessary to change the structures that relate to clinical and social care governance. We can see, for example, in September 2020, several months after Champion had reported and her recommendations discussed at Board, you produced a corporate governance, corporate and social care governance functions and structures proposal, WIT-47270. And for the avoidance of doubt I'm taking you through these steps so that the Inquiry can see and you can comment upon the journey that you undertook. 14:38 14:39

So this document, and if we just scroll over to the next page, sets for the Trust the ambition of being a top performing organisation in the UK, and I suppose it sets out a bit of a road map, or aspirational perhaps, but certainly some thinking about how that might be achieved. 14:39

You, within this paper, note the weaknesses in what was then described as a distributed clinical and social care governance structure, and that distributed - or is that another word for "dispersed"? 14:40

A. Yes.

165 Q. That distributed structure, in the view of the paper, and we can see it set out at WIT-47277, this gave rise to weaknesses which I think June Champion had echoed or spoke about earlier, and you're repeating in this paper, weaknesses which included a weak corporate quality assurance, an inconsistency in approach to 14:40

governance issues because there was a variable understanding of how to do things, and non-standard processing, as well as gaps.

So what were you seeking to achieve with this paper, having recognised that unpromising context? 14:41

A. So fundamentally my view was that all of clinical and social care governance should work as a business partner arrangement, that it should be managed through the Medical Director's office, and that the staff placed in each of the directorates to support their function in relation to clinical and social care governance should be managed centrally, but there to support the arrangements within each individual directorate. And the aspiration behind that was so that the learning could be shared across the organisation and we could move towards a more standardised approach to all of this, and that we could use, you know, a comprehensive body of people basically to understand and drive forward governance, rather than having this very piecemeal approach that just did not learn from the rest of the organisation, worked in isolation, and I had a concern represented the better aspects of some of the directorates rather than actually giving a full picture. And this - I think I took this paper back to the Senior Management Team, as it was in those days, a few times, to get this over the line, because there was concern about some of the individual directorates giving up their control over 14:41 14:42 14:42 14:42

governance and, again, there were some fairly robust conversations in there in terms of changing this model. Now, this is now in place.

166 Q. Yes. Could I just maybe assist your answer by looking at the proposed structure as it appeared in this paper? 14:43

A. Yeah.

167 Q. It's WIT-47279. And as you were explaining, I think that operational management was going to shift to the Medical Director's office?

A. Mm-hmm. 14:43

168 Q. Albeit that operational managers would continue to retain responsibility...

A. Yep.

169 Q. - for commissioning governance activity, so that the benefits of local knowledge wouldn't be lost to the 14:43 system. But the important thing was to ensure that there was a better corporate oversight of governance issues and that nothing was lost in a silo?

A. Yes. Yeah. Yeah.

170 Q. Does that - no doubt as this made its way through the 14:44 system there were no doubt tweaks and changes along the way, but does that principle, as I've articulated it, is that what you were able to deliver?

A. Yes. Now we're in the process - the Acute Directorate that's on that diagram on the extreme left-hand side 14:44 then, after I became Chief Executive, I think as I mentioned earlier we split that in two.

171 Q. Yes.

A. So that meant that there had to be further governance

development in there. So bit by bit we have been building up governance teams in underneath those two new structures. But, again, you know, having them work as a team with the rest of the system. And I think what I can see from that is, you know, where we have the other three directorates - and OPPC is now called Adult Community Services Directorate, that's ACSD - what I can see where those are longer established and have been more familiarised with the model, their approach is more mature than the other two directorates, but that that is work in progress and they're certainly building on that. 14:44 14:45

I think to give me some assurance that this is working in the way that we proposed, we've done some work looking at a review of the operational governance under each directorate structure to see how it works, and there have been - there has been significant learning that has come out of that, and in recent times the discussion with the central governance function has been about how they then build on some of the examples that are there. So you, you know, for example, in CYP they have a really excellent manual that shows how governance is delivered within a directorate, so the other directorates are now replicating that. Mental health, again in terms of its learning from the early learning events, again that's been replicated now across the piece in relation to that. And then one of the other areas that we have introduced to all of these 14:45 14:45 14:46

directorate teams has been what we colloquially call the Scottish heat map, which is self-assessment governance assurance framework that is used in NHS Scotland, and we've found really helpful in terms of mapping across these systems to identify where the hotspots are so that we can draw attention to them. So I am beginning to see the workings out of all of this in terms of the shared learning and improvement.

172 Q. Yes. This could only be delivered on the basis of significant investment? 14:47

A. Yes.

173 Q. In different Human Resources?

A. Yes.

174 Q. Did that come as a struggle?

A. I have to say Shane Devlin was very supportive. Once - 14:47 I mean it was my job to persuade the system that this was the right thing to do. Once we got to that point he underwrote this by saying it should be funded.

175 Q. And we can see in the papers, and I'll not turn up all the job descriptions, but in Post-Clinical and Social 14:47 Care Governance Coordinator, a patient ahead of Patient Safety Data and Improvement, Family Liaison Officers.

A. Yes.

176 Q. A Corporate SAI Chair, is that right?

A. Yes, that's right. 14:48

177 Q. We'll come on to look at SAIs presently, but maybe it's convenient to explore this now. What is - is that one person sitting in the corporate structure ensuring that SAIs are essentially processing appropriately?

A. So the corporate SAI Chair is, some of our SAI Chairs are retired doctors who have come back to undertake this function, because one of the challenges that we had in this was finding SAI Chairs in the first place and then people having the time do it. So they have been employed to undertake this function - and some of them also have other roles. And that has been really important again in terms of taking a standardised approach to all of this and helping these SAIs through the system, because they can become incredibly laborious. So there's a weekly report on, you know, the progress of all of those that comes through the weekly governance report. But in addition to this, this is partly how the early learning template was developed that is now being seen as something that's really helpful to the SAI process in the Trust and which has been developed now in each of the other directorates. 14:48 14:49 14:49

178 Q. And if the ambition of this reform was to make stronger, make more robust the corporate model for clinical and social care governance, how, how in real terms is that achieved? Can you give us an example of how this new model makes a meaningful difference? 14:49

A. I can give you some examples. I mean there is obviously the followthrough in relation to the SAIs and the early learning template that has come out of that, and I think the fact that the clinical teams now who are involved with that process moved to adopt learning that they have generated themselves and have that 14:50

embedded almost before we have the SAI process completed, which was really helpful. And, again, you know, that particular example, we move to accreditation status for SAIs in mental health and disability, and the Royal College of Psychiatrists has commended that as good practice and has, you know, suggested that that is adopted more widely than just us. So that has been really helpful. 14:50

In relation to the Datix, which I mentioned yesterday. Again, when we've looked at that, we have put Datix staff in there again to make sure that the Datix are followed through on and that that Datix system has been enhanced since I think May 2022 in terms of the span of areas that it can include so that we can use that to triangulate the data and see patterns much more readily. 14:50 14:51

Another example built within...

179 Q. Can I just interrupt you... 14:51

A. Sorry.

180 Q. In fact, and just remembering that there is a document that perhaps conveniently speaks to some of this. It is TRU-306245, and it's a report from Clinical and Social Care Governance regarding improvements, and it's hot off the press, like many of these documents, March 2024. Would I be right to suggest that this was prepared for the Inquiry, this document? 14:51

A. It's been prepared for two things. It was - so, when I

was pulling together the data and, again, we've got this for each of the work streams in ERG, it was to summarise this a bit more succinctly because it was so broad based.

181 Q. Yes. 14:52

A. So this was helpful to me. But also then in terms of the report that has been developed for ERG, this will be part of it, along with the readout in some of the other areas as well.

182 Q. Yes. If we scroll down to the next page, it sets out 14:52 across a number of areas reporting to government committee SAIs, et cetera, where there has been improvement, where improvement has been noted, and also where improvement is underway but not completed, and where improvement has yet to be achieved. So if we 14:52 scroll down, and I think you were - I think I cut across you when you were describing some of the improvements that are concrete in your view and that have emerged from this new way of doing clinical and social care governance. Do you want to - I can't 14:53 remember where I interrupted you, but you were talking I think about the Datix?

A. Yes.

CHAIR: Datix.

MR. WOLFE: Yes. Thank you, Chair. 14:53

A. Yes. Yes. So I had mentioned about Datix. The next thing I was going to speak about was FLO, the Family Liaison Officers.

183 Q. Yes.

A. And, again, their reach into all of this. And, again, that has been I think really important in supporting families or carers who find themselves, you know, part of an SAI process, and giving their feedback into the system, and supporting them, and helping form the Terms of Reference in relation to the SAIs. 14:53

184 Q. Can I pick up on reporting?

A. Yes.

185 Q. It's the first one in front of us and improvements to date are listed there. I understand, and we've talked about this perhaps in passing, that as part of the enhanced reporting arrangements, there is a weekly governance debrief meeting? 14:54

A. Yes.

186 Q. And I think as we maybe touched on this morning, that is the - that meeting is facilitated, if you like, by a weekly governance report? 14:54

A. Yes.

187 Q. We can take a brief look at that. TRU-306247. Sorry, that's wrong reference. TRU-305113. And this is under Dr. Austin's leadership? 14:55

A. Yes.

188 Q. Help us in the context of improving the governance processes to understand what this is doing in context. So you have this weekly debrief. This is a detailed report. I think the first page perhaps helpfully summarises it's significant content. So it's giving an up to the minute outline of various developments that flow from some governance tools. So here are your up 14:55

to the minute SAI situations, notifications and reports. Scrolling down. Early alerts, catastrophic incidents, and it goes on into litigation, national clinical audit, information governance, and then descriptions of various activities, including SAIs in each directorate, Trust wide governance issues such as litigation, Coroner's cases. So what is the purpose of introducing such a regular and, indeed, very heavily detailed arrangement into the system? 14:56

A. So this is the business of clinical and social care governance, and the aspiration behind this was to bring it all together in one document on a weekly basis to inform not just the Medical Director's office but the other Executive Directors in relation to the quality and safety of the system, you know, so that they can then use that to, you know, challenge the system in relation to improvement. But also then to report this to the Senior Leadership Team on a weekly basis, and I think - I mean it is a detailed document. The way we deal with it every week is that Dr. Austin takes us down through this, highlights the areas he is concerned about, and then there is challenge on that in relation to, you know, questions being asked to directors in terms of some of the immediate episodes, but also then any patterns in relation to this. So it's used in that way. But then it also underpins, in terms of the quality and safety meeting that goes to, that, you know, it goes to governance, and also whenever we're undertaking our risk and assurance meeting through SLT, 14:57 14:57 14:57 14:58

it helps inform that as well because, you know, it's very powerful actually having patient stories like this in a senior management leadership team meeting every week, and this is the easiest way we can get to it. Now these all tend to be the things that have gone wrong. 14:58

I think the next part in relation to this is how we - and this is the conversations we've been having with the governance team is, how do we now take this into a more robust process for learning? So, you know, when I look down through that I can see patterns arising in relation to, for example, insulin, or anticoagulants, or violence and aggression. So what are we doing in a concerted way to actually deal with those areas, and how do we report on the improvements in relation to that? So that's what they're working on now. 14:58 14:59

189 Q. So this gives up-to-date accessibility and understanding for the corporate team?

A. Yes. 14:59

190 Q. About what's going on in the services one-by-one.

A. Yep.

191 Q. And we can see it in the paper that each service is, or directorate, more appropriately, is represented. Contrast that with where you came from. Would this kind of detail have made its way to the corporate level? 14:59

A. No.

192 Q. Or would it have been - "lost" is the wrong word, but

would it have stayed within each directorate?
A. It would have stayed within each directorate.
193 Q. And spell it out for us, what is the disadvantage of it as you saw it?
A. Well the disadvantage of that was that we didn't know exactly, I think to this level of detail, what was going on in each directorate. And, you know, how some of these things were being dealt with. And then particularly where there were cross-directorate issues or where indeed there were cross-Trust issues, because some of these are interface issues with some of the other Trusts, because we work as a system, those wouldn't have been readily known to us unless they had become an Early Alert, or had become, you know, newsworthy on the back of all of that. So this opened up the system and I think has made it very clear to us what our business is on a daily basis in relation to patients.
194 Q. Yes. Thank you. Now, I want to move into some of the more - some specific aspects of this. If we go back to this, let me call it the improvement document, and if we go to, for example, the issue of incident reporting. So it is TRU-306248. I think - I hope I'm right in saying there's a degree of overlap between some of these sub-headings. So we have - let me just scroll back, I think I'm slightly on the wrong page. Improvements to date. So you have improvements to date, incident management, improvements to date, Datix incident management system. So the management system

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is an integral part, is it not, of incident management, but the specific heading here is to allow focus to be placed in describing the improvements on the Datix system itself?

A. Yes.

195 Q. But they're related.

A. They are. It's part of the same thing, yeah.

196 Q. And in terms of incident reporting and moving from the incident being reported into whether or not there is going to be an SAI, a Serious Adverse Incident Review, and the conduct of Serious Adverse Incidents Reviews have been discussed many times in this Inquiry, and a range of problems have been identified, everything from people finding the Datix system a bit of an obstacle, or a bit of a challenge to use, situations of where there are adverse incidents, clearly adverse incidents where the clinician has, for whatever reason - and it's usually a clinician - has failed to use the system, has failed to report it, or has reported it informally, so there's an inconsistency arising. And then into the SAI processes itself, and we've seen examples of gross delay, three sometimes four years from reportage of an incident in some of the urology incidents. Take, for example, some of the incidents around triage, or around stenting, issues that occurred on the ground in 2016 not getting to an SAI outcome until 2020, and some of the reasons for that have been spelt out to us. So, for example, getting clinicians to sit on SAI review panels and having the time to marry diaries, this seems

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to be a particular issue. So in terms of improvements to date around those issues, and where you would like to go in relation to incident reporting, Datix and SAI, can you give us a snapshot of where you think the organisation is? 15:04

A. So, Datix reporting can be cumbersome because of all of the steps involved and all of the various clicks of the mouse that it involves to get you from step to step. So certainly that can work as a disincentive. But I think, you know, as we can enhance its usefulness in 15:04 terms of, as I say, triangulating some of this data and making that readily available to clinicians, I think, you know, and simplifying it in terms of the steps that have to be gone through, which is what we're slowly working on, I think that will definitely help. 15:05

In relation to the SAI process, it's extremely cumbersome and, you know, we have different levels of - we've levels 1 to 3 of reporting in Northern Ireland. All suicides have to be reported as a Serious Adverse 15:05 Incident in Northern Ireland. That wouldn't be in keeping with the rest of the UK, for example. So, you know, if you look at our SAIs, half of them are related to suicide, and Northern Ireland has high levels of suicide. So, you know, in terms of a like for like 15:05 comparison that's not easy to make.

But I think that, and this is, I suppose, why the Departments is undertaking a review of all of this

currently and, you know, we've had Mr. O'Reilly, who is a retired Medical Director, come to present to us on what the Department is planning in relation to this to try and improve this system and make it more accessible, but in the interim I think the way we have found into this has been through the SELT process that I described earlier and the take up of that. So, you know, for example, as I said, mental health is an early adopter of it, and what we found with them is that they will now start to use it not necessarily just for serious adverse incidents, but if they have a case that they're concerned about and think is particularly complex, they will - particularly in the addiction service - they will step into that space and use the SELT basically to do a comprehensive formulation on the patient with, you know, a diagnostic in terms of how do we move this forward and actually improve on our learning? You know, what can we do to reduce the likelihood of harm? And they'll use it in that way. So maturationally I can see that that has been adopted. 15:06 15:06 15:06 15:06

And certainly when I have spoken to the Chair of the SAI panels, you know, his view very strongly is that the way into this is not through - in terms of driving learning, which is what SAIs were designed to be but actually don't completely realise, and end up being, as I say, a very protracted sometimes, you know, feeling like a very punitive process, the way into it is actually to give the clinical teams more input at an 15:07

early stage in describing the problems themselves and then generating the learning so that then the system can pick up and run with that. So that's how we're trying to pursue this in order to get the learning into the system, which was what the original SAI process was designed for. 15:07

197 Q. The problems I have alluded to at the start of this section that have come through the evidence, we can see from the papers the investment that has gone into trying to perhaps address some of the problems. You have invested, as we can see here, in a Datix upgrade. We can see that a Datix systems manager has been appointed. On the adverse incidents, or the serious adverse incidents, you talked about the corporate SAI appointment. There is clearly greater visibility in terms of the process of dealing with SAIs, these are the subject of report into the weekly debrief and they do reach the Governance Committee and, indeed, as we saw this morning, the SAIs are the subject of discussion on the one-to-one meetings between the Divisional Medical Director and the Medical Director once a month. So a lot of work appears to have been done. What's your sense of it now? Is there a better culture in terms of willingness to report? Is there greater emphasis in trying to move SAIs through the system in a more expeditious manner so that the learning is achieved quicker and at a time approximate to the incident when it's most relevant? Are those kinds of issues being addressed? 15:08 15:08 15:09 15:09

A. I get, you know, these are hard to put a figure on, but certainly I think since we introduced the weekly governance reporting I think that has changed some of the narrative within the organisation because, you know, every week, you know, staff across all of the Southern Trust know that we are interested in patient safety. And, you know, some of that has figures against it, some of it hasn't, and they know that every week as the Senior Leadership Team we will be interested in this. So I - you know, as I say, it is hard to put a figure on, but my sense is that it has encouraged people to speak up if they're concerned, and also to realise that, you know, as we have worked our way through some of these problems, that they're not impossible to deal with, you know, there are some solutions to these things. 15:10 15:10 15:10

198 Q. Yes.

A. Yes.

199 Q. And the availability of a process which measures when each SAI commenced, and the next stage, and the next stage, and the ability to see that there is delay or things are taking their time, and is that explained by some unnecessary delay? Is that helpful to expedite? 15:11

A. Yes, and I think that's what led us then to appoint, you know, some of the external SAI Chairs, because we realised at an early stage that, you know, the demand of chairing an SAI on top of a heavy clinical workload was too much and was too complicated. So that definitely has helped in terms of the efficiency of the 15:11

system. And I think because there's a small group of people who are coalesced around this, then I think it has made it more straightforward for them to bring the learning out of all of that to the forefront a bit more readily. 15:12

200 Q. I'm conscious that this document goes on to explain what you feel there is yet to do by way of improvement. So just if we scroll down to the next page. So you've improvements underway in terms of incident management, and they're set out there - notably the development of 15:12 the Oversight Group, which still has to finalise it's Terms of Reference. The development of a Trust SAI Policy and Procedure to assist in standardising. I had assumed, and maybe we'll go to this now, there was - at TRU-306311, there was an updated policy for reporting 15:13 and the management of adverse incidents, is that simply in draft and it's to be finalised?

A. No, it was accepted, but I think now that we're a bit further through in relation to understanding the process of the SAIs better, and now that the SELT 15:13 process is developed, I think what they're planning to do is to revise this even before the 19th December next year to develop that even a bit further. So I think, I think that's the most recent version of it, but I think there's still - they're planning a Version 3. 15:13

201 Q. Yes. Could I just ask you about the concept of just culture which finds its way into this policy.

A. Yes.

202 Q. If we just pick it up five pages in, 316 in the series,

and scroll down quickly. Thank you. We can see it there. Tell us about that principle and how important it is in terms of the, I suppose the modern climate of dealing with incidents that are perhaps harmful, but you need to know about them and you need to learn from them.

A. Mm-hmm.

203 Q. And there may well be a reluctance to communicate adverse incidents if there is a belief perhaps that there might be a punishment for the perceived wrongdoer. So does the principle or the concept of a just learning culture come in there?

A. Yes. I think I mentioned earlier, you know, the evidence base for this comes from the Drucker work in relation to just an open culture and, again, it is nested very firmly in the idea that, particularly in safety organisations - and, you know, the NHS is like the airline industry, it is a safety organisation - that incidents rarely happen because of, you know, a bad actor in the middle of it all, it's very often to do with a system not functioning in the way that actually yields the best result. So part of the approach that we take in relation to this and, you know, what we've tried do is inculcate a lot of this through simulation training.

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So to give you an example. When our foundation Year 1 doctors are new into the Trust, as part of their induction in July/August, what we now do is take, you

know, the serious adverse incidents that have happened at the time of handover in previous years and simulate that whole process and how to manage that as a system in a team. So that actually what we're encouraging them to do at an early stage is to recognise that, you know, if you, you know, fail to write a prescription properly or, you know, there's a wrong prescription produced in some shape or form, that that does not necessarily fall to one individual, that's about a system. Or, you know, if there's confusion over how to run an arrest call, or any of those things, to fall back on the system and your colleagues in terms of the support and to describe that at an early stage. 15:16 15:16

And as we started to introduce that, I think it was maybe about three years ago now, that really yielded a lot for us, and I think helped us really drive this forward because, you know, what we noticed as well was it reduced the number of juniors coming through at an early stage who were struggling in the first few months because, you know, bearing in mind that up until that point, other than shadowing or doing the "if why not", they hadn't very much experience in relation to all of this, but this was a game-changer from our point of view, and we were able to identify, you know, for example, junior doctors that might need additional support in terms of, you know, extra support at night. All of those things to help us through that. 15:17 15:17

And I think on the basis of that we have now extended that approach. You know, if we have serious adverse incidents, or we're approaching new problems that we haven't encountered, areas that we think might be new problems that we haven't really dealt with before, we will run simulation through it to gauge what the impact of that is going to be and then to take the learning back into the system. 15:17

And I think in relation to this that that helps, because within the safety of that team the individuals hopefully are supported to speak up and to recognise that this is a systems approach, but also I think then can readily see that they've also got to help each other, you know, whenever they're in times of difficulty. So we have found that useful. 15:18

And, again, I now hear it being talked about in relation to not just medicine but, you know, the nurses will run simulation, admin will run simulation, just in terms of, you know, gaming their way through processes to see what can be done. So that's helpful. 15:18

And I think, you know, this marries as well with the, you know, low level concerns reporting that's being encouraged, and the open approach to whistle-blowing, all of that, to try and encourage the organisation to speak up, you know, if they have concerns about anything, so that actually it can be dealt with at an 15:18

early stage.

And I suppose, you know, I do - on a Tuesday after the Senior Leadership Team every week, and this is the beauty of Teams -I do a Teams out across the Trust where we talk about, you know, some of the things that have happened throughout the week, but also some of the things that we've learned about, and at times I will reflect on my learning from that and what I've had to speak up about in order to try and model that throughout the system. And, certainly, you know the directors make a very concerted effort in the same way to talk about the things that haven't worked well and what has been done about that, just to try and drive that culture of "This is the way we do business, we expect you to say". 15:19 15:19 15:19

204 Q. Okay. So it's setting that example?

A. Yes.

205 Q. A couple of points, further points on the whole SAI area before we conclude with a break. Going back to the improvements document at TRU-306249. Just under - just scrolling down. Yes. So this is just in the middle of the page, "Work Still to Be Done" is the inclusion of SAI recommendations in the triangulation of governance activity information. And, yes, the need - just above that, the need for - I thought there was - yes, it's there. 15:19 15:20

"Audit evidence provided to support SAI recommendations

which have been fully implemented."

So it seems that there are two quite important items that are still on the to do list?

A. Yes. In relation to the SAI recommendations, I think, you know, as that team has reviewed what has come out of this in the past, you know the recommendations that come through Serious Adverse Incidents should be smarter, you know, just in terms of meeting that criteria and, you know, the "E-R" at the end of "smart" now is in terms of, you know, being subject to evaluation and also being resourced, right. So that features in the discussions around this. So one of the frustrations in all of this is that we have hundreds of SAI recommendations across the organisation. So, you know, what they're being encouraged to do is to pick the themes out of that to try and get the work done, because otherwise I think it feels far too overwhelming for the directorates, and they're never going to get to the end of it. So there's work being done in relation to all of that. And then that automatically lends itself to audit in relation to, you know, in the same way as we've seen in this process, you come back to see whether or not those recommendations have been embedded. 15:21 15:21 15:21 15:22 15:22

The other area that's down below that that I think is worth mentioning, is the development of the professional governance information system. Now,

Dr. Austin, who is the Medical Director, he was involved - when he was Deputy Medical Director in the Belfast Trust he was involved in developing this for the Belfast Trust in the course of the Neurology Inquiry. So essentially what this will aim to do is, all of those pieces of information that we gather manually currently, in terms of bringing them together in assuring the appraisal and revalidation of doctors, we're moving to develop an electronic system to do that so that we have, you know, a dashboard where you can see immediately where everybody is on the page in relation to that. So that's part of the work he's taking forward. 15:22 15:22

206 Q. Yes. I just want to finalise SAI by asking you for your observations in light of a patient perspective that we have received through the evidence of Meadhbha Monaghan, who is the Chief Executive of the Patient Client Council, and indeed it's probably broader than that, we have received some evidence directly to the Inquiry from patients in relation to some misgivings about how complaints have been addressed, and even arising out of the - I forget now whether it was the SCRR process or the Lookback process, but some concerns about how aspects of that were handled. Maybe come back to those general sense of disappointment in a while, but more specifically in terms of what Mrs. Monaghan has said, and this was in her transcript at TRA-11363 to 365. She said: 15:23 15:23 15:24

"I think more needs to be done internally to the Trusts..."

It might have been "by the Trusts":

15:24

"...to recognise a switch in approach of how they respond to complaints and patient feedback. I think that a lot of work needs to be done to take on board and absorb the need for family engagement in that the needs to be integrated right throughout the complaints 15:25
or the SAI process, ensuring that there is a culture around that."

And then she, I suppose, supported that observation by something said in her witness statement. If we bring 15:25
up her witness statement, it's at WIT-106704? And she's explaining in her witness statement that prior to contributing - no, 106704. And at paragraph 201, she is reflecting that the PCC reached out to families before completing this witness statement to seek 15:26
observations in respect of their experience, and one family experienced, she says here:

"...a Level 2 SAI review following the death of a daughter or a sibling through suicide while under the 15:26
care of the Southern Trust."

And that patient's experience of working through the SAI process is reflected here and there are a number of

grievances set out there. I won't read them all, but there seems to have been, one of the themes is perhaps a lack of transparency, a lack of information as to how records could be obtained, no discussion about the level of the SAI, lack of appreciation that the Terms of Reference could be the subject of discussion - problems like that. And scrolling over the page, no input, or lack of family input, in terms of the review process. A range of concerns. 15:27

Now I appreciate that - is it across all of the directorates that a family liaison officer is now embedded?

A. Yes, and I think if I am right in recognising this particular case. 15:28

207 Q. And I suppose...

A. This predated ...

208 Q. I didn't really want to...

A. Yes.

209 Q. While we have that specific case, I don't want... 15:28

A. Yes. Yeah.

210 Q. I want it to be more general than that, I suppose.

A. Yes. No, but I think just to say importantly, I mean it was learning like this that we took in, because there was a period of time for about a year when I was also Director For Mental Health and Disability as well as being Medical Director, so I am familiar with this because it was part of what I came into. And it certainly, it was some of the learning that came out of 15:28

this and other cases that I think helped us get to the point where we developed the family liaison officers, and we used the opportunity, you know during Covid, to actually develop that even further, because we recognised how important that communication was. So I completely understand this. I don't disagree with anything that's written down there. And, again, this has been what has driven improvement. So I would hope that people who come through the family liaison officers now are having a better experience, and certainly that seems to be what is being reported to us through the Serious Adverse Incident process, that they certainly I think find where the SELT is done at an early stage I think they find that helpful because they can get to see the team's thinking about their person essentially, in terms of who they were connected with, and I think they can also see the level of work that goes into, you know, everyday care of a patient. But also I think they really value the contact and the support that they get from our family liaison officers, who are very experienced in all of this.

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So I do recognise that this was certainly very live in the past, but I would hope that now that we have this in place that's definitely a better experience, and it is across the whole organisation.

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211 Q. Yes. And that's helpful. Except I suppose when you look at Ms. Monaghan's evidence...

A. Yep.

212 Q. While you say we have reacted or responded to this kind of thing by the steps that you've taken, Ms. Monaghan's evidence nevertheless is the family should be central and integral to the SAI process and the complaints process? 15:30

A. Yes.

213 Q. And maybe the work that has been undertaken hasn't fed through the system, maybe there isn't yet a noticeable change of approach, judged by what she is saying in obviously her pivotal representative role? 15:30

A. And you see I don't know whether that was an historic case or a live case, and my sense is that it was historic. But, I mean, I obviously don't know.

214 Q. Yes, but my point is she...

A. Yes. 15:31

215 Q. She has gathered this evidence and she is in a position, assumedly as Chief Executive of the PCC, to have a sense of what is going on in Trusts and how they relate to patients and families?

A. Yeah. 15:31

216 Q. And whether that's historic or not, her current evidence is, you guys in the Trusts need to make families and patients more central/integral to these processes?

A. Yes, and I wouldn't disagree with that. 15:31

217 Q. Yes.

A. And I think it is, you know, if - and I appreciate that this is a case study of one, and we can certainly look at the experiences across the Trust of all the families

that we've dealt with to see if we have changed in relation to that. But I would hope that that - I would hope that that isn't the case today, but we can certainly have a look at that and see.

218 Q. Yes. Okay. That brings me to the conclusion of SAI. 15:32

CHAIR: Yes. I think we'll take a 20 minute break and come back at 10 to. Is that 20 minutes if my maths is right?

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS: 15:32

CHAIR: Thank you everyone.

MR. WOLFE: I would like to conclude this afternoon, Dr. O'Kane, by seeking your observations on the 15:52 strengthening of the clinical audit function within the Trust, and we dealt with this very briefly yesterday.

You will recall that within one of your witness statements at WIT-44973, you observed when you were 15:52 Medical Director that the Trust clinical audit function has been significantly understaffed, and we can also see that you brought forward in January 2022, a proposal to reinvigorate clinical audit within the Trust, and we'll take a brief look at the journey that 15:53 you undertook in order to rebuild the clinical audit function, as you describe it elsewhere in your statement.

So if we go to TRU-305373? As I've said, this is a proposal which you brought to senior management meeting in January 2022, the title "Patient Safety and Clinical Audit Resourcing Proposal Strengthening Structure and Function." Just over the page you, I suppose there's a summary of what you had in mind, and it records that you were recommending the establishment of a dedicated clinical audit function and a strengthened patient safety patient data, and improvement function, and you're putting some costings around that, and the resourcing that was required, and you, it's summarised here, identified that the clinical audit strategy had noted that insufficient resources were available to support the organisational function, so you needed, or you believed that, looking on down the page, that if the Trust was to address the areas of concern it needed to get it's act together with regards to audit, and you picked up that, or this notes picked up that: 15:54 15:55 15:55

"Measurement of safety and audit outcomes are key elements for triangulation integral to good governance, the role, improvement and assurance underpins quality service provision, part of the overriding Trust objective of promoting safe, high quality care." 15:55

15:56

So that was the sell. You thought it important.

A. Mm-hmm.

219 Q. You had been in the organisation for approximately three years at that point?

A. Mm-hmm.

220 Q. What were your observations in that period of time leading to this paper, and should this paper not have come sooner in terms of the need to improve the audit function? 15:56

A. Yes, in retrospect I think if I had had it there sooner it would have been helpful. There was significant funding, as you know, put towards the original governance proposal and, again, you know, the development of all of that took a bit of time. And 15:57 then I think, you know, we were faced with just the challenges of the pandemic and the whole system changes that took place in relation to all of that, and that slowed down a lot of processes. And, you know, as we emerged from that and, you know, continued to do the 15:57 work around the Urology Inquiry and looked at some of what came out of our experiences with Covid, I think, you know, it was on the basis of that that I pushed on to get this over the line in relation to the audit function. But you're right, I mean ideally I would 15:57 have liked it done a bit sooner, but I think, you know, there were competing pressures at that point in time and then we brought this forward. And I have to say, in the course of its development, you know, it has certainly, I'll know you'll come to it in a minute, but 15:57 actually it has achieved quite a lot, so, yeah, it has been worth doing.

221 Q. Yeah. And, again, I think we touched upon this briefly yesterday. You're going to Senior Management Team

asking for a substantial pot of money, maybe not terribly substantial in the context of the broader budget, but a Trust has all sorts of financial pressures. So £600,000, you know, it's a long conversation I imagine? 15:58

A. Mm-hmm. Yes.

222 Q. But that resourcing should have been there, but wasn't there following the 2018 review?

A. Yes.

223 Q. Is that just - I think I touched on this yesterday, but I just want to be clear - is that the result of just choices made by a Trust? It could allocate £600,000 to get the resources into place necessary to promote good audit, but other things were prioritised by the Trust so it wasn't done. In you succeeding in your bid for this money other things are not going to be done, is that just the way to understand it? 15:58 15:59

A. Potentially, yes. I mean it wasn't - it wasn't I think just as acutely obvious in 2022, but, you know, as we come into the financial year for 2024/25 and our budget is greatly restricted, there will have to be choices made around a lot of these things, yes. 15:59

224 Q. Mm-hmm.

A. Yes.

225 Q. But, as I understand it, and you can help me through this, you secured additional funding to rebuild clinical audit, and appointment was made, a Head of Clinical Audit? 15:59

A. Yes. Yes.

226 Q. And he or she took the lead in rebuilding the infrastructure, I suppose?
A. Yes.
227 Q. Leading to some of the developments around audit that we've seen? 16:00
A. Yes, that's right. Yes.
228 Q. Can you just outline some of those for us? I see the development of a clinical audit policy, there's a clinical audit strategy that sits alongside that, there's a clinical audit reference group. 16:00
A. Mm-hmm.
229 Q. And the product of all of that infrastructure building is that the Trust now participates in a significant number of national audits, and your clinicians, judged by some of the evidence we have received, now feel 16:01
better supported to perform meaningful audit, audit that's compliant with the requirements of meaningful audit as opposed to exercises that maybe don't tick the appropriate standards for good audit?
A. The Head of Audit is Fiona Davidson who has taken a 16:01
really comprehensive approach to all of this and, you know, the work she produces is excellent. She followed through on the national advice in relation to HSCIB in relation to - which is the Health Safety Improvement Executive and Board I think it's called. But 16:01
essentially they provide a lot of the national guidance in relation to what audits should be around, they conduct national audits themselves and, you know, in terms of how to approach building this up she followed

their advice in relation to this, and that has got us to a place now where there are about 70 national audits per year and we're now taking part in about 30 of those per year. Some of that is restricted by the fact that we're not a tertiary centre and also some of it is restricted by the GDPR processes in terms of information that can be passed outside the system. We also take part, alongside this, with national benchmarking. So we are part of the national data benchmarking for stroke services, and for mental health and disability, and a few others, you know, just so that we can then compare ourselves in terms of our resource across the piece. So that's really helpful. Then there are the local audits that have to be carried out that drive service improvement. You know, for example, the SNAP audit, which is do with stroke, and then locally the team audits which are more do with areas where teams are concerned about their performance and function and they are keen then to benchmark themselves and then audit against benchmark criteria and then drive improvement on the basis of all of that, and that should now start to drive our quality improvement programme, because we have a small quality improvement team, and actually what we now need to get to is the point of the audit team and the quality improvement team working together to drive the improvements around some of this. So that has been the journey of this to date.

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And alongside, you know, setting the strategic direction with this, and building up the approach to audit, she has also, with the team, undertaken training and development with particularly medical and other staff in there in terms of teaching them the discipline of audit. So all of that has been ongoing at the same time.

230 Q. Yes. Let me just a little more meat around that. If we go to TRU-305501, we'll find a Clinical Audit Assurance Report to the Clinical Audit Reference Group from December of last year. And if we go to the next page we'll see that at top of the page there, in the period seven months or so through 2023, 117 clinical audits have been centrally registered. Is that a significant increase on activity compared to the previous year when you went to seek the funding to set this thing up?

A. Yes. It has at least - I don't have the figure at the top of my head, but it has - my sense is that it has at least double, if not more.

231 Q. And just scrolling down to take some of these headlines. It says:

"Audit follow-up processes are embedded and have continued to see a level of feedback and engagement on the completion status of registered audits."

Although the Trust is to establish a repository of audit actions or recommendations for further

improvement. Is that something that's being grappled with?

A. Sorry, which paragraph?

232 Q. Sorry, I'm at - the first bullet point is "Audit follow-up processes are embedded"? 16:06

A. Yes. Yes.

233 Q. And it goes on to say:

"However the Trust is to establish a repository of audit actions or recommendations so further improvement 16:06 is required to requests from the Clinical Audit Department for evidence of follow-up."

That must - in order to generate improvement that's the kind of foundation, can I suggest, that needs to be in 16:06 place?

A. Yes, it does. Now, I think some of the challenge in this - because obviously the wider audits are easy to capture, or easier to capture, in that they have to be registered nationally and then they're reported and all 16:06 of that. It's the local ones are the challenge because there has always been a tendency for people to go off and develop audit projects and then just present them without registering them or without actually, you know, establishing standards and doing it properly. So part 16:07 of what she is working with at the minute is trying to standardise and improve on all of that.

234 Q. And then we can see clearly evidence of some forward planning, the clinical audit department working with

directorates from early January to provide an updated position in advance of directorates planning for their next year programme, as you alluded to. Further resource being brought in with training capacity.

16:07

And just if we go forward to TRU-305511, this is Urology Improvement Division. And if we go over - so this is a report that sits on the back of that, I think. If we go through to 305516, we can see that the Urology Division now has an annual audit programme, and 16:08 that particular service, Urology, has, it appears, been the subject of particular support to improve it's audit output. Is that -- is that available because of the circumstances in which the Urology Service finds itself in? In other words, are you able to lever greater 16:09 support, not just for audit but in general for the Urology Service, because of the Public Inquiry and all of that?

A. Yes, I think that's fair to say. I mean there is -- and sorry I said HSCIB earlier, it's HQIP, and that's 16:09 who set the standards. I think it's fair to say that there was a lot of internal audit activity around Neurology that we had asked for, and that obviously generated improvement plans, but also I think curiosity in relation to some of this, together with some of the 16:09 things the clinicians were concerned about, you know, falling out of the Lookback Review and other things. So there has been - there is audit going across the entire Trust, but there has been a concentration of it

in Urology I think to try and support the improvement that needs to be done within Urology but also, I think, as a test bed in relation to, you know, developing the working model with clinicians in order to become involved in this and then deliver out on the audit, on the audit cycles. Because this was not a normal way of working in the past, and for some people they hadn't done any audits since they were trainees. So it was always going to take a bit of time to get everybody educated back into the model of it again. 16:10

235 Q. Yes. If we go through to TRU-305535. We can see that arising out of audit a number of key messages are brought together and communicated to the Senior Management Team and Governance Committee. There's a long list of examples I think from 28 areas on my count. Is that - just scroll up. This first one relates to Intensive Care. The next one in relation to Blood Transfusion, et cetera. You talked about the next steps being in terms of bringing the learning side of the Trust, the learning function together with the audit and making it work in a meaningful way. At what stage are we at with that? What is the, and we see some in front of us here, concrete outputs from audit, messaging going to the Senior Management Team and to the Governance Committee. So it is a positive, I suppose, that there is messages out there around risk and the need to improve on things. But what's the next step in terms of developing the learning? 16:11 16:12 16:12

A. So there will be two approaches, but not disconnected

from each other. So some of what is emerging from the clinical audit programme, particularly in relation to Urology but, you know, as we move further into auditing, appraisal, revalidation, all of those aspects, you know, in connection with the Neurology Inquiry and then, you know, the work that's being done to support IHRD, that will drive the improvement that comes through the work of the Director for Transformation and Improvement, because the quality improvement team will work directly to her but will be fed by clinical audit in terms of identifying clinically what needs to be done in terms of improvement. 16:13 16:13

The other part of this then is the feed that goes back directly into each department or each directorate. So, for example, when I look, you know, at the ICNARC data at the top, I mean the, you know, part of what this has helped to drive is we're just in the stages of completing an additional side room in ICU on the basis of the overcrowding and demand essentially, and there are plans afoot then to develop another room then beyond that. And, again, some of what has driven that has been the audit data in terms of the ICNARC outputs and just how all that fits together. 16:13 16:14 16:14

236 Q. Mmm.

A. And, again, in relation to some of the other areas that you've highlighted there, in terms of blood management and adults undergoing elective scheduled surgery, again

it's about thinking about how we support all of that. And, again, that has provoked some conversations around how, you know, surgery works with blood bank and everything else. So all of this feeds into the directorates because, you know, the beauty of clinical audit is that it is also owned by the clinical staff, so, you know, this should become part of their narrative within each of their divisions in terms of driving improvement. 16:14

237 Q. Yes. I bring those up just as random examples. 16:15

A. Yes. Yes. Yes.

238 Q. We can see, just to finish, that there is an awareness of the need to strengthen and improve, albeit I think you would probably acknowledge this is a relatively immature introduction, or service, or system, and I suppose the need for strengthening and improvement is but natural at this stage in the development. 16:15

A. Mm-hmm.

239 Q. But we can see that at least it is recognised that strengthening is required. The document is at TRU-305366. And it goes through a number of areas, commencing with "Strategic Level Improvement" and working through I think five other areas. 16:15

We can see just in terms of what you have just said, I think if we go to TRU-305371, it's a short five or six page document which the Panel will no doubt have a look at, but "Strengthening and improvement work in remaining areas". So there's the need to develop a 16:16

quality manual.

A. Yeah.

240 Q. Clinical training - clinical audit training, which is in development for this year. And then over the page, the point that I think we've been on: 16:17

"Improving, learning, and assurance through strengthening the quality of legal audit activity and it's integration in the wider governance processes." 16:17

Is there anything else you wish to add in relation to the progress that's been made with clinical audit and what it does for you in terms of your assurance needs as Chief Executive?

A. Well particularly, you know, now that we're in a stronger position in relation to, you know, regional and national audit, and in terms of the audit programmes that are happening internally, it gives more robust assurance at every level, you know, first, second, third line. And, you know, it means, we can, 16:17 16:18 you know, we can stand over the information that we get back. So I mean it has definitely strengthened that, because previously some of that wasn't very clear.

241 Q. Yes. I want to start in the morning, tomorrow morning, by looking at other issues around metrics and the use 16:18 of data. Obviously with audit it's not just about metrics, other forms of messaging or information come out of audit, but I think you might acknowledge that the External Reference Group have suggested that

further work should be contemplated around the use of metrics to enable you to better pursue your quality and safety agenda. So we'll commence with that in the morning.

A. Okay. Thank you. 16:19

CHAIR: Okay. So that's us until 10:00 o'clock tomorrow morning, ladies and gentlemen.

THE HEARING THEN ADJOURNED TO THURSDAY, 14TH MARCH 2024 AT 10:00A.M. 16:19