Urology Services Inquiry

Oral Hearing

Day 93 – Tuesday, 9th April 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 TUESDAY, 9TH APRIL 2024, AS FOLLOWS:

CHAIR: Good morning everyone. Apologies for the delay. I think we're back to "Technical Tuesdays". And in fact we seem to have difficulties on a great number of Tuesdays, but hopefully we can get on with things now. So, Mr. May.

MS. McMAHON: Good morning, Chair, members of the Panel. The witness this morning is Mr. Peter May, who is the Permanent Secretary of the Department of Health, and he wishes to affirm. 10:13

MR. PETER MAY, HAVING AFFIRMED, WAS QUESTIONED BY MS. McMAHON KC AS FOLLOWS: 10:14

MS. McMAHON: Good morning, Mr. May. My name is Laura McMahon. I'm junior counsel for the Inquiry. We met before, so welcome back.

A. Yes, good morning. 10:14

1 Q. You were our first witness a while ago, and you're almost our last, but today you've been called back so that the Panel can get an update on where we are since we started, and perhaps some further clarity on some evidence that's been provided by other witnesses as well. So, you have previously provided written evidence in the form of a previous Section 21 notice, and for the Panel's note that was dated 18th August 2022 and can be found at WIT-42367. You also gave 10:14

evidence previously on 15th November 2022, and for a note, the transcript of that can be found at TRA-00707. And after you gave evidence you kindly provided us with further information and clarity on issues that had arisen on that occasion, and the response to questions that we've asked can be found at DOH-71042. And those replies are dated 15th November 2022.

In order to allow an update, we sent you a Section 21 No. 1 of 2024 earlier this year, and you replied to that on 22nd March 2024. And if we can just go to that Section 21 notice at WIT-107060. And you'll see that that's No. 1 of 2024. Your name is at the top of that statement. And your signature can be found at WIT-107122. Do you recognise that as your signature? 10:15 10:15 10:16

A. I do.

2 Q. And it's dated 22nd March 2024. Do you wish to adopt that as your evidence?

A. Yes.

3 Q. Now, we will be relying substantially on that statement. I'm going to pick out some of the issues that you've brought to our attention, and you've provided an addendum to that notice more recently, and that can be found at WIT-107624. Again, your name at the top of that and your signature can be found at WIT-107640. And, again, do you recognise that as your signature? 10:16 10:16

A. I do.

4 Q. And the date is 29th March 2024, and do you wish to

adopt that as your evidence?

A. Yes.

Q. Thank you. Now, the addendum statement provides us with further information, and I'll go between the statements as necessary just to draw the Panel's attention to where we're at at the moment. But for the purposes of today, the structure of your evidence, I will take you through some of the headings that we'll cover within the time allocated. Firstly, we'll look at the SPPG structure and the new commissioning arrangements. Secondly, we'll look at Information Systems in Health and Social Care. Thirdly, Standards For Quality and Patient Safety. Fourthly, we'll look at reform and reviews. Then we'll look at culture and driving change. No.7, we'll look at workforce issues. 8, we'll touch on innovations around hearing the voice of the patient. And lastly we'll look at learning from other inquiries and what's anticipated the learning from this Inquiry and how that might be managed going forward.

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So, what I plan to do is just take you to various sections of your Section 21 and ask for some clarity or explanation as appropriate.

10:18

Now, the starting point of your further Section 21 is that since your evidence on the last occasion the Inquiry had the opportunity to hear from your predecessor Richard Pengelly, and you reviewed

Mr. Pengelly's statement and evidence, and although you have, don't have knowledge of all the aspects that he refers to, naturally as you took over from him, you were in overall agreement with the evidence provided by him? 10:19

A. That's correct.

6 Q. Now, just moving on to the first heading "SPP Structure and the New Commissioning Arrangements". Now, we have heard from Paul Cavanagh and Sharon Gallagher, who provided evidence on behalf of SPPG, and they explained 10:19 the new structure, just some of the nuances around that, just so we're clear in our understanding of that. They are no longer an arms length body. The HSCB prior to that had been, but the positioning of SPPG changes that somewhat. And as we understand it, the SPPG sits 10:19 within the Department and under your general authority, is that a fair explanation of that position?

A. Yes, it is. I wonder just before I say more if I could just make two very brief introductory comments? The first of which is to reiterate the apology I made on 10:20 behalf of the Department to all of those who have been affected, including particularly, obviously, patients and families in relation to the work of the Inquiry. And, secondly, just to recognise the huge amount of work that this Inquiry has already done over 90 days of 10:20 hearings. And I realise, as you said, you're nearing the end of that particular phase of the work of the Inquiry, and just to signal my intention today is to try to assist the Inquiry as best I can. If at any

point there's a question I don't know the answer to, particularly if it's factual in nature, I would like to offer that I would write to the Inquiry and provide that information thereafter, if that's acceptable to the Inquiry? 10:20

7 Q. That's very helpful. Thank you. And if we do come across any queries that either I can't explain further on the evidence or you need more information about, we can follow that up in correspondence after today's evidence. 10:21

A. So just turning then to the SPPG and it's place in things. You're correct to say that SPPG is now part of the Department of Health. The Health and Social Care Board was it's predecessor and it ended in 2022. Indeed the life of the Board ended the day before I took up my role. So I wasn't party to the legislation and the detail of the legislation, but I understand that a succession of health ministers had taken the view that the commissioning space was overly cluttered and that they wished to try to create a simpler and more straightforward approach, and that the removal of the role of the Board was one element of that, as is a more general change to the way in which commissioning takes place. 10:21 10:21

8 Q. And one of the outworkings of this renegotiation of the structures, it sounds like it was based on a desire for efficiency around commissioning, but one of the outworkings of that was that we've heard that the duty of quality doesn't apply to SPPG and had applied to the 10:21

previous Health and Social Care Boards. You've provided further detail on that in your addendum statement in, and in summary form it would appear to be that because of the functions now carried out by SPPG and the way in which services are reconfigured under this new structure, that the legislative requirement, or the attachment to a duty of quality under the legislation to the HSCB falls away under SPPG, purely by drafting mechanisms it seems, but can we assume the expectation is that the duty of quality in general terms, although not a legislative requirement, is something that is imported into the mindset and the service provision of SPPG? 10:22 10:22

A. Well, absolutely, it's still a critical part of the work that SPPG does to oversee the quality and safety agenda working in partnership with the Public Health Agency. The reason for the change is that in 2003 when the duty of quality was first introduced, it was specific in relation to -- for care for individuals. At that time the predecessors to the Health and Social Care Board did have some responsibilities for care to individuals, particularly in the childrens and social care space. Those responsibilities were transferred in 2009 when the Health and Social Care Board was established, but in practice the Board itself didn't perform those functions, it delegated them to Trusts. Clearly if it's legally responsible it still had an accountability for the delivery of those functions, but in 2022 the decision was made that those functions 10:23 10:23 10:23

should sit with Trusts, they had been carrying them out for many years, and it made more sense for Trusts to have that role. Hence the SPPG no longer had a role in relation to individuals. So, as you say, it's a consequence of the way in which the legislation was drafted that the duty of quality then didn't apply to SPPG in that formal sense. But there are many ways, and we'll come on to them no doubt in the rest of the evidence, in which SPPG does play a critical role in relation to the quality agenda. 10:24

9 Q. If we look at your statement at WIT-107063, you've made reference to broad oversight arrangements in relation to SPPG at paragraph 9. And when you say "the group", in this context you're referring to SPPG, and you say the following: 10:24

"The group is subject to the same scrutiny as the rest of the department by the Departmental Board which includes two Non-Executive members. The Department's Audit and Risk Assurance Committee was established to 10:24
advise the accounting officer, through the Departmental Board, on the quality of assurances they receive about strategic processes for risk management, governance, internal control and the integrity of financial statements. The Committee membership comprises of two 10:25
Non-Executives of the Departmental Board and a further two independent external members. The oversight of the committee extends to SPPG and those former functions of the Board which are now under the direction of the

Department."
There had been some evidence received from some of the other arms length bodies around the oversight provided to them by their own individual boards and how they considered that to be significant in terms of governance. Are you content that the new arrangements allow for the continuity of good governance in relation to the functions, the now functions of the SPPG?

A. Yes. I think the other thing that isn't drawn out in paragraph 9, and perhaps could usefully have been, is, the Department is accountable to the Northern Ireland Assembly, and the Health Committee very directly, and the work of that Committee will oversee the work of all of the Department, including SPPG. Obviously the Committee also looks at the work of arms length bodies, but it tends to have a particular focus on the Department.

10 Q. If we go to the next page at paragraph 15 and 16. When the Chief Executive of the RQIA gave evidence she informed the Panel that the SPPG, or the RQIA, has no oversight role in relation to SPPG, where they had had previously with HSCB, and you deal with that at paragraph 15 and you say the following:

"The change in legislation under pins the organisational and operational position that SPPG does not provide care to individuals and as such the Regulation and Quality Improvement Authority (RQIA) has no oversight role in that regard."

And at 16:

"The new relationship with SPPG is being redefined and will reflect SPPG's constitution as part of the Department and its core functions as set out above." 10:27

So that explains the reason why. Again, it falls back to the reconfiguration. When you say the new relationship with SPPG is being redefined, what is it that you're referring to in that particular paragraph? 10:27

A. Well, I think that the logic is that it may well be that there needs to be some form of a service level agreement or something that's put in place, or a Memorandum of Understanding, as to how the RQIA can take account of the functions of SPPG where they're relevant. 10:28

I think for me it wouldn't be sensible to suggest that RQIA would be the right organisation, for example, to do a review of commissioning or planning within Health and Social Care. But if they were doing a scrutiny, or an inspection, a review, within a Trust or across our Trusts in relation to a particular speciality and an issue arose in relation to commissioning, then it would seem perverse to me that they weren't able to follow that thread back into the work that SPPG does. So, it's to try and set that kind of nuance in place so that there's not a barrier there to the RQIA being able 10:28 10:28

to conduct it's work in the way that it needs to.

I think that there's probably a wider dimension to this that's worth drawing out and which I suspect you may come to later, which is, the Department has a desire do a review of regulation more generally. There was some work done prior to the pandemic in relation to that. I think that work needs to be updated, and I think it was never entirely comprehensive in any case. 10:29

We are currently, and again this maybe a theme of the evidence I give, in a resource constrained environment, and as a result we've not been able to move ahead with the review of regulation. I think there are some other better reasons why we've also not yet moved on the review of regulation, which again I think you will come to later in the evidence that you're asking me to give. 10:29

So I do think that there's scope to look again at some of these in that review of regulation and to understand whether there are any lacunas as a result of the changes made which the draughtsman and the people who led the policy for the legislation I think were accurate in redefining the roles, but we just need to make sure that we've got a system that works always now. 10:29 10:30

11 Q. And just you've mentioned the RQIA and the work done prior to the pandemic. I'll perhaps just take the Inquiry to the paragraph in your addendum statement

that deals with that at WIT-107632. Paragraph 32. And just what you've said, you say at paragraph 32:

"Prior to the COVID-19 pandemic the Department had developed a new draft regulatory policy framework. However, further development work is required, including consultation on the draft policy. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context, work on the review of the regulation is currently paused to allow for other priority projects to progress." 10:30 10:31

Now, we'll look shortly at the reforms and reviews that are ongoing, but from the regulatory point of view that's on hold? 10:31

A. It is at the moment, yes, and the decision was made that there were other things that we needed to advance more urgently and with a view to creating the right environment within which to do the review of regulation. In my experience, if you look at regulation, if you approach regulation at a time when you don't have the system in the place that it needs to be in, you can end up with an overly defensive reaction and it can be very hard to bring about change. Whereas, one of the things that we've been looking to do is to advance those areas that will develop and bring about cultural change within the organisation, 10:31 10:31

such as the review of SAIs, through the review of MHPS, the Raising a Concern Policy that was published in March, and so on. So I don't want to go over all of those because I know you'll come to those, but it's just to signal that by making those changes we're trying to create a different environment within which then to locate the review of regulation, and we think that that is a better way to go about the ordering of the work.

12 Q. And we go back to your original statement then at WIT-107083. Just deal with the regulation point now. 10:32

A. Sure.

13 Q. As we've moved onto it. Paragraph 77. And just for context, the question that we asked you and the answers I'm going to read out relate to the following question: 10:32

"Given the current pressures affecting all parts of the health and social care system, do you consider that further regulation is the answer?"

10:33

And you say the following:

"As I have acknowledged in my response to Question 7, the regulatory landscape is already a complex one with a range of bodies discharging various roles and functions which exerts some measure of regulatory influence either direct or indirect. Further, research and studies in the UK and beyond have acknowledged the vast range of regulatory interventions in health care 10:33

systems more generally, the number of bodies involved and vast resource expended."

Paragraph 76:

10:33

"Further regulation should not be a default option and seeking to introduce more regulation in response to a significant service or system challenge, in particular given current pressures on the system, may not always be the best response." 10:33

Paragraph 77:

"The Department has acknowledged, however, that the current legislation underpinning the regulation and 10:34 inspection of health and social care services and the roles and functions of the RQIA dates back to 2003. The delivery and provision of health and social care has evolved significantly in the intervening period. A future review of regulation would provide a platform to 10:34 consider any identified improvements in the regulation and monitoring of services, and to consider what is the right model of regulation across the full system and sectors of health and social care provision.

10:34

78. A new draft regulatory policy framework had been drafted prior to the COVID-19 pandemic. However, further development work is required, including consultation on the draft policy."

And then you make your point about the budgets. And then at paragraph 79:

"There is also a need to balance regulatory intervention with support for learning, improvement and development. The Department is progressing a number of policy strands designed to further support and help embed an open, just and learning culture across our HSC, aimed at better supporting staff and patients and ultimately delivering improved care. This work recognises and takes account of emerging evidence and practice." 10:34 10:35

And then just to finish that at paragraph 80: 10:35

"A core ambition of this work is to further enable an environment which identifies and learns system wide lessons when things do not go as planned in delivery of care, to deliver system improvement and leading to better outcomes for patients and staff providing services. This is best achieved by creating a psychological safe space supporting staff to engage openly in learning processes as part of an open and learning culture, avoiding a blame culture, which is counterproductive. This also supports staff to communicate early with patients and families in a compassionate, open and honest manner. Where an incident or event requires accountability for action, 10:35 10:35

this should be proportionate, just, and prompt, taking account, where relevant, of system factors. An open just and learning culture which co- exists with appropriate and just accountability is key to support delivery of safe and compassionate care and protecting the welfare of our staff."

Just in relation to paragraph 80, that seems to set out in general terms the basis for any regulatory system or governance system, in that people should feel safe to either trigger or bring to other's attention concerns that they have, and that those concerns should be dealt with swiftly, justly, and speaking with all relevant stakeholders. 10:36

Given that the regulatory pause that's been put on the developments so far because of budget constraints, are you content that that pause will not detrimentally impact the current governance arrangements that are in place through the Trusts? 10:37

A. Yes, as I tried to draw out in the answer to my previous question, I think the budget is one thing, but there's also if you try to change everything at once then in my experience that doesn't work well. So I've tried to set out why there's a logic in trying to address the kinds of projects that we are taking forward in relation to SAIs, the Being Open Framework, which I didn't reference earlier, the work on MHPS those are all things that I think are enabling measures 10:37

that should support the review of regulation and make that work better in due course. So, yes, budget is a constraint, but it's not the only reason why we've done it the way we've done it, and I think if you try to do all of those things at the same time, that would be more change than the system could reasonably be expected to accommodate at any one point, and then you end up with the risk that people don't understand what it is that you're trying to put in place. 10:37

14 Q. And just to complete the point, you've mentioned some of the work underway, and at paragraph 82 you deal with -- provide some examples of that. Paragraph 82 says: 10:38

"Work underway led by the Department to support this policy agenda includes, but is not limited to, an emerging Being Open Framework, the redesign of the SAI procedure, early work on an underpinning charter, the recently published Raising Concerns HSC Regional Framework..." 10:38

-- and you've provided a copy to us:

"Ongoing review of Maintaining High Professional Standards, work due to commence shortly with the Northern Ireland Public Sector Ombudsman to review the HSC complaints procedure and a review of HSC Occupational Health services." 10:38

Now that's work that's ongoing and is it the case that

the issues that have arisen through this Inquiry, and that have been made public through evidence, is the learning from that on an ongoing basis being used to inform, where appropriate, some of the work that's already planned or in place? 10:39

A. Yes, that's absolutely right, and it's also the case that previous inquiries have made recommendations in a number of these areas as well, particularly the Neurology Inquiry. So we've been seeking to take the learning from all of these incidents and inquiries to 10:39 make sure that we put in place something that is designed to make the system work better in the future. All of the areas that are referenced in that paragraph that you quoted there have involved very heavy levels of engagement with clinicians and people who work 10:39 within the health and social care system. So this isn't something that's being done in some sort of isolated way, it's very much being done engaging with people who work in the system in a number of the areas. There has been relatively recent reviews and changes 10:40 made, for example in England, where we can also look to learn from experience there, and I think that that's been very helpful to us in a number of areas, because these problems are not unique to Northern Ireland. They are -- some of the challenges you face trying to 10:40 create a system that has the right balance is true everywhere and, you know, we need to make sure that we are absolutely focused on getting the right balance rather than if you move too far in one direction then

you often find that that has unforeseen consequences that also bring about negative outcomes in different ways.

15 Q. So there is an active focus on looking at what has already been learned from other jurisdictions? 10:41

A. Absolutely.

16 Q. And importing that as is possible.

A. Yes. And a number of the reviews will either have individuals who have direct experience or will have made a point of going to talk to those individuals 10:41 themselves.

17 Q. I just want to ask you a couple of questions about the new commissioning model. You've mentioned it in explanation of the restructuring around SPPG and the HSCB. There had been some suggestion in the evidence 10:41 given by Chief Executive of the PHA, and just for the Panel's note Mr. Dawson's evidence is at TRA-10732 to 10736, and in general terms, Mr. May, he set out some of the changes the new legislation has brought in, and one which is that the previously legislative 10:41 requirement of a dual mandate for commissioning between the PHA and the HSCB, SPPG, no longer requires the PHA signoff under the new legislative framework, and I just want to ask you -- I think that was before your time that the legislation was drafted and the legislative 10:42 intent, I don't want to ask you information about background to legislation that you've no knowledge of, but do you get a sense that that was intentional to streamline commissioning services, and do you have any

concerns that the absence of a dual mandate for commissioning services in any way dilutes potential oversight or governance?

A. So my understanding is that the intent was not to somehow cut the Public Health Agency out of the commissioning process. I think I'm clear that the PHA needs to work hand in glove with SPPG in order to deliver, whether you call it commissioning or planning process, whatever, the way in which you go about procuring the services that are needed from the health and social care system. They have unique expertise around population health and a range of other areas, which are absolutely intrinsic to the delivery of that system. 10:42 10:43

My sense, although I have not seen this written down, my sense is that this may well have been a consequence of -- a natural consequence of the way in which the Board was being, it's role was ending and being brought within the role of the Department, because prior to that the legislation, as I understand it, had said that -- it was, as you say, a dual mandate between the Board and PHA, but in the event that there was not agreement then it would be for the Department to decide. Clearly if SPPG is also the Department then that becomes, legislatively it becomes a bit of a nonsense. So I suspect that the decision was taken not to make it a requirement on the first hand when the port of appeal would be to another part of the same entity, but rather 10:43 10:43 10:44

-- so I think that was the intent that lay behind it.

As I said, I think I am clear, I know SPPG is clear that this is -- this has to be a joint enterprise and one that works together. So I don't, I have not identified any difficulty in practice yet with this approach. Of course if there are, and I don't believe that Mr. Dawson drew out any practical challenges in his evidence, so I'm happy to keep that one under review if there's a need to look again. 10:44

I do know in other areas, for example, in safety and quality, there has been a service level agreement put in place between the PHA and SPPG that defines roles and responsibilities, and I know there's ongoing work to look at how that could work more widely as well. 10:44

18 Q. And you've provided an example in your statement of how that new arrangement and the expectation of the parties may be reflected in the HSC Framework Document. I'll take you to that at WIT-107065, paragraph 20. Yes, paragraph 20. You say: 10:45

"Following the minister's decision, the HSC Framework Document will be updated to reflect the new commissioning approach which cements the role of SPPG and PHA in jointly planning and managing health and social care services, following its implementation later this year." 10:45

At 21 you say:

"In the interim, SPPG and the PHA have continued to work together to support the planning and management of HSC services through, for example, effective implementation of agreed care pathways, addressing variation of performance and service reconfiguration."

And at 22 you say:

"Whilst the Department ultimately has approval for the commissioning of services, this could not be discharged without the joint endeavours of both SPPG and the PHA. For example, in recent years, SPPG, in partnership with the PHA, have reviewed and developed plastic surgery services, introduced post-Covid services, and progressed the reform of maternity services."

Mr. Dawson in his evidence highlighted the areas of expertise his staff have and, as you say, they have expertise around population health and also individual expertise among their own, some of which are clinicians and other health care professionals?

A. Indeed.

19 Q. So we can take from what you've said in your statement that it's anticipated that partnership agreements, drawing on expertise in order to better inform commissioning and planned services decisions is something that should be taken as read at this point?

A. Yes.

20 Q. I wonder if I could take you to just an extract from evidence from SPPG from Sharon Gallagher. It's at TRA-11055. And this is around the delivering of safe services. Line 15 is my note, but I might need to take you back to the question just so you know the context. Yes. I was asking a question in relation to what Mr. Devlin had said in his Section 21, and giving he had set out some criticisms, his views of the way the SPPG and the HSCB were operating at that point at the time of the Section 21 to give Mrs. Gallagher and Mr. Cavanagh an opportunity to update and explain what they considered about his view. And Ms. Gallagher then, just the next page down, please, at line 16 -- I'll start at line 8 because it will give you the context. 10:47 10:48 10:48

"In terms of the delivery of high quality services, I mean we've talked about this earlier, that sits within the purview of the Health and Social Care Trust, so the targets are part of the picture, but safe quality services sit within the domain of the Health and Social Care Trust. In Mr. Devlin's defence our demand capacity gap has increased. That was made even worse by Covid. So the provision of high quality services as described by Mr. Devlin had, of course, diminished, because we were in a position with ever increasing waiting lists and, you know, during a period of Covid and recovering from Covid. So I can understand why his perception would be that these things had conflated. 10:48 10:49

But as I mentioned earlier, this is a very complex working environment with many, many factors coming into play."

Now, Ms. Gallagher has said that the delivery, the high quality delivery sits within the purview of the Health and Social Care Trust. Just before we move on from the commissioning topic. Who, in your view, has ownership of commissioning safe services? 10:49

A. Well, the responsibility for commissioning of services would sit with SPPG and PHA working jointly in the way that we've just described. I think -- I don't know if it's helpful or not, but I wonder if I try to draw out -- for me I always think about safety and quality of services in two interlocking ways. So the first of those has the individual patient at the centre, and the role that individual clinicians play around that individual, and then all of the clinical governance arrangements that work within the Trust environment, and I think, you know, in a delegated accountability system such as that that operates in health and social care, that's an entirely appropriate model and one that no department or central body could ever hope to play a role, and obviously professional regulators play a role there to. 10:49 10:50 10:50 10:50

The second interlocking way is to think of all patients at the heart, and that is fundamentally the role of the Department, and everybody, to think about how safety

and quality is delivered for all, and there are inevitably -- and Sharon Gallagher was referring to this in her evidence -- if you have a very long waiting lists then the overall quality of care is being affected. So keeping those two interlocking concepts together, and understanding the respective responsibilities for each is the way I tend to think about safety and quality. I don't know if that's helpful, but that's just to try and explain for me, otherwise words around quality and safety can be asked to bear too much weight because they're being asked in different contexts to apply to slightly different things. 10:51 10:51

21 Q. And you've referred to standards for quality and patient safety in your statement, and perhaps just on the back that of we'll move on to that particular topic and look at the way in which the Department views those issues. 10:51

A. Sure.

22 Q. WIT-107075. 107075. At paragraph 51. Thank you. Just in the context of this, for the Panel, we asked you: 10:51

"What is your view of the importance of setting appropriate standards around, for example, quality and patient safety for health care providers? Who is responsible for doing this? Do you have a view on the effectiveness of any groups, committees or organisations in agreeing these standards?" 10:52

And you say at paragraph 50, just by way of introduction:

"Delivery of health and social care services is increasingly complex. It is in the interests of all stakeholders, including HSC Trusts and other service providers, commissioners, and service users and carers to try to minimise complexity where possible. The use of standards is one mechanism to help achieve this." 10:52 10:53

Then at paragraph 51:

"The Department of Health's Quality Standards For Health and Social Care were published in 2006." 10:53

And for note they can be found at DOH-71901.

"These standards remain extant and set out the quality standards that the Department considers people should expect from HSC services." 10:53

Now, just on reading that, the standards would appear to be 18 years old, and the landscape has changed enormously in health care. I'm sure you would agree with that. Is this document reflective of these quality standards for health care that would be expected now, or is it something that's under review or potentially to be re-visited? 10:53

A. Well I think it's good practice to look again at things, you know, after a certain period of time, and so, you know, in due course we would want to do the same with these standards.

10:54

I have to say though, in contrast to the likes of MHPS and SAIs, where I think it's very clear that there are material problems with the process that is in place, I haven't, in the two years I've been in the Department, had anyone come to me to offer a view that these quality standards are badly out of kilter with what is needed today. So I'm not saying they're perfect, I'm sure there are ways they can be improved, but for me that makes them of a lesser priority than the work we've described now and, indeed, the review of regulation that we've already discussed as well.

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10:54

23 Q. And you've been frank about that at paragraph 54, where you say:

"The Department recognises that there are likely to be opportunities and benefits from evaluation and review of the 2006 standards. The Department is currently operating within a constrained budget and is required to make decisions in relation to the work that can be delivered within current resources. In that context work to review the 2006 standards is not currently planned for the 2024/2025 business year."

10:54

10:55

And as you've said, that's entirely reflective of

prioritisation of where problems may be?

A. Yes.

24 Q. And the need to address those. And, again, just back on the point that you had made earlier about there being learning from other jurisdictions. You say this at paragraph 56: 10:55

"Given the relatively small size of the health care ecosystem in Northern Ireland, we do not have the resources to replicate work undertaken by national standard setting bodies and expert groups. To seek to do so would not be good use of public resource. Instead, Northern Ireland is well placed to avail of such standards and to consider these for application in Northern Ireland to protect and improve safety and quality and to participate in development of such standards. Northern Ireland has local processes and systems for assessing and adopting, or otherwise, such standards when they are developed. Consideration is also given to any unique considerations which would require a bespoke Northern Ireland response, although in reality there are few such factors." 10:55 10:56 10:56

And an example of -- you mentioned service level agreements and the potential for use of those at local level, but just on the issue of quality and patient safety, you mention at paragraph 57, one with the NICE, you say: 10:56

"One good example of this is the Service Level Agreement (SLA) that NI has in place with the National Institute For Health and Care Excellence. NICE's role is to improve outcomes for people using the NHS and other public and social care services in England by producing evidence based guidance, quality standards and performance metrics and a range of information services for Commissioners, practitioners and managers across health and social care. The Department established formal links with NICE on 1st July 2006, whereby guidance published by the institute from that date is reviewed locally for its applicability to Northern Ireland and, where appropriate, endorsed for implementation in health and social care. This link has ensured that Northern Ireland has had access to up-to-date independent professional evidence-based guidance on the value of health care interventions. NICE technology appraisals, clinical guidelines, public health guidelines, and COVID-19 Rapid Guidelines are considered and endorsed for Northern Ireland as appropriate. In Northern Ireland HSC Trusts are responsible for implementing NICE Guidelines and the Department's Strategic Planning and Performance Group works closely with the PHA to monitor and seek assurance on implementation." 10:57 10:57 10:57 10:58

The Inquiry has heard evidence on the way in which NICE Guidelines find their way through the filter from the Department. It's clear from your statement that the

Department's responsibility is to access information on standards and quality, or have that fed through the Department and to disseminate that among the Trusts, and then to focus that on areas of clinical practice that would be best informed by those guidelines. So there is that continuity of quality and standards. Is that a fair summary of the Department's role?

A. Yes. And in addition, depending on the nature of the guidance that is being passed out, so there may be some assurance sought from Trusts or others about the way in which they have sought to comply with that guidance.

25 Q. So there is a level of oversight or an ongoing relationship around that?

A. Yes. Usually through SPPG and the PHA they will be making those judgments. The Department can do so as well, and the Chief Medical Officer would often be involved in looking at what comes through from NICE, for example.

26 Q. Is that an example, perhaps, of what we were speaking about a moment ago, about how the commissioning of safe services is almost embedded in the system by the fact that the standards and quality assurances, there's an expectation that Trusts will reflect best industry standards?

A. Yes.

27 Q. And, of course, in mentioning quality standards for health and social care, you've also made reference to the statutory regulators for the different professions; the GMC, the NMC, and the way in which they interact

with other aspects of standards that are applicable. I wonder if I could just touch on the Trust's Boards and their relationship with the Department. It would seem from the evidence received from many witnesses that they have an important role in overseeing the standards of quality and patient safety, and I just want to just bring up a couple of things that have been highlighted by some of the witnesses.

11:00

First of all, we'll look at your statement where you mention the succession planning for Boards, WIT-107113. Paragraph 168. We've asked you generally questions in relation to problems around recruiting and retaining and developing Board members, both at Executive and Non-Executive members, so we've asked you a few questions around that, and I want to highlight some of your answers. Just paragraph 168. You say:

11:00

11:01

"Succession planning within the Boards of ALBs is a priority for the Department with end dates for current appointments actively monitored when planning the order of competitions and reserve lists created and utilised to address vacancies that occur between competitions."

11:01

Then at 169:

11:01

"Within my Department the Public Appointments Unit has a comprehensive programme planning process in place. This includes consultation with ALB Chairs on issues

such as monitoring term end dates, agreeing extensions to terms, and second term reappointments, competition scheduling, and once competitions are completed, agreeing the commencement date for new appointees. Where possible Board appointments are sufficiently staggered to ensure that there is appropriate retention of experienced Board members balanced by the influx of new members bringing fresh challenges."

11:02

One of the things that had been highlighted had been that there had, on occasion, been swathes of lost expertise or corporate knowledge around Boards at one time because of the way in which tenures were awarded all at once. Is that something that from those paragraphs would seem to be in the past and there's a recognition that staggering this is a more appropriate way to maintain both expertise and corporate knowledge?

11:02

A. It's certainly something that we've been trying to do more of. I suspect we still have, you know, a bit more to do, but we have made some progress in that respect. In the past, if I go back I don't know, 10 or 20 years, it would quite often have been the case that a minister may have decided to, to have a kind of automatic reappointment for a second term, as it were. Most ministers, in my experience over recent years, have taken the view that they would like anyone who wishes to serve a further term to go through the same process as anyone applying for the first time. That then can mean that you end up losing more experienced Board

11:03

11:03

members at one go than is desirable, and that's why some staggering is helpful. And also, of course, you can't rule out there may be a group of people coming to the end of their second term and best practice is that they wouldn't serve more than two terms. So, yes, we are working to make this better and I think we are making progress in it. 11:03

28 Q. Now, you mention at paragraph 171 that:

"The primary responsibility for providing the resources required to enable Board members to discharge their duties appropriately lies with the individual Trusts within the overall funding provided by the Department of Health." 11:04

So there is that autonomy for Trusts to -- can they make local decisions around how they structure and operate their Boards, or is there a requirement that Boards are set out in the same way across all Trusts?

A. Boards -- Trusts have a lot of delegated authority in respect to how they work. I mean there are some requirements on all Boards to meet best corporate governance standards. So you would always require, for example, an Audit and Risk Committee or whatever it might be. So, you know, there'll be some basics, but I don't think that they are contested. 11:04

The point around resources may be one that emerges on a number of occasions in today's evidence. I think what

I've been trying to do is to move away from a model where the Department might provide money for very specific purposes, because then you start ringfencing funds, and that then, in my experience, often leads to inefficiencies in the way that resources are spent, and a rigidity in the system. Whereas, if you're providing the Trust -- and most of the Trusts are, you know, receiving the best part of £1 billion, Belfast significantly more than that -- if you're receiving that amount of money with a clarity about what it is that needs to be delivered across various domains, then that seems to me a much better way of going, rather than saying "Here's a few thousand here to train a Board member". I mean that becomes, for me, something that invites the Department to start to micromanage in a way that isn't helpful. 11:05 11:05 11:05

29 Q. I just want to read out to you to see if you have any comment on some of the evidence from Board members when they came to give evidence to the Inquiry. Eileen Mullan's evidence can be found at TRA-10022. It's probably unfair to Ms. Mullan to start off with her sentence "These are not attractive roles". She was talking about Board membership and NEDs, and to be fair to her, she spoke very highly of how rewarding these roles are and how committed the individuals, and indeed she is, in fulfilling these roles. So just that's the caveat of what I'm about to read. And she says: 11:06 11:06

"These are not attractive roles. You've got to want to

do this. You don't step into a Health and Social Care Trust as a Non-Exec because you've some time on your hands. You do it because you want to bring your skills, your experience, and your absolute commitment to health and social care to the table. I firmly 11:07
believe, and it is with my Boardroom Apprentice and other hats on, people want to serve. They want to learn to do that. So let's create the space for people to be able to serve on our Health and Social Care Boards and get that right at the beginning. Succession 11:07
planning needs to be thought about the moment you appoint somebody. The senior executive team's succession planning, I know from talking with our current Permanent Secretary Peter May, this is something he is focused on, something he has focused on 11:07
in relation to the training and development of Non-Executive Directors and that induction piece, that is on his agenda, and he is watching it and he wants that to happen. We need to think of how we make these roles, not just Non-Exec, but the senior executive 11:08
roles, attractive to encourage people to apply because they are incredibly rewarding."

Now, you got a mention in dispatches on that issue, but does that indicate that there is an ongoing dialogue 11:08
around this and the ways in which you jointly can improve this and try to bring further stability around Boards?

A. Yes, I think that's fair. We talked a little bit about

appointment processes, but obviously the more fundamental thing is when people are actually in post and how you work with them. For me, the Board has a central role to play in the accountability mechanism and they're there to both support and challenge the executive team, and they need to determine what the right balance of those two is, depending on the issue and where things are. And I expect and look to Boards, and particularly to Chairs, to raise up to the Department and to me, issues that they feel, you know, their Board are not able to address and are concerned about. 11:08 11:09

I think Eileen is right to say that these are -- Trusts are big and complex organisations. So, you know -- and our risk profile at the moment, for reasons that are not the responsibility of Board members or, indeed, the executive teams, is, you know, it's a lot more loaded than you would really like, because we do have a demand and capacity gap, we do have a very significant resourcing challenge at the moment, and that's likely to continue in '24/'25 at least. And as a result, you know, the risk that something will go wrong in systems that are under very significant pressure is greater. So all the more reason to work with Boards to support them. We do provide a basic induction for all Non-Executives, but in addition to that the leadership centre has put in place a series, a half day course for Non-Executives to invite them to come together from 11:09 11:09 11:09

various health and social care organisations, and I've been to a couple of those events recently to offer a departmental perspective, and I know each Board is being offered a day for its Board to go away and to think about how it operates as a collective, again through the leadership centre, and I think those are good initiatives and ones that we would want to support.

I don't think that those are things that the Department should run itself because, again, that's inviting us to get into the space of trying to tell Boards what they need and what they don't need, and I think this needs to be much more something that Boards themselves determine, and we provide, as I said, the support that is needed and, indeed, the input that's needed to any training they do decide to take forward.

30 Q. And, of course, the Department has a vested interest in Boards operating effectively and being...

A. And as accounting officer I have a particularly vested interest.

31 Q. Yes. And the personnel and the expertise on that. The evidence before the Inquiry, and it's for the Panel to consider that evidence, but there has certainly been a spotlight on the absolute essential nature in the governance train of an effective Board?

A. Yes.

32 Q. So for the Department to have that quality assurance, it would seem that Boards are a particularly

fundamental requirement that that is both properly manned but also properly functioning.

I'll just go to what Maria O'Kane said at her evidence at TRA-11670. And this was around Board composition. 11:11
And I take the point you've said that there has to be a line of demarcation so the Department isn't seen to be, I use the word "interfering" in a neutral way, but getting overly involved in the management of the Trust. But the sentence that has been asked is: 11:12

"Can the Department do anything to assist Trusts in this respect?"

And, again, this is around Board composition. And 11:12
Mrs. O'Kane said:

"It's possible. I know that certainly, you know, the foundation Trust structure in England is different in that there are councils and there are Trust Boards, and 11:12
there's probably a lot more input from the public. But, again, I imagine one of the limitations on this is we are working in a really financially restrictive environment currently and all of these things, obviously, have to be accounted for. But certainly, 11:12
you know, anything at all that can add to the breadth and depth of the expertise and the time allowed to the Non-Executives I think would be welcome."

So there's no particular directed expectation from the Department in Mrs. O'Kane's evidence, but she does raise the resource issue, and one of the issues that came up in evidence in relation to the Board was the remuneration of Board members and how reflective that may be to the time commitment and the level of expertise some of the individuals bring. I just wonder if you have any view in relation to that or is it anticipated that there will be any review of fee structures or does the Department -- what's the Department's view on that issue generally? 11:13 11:13

A. Well, I think firstly I would commend those who put themselves forward to be on Boards for their public service, and I always say that when I meet them. We currently provide three days a week for Chairs and a day a week for Board members. Of course if I see a strong evidence base that suggests that that's inadequate, then we could look at it. We don't currently have plans to look at it. 11:13

What I would say is that inevitably in a big and complex organisation like a Trust, it would be possible for Non-Executives to spend all of their time on Trust business, and if you end up with full-time Non-Executives I think you then run a risk of blurring the line between what's an Executive and Non-Executive responsibility. So the Non-Executives are there to hold the Executive team to account, to support and challenge them in the work that they do, not to do it 11:14 11:14

themselves, and I think that's an important distinction. So I can understand particularly when Board members are newly appointed and they're going through induction, as well as learning lots about the organisation, it may be that, you know, they feel the recognition of that in terms of the time isn't quite right. So there may be things that we should look at there, I don't rule it out, but it's not something that has been -- I've not had representations on this specific in the two years I've been here. I've had representations from Boards and Chairs on a range of other things, but I don't think, you know, this is one that has been particularly strong. I have read and heard the evidence that's been provided, so I recognise there is some sense of a need here. So let's -- by all means, I'm happy to reflect on that. 11:14 11:15 11:15

33 Q. I wonder if we could just finish, or go to another topic before we take a short break? It's Information Systems in Health and Social Care, and it's a short topic, but I'd like to just ask you about some of the improvements that have taken place. If we go to your statement at WIT-107069. The question we asked in your Section 21: 11:15

"What is your view of the importance of enabling a health and social care information system that can be used by organisations to drive improvements in safety, quality and performance, and inform integrated governance at each level of the system? Is such a 11:16

system envisaged? If so, set out the details."

So at paragraph 30 you say:

"The Framework Document 2011 sets out the extant roles and responsibilities and arrangements for discharging same across the Department and health care system." 11:16

Paragraph 31:

"The use of information systems to drive safety, quality and performance operate at a range of different levels and require both ready access to the right data and the ability to combine a variety of datasets to provide a complete picture. For example, in relation to how HSC Trusts are overseen, during 2023-24 the Department tested the use of a Balanced Scorecard approach at the ground clearing meetings which were held in preparation for subsequent accountability meetings with the HSC Trusts. This approach is expected to involve the extraction of pertinent information from a wide range of systems to support a holistic view of Trust performance as part of accountability arrangements across a number of domains, including, for example, performance, safety and quality, patient experience, and productivity and efficiency." 11:16 11:17 11:17

Paragraph 32:

"The Balance Scorecard approach will be evaluated before any decision to embed this as a new process to support departmental accountability arrangements with HSC Trusts." 11:17

So just on the Balance Scorecard approach, is that a new way of bringing in data that allows an overview to be taken in relation to performance and safety and quality? Is that to inform the Department or both the 11:18
Department and the Trust? What's the sense of that?

A. Well, it would be designed -- it would be something, a tool the Department uses, but it would absolutely be something that is visible to the Trusts and the Boards. So there'd be a clarity that that's what we were 11:18
looking at in terms of each of those domains. We actually, as a senior team, had a meeting to discuss, yesterday, the kind of measures that could be introduced against each of those domains, with a view to trying to minimise those, to keep them to a small 11:18
number of really important measures. The risk is always that you can identify 6 or 10 other things that you could usefully measure as well, and then it becomes a very cumbersome process. But if we're clear what we think is really important, that can also help to focus 11:18
Trusts and their Boards on what's important. And as with all of these processes, the data will give you a starting point, but there's also then a need to use the experience that, you know, the Department has of its

engagement with each Trust, to understand, you know, whether that correlates with the experiences that we're seeing.

So your question was whether this was something just for the Department or for the Department and Trusts, and it is for both. But it is something the Department would put in place, because it would be the accountability mechanism that it would use and it would support then, and essentially replace the commissioning process as a result. 11:19

34 Q. Is this anticipated that this is information the Department will interrogate or be curious about so that they can go to the Trust and say "We need a little bit more explanation about what's behind this." I presume from your explanation it's both qualitative and quantitative? 11:19

A. Yes.

35 Q. So is there an expectation -- and the context of the question is in some of the Board information that was received by the Southern Trust Board, there was some suggestion that there was an absence of curiosity to get underneath the data, or underneath the one dimensional lines of information that they were being provided. Is this something, is there learning from that for the Balance Scorecard? 11:20

A. So I don't think -- assurance processes shouldn't be tick box exercises where you get a piece of data and you say "well that's all okay then". As I said, you've

got to correlate that then with the experience that, you know, the organisation, the Department of Health in this case, has multiple interactions with each of the Trusts on a very regular basis. So it's also about understanding those interactions alongside whatever the data is telling you.

36 Q. Given some of the evidence that the Inquiry has heard, is there a sense, from your perspective and your interaction with both this Trust and other Trusts, that the quality of communication has improved, or the ability to question information, is there any sense that there is a greater sense that people are unafraid to raise issues of concern at the earliest point?

A. Well I don't think I can offer a comparative view, because I wasn't here prior to two years ago, but what I would say is that it's been a focus of mine to try to engage with Trusts, both at Executive and Non-Executive level, and the feedback I think suggests that that is succeeding both in individual and at a systemic level. So -- sorry, could you just repeat the question again? I think I'm going off on a tangent.

37 Q. I'll try my best! The context of why I was asking you that is, we've been here as long as you've been in post, we're nearly the same age, I suppose, in that respect. Has there been incremental learning in your position as Permanent Secretary where there is more openness, that there is a sense of learning as we have gone along, that the Department has also gone along in their learning as to how to interrogate Trusts or to

oversee governance, has that been an organic thing?

A. Absolutely. We've certainly been putting time and effort into how we do -- take a helicopter overview of where a Trust is in order that we can understand what support they need and whether there are any interventions the Department can contribute to. And, you know, then where we do identify those then there'll be a more detailed conversation with the Chair, or with the Chief Executive, or with both. I think it's one of those ones where you can never be sure that you've got it completely right, but I think that we have made some good process. I don't, myself, have a sense that there is a reluctance on the part of Trusts to be open with us about problems that they're facing, and I welcome that, and I think that that is an important part of creating the right kind of culture. So, you know, obviously that goes to how we react when we're told that things are not where they need to be in specific areas and how we build together confidence around the plans that the Trust should initially put in place to address those difficulties. 11:22 11:23 11:23 11:23

38 Q. You've also mentioned the Electronic Patient Record system. Obviously our focus is on governance and the way in which some of these systems may assist in improving that. At paragraph 33 you say as follows: 11:24

"Looking at how clinical information is joined up, the successful introduction of the Electronic Patient Record (EPR) at the heart of the Encompass Programme

required a review and standardisation of clinic pathways by health care professionals. Going forward the information from the acute and community care sectors that the EPR makes available will significantly enhance the drive for improvements in safety, quality and performance, and inform integrated governance and will compliment existing data and information systems. The system will provide near real-time data which can be used to benchmark HSC acute care and community care services across Northern Ireland, and with other Epic system users in the UK and worldwide." 11:24 11:24

Now that's clearly an attempt to joined up thinking of data provision around patient information at the point of clinical need, and you've mentioned Encompass, which seems to be quite a significant project. You've mentioned that at paragraph 43. We'll just look at that. 107073. 11:24

So you're explaining the Encompass system. We've asked you specifically to explain the purpose of it, the extent that it has been rolled out, how it functions and how it is intended to benefit health and social care organisations, and staff, and patients and carers, and what is the timescale? And you've provided the following information: 11:25 11:25

"The Encompass Programme is a clinical and operational transformation programme with an Electronic Patient

Record solution supplied by Epic at its heart. Northern Ireland is the first system to adopt this unified approach to an electronic health record at integrated care system level and is the first in the UK to incorporate social care as part of this endeavour. It is the largest implementation of the Epic platform in Europe.

The flagship programme will see Encompass replace or link with the vast majority of clinical systems currently in operation in acute and community care settings, replacing existing often end-of-life Patient Administration Systems and clinical record systems across HSC NI. The EPR will provide those working in acute and community care with a single holistic, appropriate view of a patient or service users' interaction with those sectors. Primary care professionals will also have appropriate access to the information."

11:26

I wouldn't want to put Encompass in a nutshell because it does seem incredibly complex, but is this a way of trying to get everything that's relevant and necessary clinically about people together in one spot so that they can be accessed by the relevant primary care professionals at the point of need? Is that at least one aspect of it?

A. Yes. I mean Encompass is probably the largest single change programme that health and social care has

undertaken because it requires everybody who has contact with individual patients to do things radically differently to the way they would have done them before. And as a result, as with any major change, you will find that there is a spectrum of views about how easy or otherwise it is to use that system. But I was talking to the Chief Executive of the South Eastern Trust, which is the Trust that has already gone live recently. She was identifying clear benefits in relation to patient safety, in relation to patient experience, and in relation to efficiency in a range of different ways. So we've got more to do because there's still a few teething challenges, as you often find with the introductions of new systems, but I am confident that the Encompass system will be a big step forward, particularly assisting actually the safety and quality agenda, and I think that's been the experience elsewhere of where it has been brought in. 11:27 11:27 11:28

39 Q. And the rollout of Encompass involves training all of the staff on that I presume? 11:28

A. Yes.

40 Q. What's the sort of timeframe for that? Is there an end date for final integration?

A. Do you mean when will it be rolled out across all of the Trusts? So our current target is that by this time next year all the Trusts will have gone live with Encompass. The Belfast Trust will go live in June, the Northern Trust in November, and then the Southern and Western Trusts are March/April next year. That's 11:28

obviously subject to readiness assessments which are detailed in relation to each of the Trusts, but that's the programme, and I think that may be set out elsewhere in the statement.

41 Q. And given that the expectation that Encompass will help the health and social care in Northern Ireland work more effectively and efficiently through regional standardisation based on best practice, which is from your statement, it's anticipated that one of the wins of Encompass as well as the efficiency will be better governance? 11:29 11:29

A. Yes. So as I said, there's a big safety and quality dimension here. By creating agreed pathways, pathways that are set by the clinicians in each speciality for how conditions will be managed, you should remove unwarranted variation from the system. You are reducing the likelihood or the risk of medication being done in a way that's not appropriate, you are increasing the ability of patients to track their own engagement through the My Care portal, the patient portal. And, as I said, in addition, there should be some efficiency benefits. The other way in which the patient experience is improving, and the fundamental way, is that they should only be telling their story once and then every clinician can come and see what that story is, rather than having to ask the same set of questions, and anyone who has been had in a health and social care setting will know that that's a big challenge. 11:29 11:30

42 Q. And the Inquiry has heard evidence that in this jurisdiction patients don't automatically or routinely get letters about their care from hospitals, it's usually sent to the GP. There is some individual practice that it does happen, but there's no uniform policy or standardised approach in relation to that. Is Encompass a way in which people could access a section of that to find out if they have been referred for tests or if a letter has been sent to the GP and, indeed, what it says? 11:30

A. So, certainly I think it could do some of that, it may not do all of it. I think things like the discharge letter, if you're leaving hospital, then that would be available to you on the My Care portal. You would be able to access the results of some tests at least. I think though, importantly, we shouldn't forget that there is a human dimension to some aspects of this, so there are some tests that you wouldn't want to be telling people the answer by them going on to an app to find the result. So, you know, I don't think -- I think we just need to make sure that we have a nuanced view of how that patient portal will work in practice.

Similarly, the language used by some consultants, at least in writing to GPs, wouldn't be accessible to members of the public, so we just need to make sure that what's being made available to members of the public is stuff that we can reasonably expect them to be able to use and make use of sensibly.

43 Q. And, indeed, a lot of members of the public may not have access to the technology to be able to...

A. Well, I think that's a relatively small number now, and a decreasing number, but I accept that there will be cohorts that that applies to. 11:32

44 Q. Chair, I wonder if that is a convenient time?

CHAIR: Yes. We'll take a short break and come back in 15 minutes time, which if I've worked it out is ten to twelve.

11:32

THE INQUIRY ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

MS. McMAHON: Mr. May, I wonder if we could move on to some of the issues of reform and reviews that you've mentioned in your Section 21, and if we go to your statement at WIT-107116, at paragraph 178. Now this is in relation to the reform of maintaining high professional standards, and you say: 11:49

"A review of MHPS commenced within the Department in 2023 with the establishment of an independent review panel under the direction of the MHPS Review Steering Group. The Panel consists of three individuals who are external to the Department of Health, HSC NI. Each bring differing expertise to the project covering operational experience of the MHPS framework, medical leadership, governance, employment law, rights,

knowledge, and restorative just and learning practices."

And then you give us an update at paragraph 179. If you could just move down to 181, please? And in relation to the outcome of the review of MHPS you say at paragraph 181:

"An initial working draft report will be produced and presented to the Steering Group by the end of March 2024. This will contain the review panel's initial key findings and recommendations on the way forward for MHPS within the HSC. It is hoped the final report will then be presented to the Department by June 2024."

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And you say can a copy can then be shared with the Inquiry once published. Just in relation to those timeframes, where are we at the moment?

A. The Panel met the Steering Group at the end of March and made a presentation rather than offering an initial draft report. I'm not on the Steering Group, but the presentation covered, I think, the main areas. I had met the Steering Group a few weeks before that just to understand where they were, and my understanding is that their key finding is essentially to say they're not clear, they don't believe there should be a separate process for managing standards for doctors compared to other employees for health and social care, other practitioners, so I haven't seen the detailed

outworking of that yet, and they're going to develop that into the report. We are still anticipating receiving that report by the end of June, and I'm conscious that it is part of the Inquiry's Terms of Reference, so we would be keen to engage and share that with the Inquiry, not least to understand if the Inquiry has any views on it. I recognise that in timeframe terms there could be a tension here, because the Inquiry report is likely to be some way off, with the best will in the world, but we may -- if the -- if there was some way, and perhaps more informally, of discovering whether the Inquiry felt that was the right direction of travel, that might be extremely useful to us, because I don't think the Inquiry would want us not to start doing anything on MHPS until after the Inquiry report is published. So we might just need to have an engagement about how that would work in practice.

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CHAIR: There should be no difficulty with that, Mr. May. There should be no difficulty with some sort of engagement once we see the report.

11:53

A. Thank you.

45 Q. MS. McMAHON: Just for the Panel's note when they're looking at the evidence again. Maria O'Kane's evidence on this issue can be found at TRA-11730, where she says:

11:53

"The Trust was asked to give feedback to the Department on their MHPS review and they offered suggestions."

Also at TRU-306519, there was a review of the MHPS stakeholder engagement questionnaire and the extent to which that was fed into the review. So that's -- the update on MHPS, then there was a review of SAI procedure, and you deal with this at WIT-107117, at paragraph 183, and I think we're actually on that page. Yes. So you say: 11:53

"A redesign of the current Serious Adverse Incident (SAI) procedure is progressing led by the Department. This will result in a new framework replacing the current SAI procedure. SPPG and HSC Trusts, amongst a range of other partners, sit on the programme Board Redesign Development Group." 11:54

And then at 184:

"The programme of work will seek to address relevant recommendations arising from the IHRD..." 11:54

-- which is the Hyponatraemia Inquiry, and the Neurology, INI Neurology Inquiry,

"...alongside recommendations from the RQIA review of systems and processes for learning from SAIs, which together have provided a clear and strong evidence base underpinning the need to fresh and redesign the current approach to learning following SAIs." 11:54

185:

"The SAI Redesign Programme is being progressed by a redesign working group and a redesign development group. Membership of these groups comprises senior colleagues from the Department and from the HSC, including Trusts. This programme of work will introduce a new framework to deliver learning and improvement from patient safety incidents events through a new streamlined and simpler review process. The Departmental work will not focus on reviewing and refreshing all local systems across HSC Trusts and delivery areas, rather it will deliver a clear overarching regional framework together with supporting methodologies, learning and improvement tools, and relevant guidance." 11:55 11:55 11:55

CHAIR: Sorry, Ms. McMahon, I hesitate to interrupt you, but there seems to be a drone. I don't know if that's internal or external. 11:55

MS. McMAHON: I thought that was just local to me.

CHAIR: No, definitely not you, Ms. McMahon.

MS. McMAHON: I can hear it as well.

CHAIR: I don't know if it's inside this chamber or whether it's something happening outside. Can I just ask PI-communications if they would check the equipment isn't creating it in any way. It seems to have stopped. 11:56

MS. McMAHON: It does. It stopped when I stopped

speaking, but I won't take any correlation to that droning. I'll go back. If that's okay, I'll go back and it's paragraph 188.

"It is anticipated the new framework will deliver a fundamental change in how HSC organisations review and learn from patient safety incidents resulting in improved care. The new framework and supporting guidance will be less detailed and prescriptive in many aspects in contrast to the current SAI procedure." 11:56

Then you set out at paragraph 189 the areas of key focus for the current phase of the SAI redesign work, which include:

"Further involvement and co-production activity with both patients, families and staff, and wider stakeholders, to seek views and to build confidence in emerging proposals.

Redefine and rebalance the oversight and assurance functions, local and regional, as part of the new framework and how these will work in practice.

Achieve correct balance between greater organisational autonomy and flexibility and redefined organisation and regional oversight and assurance roles.

Further drafting of the new framework in supporting guidance.

Opportunities for managed prototyping aspects of the emerging framework and planning to deliver a managed

transition to a new framework.
The policy team is targeting a consultation on the new framework in autumn 2024."

Now, I think you mentioned from a section I read just a moment ago that there had been information gathering or suggestions or advice sought from other key stakeholders in relation to this. The Inquiry heard evidence from the Chief Executive of the Patient and Client Council, they had undertaken a specific piece of work around the voices of patients and service users and the way in which they experience the SAI process, and they gave - Ms. Monaghan gave detailed information about the way in which some people were dissatisfied about the process, and I'm sure that's not a surprise to you that there are considerable flaws perceived or in reality from both clinicians who have to inform the process, but also end users whose experience perhaps is used as a basis for an investigation. So, is it anticipated for the Inquiry's purposes around governance that this new framework will result in better outcomes for all of those stakeholders in the SAI process and also tighten up aspects of governance that are arguably absent in the current process?

11:57 11:58 11:58 11:58

A. I think the obvious thing to say is if it doesn't achieve that, given the shortcomings that have been identified, as you say, in various sectors, then it won't have achieved what it set out to do. So, as with -- and I think similarly to MHPS, the delivery of the

11:59

report or the outcome is one thing, implementing it well is actually a bigger and more important task. And often it's not the words on the page that are the problem, it's the way those words are interpreted within organisations or in the way processes work. 11:59

I think SAIs, it is also fair to say, there will -- we should not imagine that there'll be a world in which everybody is always happy with everything, and SAIs I think is particularly one of those areas. The purpose 11:59
of SAIs is to produce learning, and in particular learning for the organisation for the individuals, learning for the system. There will be people, including potentially those who have been affected by incidents, who have a different focus as they approach 12:00
an investigation and see it as an investigation rather than as a learning exercise, and that will be -- it will be really important to try and be clear what SAIs do and don't do, and at the moment I think there's a risk that people -- there's a kind of obscuring of that 12:00
in people's minds.

So I suppose I'm saying that with a view to conditioning expectations about what will and won't be possible through a review of SAIs. But you are right 12:00
also to draw out that the review should also improve the speed in which the SAI takes place, the way in which learning is disseminated, and in particular how, for example, learning is identified, including from

multiple SAIs, and there's an important role for the Department through SPPG and the Public Health Agency in trying to look at those systemic lessons and draw those out. So those are all things I think it's reasonable to expect that should happen, and it should improve people's experience in a number of ways. As I said, I just think we need to be careful not to assume it will make everybody happy all of the time, because that probably won't be the case.

46 Q. I think to be fair to the witnesses who gave evidence on this issue, there was a recognition that at times there was a mismatch of expectations what SAIs were meant to do and what they could do and what people thought they might do? 12:01

A. Yes. 12:01

47 Q. So there was -- as you've said, hopefully there will be some clarity gained with the new framework document. We had asked you about other developments, in particular a review of Early Alerts, and you say -- just if we move down to paragraph 192. Sorry, my mistake, 191, and you say: 12:01

"On 15th November 2022..."

-- which is when you last gave evidence: 12:02

"I committed to a review of the Early Alert system when giving evidence at the Urology Inquiry."

And then you give us the evidence that you gave. If we move down to the next paragraph, at 192 you indicate that:

"Due to resourcing pressures this work has not yet substantively commenced although some early planning has taken place. It is currently anticipated that a review of the Early Alerts process will be undertaken by the Department in 2024." 12:02

12:02

Is this again just an example of competing priorities around what can be done and what needs to be done more urgently?

A. Yes, essentially it's a prioritisation exercise. I hope that the Early Alerts will be a less major piece of work than SAIs, and I think it is realistic to expect that that is the case. But I'm also conscious that not only are the team that will be taking this forward leading on a number of the areas that we've already talked about, but they also are likely to be drawn into supporting the Covid Inquiry quite substantially due to other tasks they took on during that period. So it is just a question of balancing and making sure that we are able to deliver on the targets that we set ourselves. 12:02 12:03 12:03

48 Q. Again on the Lookback Guidance Review at 193. If we go to 195. It had been anticipated there would be a review of this, and you say at 195:

"A review of the Regional Lookback Review Guidance has been agreed and the completion of this work will be subject to staff resource availability."

Again is that for the same reasons you've just outlined? 12:03

A. Yes.

49 Q. If we go to 196, in relation to reforms and action that has been taken and move forward, you say at 196:

12:03

"In February 2023, the Department commissioned the Getting It Right First Time team to complete a review into Urology services. One of the key reasons for undertaking this review was to ensure that recommendations could be identified and implemented at 12:04 the earliest possible opportunity to facilitate the improvement in the extensive waiting lists in this area and to ensure that patients are treated as quickly as possible to ensure best possible outcomes."

12:04

Then we move to 199, the outcome of this Getting It Right First Time Report, and you say:

"The report has identified a series of 40 recommendations to improve the service in addition to a 12:04 list of recommendations for each HSC Trust. These recommendations have been accepted in principle by the Department. Work is already underway on many of the recommendations. However, others will require funding

and resources. The recommendations focus on the themes of maximising surgical assessment, diagnostic capacity, and improving efficiency, strengthening pathways and protocols, exploring non-consultant grade skills mix and training and regionalisation of services. Funding requirements have yet to be fully quantified but will include investment in the workforce, which includes creation of additional posts and training of staff, along with capital funding for equipment and infrastructure." 12:05

Now, the Inquiry has had sight of that documentation, but for their note, the Recommendation Action Plan dated 6th March 2024 is at TRU-306468, and when one looks at the Action Plan, and the recommendations and the RAG that they have applied to it, the red, amber green way of designating priority for recommendations, quite a significant amount of work appears to have been done on what can be done at this instance, but it's clear that the Department has a role in relation to funding and some oversight in relation to improvements in that respect. The updated position on that, is there any movement forward? Does the Department envisage any extra capital raising for the implementation for those particular recommendations? 12:05 12:06 12:06

A. So, for the purpose of the '24/25 year, we're still waiting for the budget outcome as things stand. I mentioned earlier that that budget outcome looks as though it's going to be very constrained, and the

ability to do new things may well not be easy. So I don't want to prejudge the outcome of that. But I did get -- I did have a meeting with the team in the Department who are leading this work, and they did say that there was a strong clinical buy-in to the recommendations that is have come forward from the GIRFT Review, and real momentum in terms of taking the actions that we can take. So they were clear that they thought it would be possible to make progress in most of the areas, in pretty much of the areas set out. There may be limits to how far they can go, in the absence of new money, but they can at least start the work in a range of those areas. So that I think was, for me, a positive signal, both in terms of orientation and of progress, and we will be issuing a progress report formally, probably in the summer, as to where we've got to against each of the recommendations. 12:07 12:07 12:07

50 Q. You've mentioned about the restriction in capital and the difficulties then that will be faced by constrained budget. When Mrs. O'Kane gave evidence, she gave us an example certain audit and tracking functions that had been funded by the Trust at risk, which she had said they yielded real on the ground improvements in some of the areas where harm was in the past caused, and as a result of that they have seen significant improvement are. And for the Panel's note that is Mrs. O'Kane's evidence at TRA-11742 line 6 to TRA-11744 line 16. Now, the nature of the functions of the audit and tracking functions that she had identified, didn't seem 12:07 12:08

to face some of the major hurdles and obstacles of other requirements, such accessing nurses and doctors and requiring significant funding, and they were more about filling in of admin roles and reconfiguration that the Trust had funded at risk. Given the identification by Mrs. O'Kane that those sort of changes yielded real on the ground improvements in areas where harm had been caused in the past, is that something the Department might consider funding going forward rather than on an at risk basis by the Trust? 12:08 12:09

A. I'll come to the specifics in a moment, if I may, but just perhaps at the risk of repeating myself go back to, you know, the Trusts are given large budgets, and I think it is for them to determine where their priorities should be. Clearly if we want to commission new services then there should be an expectation that with new services comes additional funding. 12:09

In relation to urology, I think the Southern Trust has seen quite a significant investment in urology services in recent years, around 2.9 million over a number of years. In relation to the specific administrative functions, my understanding is that in 2019 there were three of these roles that were being funded. Through SPPG that's now increased to 11. Obviously I'm not cited on whether the Southern Trust has more than 11 people in post or not, and I think that's getting to a level of detail that probably isn't where I would want to be anyway, but it's just to signal that there was a 12:09 12:10

recurrent investment of about 180,000, I don't have the precise number, over to support those additional administrative roles in the area that you describe.

51 Q. And when you mention around the issue of money, and it's not always about money it's the way the money is allocated as well, rather than just the amounts, that was something that was given in evidence by Sharon Gallagher of SPPG, and we don't need to go to this but I'll just read this out for the Panel's out at TRA-11015. Ms Gallagher said: 12:10 12:11

"We are in a demand capacity deficit. Waiting lists in Northern Ireland are longer than anywhere else in England, Scotland or Wales, and that is something that as a senior team in the Department we pay huge attention to. Over 50% of the block grant is allocated to health, so around £7 billion a year is allocated to health." 12:11

She also said: 12:11

"It is a matter of public record that no service is currently achieving or receiving the funding that is required to meet the deficit, and in that regard it is really important that we provide safe services because the provision of them or access does not come at a premium to safe services." 12:11

And in relation to urology, we have mentioned the

funding that has been allocated there. Mr. Cavanagh in his evidence says at TRA-11017:

"I think only one other acute speciality has received more funding in the last 15 years than urology." 12:12

So that's to tie in their evidence. There has been a lot of mention of culture and changing cultures in the Trusts, both in relation to the individuals feeling safe enough to raise issues, but also for others to 12:12 feeling confident enough to ask questions, and people to highlight issues in the first place. What do you consider is the role of the Department in assisting Trusts around the culture regarding governance to ensure that there is an environment in which anything 12:12 touching upon patient quality or risk does find it's way to the right ears and that change is effected?

A. I think the Department is responsible for setting the overarching policy and strategic agenda for developing detailed frameworks that may be needed to support that, 12:13 and then for seeking assurance from the Trusts as to the extent to which they have been able to meet the terms of those policies and frameworks that are put in place. So to use an example, we've employed an independent expert, Peter McBride, to lead some work on 12:13 a Being Open framework for HSC, and he's done that initially at the request of Belfast, starting in Belfast, because of the challenges they faced in the Neurology Inquiry, and then the Southern Trust, again

at the request of the Chief Executive. He is now working with the other Trusts also to engage clinicians about what is needed in such a framework? What is it that is stopping people from coming forward and raising concerns? How do we get to a place where being open is the norm and not just when things have gone wrong? In other words, it's an all of the time piece. And he's developing that framework at the moment, and I hope that will be available fairly shortly. And, again, would be a task around how that is then implemented and brought about. 12:14 12:14

But culture is absolutely the heart of all of the work here, and something that I and the team in the Department are really focused on as to how do we develop the right kind of culture, both in terms of how the sorts of examples that you've raised about people being willing to raise concerns, but also in terms of the engagement we have with our -- all of our arms length bodies as well. 12:14

52 Q. And I think you've written to the Boards recently in September, 23rd September 2023, around the HSC Board Member Handbook, emphasising, re-emphasising the importance of the existing responsibilities and other policies that applied, and for the Panel's note, that's referenced in Mr. May's statement at WIT-107103, paragraph 137. And you've kindly provided a copy of that letter which can be found at WIT-107560, and the following three pages from that. 12:15

A. I think one of the useful things about that handbook was that it had quite a long section towards the back giving some case studies that tried to draw out how the kinds of concerns that might find their way to a Board, what is the kind of checklist of things that you may then want to, a Board member may want to consider and look at, and I thought that was something -- it was done before my time originally, but I thought that was a really good part of the handbook. It wasn't just a long list of things you should do, it tried to make it something that had been applied in a way that would be useful to Board members. 12:15 12:16

53 Q. Now in relation to driving change, you've highlighted some of the areas of developments in your statement, and if we go to paragraph 90, WIT-107086. Sorry, 107087. Where you mention the HSC Performance and Transformation Executive Board, and you say: 12:16

"It brings together leaders from across the health and care system to bring a collective approach to driving change. The Expert Clinical Panel (ECP) brings together senior clinicians to collectively consider key transformation initiatives. There is also an ongoing commitment within the Health and Social Care Workforce Strategy 2026 to continue to align and support a collective leadership culture within the HSC through the full implementation of the HSC collective leadership strategy. This action is the responsibility of HSC employers. HSC Trusts devote resources to 12:16 12:17

learning and development, which include support and training for staff taking on leadership roles."

So, is that a further way in which people with the right information and the right knowledge and experience can come together to help transform care where that's needed?

A. Yes. I think somewhere else in the statement we had set out that the three different groups at overarching strategic level, the Performance and Transformation Executive Board, the Expert Clinical Panel that's co-Chaired by the Chief Medical Officer or the Chief Nursing Officer, and then the ITAB, the Independent Transformation Advisory Board, that brings in some people within health and social care, but also representatives from outside, including from some business in third sector organisations as well. And that's the kind of overarching strategic frame. And then within -- under that there are a set of detailed programmes, of which the Workforce Strategy would be one.

54 Q. And you mention the Workforce Strategy in the next paragraph. If we just move down to 91?

"The Department's ambitions for the development and Health and Social Care Workforce are outlined in the Health and Social Care Workforce Strategy 2026 Delivering For Our People, which was published in May 2018. This was in response to a recommendation in

Health and Well-Being 2026 Delivering Together. The outworking of the expert panel led by Professor Rafael Bengoa, tasked with considering the best configuration of health and social care services in Northern Ireland."

And then you go on to explain the way in which the strategy was developed. Now we're closer to 2026, the timeframe mentioned. What's the position in relation to this particular strategy at the moment? 12:19

A. So there has been a lot of work undertaken. I think there are -- there are still major challenges in relation to workforce in health and social care. There is no doubt at the time this was written in 2018, no one was predicting the pandemic, and that has obviously 12:19 materially impacted on the experience of the workforce in work and something that has required some adaptation.

The headline figures show that since 2018 there have 12:19 been really significant increases in all areas of workforce, including all of the major health professional areas. I think it's around 18% for doctors, and over 15% for nurses and allied health professionals. So there has been major investment, but 12:20 we know that there remain real challenges within the workforce, and you've referenced already on a number of occasions the demand and capacity gap, and that is absolutely driving this, because it means that people

are working really hard every day, but at the end of the day their workload is either the same or greater than it's ever been as a result of that demand not being met. So we aren't unique in facing those problems. They are and feel really acute for our region, and it is something that we are all working as hard as we can to resolve. But we are also facing constraints. And so it does feel sometimes as though, you know, you're trying to deliver that change with your hands tied behind your back because you don't have the wherewithal in order to make the investments that are going to be needed in a variety of areas that will make the change that's needed. 12:20 12:20

Not all of that investment -- I know this Inquiry has focused on urology, which is a hospital based service, but not all of that investment is needed in the acute sector and there's actually a need, a particular need to invest in primary care and in social care in order to stabilise those sectors and in order to ensure that they are able to deliver the maximum that they can do in order that that can assist the acute sector. 12:21 12:21

55 Q. And you've provided a breakdown of some of the figures in relation to staff retention across the HSC in your addendum statement. For the Panel's note, that is WIT-107634, and relevant paragraphs are 45 to 48. At paragraph 48 you say: 12:21

"All staff groups have seen a decrease in vacancies

actively being recruited since 31st December 2022. At 31st December 2023, there were 5,906 vacancies actively being recruited across health and social care in Northern Ireland. This equated to a vacancy rate of 7% and was a decrease of 2,410 vacancies since the serious high point at 31st December 2022, which was 8,316. The total number of vacancies under active recruitment at 31st December 2023 is 29% lower than at 31st December 2022, and 18.4% lower than at 31st December 2018." 12:22

12:22

So that gives the Panel a snapshot of some of the challenges faced in both recruitment and retaining staff.

Now there has been movement in the development of new roles, advanced practice roles? 12:23

A. Yes.

56 Q. Has that been as a result of demand from the Trust, or is that led by the Department, or is it a match of both? 12:23

A. Well in principle it should be led from within Trusts on the basis that, you know, that they identify the need. I think the Department does have a role to play both obviously in terms of the commissioning of the training needed, but also in terms of drawing out whether it is best practice from other jurisdictions that could apply to our region to help with that, and I know in the context of advanced nurse practitioners, the Chief Nursing Officer, Maria McIlgorm has been a 12:23

really strong advocate of that and trying to demonstrate and help Trusts to understand where those roles can really add maximum value, often being able to perform functions that are currently undertaken by consultants who could then be freed up to do other even higher value work as a result.

57 Q. And is that -- are they posts that would be expected to be funded from existing budgets rather than there being any capacity to provide additional monies?

A. So there's two aspects to this. There's a training cost, and training costs would be met predominantly by the Department for all training pre-graduate and post-graduate training. There may be areas where there is a sharing of cost, and if a Trust identified a need to go and, you know, really develop this in a big way, you know, there may well be constraints as to what we could afford to deliver. 12:24

In terms of then appointing somebody at the end of it, then it would be for the Trusts to identify the role there. You wouldn't necessarily expect that the ANP would be an entirely new role, and you would expect that they might be surplanting some of the work of a doctor, for example, or existing nursing staff. So it's not necessarily all additional. I think we need to guard against the sense that any idea always has to have a check that goes with it, because that I think then reduces people's innovation, and particularly in the current climate will make it harder to make the 12:24 12:25

kind of changes that we need to make.

58 Q. Now, you've mentioned that this transformation around the way in which workforce is used, not just new ideas around it, the way in which the specialist skills of people are identified and focused where they're needed, 12:25
that that might help increase capacity, with the capability of retaining people, because there is a pathway through which people may move from a career perspective.

12:26

One of the things that the Department has identified, and you say this at paragraph 109:

"A lack of exposure of training grade doctors to HSC Trusts outside of Belfast can impact negatively on 12:26
recruitment to the substantive consultant posts in these locations."

Was that something that just was organically discovered, that the failure -- people weren't 12:26
attracted to working outside Belfast because they hadn't been sent there as part of their placements?

A. It's a case that has been made by a number the Trusts, in particular the Chief Executive of the Western Trust, has made that argument strongly and, you know, we do 12:26
want to take a look at how our training grade doctors are distributed. We need to make sure we get the right balance here, because they are training grade doctors so they need to be going into roles that will give them

the experience they need to enable them to develop, but that ought to be possible in a range of locations. So, I wouldn't want to suggest that it's only Belfast that has training grade doctors, because that's not the case, but we will look at whether we've got the distribution right and we'll work closely with our doctor training agents in order to achieve that.

59 Q. Does that in some way also dove-tail slightly into the hospital reconfiguration blueprint that you mention at paragraph 29, where it will describe Northern Ireland hospital system and emphasise the importance of viewing it as an integrated hospital network, is that a way of getting away, I suppose, from what we in Northern Ireland might see as different Board areas, and where people may have to go for treatment, is it more seeing it as holistic service provider and focusing on where people are best placed to access health care?

A. Yes. I mean it's looking at how we -- we have done a lot to develop centres of excellence through day procedure centres, elective overnight centres, and rapid diagnostic centres, and those are showing good benefits now. So for the last six quarters our treatment waiting times have reduced, and that is a positive, but we have still got a long way to go, and we need to build on that. So how do we maximise the use of those centres of excellence? How do we draw on the speciality reviews? So there was a review of general surgery conducted in I think 2022, and that made various findings about the standards that needed

to be applied in hospitals, and as a result there has been some quite significant changes to how general surgery is delivered across the region to meet the safety and quality standards that are required, and often in response to challenges recruiting staff. And then within -- at a more granular level, one of the things that the GIRFT Urology Review drew out was the importance of, even within specialties, having centres of excellence and not expecting all our procedures to be conducted in each Trust or in each hospital. So that's something that is being looked at and taken forward in the implementation of that, which you referred to earlier. 12:29 12:29

The final point perhaps to make in relation to the blueprint and the network is that there's also logically a consequence for how we would see our clinical workforce as well. So in principle the clinical workforce can work in more than one Trust and in more than one hospital, but often in practice that doesn't happen that much. Whereas, you know, I think in order to meet the networked ambition, that's something that we do need to look at in more detail. 12:29 12:29

60 Q. The blueprint, is there a timeframe, or is this the very early stages of the evolution of the way in which service may be delivered in Northern Ireland and, indeed, the way people may view Northern Ireland health care service provision? 12:30

A. The work is well developed in terms of the blueprint

and a kind of summary document that tries to draw out the conclusions, and we're currently engaging with our minister about how we would like to take the next steps of that forward.

61 Q. You've mentioned some of the other developments, and we've talked about those earlier. Just for the Panel's note, the Department has also completed strategies and service reviews in a range of areas which set out clear plans for the future, these include published cancer and mental health strategies as well as the review of urgent and emergency care services in Northern Ireland and the Elective Care Framework. That framework can be found at WIT-51386 to WIT-51461. 12:30 12:30

Now the Elective Framework was published in June 2021, and sets the direction of travel, as you say in your statement, as to how change would be brought about to improve elective capacity and capability and reduce waiting lists, and you say at paragraph 129: 12:31

"The Inquiry will be aware from my earlier answers that progress has continued to be made against the actions in that framework with the most recent update being published February 2024." 12:31

You go on to say in that paragraph, and you've mentioned this before:

"The elective capacity has been enhanced by the

development of elective care centres, two rapid diagnostic care centres at Whiteabbey and South Tyrone Hospitals, and megaclinics have been introduced to maximise patient throughput. There has also been service reviews in general surgery, orthopaedics, urology and gynaecology. Work to date has delivered results with the overall treatment waiting lists reduced by over 12% in the 12 months ending 30th December 2023, with six quarters in a row with reducing lists. Our longest list, general surgery and orthopaedics, have been reduced by 20.8% and 7.6% respectively between December 2022 and December 2023. The scale of the problem is significant, but transformative work and recurrent investment would go a long way to address some of the core issues within the system. This transformation work sits alongside ongoing performance management and monitoring of achievement against HSC service delivery planned targets which were set for 2023/2024." 12:32 12:32 12:32

12:33

A lot of the evidence before the Inquiry has been around waiting lists, waiting times, the difficulty in delays people face in accessing services and, indeed, some of the documentation would seem to have set a pattern of escalation clearly from 2010 waiting lists, and the numbers that were being concerned about then by clinicians and managers almost seem like halycon days when we look at some of the waiting list figures now, and even during the tenure of this Inquiry there 12:33

have been many press stories around waiting lists and the way in which the service arguably is unable to cope with the demand and capacity issues. The word "crisis" has been used for the health sector quite a few times in the Trust, in the press, and do you -- is it something that you would accept is the health system in Northern Ireland in crisis? 12:34

A. So everyone can chose their own language. I would say that all parts of our system are under very severe pressure and, you know, there are major challenges in terms of being able to deliver the kind of health and social care system that all of the people who work in that system want to be able to deliver and to be proud of. There are -- we are at a stage where the scale of those problems means there are no quick answers, but the risk, as I see it, is that the current budgetary constraints actually risk making the situation worse rather than enabling the work to be done that would make it better. 12:34

62 Q. Could you expand on that a little bit more, why that's the case? 12:35

A. Well, as I explained on a couple of occasions already, you know, the risk is that the budget will not be sufficient to enable the existing work to continue, there may need to be reductions in service in some areas, obviously depending on the outcome of that budget, let alone actually moving to put in place the transformation that's going to be needed across all of the areas. I've mentioned primary care and social 12:35

care, as well as a focus on waiting lists and the acute sector as well.

63 Q. I just want to finish up on the issue of the learning from previous inquiries, and hopefully from this Inquiry, and you've very helpfully provided an update in your addendum statement at WIT-107628. And for the Panel's note it's paragraph 17 to paragraph 44. I'd just like to read some of this out to give a flavour of the current framework around the way in which the Department manages information that they've received from these various Inquiry recommendations and what's anticipated they will do with that information. And this part of your statement is entitled: 12:35 12:36

"The Department's progress on implementing recommendations from previous public inquiries." 12:36

At paragraph 17 you say:

"In April 2023, the Department agreed to formally amalgamate the Hyponatraemia related deaths and independent Neurology Inquiry Programme Management Boards into a single Department of Health Inquiries Implementation Programme Management Board..." 12:36

And you have attached a copy of the Terms of Reference. Then you've set out what these, the reasons behind this, and the commonalties and the potential benefits of amalgamating these issues. Sorry, the

recommendations from both of those inquiries.
And at paragraph 19 you say:

"The first meeting of the IIPMB took place on 21st April 2023. The IIPMB Terms of Reference will be kept under review and will be refined and revised as appropriate." 12:37

At paragraph 20 you say:

12:37

"The IIPMB will also explore, if appropriate, how best to bring oversight of the implementation of recommendations from other public inquiries, such as the Infected Blood Inquiry, Urology Services Inquiry and Muckamore Abbey Hospital Inquiry, under the scope of IIPMB in due course. The importance of integrating the implementation workstreams being progressed by external delivery partners is recognised by the Department. This includes engagement and collaborative working between the Department, the health care organisations, the General Medical Council and the independent sector organisations as well as partnership working with other relevant organisations." 12:37

Just on that particular point. Is there an understanding and perhaps a broad commitment from the Department that should it need to bring in other sources of expertise to help bring about the recommendations from this and other inquiries, that 12:38

it's prepared to do so? For example, in the RHI, the Audit Office was responsible in some respects from overseeing the outworking of those recommendations because of the nature, obviously, of the recommendations, but is there a recognition that there may be some cross-fertilisation of oversight needed to bring home these different recommendations? 12:38

A. Yes, absolutely. I think there's a number of different dimensions, and perhaps I could just briefly break them out. So in relation to taking forward individual recommendations, there may well be the need for external input in the way that we've described already in terms of MHPS and SAIs and there being open framework. Those are all good examples where there are external people who are playing a leading role in taking that work forward to assist the Department. 12:39 12:39

The second is, in terms of oversight, what we've done through the Integrated Programme Board that you've highlighted here, is we've introduced, in addition to a Steering Group that I Chair, there is a panel led by and exclusively populated by people who are not in health and social care, who are providing an assurance role as to whether or not a recommendation properly is signed off or not. So it's not us signing off a recommendation saying that's okay without -- so it goes through an assurance panel and the assurance panel look at it, there's a very detailed approach taken to ensure that not only the words on the page have been done, but 12:39 12:39

the spirit under-pinning it is in place, and then that will come forward to the Steering Group with that imprimatur on it. So just to be clear, there's also a service user group that also looks at those elements of the work, particularly in relation to the Neurology Inquiry. 12:40

It's my expectation, obviously you haven't written or let alone us having sight of the report yet, but it's my expectation that this Inquiry will raise some themes that are very similar to INI in particular, and that, therefore, integrating the implementation into the one place will be the most sensible thing to do because, you know, this Inquiry is in arguably a more challenging place in that work is already proceeding as a result of other inquiries having taken place. So part of what may well come out of this Inquiry is a sense of whether the direction of travel that is already in place is the right one or not. And insofar as it is, you know, hopefully that will put wind in the sails of what needs to be done, and insofar as it isn't, then it allows for corrective action to be taken. 12:40 12:40 12:41

64 Q. We haven't touched on everything in your statement, but the Inquiry has all of the information you've provided to update them, so thank you for that. I don't have any further questions for you. Is there anything -- I know you made some comments at the beginning of your evidence, but is there anything else you wish to add at 12:41

this point, anything further to say?
A. No, I don't think so. Thank you.
MS. McMAHON: Thank you. The Panel will have some questions for you.
CHAIR: Thank you, Ms. McMahon. Thank you, Mr. May. Just a few questions from us, first of all from Mr. Hanbury.

MR. MAY WAS QUESTIONED BY THE PANEL AS FOLLOWS:

MR. HANBURY: Thank you, Mr. May for your evidence. You'll be pleased to hear that Ms. McMahon has already asked a good few of them. Starting off with GIRFT, we've mentioned this already before.
A. Yes.
65 Q. MR. HANBURY: And you mentioned there was good buy-in from the clinicians, which is excellent to hear. And we've already heard about in particular sub-specialisation, where Southern Trust are taking on the complex stones, and Western seems to be taking on penile surgery and this kind of thing, although that might have been going on before.
A. Yes.
66 Q. MR. HANBURY: Are you aware of any other specific sub-specialisations that the urologists are discussing, or is that level of detail...
A. I'm afraid you're taking me outside my comfort zone. I'm happy to try to ask -- because there is a group which has the unedifying acronym of PIG, it's the

Planning and Implementation Group, that draws together clinicians and members of the Department, and I can certainly ask whether there are other examples. I think the GIRFT Report was recommending that we would go beyond what was already being put in place by way of the stones, so I imagine that this will be -- there will be others, but I don't have the detail I'm afraid.

67 Q. MR. HANBURY: But you would generally support initiatives from the clinicians, I would hope, following all this? 12:42 12:43

A. Yes. Absolutely.

68 Q. MR. HANBURY: Okay. So moving on to waiting lists. We heard back in about 2018 that Mr. Haynes and Mr. O'Brien put together a sort of document to say -- with the analysis of the theatre capacity essentially they had, they could really only just do red flag and urgent work, and it didn't sort of seem to go any further, sort of escalations and this kind of thing. I mean, was that sort of situation something in retrospect your department should have been aware of at the time? 12:43 12:43

A. So I would have expected that at least the, what was then the Health and Social Care Board, would have been engaged in that conversation, because I know that today SPPG looks at theatre utilisation, theatre availability in respect of services. So I imagine that that was happening in 2018, although I confess to not knowing for sure what the situation was then. 12:43

69 Q. MR. HANBURY: And...

A. So your question was then about the department...

70 Q. MR. HANBURY: I suppose sort of what should have happened then, that looking back if you were in charge then?

A. Yeah. Well I guess perhaps rather than trying to answer a 2018 question, if we identify a capacity challenge today, the question is how best do we address that? And what I'm signalling, given the current financial climate, which isn't the one that I would like us to be operating in, that we have to make the best use of the resources we've got. So we do need to look at how we do things and how we make better use. So, for example, in urology my understanding is that there has been a very significant shift towards day case procedures in all sorts of areas. Now, for me that is a win/win. It's a positive for the patient because the patient will have a better experience, will have a quicker recovery time almost certainly as a result of that, but it's also a positive for the wider system because it's freeing up capacity that otherwise previously would have been used for overnight stays and all of the rest of it. So there's a range of different ways where we need to look at all of those things. I don't think we've got to the end of the list of things that we can do in that respect. 12:44 12:44 12:44 12:45 12:45

If, at the end of that then there's still further capacity, then of course that's the area where the investment is then needed in order to address that. So

that's my thinking process as to how we would go through that.

71 Q. MR. HANBURY: Okay. Thank you. Just one last thing on waiting lists. I saw you had your change and withdrawal policies. So obviously some more critical look at what actually is on the waiting list and looking, I guess, at the sort of lower priority procedures, for example, vasectomy, in the sort of context of people waiting a long time for more urgent things. I mean is that something that clinicians are now looking at, not just for urology but for other specialties where there's a conversation about lower priority treatments and whether the health system can and should fund them? 12:45 12:46

A. We've certainly started to look at that. It is a complex area, because I think it's fair to say at the moment the public expectation remains that if there is a procedure which they have a need for, a clinical need for, then it should be delivered. But there is a reality that for those who are facing priority -- procedures, for example, which are routine in nature, and perhaps then our waiting lists are not moving quickly enough and they're not getting to the top of those lists any time soon. So I do think that that is a conversation that needs to be developed and grown. As I said we are, I think, really in the footholes of that. 12:46 12:46

72 Q. MR. HANBURY: Okay. Thank you. Moving on to national audits. They can be a sort of good driver of quality

and change. Talking to the urologists, there was legal or administrative difficulties submitting Northern Ireland patients to BAUS, the British Association of Urological Surgeons Audit. I mean is that something that's still a problem in your view, or if it is, is that something that you can help us with? 12:47

A. Yeah. So, there have been some challenges in terms of how patient information is shared. It's and information governance challenge. There was some legislation passed in 2016 that needs to be updated in order to enable that. I think at the time that the legislation was passed a number of Assembly members had some concerns about how patient information would be used. But there are, I think, strong arguments as to why being part of national clinical audits would be a good thing for everybody, including for those patients, in terms of giving greater assurance about safety and quality and identifying any areas of concern at an earlier stage, which is part of the fundamental problem that underlines both this Inquiry and the Neurology Inquiry. So it is something that, you know, I don't know whether it's something the Inquiry is going to make a recommendation around, but I can absolutely see the benefits of removing anything that would be an inhibitor in that area. 12:47 12:48 12:48 12:48

73 Q. MR. HANBURY: Thank you. Just the last one from me really. Long outpatient waits and waits for follow-ups and things is a recurrent theme in England as well as Northern Ireland. I was interested -- just one comment

from the Royal College of Surgeons action thing was about 82% of patients don't mind travelling up to an hour, which was I think in your statement. In view of that, do you think looking back the initiative to do lots of outreach clinics is still a good one or has that thinking changed? 12:49

A. I'm not aware of there having been a change in that area. I think where it is sensible to do so, delivering outpatient clinics close to where people live is a good thing. But, you know, obviously one needs to ensure that that's not at an unreasonable cost in terms of what else could be achieved. There is a move more generally to look at where patient initiated follow-up might be a sensible way forward. Obviously that doesn't apply to all areas, but there are plenty of best practice as to where that co-operate. So that too, whilst it's not quite the question you asked, is another area that is being looked at at the moment. 12:49 12:50

MR. HANBURY: Thank you. I think I'll stop there. Thank you, Chair. 12:50

CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

74 Q. DR. SWART: Thank you. I think you've helped us to understand how things are at the moment in a very clear way. I'm interested in the whole area of implementing recommendations from inquiries, and this is something that has been looked at recently in England, and I have, myself, been on the end of many, many recommendations over many, many years, and the overall learning seems to be that the recommendations are 12:50

accepted, but they're not always implemented, and that I'm sure won't surprise you. So that's one feature. The other feature is that in nearly all the inquiries the themes are similar. They're not exactly the same, but there's a definite congruence around things like culture, commitment to learn, promise to act, safety and all of those things. So you've put together this group, which hopefully will try and bring sense to the recommendations from a number of inquiries and a number still to come. 12:51

What discussions have you had in that group of trying to put some proportionality into that? Because you've got already a lot of recommendations. It's a very broad range of things. Not all of it will be achievable. Not all of it is resource dependent, but quite a bit may well be. What discussions has the group had about how to pull the building blocks out? Now you've mentioned a few things that you're concentrating things on straight away in advance of regulation, and I can see that. But have you had other discussions about "these things are the most important" and what those things might be in your head, what's the sense? 12:51

A. Well, part of the reason for trying to join together the implementation groups on the different inquiries was to enable that wider view to be taken and to understand where there are inter-relationships, because not every inquiry recommendation necessarily points you 12:52

in precisely the same direction. So, you know, I'm clear that we're trying to take the spirit of the recommendation, you know, and that includes, you know, obviously the Neurology Inquiry is more recent, but being able to talk to those who were on the Panel for 12:52
that Inquiry to understand precisely what they meant, because sometimes the words don't translate as well or it's harder sometimes to be sure that we've got that exactly right. And then from that to try and take an approach that by having the themes that are set out, 12:53
themes set out in the statement that they offered, that's a way of trying to join this up with normal work, because we shouldn't see -- you're doing an Inquiry over here and you've got this over there. So, you know, if the issue is around workforce, how does 12:53
this get embedded in the workforce strategy so it becomes a part of business as usual as soon as possible, whilst still needing to be able to report on the implementation of that recommendation to satisfy proper accountability mechanisms elsewhere. 12:53

For me, you know, this is all about culture really.

75 Q. DR. SWART: Yes.

A. And it is about the supporting -- all of these mechanisms are mechanisms to support the delivery of 12:53
the culture you're trying to achieve. I think I'm clear that there is a will within the system to take action, because no Trust, no clinician or senior manager wants to be subject to an Inquiry in the

future. And so I think that there has been quite a positive response, a willingness to learn and take on board what is intended here. And for me that's a positive sign, and one that means that, you know, we're certainly not -- we've not got there yet, but we are 12:54
making good progress in a number of areas, and that whole focus for me around the Just, Open and Learning Culture, the idea that that could become a patient safety framework essentially, an English patient safety framework that we could draw on that we've been looking 12:54
at. So for me that would be one of the critical things that might emerge from this series of inquiries and might then act as a strong pillar for the future, if that - does that answer your question?

76 Q. DR. SWART: That's exactly what I was asking about. So 12:55
my own experience is that patient safety is the one thing that everybody can easily align around. However, it's a glib word, and people have to understand what it means, and I don't just mean managers and people who aren't clinicians, the clinicians themselves need to 12:55
have a common understanding of what that is, and that requires training, it requires attention, the same kind of attention up and down the line, if you like. So I think if you look at the inquiries, they recommend various things in that area and it generally doesn't 12:55
happen in a coordinated way, and that leads me to the question about what, what discussions have you had about the need for a common understanding around values and safety, and the safety culture dimensions across

health, social care, and so on in Northern Ireland, because it isn't just about the acute sector, if this is to work well it has to involve primary care and social care and so on. Has that been built into discussions at any point? That's really stealing from the English Patient Safety Framework documents that are out there. But where has that gone? Is there thinking in that space?

A. So I think the Patient Safety Framework that I've seen from England has around 10 different segments to it. 12:56

77 Q. DR. SWART: Yes.

A. And what we've done is we've begun working on a number of those segments, but we haven't yet taken it forward in all of the areas. So there will already be excellent guidance in relation to safety in a range of areas, but I'm not conscious that we have necessarily drawn that altogether in one place yet.

78 Q. DR. SWART: Yes. Well I think it's the area that people have struggled with, despite recommendations in England where there has been a lot of work in this area, it's still not really embedded, for a variety of reasons. And that brings me to the Board as well. You, obviously, correctly have stated the responsibility of the Health and Social Care Trust itself, and of their Board, and of the importance of the Board. But training for Boards in this area has not, I don't think, necessarily been undertaken in a systematic way. Is that something which could receive some sort of Department support, rather than each Trust

being asked to invent their own programmes, modelling again on things that have happened in England?

A. Certainly. Look, I mean I agree that we should haven't five different versions of something like that. I'm open to discussion. The Trusts have been -- I've been very keen to try and encourage a system wide approach and to try to -- in all sorts of areas, not just in relation to patient safety. 12:57

79 Q. DR. SWART: Yes. Yes. Yes, I'm just using that as a pin. 12:57

A. And to be fair, the Trust Chief Executives have been keen to take that up. So they are looking at the development of what they're calling a provider collaborative, that might be a way to try to work out which bits need to be done on a common basis, as it were. 12:58

80 Q. DR. SWART: Yes.

A. Now whether it's the Department or that patient collaborative that were to lead something like the development of training in this area, I'm happy to consider further. But your point that, you know, we should have something that enables Board members to understand their roles in this area is a valid one and, you know, if we need to do more in that area I'd be happy to look at that. 12:58 12:58

81 Q. DR. SWART: This again comes from learning in England where the comments made in various bits of documentation that the Non-Executive Directors are not actually able to challenge around quality and safety

issues and so on, because they haven't had appropriate training and haven't been expected to do so. Now that may not be universal, but it is also my own experience that its variable.

A. Yes. 12:58

82 Q. DR. SWART: Mostly these people are very receptive to understanding more about it, it's not too difficult, too time consuming, nor too expensive, frankly?

A. And I think we just need to be clear on what we're training them on. 12:59

83 Q. DR. SWART: Exactly.

A. We're not asking them to become clinical experts.

84 Q. DR. SWART: No.

A. And they need to work out what assurance they can take from those who are tasked with providing those 12:59 assurances.

85 Q. DR. SWART: Yes. No, that's why it has to be targeted in a certain way.

A. Yes.

86 Q. DR. SWART: On a similar vein, but not the same, we 12:59 have heard quite a lot about difficulties in the medical leadership hierarchy at Southern Health Care Trust in terms of dealing with certain issues, and that might be dealing with concerns about doctors leading up to MHPS, it might be an operational professional 12:59 confusion, a lot of it is around the time for medical leadership, the development of medical leadership. If clinical leaders are going to be in positions of "authority", just to use that word, it does need

development and training. What is your view on whether Trusts should do that all individually or whether that should be a department leadership centre endeavour and how comprehensive that needs to be?

A. So, the leadership centre already offer a range of leadership courses that are open on a multi-disciplinary basis, and I was at an event a couple of months ago hearing some of the conclusions from the work, and there were doctors, and nurses, and AHPs, as well as managers, and I think in that kind of leadership training the multi-disciplinary approach had a lot to commend itself, and I was -- the energy in the room was really good to feel as well. 13:00 13:00

There may, in addition, be some clinical leadership that is required, and one of the things that I am keen to try to inculcate is a sense that, you know, the problems that we face as a system are problems that we need all parts of our system to come together to try to resolve, and I've been talking to our Chief Medical Officer and Chief Nursing Officer about how we might go about perhaps, you know, starting with some sort of a conference or something like that that will enable that to happen. And from that, I think rather than -- I'm always a bit reluctant, not being a health expert, to sit at the centre and say "What we need is one of those over there somewhere", much better if that emerges from within the group, drawing, as you say, on best practice as to what might be needed. So, you know, I think 13:00 13:01 13:01

absolutely I'm sure that there's something that we need to look at in that space.

87 Q. DR. SWART: Okay. Finally just the Encompass Epic thing sounds amazing, if that can all work.

A. Yes. 13:02

88 Q. DR. SWART: What are the risks identified so far in terms of this programme and what are the mitigations against that that have been built-in?

A. Well at a granular level there is a very extensive risk register, and set of mitigations, as you might expect. 13:02

89 Q. DR. SWART: Yes. Yes.

A. And, you know, the risk is that, you know, there have been Epic implementations that haven't worked, but the vast majority do work, and all the more recent ones have worked. I have to say given the experience in the 13:02 South Eastern Trust, that's given me confidence about the ability for the future. We do have some challenges. There was a downturn in terms of the level of both outpatient and in-patient and day case procedures in the immediate period of implementation, 13:02 and that is normal, but we've found it more difficult to get back to the level that we need to be at. So that is a core focus at the moment, because clearly Belfast is a much bigger Trust and as a result the impact would be still greater if we weren't able to 13:03 achieve that more quickly.

But part of my confidence lies in the fact that the South Eastern Trust have acted as the pathfinders and

that, therefore, many of the problems will have been resolved before other Trusts get there. Belfast have some regional services, so for them they'll be doing some things for the first time, so that's an area of particular focus. But beyond that, you know, it is about enabling the capacity to change within the workforce because, as I said, it affects everybody and requires everybody who interacts with a patient to do things differently, and that is a big change if you've spent many years doing things in a particular way. So it's not just about attitudes to change, it's also building capacity and so on. 13:03 13:03

So there is -- there was a really strong systemwide effort at the time the South Eastern Trust went live, both in terms of surging people into the South Eastern Trust, but also an acceptance that there would be a need for other Trusts to help out in terms of some urgent procedures, and that's still ongoing at the moment. So those are the kinds of mitigations that exist. So I don't know if I've answered your question? I can give you a much more... 13:04 13:04

90 Q. DR. SWART: I mean it's not really answerable in that way.

A. Okay. 13:04

91 Q. DR. SWART: I was really just wanting a sense of, you know, did you have enough clinical involvement in it, enough ongoing support?

A. Yes.

92 Q. DR. SWART: You know what -- how is this being sold in terms of safety? I mean, you know, these things have a major impact, don't they?

A. Yes. I mean I think everybody sees that it has a massive patient safety impact, for the kinds of reasons I described earlier. There is strong clinical buy-in and, you know, that's been really important as part of this. So this isn't something that someone in an IT Department thinks is a good idea. This is a major change driven by technology, but it's the major change that we're focused on, the technologies to enable us to get there. 13:04 13:05

93 Q. DR. SWART: And just -- I started off with learning from inquiries. We will obviously be producing a report. You will have looked at lots of inquiry reports, you've got this group set up, what is most useful in terms of how these things are phrased? So, you know, just to start you off, it's probably not useful to have 300 recommendations that are very specific, if I was on the receiving end of it. But what is most useful? Is it more useful to do what Bill Kirkup did in East Kent, which is to say "Look here guys, I've written lots of inquiries and nobody implements them and it's all too complicated, so I'm going to phrase these recommendations differently", and really what he's doing is getting to the spirit, to use your words, what is most useful? 13:05 13:05 13:05

A. So for me, as I think I said in my earlier evidence, I'm conscious that you are coming to this after other

inquiries have reached recommendations. So I suppose my -- what would be most useful to me is if, in looking at what you recommend, you try to build on what is already there and, as I said, put wind in the sails of what you think is going in the right direction and be 13:06
clear about what different or additional is needed in order to address the challenges. You've heard lots of evidence. Because time has passed quite significantly, the world has also moved on. So part of the -- so for me this is -- I would encourage you to take a system 13:06
view of this. What is it that's needed systemically in order to address things? There may be some specifics, of course, but as you've helpfully hinted, vast numbers of recommendations can be, you know, if you start chasing ticks in boxes rather than a focus on what 13:07
really matters. So it might be just because of the positioning of this Inquiry in the context of other inquiries, it just takes a slightly different approach in order to land it, and then again, if the Panel were, or representatives of the Panel were willing to be 13:07
engaged with afterwards to make sure we had understood properly, that would be extremely helpful as well.

DR. SWART: Yes. Thank you. That's all from me.

94 Q. CHAIR: Thank you, Dr. Swart. Well if it's any reassurance, I'm a great believer in less is more, 13:07
Mr. May, so I don't think you'll be getting 300 recommendations from this Inquiry.

Just a couple of things just when you were giving

evidence that I wanted to ask you about. One of the things that we heard that went wrong here was the fact that because of financial constraints money was diverted from governance systems essentially to frontline services, and as a result people weren't 13:08
picking up on things. I talked to Dr. O'Kane about this when she gave evidence, how could we ensure that the auditing of systems and the governance systems are sustainable and that that does not happen again? And one of the things she suggested was ringfencing for 13:08
governance in the financial package that a Trust is given. And I wondered, given that you don't like ringfencing and being dictatorial, but is that one area where there maybe a call for ringfencing that type of finance? 13:08

A. I think I'm just very sceptical about ringfencing and the impact that ringfencing actually has on the way organisations work, and whether it really delivers, because you're only really measuring an input. You're not measuring what is delivered with the money. So, 13:09
you know I'm conscious -- if you look back, the Trust each year reports on how much it spends on governance activity, which would include all of that accountability piece. For the Southern Trust that has increased from 20 million to 30 million over recent 13:09
years. So even allowing for inflation, a more than inflation increase, and when SPPG makes an investment for a new service or a new development, there's a 10% add-on designed for additional governance requirements

and/or, you know, the sort of basics that are needed to make it work, as it were. So it's not that there is nothing already provided in that space, that is normal. I would, I think, prefer to be clear what, you know -- this is somewhere where the assurance mechanisms fell down. If there wasn't a function performing these then there was no assurance being provided in this area. And, so, I think it's about being clear on what's the minimum standard that is required in terms of the outcome? Rather than looking at the minimum input required in terms of bums on seats. 13:10 13:10

95 Q. CHAIR: So it's basically directing the Trust not in terms of finance and how they deliver, but what has to be delivered?

A. Yes. 13:10

96 Q. CHAIR: Okay. And coming back to -- well two more questions from me. You'll be glad to know you'll be getting away soon. But joined up information, Encompass is designed to give joined up information to any clinician faced with a patient and to allow a patient a say in their own health care by giving them information. If I've got it in a nutshell that's what it's really designed to achieve. But in the current situation where a lot of people are now taking the situation that they find themselves in into their own hands and are paying for treatment privately, where is the interface between the private treatment and the Health Service treatment? How does that join up in terms of Encompass and providing a clinician who is 13:10 13:11

maybe to see someone in a private setting who then ends up in the health care system for other treatment? Where is the join up? I mean, for example, we saw a difficulty when there was a waiting list initiative with information being given to the private sector, one of the patients who came to speak to us, that information -- their file wasn't handed over, resulting in complications, and very serious complications for the patient. So where is the interface between the private sector and our health care system? 13:11

A. Yeah. So that's an interesting area and one where I might be able to give a fuller answer, if I was able to write. There is no -- clearly the independent sector won't have the Encompass system, so there's no automatic interconnectivity. Primary care have access to Encompass and so can have a sort of a read access to it. So one of the ways in which any connection might be made is through primary care. But we do have, and this goes to -- I think I made a point earlier about safety in two dimensions, one of which has the individual patient at the heart and one of which has all patients at the heart. So with information systems, Encompass might have the individual patient at the heart, but actually if you look at all of the data that's going to be needed Encompass isn't the answer to that problem, and so we're looking to create, something called a data institute, that would enable different sources of data to come together and for us to make sense of that in a better way. And that would then

13:11 13:12 13:12 13:12

inform the likes of the Balance Scorecard that I described in terms of Trust management. But I haven't specifically answered your question about the connection with the independent sector. And I think, I think it did come up in a meeting I was in, but I don't remember the detail of it, so I'd like to be able to write to you, if I may? 13:13

97 Q. CHAIR: That certainly would be useful just to know, because obviously from a patient safety point of view it is important that there is that connection in some way. 13:13

A. Yes.

98 Q. CHAIR: Then just one other thing. We're hearing this week from Mr. O'Brien, and we're very well aware of the waiting lists, and one of the points that he makes is that the emphasis in dealing with waiting lists and tackling them is always on the red flag, the cancer patient, whereas there are a lot of people languishing on waiting lists who are equally meritorious in terms of the treatment that they need, but the emphasis is always on the performance of cancer treatment. Now that's not to say that that's not important, but I just wonder has the Department thought about how can we address those people who aren't seen as red flag but may be urgent, may be routine, but who are actually suffering? 13:13 13:13 13:14

A. Well, I think that's at the heart of the challenge that we face at the moment. There is properly a clinical prioritisation, and that goes to the harm that might

come to the individual or the potential from intervention. And, as I said earlier, there is a reality that those on routine waiting lists are not getting to the top of those lists in anything like the timeframe that is acceptable. So our system needs to 13:14
be able to -- we need a way both of being able to meet the new ongoing demand that is coming in every day, week, month, year, and alongside that we will need some additional investment to address the backlog, because the backlog is causing ongoing challenges in all sorts 13:15
of areas that are then making it more difficult to deliver. So primary care, seeing people who are on waiting lists, coming back to them to say their complaints have got worst, or "Am I closer to the top of the list yet?" Our urgent and emergency care 13:15
departments are seeing people who are on a waiting list who maybe their condition has worsened and are then becoming patients there. If we were able to do those two things together then -- and that's easy to say and difficult to do, and I keep coming back to the 13:15
challenges that we face in the short-term, but our approach here is to try to develop an approach that will grow our capacity and then to recognise we are going to need some additional way of addressing some of the very significant backlog that we have at the 13:15
moment, because no -- investment just in more of what we've got is going to get us to where we need to get to in anything like an acceptable time period.

99 Q. CHAIR: I suppose part of that will be managing

expectations for patients. You know, you're saying that everybody expects if they have an issue that they can be treated straight away.

A. Well, yes, or -- yes, indeed.

100 Q. CHAIR: But equally I think one of the success stories, if you like, in the urology field is Lagan Valley and the day cases that are there. And I just wonder is there an education task here that the Department has in educating the public, "Look, you might have to leave Fermanagh and go to Belfast or vice versa, but it'll mean you'll get seen sooner", and I think there is something to be said for informing the public about how they can -- how you're setting about improving the health care system? 13:16 13:16

A. I absolutely think that there's always more that can be done by way of communication. We have had some recent examples where services have moved. Both -- for example, general surgery is not now -- emergency general surgery is not being delivered at either Daisy Hill or Southwest Acute Hospital, and the numbers of people affected are very small. There is -- there are some people who are concerned, but I actually -- I do believe that most people are accepting of the need to travel further to get a proper service, to make sure that the service they're getting is of the same quality there as they would be getting everywhere else, and we've got more to do to persuade others who have not yet got that far, and there's often a concern that because that service is leaving it means we don't need 13:16 13:17 13:17

the hospital at all, and that's not the reality. It is about working out what each hospital is for, and the blueprint document is designed to help to explain that and to say that, you know, this hospital might become a centre of excellence for these things rather than trying to deliver the full gambit of services. And, yes, that will mean some people will need to travel further and that there will be some inconvenience associated with that. But it is still -- it is actually practically going to be the only way that we can deliver a service. Clinicians don't wish to be part of small services where they don't feel they've got the necessary skill set because they don't get to do procedures often enough, and so on, and we can't assure the safety and quality of those services either. 13:18

CHAIR: Okay. Thank you very much, Mr. May. Your evidence has been very helpful.

A. Thank you.

CHAIR: So I think that's us finished for today and I'll see you all again tomorrow at 10:00 o'clock. Thank you. 13:18

THE INQUIRY ADJOURNED UNTIL WEDNESDAY, 10TH APRIL AT 10.00 A.M.