STERG – 28/7/2023 – agenda item (postponed to 29/9/2023)

Suggested themes and considerations for the SLT – Days 42 - 49

The aim:

- to build public trust and confidence in patient safety and person-centred quality care
- to raise professional standards within the Trust
- to address and make provision for good staff wellbeing and morale.

Transcript notes and analysis

- to listen and identify some learning as the PI is in progress, to support Maria in helping her to keep in touch with the emerging themes and to assist the Trust in using this lens to consider modifying practice.

- to reassure the staff, patients and the public that the Trust is listening and is making efforts in real time to improve the standard of care for patients and raise the bar in terms of professional standards. Some of this intelligence gathering may already be happening within the Trust as well and it would be interesting to compare notes.

- we are not sure when the PI Report will be published with its conclusions and recommendations, in the meantime the Trust can be seen to be proactive.

STERG - the emerging themes from the PI transcripts.

- can strategy, practice and evaluation be considered in response and some guidance given on a possible route map for the next steps and potential medium-term goals?

(Note – please refer to the documents Part 4.0 'Public Inquiry – notes and reflections' to give wider context to the points in the themes below. These papers have been circulated with 'Suggested themes and recommendations for the SLT')

THEMES

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

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1.Leadership and Governance

Tracking, clinical decision-making, and audit

Q. Could I just bring you then to the overarching SAI report. If we go to the section on governance and leadership, WIT-84302. It says in the third bullet point, it largely repeats the sentiment we've already seen, that: "There was no system to track if recommendations were appropriately completed". Can you see the sense, from a tracking perspective and from a patient's safety perspective, of having a tool, whether it is a live tracking device or whether it's some form of audit to be in place, to bring the monitoring of the treatment further along the line?

A. I can definitely see the benefits of it. If it was properly resourced and the functionally within CaPPS expanded to allow you to track a patient through -- say, they had a bladder cancer through maybe multiple occurrences or stuff like that, there definitely would be a benefit for the patient.

Q. In light of what we heard from you in evidence earlier this morning, would I be correct to form the impression that given the resources that you had at that time within tracking, it wouldn't have been feasible to do much more given the resources you had?

A. I would agree, that's totally right. The tracker were under immense pressure with increased workload. They were struggling to track what they were commissioned to track, you know, 31-day and 62-day to first definitive, let alone a whole patient's pathway for years.

How are the realistic expectations of staff working in the Trust set, monitored, reviewed, and adjusted?

Q. The incident report which I showed you there, the essence of it was that it appeared that a direct referral had been generated in your place in the Southern Trust but hadn't been received or dealt with in Belfast, and it took a GP to write in a year later and raise the alarm. Can you help us to understand what might have gone wrong there?

A. I suppose because -- I don't know the case exactly but I suppose one thing that could have went wrong is they had hormones commenced, their first definitive, then oncology referral was generated from the Southern Trust. Therefore, because they have been closed in CaPPS, they wouldn't have been tracking that to see that they had got the referral. It's the only explanation that I can give.

Q. But again, not knowing the case –

A. Yes.

Q. -- and I know we're in a sense speculating, but in terms of any case going that route, you've outlined the kind of correspondence that must be generated –

A. Yep.

Q. -- at your end, at the Southern end?

A. Yep.

Q. If that is not responded to for whatever reason, Belfast Trust have a computer problem or somebody is not doing their job properly or whatever it might be, what is the alarm bell in that situation; what is the safety net?

A. In my time I don't believe there was a safety net there, but looking back now, there needs to be one, you know, to follow up those patients that aren't being actively tracked. But once we have done

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our -- to me it is with the consultant, the patient is the consultant's responsibility. Because oncology referrals would also have been generated, it just wouldn't have been say a CaPPS oncology referral, most consultants would have followed that up with an actual written letter to oncology that maybe contained more information on that referral than the CaPPS referral.

Is there a safety net in place now for patients who are not being actively tracked?

Q. At WIT-80977, you are referring to the lookback exercise in relation to the role of the Cancer Tracker and the benefits of tracking patients past their first appointment. Is that improved, in your experience? I know the Panel heard the Cancer Tracker evidence this morning, but from your experience is that system in any way better for you?

A. I think there is still improvements to be made on it. I'm not sure if they are still funded to only go to that point of first definitive treatment. But there certainly is more engagement in relation to the audit processes.

Q. Now, you've said, looking back in your statement, that you didn't think governance arrangements were fit for purpose, and. Is that something that you still feel –

A. I felt from the outset when the Mandeville Unit opened, you know, where people went for cancer treatment, there was no footprint at all for Urology within that setting. I found that strange. It removed the opportunity of meeting on the corridor or seeing the door open in an office where you could put your head in and say 'any progress with, you know for example, the advertisement for the CNSs, or any new equipment requirements. We didn't have that. They were in their corridor and we were in ours and the two never passed, except there you would have seen these people at the AGM or MDT. There wasn't engagement all the time. We would have worked closely with the cancer trackers and red flag team. They would have been in and out of the unit so we would have significant engagement with them.

Q. Is that the situation now; is it still that disconnect?

A. There is more to do. I thought about these just recently. We are as a team improving and striving to continue to improve. I have no doubt the cancer team is doing that and others,

'the findings indicate a disconnect between Urology MDT and Cancer Services management'

'we just haven't had the opportunity yet to come together and say what all has been achieved thus far, and collectively how much further can we go.'

Has the SLT checked recently on the connecting progress between Urology MDT and Cancer Services?

Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently?

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of pathway tracking that was alluded to in the testimonies yesterday but, to the best of my knowledge, that isn't currently in position at present.

Q. And do you think that would be a good idea?

A. Absolutely.

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Note the improvement in the provision of a key worker for patients with a new diagnosis.

Has the SLT knowledge of how ready is the system to address 'whole pathway tracking'?

Q. Thank you. In terms of the key challenges that remain to be addressed arising out of the recommendations, you have highlighted already the difficulty that might affect more Trusts than the Southern Trust in dealing with the tracking issue. Is that the key challenge or the most difficult recommendation to comply with?

A. I think actually the whole thing around the audit of MDT, I'm not sure that any Trust is resourced to provide the level of audit that we would like to do. In regards of assurance around processes and systems of the MDT, and we have talked about it as a group of cancer operational managers, that it is definitely something that we would all like to do; we just haven't been resourced to do it. I know Southern Trust has gone at risk to appoint our two posts in, and we will see the benefit of all those posts in time. But it's at starting point, and we certainly would like to do much more audit than what we currently do. In particular around the key worker side of things, we also would like to audit and ensure that the key worker, in relation to those recommendations, they are actually doing what we say they are, you know, in that they are allocated, they have provided the information and those kind of things. We are not just resourced yet to do that.

Are there any interim audit measurements in place on the placement and effectiveness of the key worker role?

Quorate

Q. You do mention as well in your statement about the MDMs and the quoracy issue. We have heard something about that yesterday and have and will do from other witnesses. Your experience that was if there wasn't quoracy, then at times patients discussed at regional meetings. Can you just explain that, how that came about?

A. If there wasn't a radiologist on hand and a decision was pressing or was time-sensitive and needed to be made, that patient could have been added on to the regional meeting. It's not that they -- if we'd had a radiologist, that wouldn't have needed to have happened, but that's on occasion what did happen in order for the patient to proceed down their pathway.

Q. You have said that can lead to a delay in decision-making. Was that because of the infrequency of the regional meeting or because of some other reason?

A. Because the regional meeting is for specific cases that need to be discussed there. Had we had quoracy within our MDM, some of those cases that were discussed there perhaps wouldn't need to have happened there, so it's maybe putting stress on another MDM when it was really our responsibility to have a quorate MDM to have them discussed there.

Q. In practical terms, if a radiologist was absent locally and there was one available regionally, they could use their expertise?

A. Yeah, on occasion.

What percentage of patients currently are discussed at regional meetings due to lack of MDT quoracy in the Trust?

Q. The second point is the quoracy is low due to low clinical oncology and radiology attendance. It had been, in October 2017, 25% attendance and it was now 11% by May 2018. You say that only five

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meetings were quorate throughout 2017 and it is perceived that this has decreased even further. "Therefore, more patients are not benefiting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision-making process and treatment. 3. Long waits for routine referrals. Due to increasing number of referrals, services concentrating resource on meeting red flags and urgent demand. Routine referral waiting times have increased from 52 weeks to 128 weeks, present day. Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded." The Inquiry has heard evidence that routine referrals, sitting back, not getting priority because of the red flag in urgent referrals, posed a risk to patient safety. I presume that's something that you would agree with?

A. Yes.

Q. In relation to the quoracy, you have identified there delays in decision-making processes in treatment. So, the level of oversight that perhaps is anticipated by full attendance at MDT for Cancer Services is absent if quoracy is not met and the right people aren't round the table?

A. That's right.

What are the 2022/2023 quoracy figures for MDT meetings in Urology and cancer?

Job description, appraisal, and handover

Q. We will bear that reflection in mind and explore it for what it means shortly. But can you tell me from an organisational as well as an individual practitioner's perspective, what is the importance of job planning, in your view?

A. I think it's really very important. It's the key contractual document that should be a partnership approach between the consultant and the Trust to identify the supporting mechanisms that are needed to allow consultants to deliver the work. It's an opportunity for them to discuss with their clinical manager what is expected of them and what they will need to enable them to deliver that for the year ahead. So, it's very much a performance management type of tool in the sense of having those meaningful discussions to decide how is it possible to deliver the work that has been assigned, and it should also then feed into demand and capacity information so that that's driving the job planning discussions.

Q. You mentioned demand and capacity. Is job planning a tool which can address that issue?

A. I believe it has the potential to. I think that's the original intention of it in relation to it should commence with a review of what the service needs to deliver for the year ahead, with the service. That should be considered and then designed into individual or team job plans with job plan objectives to align, taking on board what supportive resources or supporting mechanisms a consultant may highlight at those meetings that are needed to deliver the service**. It allows then the service to ensure that objectives are aligned and job plans are aligned with the direction of travel that the service has to deliver and commission to.**

Currently - how streamlined is the flow from individual job planning to the objectives and direction of travel that the service has to deliver?

Q. I suppose, used properly, job planning, if it's actually done, will leave the employee, the clinician, with an understanding, and the manager would have an understanding, as to what's expected, and failure to deliver on what is expected will lead to questions or challenges being posed; is that fair?

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A. That's fair, yes.

Q. It provides a basis upon which inquiries can be made?

A. Absolutely.

Q. Those inquiries could potentially lead to a disciplinary route; is that fair?

A. Yeah, potentially, yes. I mean it's a contractual document so it's a contractual requirement on both parties to participate in it.

Q. Equally, in some cases the failure to deliver on objectives within a job plan might raise a wide range of other issues, the need for help or assistance?

A. Absolutely, yes.

Q. It may lead to conclusions in relation to how well the service, how well the employer is assisting the employee, supporting the employee to deliver on the plan. But it's important to have that baseline, isn't it?

A. Very important, yes

Taking time to establish a clear baseline for the contractual document between the employee and the employer is key to understanding and delivery.

Q. Okay. You described very eloquently potential uses of job planning?

A. Mm-hmm.

Q. The challenges, which I think many Trusts face; you would not be alone in that?

A. Yes.

Q. Again, have you an agreed strategic approach to this for the future led by a senior doctor who is saying this is what we are doing?

A. I think that's what we are moving towards. We have had early discussions with our local negotiating committee that this is the area we want to focus on, and our Medical Director is fully behind that and that's the direction we are going.

Q. Have you ever used job planning as the tool you described it could be used as the basis for disciplinary action, if somebody is not fulfilling their job plan? Has that ever been done actually?

A. Not to date, no

Q. Has it ever been done the other way around, to say this consultant can't fulfil their job plan and they need support?

A. Yes. No, I think that does happen, you know, in terms of some of those areas which are very good at job planning. I think our focus is we want to get back to the importance of a job plan meeting and actually having a face-to-face meeting.

Q. Have you actually taken a consultant to say you are not fulfilling your job plan, this is a problem, you have to do something, we have to do something together?

A. Yes. No, we haven't got to that stage, no.

The importance of having a face-to-face job planning meeting.

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Trust Board

Q. Mr. Devlin refers to reports that are sent up to the Board from the committees in his witness statement. He says that it is a fair reflection -- sorry, in evidence he said that it was a fair reflection that reports from committees aren't generally the subject of great debate or input at Board level?

A. Yes.

Q. Would that have been your experiences also?

A. It would. I think what the non-executive director members and the Chair of those committees would have brought for noting, you know, there would have been an update, maybe a verbal update on just what the last meeting had been about, et cetera. But I suppose the assumption was that's why you had the committee, the committee to do the work and to do the challenge, the discussion on behalf of the wider Trust Board. So, I would have said there wouldn't have been a lot of time spent on those at Trust Board.

Q. It seems that there was a slight shift, you have said, about the assumption in that assumption. Mr. Devlin states in his evidence: "It was not a regular occurrence for information that was discussed at committees to have any detailed conversation at the Trust Board." Then he goes on to say: "We did in probably October and November 2021 then begin to have a conversation about risk appetite and about what the process should be for escalating from committees to the Board."

A. We did.

Q. Given that was only in 2021 and given the historic nature of the issues before the Inquiry, do you think that conversation should have been happening sooner?

A. I think that's a fair comment.

Is the SLT confident that the Trust Board is now receiving and reviewing all the relevant reports and papers in accordance with the Trust's brief?

Silo mentality – segregation operationally as opposed to integrated working

Q. And why is it that escalation is regarded as a substitute for action. Now I don't expect you have to have the total solution to that, but do you have any reflections as to why that's the case, other than the extreme work pressure, which we have heard about and which is acknowledged and the complexity of the organisation, is there anything else, do you think, that's fundamentally responsible for the fact that a number of things don't seem to have filtered up to the right people?

A. Yes. There's probably something in the space and it's very much in the governance space, I guess, people being very clear on what their roles and responsibilities are and it's not necessarily somebody else's responsibility. So whether there is a diminution of people's understanding of what each person is responsible for and what you are certainly responsible for as a leader, I don't really have the answer to that. I do think, as you have articulated quite well, I suppose probably my own assessment and my own experience. Like I said, I would reiterate the fact that I do think it's not just as simple as saying culture, I think there is more to it than that. And I do believe there to be subcultures, but clearly it's a leadership challenge at all levels.

Q. So, in that vein, there is my impression, and I think we have heard evidence that people have concentrated very well in their areas –

A. Silos.

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Q. -- of the different committees and in their professionals areas, so you can call it silos, you can call it all sorts of things, but it doesn't seem to be integrated governance in action as far as the evidence we have heard. So what discussions have been had at Board level about how to make a more integrated approach to performance, et cetera, a reality, because it's another thing that's easy to say and difficult to do. My question is around does the Board regularly discuss this, has it discussed it, did you have any contribution to that discussion and, in that regard, what did you regard your role as a Board member in terms of facilitating the difficult discussions underneath some of these issues?

A. Okay.

Q. So that's quite a broad area.

A. There's quite a lot there, yes.

Q. It's about integrated governance and how you as a Board member can execute your responsibility for everything, it's not just within your portfolio?

A. Sure.

Q. And whether the Board in a wider sense really grasps the need for that given the breadth of the issues you are facing?

A. So if I start with thinking about the intent of the Performance Committee, for example.

Q. Yes.

A. The intent behind the Performance Committee was to consider performance in a broader optic, and not just about –

Q. The numbers?

A. -- the targets et cetera. So when we would have had a session on cancer or whatever, I mean the Board determined whatever area to drill down into in a deep dive type thing, it was an opportunity then as Board members to really get under the surface of some of those things.

Q. Did you, do you think?

A. No, I think we made a start. I think we did make a start. What I can say as a member of the senior -- here's how I measure that: As a member of the senior management team those meetings started in October 2019 and at every meeting I learned something. I think that is a measure of what I wasn't otherwise finding out some way else. So there was an opportunity for people to talk people into the other issues they were facing within their services et cetera. So I think that could be part of the solution certainly going forward.

'but it doesn't seem to be integrated governance in action as far as the evidence we have heard'

On a scale of 0 – 10(being fully integrated) where does the SLT rate the current level of integrated governance?

Priorities

Q. Now, I asked you before the break about learning, and I think it was my word to say **there was ad hoc learning from the SAIs.** I just want to indicate from your witness statement that you are a member of the Task and Finish group. You refer to this at WIT-85936 at paragraph 20.5. This was a group established in 2021 to action the outcomes of the Urology SAI recommendations by the Trust?

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A. Yes.

Q. Is this a way in which learning comes back out through the formal system to the CNS, or does the learning sit within the group?

A. So, in a way it's turning the learning into an action that results hopefully in an improvement. Myself and Kate - I think it's myself and - no, myself and Patricia - are within that Task and Finish group. But as for updating the CNSes per se, no, that isn't part of the remit of that group.

Q. So when it's tasked to action the outcomes of the recommendations, how do they do that?

A. So, I have been involved with the service user group. There's going to be a survey as to what information and role they expect within their journey, and we are looking at the information that's given. Out of also this Task and Finish group, I think that is where the additional audit resource has come from in terms of us now having a list each month of the new diagnoses and being able to cross-reference those. So there has been good that has come out of it, but there's more to be done.

How robust are the plans to cascade and embed the learning from the Urology Public Inquiry throughout the Trust so that a similar statement 'there was ad hoc learning from the SAIs' will not hold true?

Q. Yes. To try to summarise your experience over the last 10 or 15 years in performance –

A. Mm-hmm.

Q. -- in measuring performance and trying to assess what flows from it and what can be done about the difficulties and pressures faced, is it the reality that demand has outstripped, and continues to outstrip, the capacity to address the needs of patients in your local population across SEC as well as Cancer Services?

A. Yes, that's a fair enough reflection. It's not unique to Urology, it's actually the case for a number of the specialty areas.

Q. The Trust recognises that this places patients at risk and has communicated that to the Commissioner?

A. Yes.

When the Trust last communicated to the Commissioner that demand continues to outstrip capacity

In Urology - what was the response?

Training

Q. Your view that it's an important tool, or potentially important tool, together with something like appraisal which may allow the Trust to better understand what's going on in a clinician's practice, the challenges he or she is facing, issues that perhaps lie beneath the surface which have not yet been identified, all of those things are potentially discoverable through a good, robust job planning process?

A. Mm-hmm.

Q. The fact that this was let sit for so long and never delivered, does that perhaps reflect a failure to understand on the part of medical management the potential wins or gains that can be achieved through good job planning?

A. I think that's fair, yes.

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Q. Is there any ongoing work, or any work in light of what we know happened in Mr. O'Brien's case, around job planning?

A. Yeah. There's constant work with job planning in terms of working with our local negotiating committee and providing training sessions, and lots of things to try and see how we can support clinical managers because it is an important task, but also ensuring that it's a doable ask for them. But yes, we are trying to put a lot of effort into -- because job planning is also a tool to attract doctors to the Trust, and to use as a retention tool as well. So, we are looking at how job planning can be used imaginatively. It's a professional contract between consultants and their Trust, but to use it in a way that we can actually use it as a retention tool and an attraction tool as well. We are looking at it from all of those aspects.

The importance of training to a good standard all those involved in job planning and drawing up professional contracts.

Q. Why do we have a situation where, from some witnesses who put their hands up to do a medical management role, whether it's clinical director or associate medical director, why does it appear, at least in some situations, to be the case that senior medical managers are coming in when they don't have the right amount of time available to them, haven't had training, obviously are unable to attend important meetings –

A. Mm-hmm.

Q. -- why does that continue to be a problem and one which, if I may say so, the Trust has just had to tolerate or accept?

A. I think the difficulty is medical management posts are not commissioned, they are not funded, they are not resourced. The responsibilities, I think, have extended significantly in recent years as a result of, you know, all of the different processes that are put in to manage and that they are responsible for and the demands on the service. Our workforce plans, I don't believe, have taken into account, I suppose, the fact that we need clinical managers leading and that, therefore, then takes them out of their clinical practice. I think the demands on the hospitals are so significant that that's a very challenging thing to do. But if it was properly commissioned and resourced and training associated behind it, then I think you would get individuals who are -- you know, we are seeing now adept fellows is a thing which has been established where junior doctors are taking time out of their training scheme to buddy up with a line manager and work on leadership projects, which is a really good positive step forward we wouldn't have had in the past. So that gives an introduction to management, but that probably needs to continue and have the opportunity that you are not just a consultant one day and clinical director the next, but there's actually a formal process and career path for clinical managers to follow

Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers?

Q. You also mentioned that there are no standards for a clinical leadership but there are standards, aren't there? The GMC sets out standards. There's the Federation Medical Leadership and Management Standards; there's a range of competencies. Is the Trust attempting to bring some formality to those competencies in in its training programme, or is this also still work in progress?

A. Yeah, I think that's something that's being considered in terms of some of these development programmes for clinical management leadership structures. That has been covered in previous

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leadership training programmes. I think when you have a cohort of staff and changeover of medical managers, it has to be ongoing continuous thing.

Recognising that there will always be an element of staff changeover - are systems lined up and the training in place to make sure that all new staff are up to speed with the relevant standards?

A.At that stage there was no corporate programme for training staff on incident reporting, risk management, because if you don't train staff on how to report an incident, you get a lot of unnecessary work later on, you know, if they grade something either catastrophic that wasn't; or vice versa, you can miss the importance. The coordinator should also have a role in terms of themeing your incidents that are coming in, and really pushing near miss reporting. We just weren't doing any near miss reporting at that stage. **You want to get your near misses reporting done because that's your opportunity to fix systems before there's harm done. That wasn't happening; there just wasn't the capacity to do it.**

How widespread in the Trust is training for staff on incident reporting and near miss reporting?

Q. Again, the system for spotting what the Trust has called irregular prescribing, is it down to the alert pharmacist on the ward spotting the problem or is there a more sensitive way that these kinds of issues could be spotted if they were to occur again?

A. Unfortunately, at the minute it is still down to alert staff, whether it is the pharmacist or obviously the nursing staff or other medical staff. Our prescribing system in Northern Ireland based on wards and medicines administration system is paper-based, so there is no way of sitting back and having an overview. Now, I'm sure you have maybe heard already from other witnesses about Encompass that is coming. It's unfortunate. Back in 2015, I was sitting on a working group. They were going to introduce electronic prescribing and medicines administration system to all Trusts back, I think, 2015. In 2015/2016 that work was stood down because they thought at that point Encompass was going to come quite quickly and there was no point in investing in a standalone system when a bigger system was going to knock it out, you know, knock its position. So, that work was stood down. Today, we still have a paper-based system until Encompass starts in the South Eastern Trust later this year. If you have a full electronic prescribing system administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It would allow you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having alarms ringing, shall we say, that there was something unusual happening.

With the Encompass system being introduced later this year in the Trust, have training opportunities for all staff using this system been mapped out ensuring that the training is accessed before its introduction?

MHPS

Oversight Group

Management

Q. You speak about learning and improvement in your statement. We don't need to go to it but it's at WIT-85932. You have given some bullet points of the way in which communication and action planning could be improved. Some of these focused particularly on practical application of your skills to the

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system, if I can put it like that. You have said that one of the ways in which the system could be improved is to enable clinical nurse specialists to have access to a managed DARO list. Could you just explain that a little bit?

A. So, this is a list that secretaries hold for the consultants. I think the actual terminology is Discharging Awaiting Review or Outcome. These are patients waiting scans or a blood result to come back. I'm thinking more of this in terms of my nurse-led work as a safety net for that. At present, I don't have any way of monitoring, apart from me keeping it all on a spreadsheet and revisiting it every week. If I have ordered a scan for a patient, currently the radiology scans don't come back to the nurse that ordered them, they will come back to the consultant. They don't populate in my ECR automatically for sign-off. I now have it set up that my PSA bloods come back to me, so I don't have to go, and not waste time but use time to find them. They are populated on a list, a sign-off list that I can just go to, but the same doesn't happen for the scans. It's just another layer of safety that could be there and prompting me that to look for that.

Q. So you might order the scan as such but the result goes back to the clinician?

A. Yes.

Q. Would it be something that might assist if the result were to go back to both you and the clinician?

A.Yeah.

Is this an idea that the SLT agrees with, if so, what are the steps to implementation?

Q. Just in relation to the concerns overall, you say that you feel "I should have been made aware of the aforementioned governance concerns within Urology." Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

A. Absolutely, and then there's a balance to be struck.

Q. But if you had have known about issues sooner, what difference do you think it might have made?

A. For a start, you would have had more of an awareness. Referring back to the two cases that we discussed, I think I would have handled those very differently had I had an awareness that there were issues in and around those processes.

Q. And handled differently how?

A. I would have went to my lead nurse and my Head of Service also.

Q. So, you would have escalated the issue?

A. Yes.

'Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

Absolutely, and then there's a balance to be struck'

How does the SLT define this balance and then communicate it throughout the Trust?

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Q. How would you explain that? Is that explicable, that issues would be troubling management for, let's call it several years, and yet nobody saw fit to elevate it on to a formal process until 2016? How is that explicable? Does that tell us that managers didn't understand? Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated? What's your best assessment?

A. Potentially a factor of all of those, I think. I mean they were aware there was a Medical HR Department, so I think that that shouldn't have -- we should have been contacted, and I don't know the reason why we weren't. I think there's some work we need to do in changing that culture, that you know maybe there's a feeling if you contact HR, they're going to escalate things to a formal matter whenever it's not necessarily about that. You know, there's lots of positive things that can come from an MHPS process, it's not a negative thing. There's lots of supportive measures that can be considered; there's lots of structure and framework that can be put around to support individuals to get an early resolution. I think there's maybe a fear that if you tell HR, that it's like pressing the button, a nuclear button, and things will be escalated. Maybe that's what we need to ensure is not engrained in thinking. I'd like to think that's not a case now, we are contacted very regularly by our clinical managers about issues just for advice and reassurance in terms of how they are handling things. But maybe back then, there was more fear around that all.

'Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated?'

Is there an element of fear that still exists in the Trust when it comes to dealing with the shortcomings of some clinicians?

Q. I was going to start with that one. Just following on from that, is there a single person in the Trust who is leading any sort of, you know, big idea, innovative approach to recruitment for medical staff specifically? Where does that sit?

A. Well, it probably sits within our HR Director's remit in terms of, you know, we do have recruitment campaigns –

Q. But have you got a big strategic idea –

A. Yeah. I think it's something we are looking at.

Q. That the Board is involved in? I mean, this is a Board issue really?

A. Of course.

Q. It is so significant. Is that there or –

A. We have it listed on our Corporate Risk Register in terms of our ability to recruit medical staff.

Q. Have you got somebody saying I am in charge of this?

A. Yes. Possibly not.

Is there a plan to have a lead in the Trust with this responsibility?

Q. The other thing that has come out is a sort of secrecy and mystery and all of that, but also a reluctance to manage doctors, not just not to ring HR, which you have described as perhaps due to fear of process. I am presuming you are implying that HR is trying to be less scary in that regard?

A. Yes.

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Q. But there also seems to be a general reluctance for doctors to manage doctors, for managers to manage doctors. Is that something you have observed, and why do you think that is?

A. Yeah, I think it probably has been something -- I guess medical staff are -- they are so used to being autonomous workers and independent workers. But it's difficult. I mean, it's not something that I think -- I think it's a journey that we are on in terms of ensuring that they are managed in the same way as anyone else would be managed, and I think that's important.

Q. Do you think that's improving? A. Yes, I definitely do.

Note - the importance of continuing this journey of consistency, transparency, fairness, and equality with all the staff in the Trust.

Can I just be clear because it's perhaps my misunderstanding of the language used here, but it seemed to me that you talked a lot about escalation. To my mind, escalation is where you move something up to somebody more senior so that they can do something about it. Sending it back to the head of service, to my mind, is really not escalation. Is that not just sort of, well, you know, this is your problem, you need to deal with it?

A. Do you mean the head of service within the specialty?

Q. Within Urology, yes.

A. Generally, whenever I was escalating any issue, that would have gone through to the operational support lead, to the head of service and the assistant director within that area.

Having raised an issue to be escalated in the correct sequence, what is the guidance on action when the issue remains on this person's desk and goes no further?

Q. "What we really need in the Trust is the recruitment of a radiologist with an interest in general urology, someone that can partake in the GU Service and attend and take the MDT. The only way to achieve this is to make a real attempt to recruit by putting out interesting job plans that offer more than the bare minimum, mentions of flexibility, offsite SPA, more than 1.5 SPAs, recruitment and retention premia. I remain unclear why the Trust does exactly the opposite and how it expects to recruit in the circumstances, which leaves me, as a sole practitioner, which is not safe and not recommended by the College." So you're explaining yourself in fairly strident terms.

Q. Did you ever get direct feedback yourself on this point that you're making, that we need to, as an organisation, make the role more attractive, to be more proactive in our recruiting strategy?

A. No, I don't think so. I think this was something that I suggested a number of times over the years and I didn't get any feedback.

How does HR review the quality of its recruitment strategy and content of job adverts?

Q. The inquiry has heard some evidence about I suppose the difficulties faced by medical managers, those in the AMD, CD Clinical Lead cadre; busy clinical practices but also a heavy job description that goes with these managerial roles?

A. Very much so.

Q. Any particular reflections to offer on how that might be done better?

A. Again, I suppose it came back to when I put the proposal in about giving protected time for, particularly, clinical staff to focus on governance. I would still have that opinion, either that or maybe

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outsource some of it to - what I am doing at the moment - recently retired people who are still experienced enough that they can bring their recent knowledge to Chair SAIs and take that pressure off Trusts. But I think the Assistant Directors were slaughtered at the time, and they still are in terms of their workload. So things like this were a tiny -- I know they weren't -- in terms of significance, they weren't tiny but in terms of their massive workload. Also, the Assistant Directors as well would have been carrying a one-in-six on-call rota on top of their day job. In terms of the operational management of the hospital and the out-of-hours and weekend period, there wasn't such a thing as compensatory rest for that level of staff. It was massive. Even though, yes, for those poor patients, it's a huge impact, in terms of the daily workload, trying to find time to focus and keep on top of meetings and things, it was just huge for the Director and the Assistant Directors as well.

Q. Is there a sense or do you have an experience of is it left to those in operational management to give informal nudges to clinicians to get things done, and get things done better if there were shortcomings, but really it's up to the medical management, the AMD, to take more decisive action if the operational managers are not able to achieve a successful outcome, and at least exhibited through interactions between some medical managers and Mr. O'Brien, there has been a slowness about taking robust action so that things are allowed to drift. Is that part of a culture that you recognise more generally?

A. I wouldn't call it a culture as such but it is probably a symptom of how job plans and things are arranged in terms of obviously the medical staff, their focus is their patient-facing activity. Obviously the operational staff see the issues starting, and they see -- the admin team and the governance would have known that maybe a panel wasn't meeting, so they would have nudged. Actually if then there was some reason that there was a decision not to meet, they couldn't make the consultant meet or run that panel, because they weren't in any sort of line management control. So it had to go back to the medical management line if the nudges weren't working.

Q. Yes.

A. So, it was out with their scope of control to make it happen

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What are the criteria for the SLT in considering the potential for outsourcing some of the Trust's work to ease the pressure on workload?

Does the view 'I think the Assistant Directors were slaughtered at the time' hold true in the Trust currently?

The Panel have heard some -- as you say, the Chief Executive post was a position held by numerous people over the years. Did you think that was a particular cause of concern for you as a director?

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A. Oh, it definitely was. I mean, of course it is. The senior team needs -- for me, it was about trying to redefine. You know, I changed what I did. I think I mentioned in my witness statement as well in terms of trying -- as each Chief Executive comes in or is trying to navigate their paths, their vision and how they wish to have things done, a director with the responsibility for planning and performance et cetera, I would have been working differently and trying to drive forward the vision of the Chief Executive and work closely with the Chief Executive. So, that was a challenge. It was a challenge also because it wasn't just Chief Executive changes. You'll have heard from some of the other evidence, I am sure, but we did have changes to our senior team in terms of creating a new role in the Director of Nursing, and different things that were shifting. For the matters pertaining to this Inquiry, the assistant director team and the Acute Director was a very stable team as in it hadn't changed over that period of time, but there was a lot of change and movement within it. I mention also that within the Governance team, and I think Tracey Boyce's evidence yesterday alluded to that in terms of quite a lot of changes in that as well. So, all of those changes do make it more difficult. There has been a lot of expertise lost and experience lost.

Q. It is also the case that some of the changes brought about by new Chief Executives can also be beneficial?

A. Oh, absolutely

The senior team in the Trust has seen significant personnel role changes in the last ten years with the potential loss of corporate memory. How is the SLT addressing the challenges in nourishing and establishing stability and consistency in senior post holding going forward?

Q. When they are on their third or fourth time ringing up, what kinds of things did they say to you?

A. Well, a lot of it was frustration. It was frustration too on my part because there was nothing we could do. I think they accepted that, that it was out of our hands.

Q. Was there ever a time, for example, when you could liaise with some of the nurses or someone else to talk to them, because a lot of them would have had quite clinical complaints, I would think, and they would need someone to talk to. Were there any discussions about how that might be managed within urology, as far as you were aware?

A. We were never actually advised that we had the nurses there for a backup. That was never something that I was aware of, and I don't believe any of the other secretaries ever transferred to the clinical nurse specialist.

Q. What do you think; do you think that would have been helpful?

A. Well, I know now that that is expected and, yes, it would be very helpful. But at that particular time, those clinical nurse specialists were up to their eyes with work so they didn't need patient calls as well. You know, they were under-resourced as well.

What is the view of the SLT on CNS's being available to support secretaries when patients are frequent callers?

Q. "This incident demonstrated that the secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every attendance on a timely basis. I would have expected that Noleen Elliott, Mr. O'Brien's secretary, would have been following up with her consultant Mr. O'Brien to advise that he had not dictated on clinics. Also I would have expected that when she was aware of delays in dictation, she would have brought that to the attention of her service administrator, Andrea Cunningham. If this

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had happened, this would have been apparent on the backlog report and would be visible to myself", and those others she mentions. Do you accept that criticism, that this was an aspect of your role that you should have been performing?

A. Not really, no. As I said I looked -- I believe that that backlog report was a secretarial backlog report. I was never told that I was to highlight the backlog of a consultant on that backlog report. There was that mechanism of that 3D report that was already in the system for the service administrator to see what was outstanding.

Do all the secretaries in the Trust have a complete understanding of the full purpose and requirement of the Backlog Report?

Katherine Robinson is reporting to Anita Carroll, "see the attached list". "This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome to some of these patients. There is a risk that something could be missed so I am escalating to you although I know that a lot of the time Mr. O'Brien knows himself what has to happen with patients. Unfortunately this was not highlighted on the Backlog Report."

We have just looked at an example of what a backlog report looks like. "The secretary assumed we knew because there has always been issues with this particular consultant's admin work from our perspective. As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality. The secretary also advised that at present Mr. O'Brien is working is some of his backlog admin report as he is off recovering."

'As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality'

How regularly is the Backlog Report being monitored for adherence?

Q. If that patient had been on DARO, the service would have had visibility of the fact that results had come in from radiology; isn't that right?

A. That's right, yes.

Q. And would have had visibility that those results hadn't been actioned because the case still remained on DARO?

A. Yes. So our service administrator -- the narrative, should that person have been on DARO, how I would have validated that DARO would have been "result with Mr. O'Brien to see and action". Now, that happened on a regular basis but our service administrator never came back to say why has this not been actioned, so I'm not sure whether it would have went anywhere. All right, it would have been noted on the DARO but whether those sorts of things were ever actioned, I am not concerned -- I am not convinced that they were.

Is the monitoring of DARO a watertight system in practice?

Q. Yes, but what I'm saying is regardless of whether the patient is on a tracking system, if you as the secretary see something untoward in the result, do you have any role - I am thinking here from the perspective of an additional safety net - to get the thing moving with the cancer tracker?

A. No, no. No role, if that's what you are saying.

Q. You had no role in that respect?

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A. No. I never referred anything to the cancer tracker for MDT discussion.

Post Inquiry – will there be a refresh on the role and responsibilities for all secretaries within the Trust?

Trust Improvements

Q. "If I or others, while working as a Cancer Tracker MDT coordinator Band 4 or as Cancer Services Coordinator Band 5, raised any concerns that were identified as a serious adverse incident, I do not recall being advised of the outcome of any investigation if it was logged onto the Datix". This, you say, was due to being a Band 4 or Band 5, and it was your understanding that you did not need to know. So that I can fully understand, hopefully I've got this right, you might have raised a Datix incident report, we've seen one example already and I think you cite other examples?

A. Yes.

Q. You've raised them because of a concern that clinicians providing a service to patients which impacts on your service were maybe - this was the reason for the investigation - were maybe not doing their job properly; there had been some issue or concern, perhaps a delay, leading to an impact or potential impact for the patient. Is it not important that you should know how such reports have been dealt with so that you can learn –

A. Yes, I would agree.

Q. -- for the future?

A. Yes, I would agree with that. I think it is very important for that information to be passed down so I was aware and I could also make my team aware, because if you don't know what's happened or what's went wrong, how do you fix it?

The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked?

Q. You have also said that the CNSes are now allocated to the consultants' result clinic. When did that process start?

A. That would have started when we came back from our period of redeployment in probably March '21. At the same time, the managerial duties were taken over by the manager of Outpatients. Basically, my managerial duties were taken over by Outpatients, and the manager of Outpatients was responsible for managing the other staff. That freed up the nurses to be able to be more proactive within that role. What happens now is night and day as compared to what would happened at the beginning of my tenure. So, we get the schedules through, we know when the clinics are happening. Usually because I can do the e-roster from my previous role, I have kept that on for just the CNS team. So, once we know what clinics are running, I can allocate a CNS to that clinic. What the CNS does in the morning or the afternoon of that clinic, she has the clinic list in front of her; she will screen through using ECR; she will know exactly how many patients require the key worker input; she will have all her information sitting, and indeed she will be proactively in the consultation with the patient, the consultant, and family.

Q. That's expected that the nurse is in that consultation for the results?

A. Yes.

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Q. Is that a result of two things, the reduction in the admin duty appointment of someone to take over those duties –

A. Yes.

Q. -- and also greater resources for CNS?

A. Yes.

The success of a nurse-led intervention – a development in practice and a good news story. How can the SLT/communications department relay 'good news/constructive developments' to the Trust - boosting morale and narrative?

Q. You have reflected as well at paragraph 24.5 of your statement that when you raised matters through the escalation process, you didn't receive any response. Typically you were, if you like, out of the loop or kept out of the loop in what was being done or what had been done. Do you feel that more feedback to teams on the ground carrying out your kind of role would have been useful?

A. Yes. It would have been useful to know -- obviously we don't need to know everything that's going on and some of those things were confidential, but it would be -- even just to know that, you know, we are dealing with it and take our reassurance that we are dealing with it, because there was a feeling that we were continually escalating things; we were, if you like, adhering to our side of the process but we weren't really sure what was happening outside of that. So yes, it would have been nice to know that.

Note – another witness expressing the importance of 'closing the loop' when they have raised a matter through the escalation process.

Q. "I believe the previous governance arrangements relating to the Cancer MDTs were not sufficiently robust to identify the issues in Urology." "A cancer MDT administrator was appointed in January 2022. They are now leading on establishing robust governance arrangements around the cancer MDTs."

A. Yes.

Q. And that's in place. How effective are all of those posts, those additional posts, how effective are they in bolstering or reassuring you around governance?

A. Those are very effective, you know. They can run reports to give us an assurance that when decisions are made at MDT, that, you know, we can now monitor the outcomes and assure ourselves that those outcomes are actually happening.

Q. He does mention that the peer review process was stood down during Covid and, at the time of his statement, had not recommenced. Has that recommenced, do you know?

A. Not a formal commissioning of peer review or peer review visits; that isn't happening. However, in the absence of that, I think it's good practice to continue to monitor our MDTs against the measures that are there. So, you know, our service improvement will continue to monitor our quoracy, monitor key worker role. That work will continue to happen, even though it's not properly commissioned or we do not have formal site visits.

Are the plans for peer review and peer review visits to start again?

Q. Yes. The SAI made some recommendations about how things could be done better. I suppose if you didn't appreciate that things weren't entirely optimal, then you perhaps didn't appreciate the need

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for improvements but I'll ask the question anyway. Have you noticed any change in the MDM environment since these issues emerged in 2020/'21? Have you noticed things being done differently? For example, is the team -- is the membership of the meeting better supported in any way, is it better organised, is the discussion any different?

A. A lot of it's similar but there seems to be more emphasis on particularly making sure the patient has a key worker. That's one thing, or a nurse who's kind of looking after that patient. That's something that I have noticed, there's been more emphasis on that. Maybe some other things but I can't really put my finger on them particularly. But there just seems to be maybe more structure and...

Q. Yes. The Trust have carved out a new role for the person on the management side, if you like, who attends. So it's now an Angela Muldrew who is the MDT coordinator. It is said of her that her time, she's now better enabled to give more focus and more support to the needs of the MDT. Is that something you've observed from your role or do you think that's more recognisable in the hands of a urologist?

A. Yes. I think the urologists would know more.

The have been recent improvements in Urology in the Southern Trust - in meeting quoracy at MDT, the appointment of a second radiologist, the appointment of an MDT coordinator and the addition of more CNS's. These developments will have contributed to raising staff morale and improving the delivery of patient safety and care.

Q. Is there anything within the current system that allows you, the radiologist, or the tracker or any other responsible person to know that the clinician hasn't yet actioned the report?

A. Yes. So, this is what I mean by more recent changes. These are things that are being worked on. As we currently are, there is no way of knowing what's happened.

Q. So, there is a mechanism by which you can check to see administratively whether your report has gone out, you do the dictation and it's checked. Then does an administrator, a clerical person, issue that for you?

A. No. So, if the report goes automatically electronically, it just goes out, straight onto automatic, straight onto the electronic care record. There is a paper report sent as well at some point. It will be a little bit slower, obviously. That's done by the administration staff. If there's a flag put on, then that's when the administration staff would be involved as well. They would send the email to the referrer.

Q. So, as we stand in 2023, where do you think the gaps and the improvements are necessary?

A. Well, there's lots of improvements that -- I mean, there really is a lot of improvements that are possible, from using, you know, mobile devices to be able to alert consultants; you have to be sure who's covering and you have to make sure that the report goes back to someone who's actually available, not someone who's on leave; or there is a safe mechanism for someone else to check if someone else is away. There has to be an acknowledgment of reports; when you receive them that you have to acknowledge that you've received them. If there's recommendations, then someone has to check that those recommendations have been followed, or if they have not been followed, why they have not been followed. Lots of back-up, admin staff to do all these tasks of reporting and checking. So there's quite a lot of change.

What are the SLT's thoughts on these suggestions?

Is there anything else you would like to say or want to cover while you're here?

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A. No. Other than, you know, I'm very sorry for the position that we're in and it's a source of deep regret for me for that. In terms of some of the work that's going on now to address maybe improvements, and particularly the governance link, I think some of that is going in the right direction. We described the governance report. One of the things I had started, and it's maybe just because as I'm talking now - I don't think it's in my witness statement - some things that I think is important in terms of relationships and stability within the Trust and the leadership and bringing together information, is, I had, as you know in my witness statement there, some responsibility around the quality improvement sort of agenda. In particular, in 2016 I had established a quality improvement steering group, which was intended at that time to do what the systems don't do yet, which is a bit more triangulation of information and insights from a number of sources. That group had been established, but it never really got full traction because of the changes in personnel, et cetera. It continued to meet. But I think there is something there in terms of learning around, aside from just data driven - which is important - data driven indicators and change and bringing information together. But the relationships particularly across the professional disciplines, that steering group we had established had the Head of Social Work, Head of Nursing, Head of Medicine, with a key indicator around enabling our workforce. One of the thing that was described, I suppose now that you have asked the question, I did hear some evidence from Marc Williams. One of the comments he made is that the organisation didn't encourage people to improve services. I would disagree with that quite strongly. I think the point of establishing the quality improvement function within the organisation was to do just that. We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted. In the first year of establishing the improvement team, Dr. Wright and I had established from the governance agendas, and in particular the complaints data, around issues around communication and, at that time, infection prevention control. We did a campaign with staff on a broad spectrum of encouraging people to do improvement projects, and we committed in support of 15 projects in that year, taking information that was coming from governance. I think that's something that could still be done more, that there could be a bit more done in that space.

'We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted'

Has the SLT updated its approach to quality improvement projects?

2. Quality and patient safety

Q. What was the impact of delays in returning triage for you and your staff, first of all?

A. It was a lot of chasing up for the red flag appointment team because they were constantly checking what was coming back in, updating their spreadsheet. If they're still outstanding and they still maybe would have escalating again that these are still outstanding. The trackers then would have been updating the CaPPS System, linking in with the red flag appointment team. It probably would have caused a lot of emails back and forwards trying to track the progress for each patients. And still being mindful that their clock was ticking and you were trying to get the patients in to be seen.

Q. So, against the background where there are all sorts of pressures, as you have described –

A. Yep.

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Q. -- this was an added difficulty that you could have done without?

A. An additional pressure, yes.

Q. Was there a concern that delay risked harm to patients?

A. I don't think at that point, no, there wouldn't have been. It would more just to get the referral back just to get the patient seen in clinic. As I say, at time investigations could have been questioned by the time the referral had been returned.

An example of how an incomplete task in one part of the system can have knock-on effects on other people in delivering their roles and most importantly on the care of patients.

Q. And you agree that there should have been a key worker allocated?

A. Absolutely and I struggled with trying to determine why that wouldn't be the case. I did note, on looking back at the evidence, that some of the patients were admitted through the Emergency Department and that progressed, you know their diagnosis. We did not have the resource to check who was on the in-patient ward at any given time. If patients were admitted through ED and were diagnosed with a cancer of whatever nature in relation to Urology, we depended on the consultant or registrar to let the CNS team know that, so that we could go up and meet them with their family and bring information to them. And we have done that on occasions, we would hope with additional resources and the way we are planning things now that we can do, you know, there is more improvements to be made in relation to that.

Has the loop-hole of patients who come through ED onto a cancer ward been addressed in relation to having access to a key worker?

Q. You reflect on those cases in your witness statement at 7.28. You say: "I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done. From my perspective, I feel I could have been better informed regarding what had or had not been done about my concerns". In this regard, those were concerns that hadn't actually been raised with anyone beyond Mr. Haynes?

A. Correct.

Q. You didn't raise them with Martina Corrigan –

A. No.

Q. -- or with anyone within your own line management in nursing?

A. Yes. And with hindsight, I think if I had to do that again, that's what would have happened.

"I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done''

Important recognition of the anxiety that patients can endure on waiting lists.

Q. We have seen that letters weren't automatically copied to patients from the doctors, but we get the impressions that the nurses usually did do that; is that your experience?

A. Yeah. I know within my nurse-led clinics, I would always copy the letter to the patient. A number of the consultants do this also.

Q. Is that happening more now, do you think? Not universally, possibly.

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A. I think it's the same as what it had been, yeah.

What is the SLT's line on the policy of patients automatically being copied in to letters from doctors?

Q. You mentioned a range of KPIs. Do you ever see those KPIs for the cancer nurse specialists or does that go as well as?

A. For the nurses in my area of responsibility, yes.

Q. What are the recurring themes from that, if you had to summarise it for us? You know, they are doing a lot of very important work; are there some recurrent issues coming up from their KPIs that you have had to take on board in terms of making improvements, for example?

A. I think one of the KPIs is regularly doing a holistic needs assessment with patients. You know, yes, when patients have a diagnosis, they want to know what's happening to me, what's my treatment planned, how long can I expect this to last, and then obviously, you know, when patients get to the end of their treatment, we, at that point, try to do another holistic needs to see, do an end of treatment summary to see what the key issues are moving forward and how we can support those patients living with and beyond their cancer diagnosis.

Q. Does that go to a Trust committee on patient experience, or how do you –

A. Yes.

Q. -- report upwards on that?

A. So, that would go to our PPI Panel within the Trust.

Note – the important value to the patient and the clinician of conducting a holistic needs assessment with the patient

Q. You've reflected in your statement - I needn't bring it up on the screen but it's WIT-60286 - that you received support from urologists in relation to your expressions of concern around the standard of the independent sector work.

A. Yes, I think that's true. My memory is not very clear on that but I do remember some of the urologists not being too happy about the reports, yes.

Is the SLT happy with how the Trust monitors the quality standards of any services provided by the independent sector in the Trust?

Q. You got into this helping governance out roll particularly because of your background, I think, in the patient safety research, and governance alongside that. What was the biggest thing you learned from that research? Then, if you had been able to do something really that would have made a big difference in the Trust, what would that have been based on that, because it's bound to have changed your outlook considerably.

A. Hmm, that's a good question. Probably for me, the thing I learned the most was the value of near miss reporting or no harm incident. I think for me that was one of the biggest things because the number of times when you look at something serious, for example if you take the case of the -- the thing that really got me interesting was the case of Wayne Jowett, if you know it?

Q. Yes, I know it well.

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A. So, that piqued my interest way back in 2000 in terms of how that could have happened. When you read into his case, he was the tenth child or adult to die as a result of that incident. The fact when you start to look into that and you get into the background to that, the number of times there have been near misses with heterocycle chemotherapy like that, where luckily someone had spotted it. To me, that was a big driver for me in all the work I did, to try and encourage staff to tell you when it nearly happened. For the staff, particularly telling you about something that nearly happened is a lot less scary than having to come forward and say someone has been harmed, so it was win-win. It was win for the staff; they felt more comfortable telling you about it. Then for the Trust, the organisation, you had that opportunity to fix it.

Q. What would you done with that, if you had been able to? Do you see that as something that could have made a difference to the culture at the Southern Health Care Trust, and what were the barriers for doing something like that?

A. I think the barriers were resource. As I say, the vast majority of incident reports we got, harm had occurred, or a level of harm. You would have needed a big resource in terms of training, encouragement and facilitation of staff. I think it would have rolled as it did, we found in pharmacy. Once staff understood what you were trying to do with near miss reporting, it wasn't scary, they could see the benefits, it then took on its own role, because certainly you'll have seen in some of my papers, we started a newsletter –

Q. Yes, I have seen that.

A. -- in the medicine safety. They used to be called cheese news, which was very -- we had a wee cheese thing on it but we changed that. Staff looked forward to getting that. Again, we were trying to be proactive, what nearly happened, and share with them, make it interesting news articles, fun, to try and pique their interest and get them to look forward to reading it every week

How can the SLT impact a shift in culture in some areas of the Trust where staff are encouraged and supported to move from a reactive approach to a learning and proactive approach to patient safety and quality care?

A.The other area, and again under Mr. Devlin's Chief Executive accountability meetings, I think, yes, you will have had that in your witness statements as well. There was, again albeit you could say it is siloed in the sense that it is looking at specific directorates, but it was certainly aimed at, we created those dashboards to try to say well what the safety indicators, what are the quality indicators. So my team were very much around trying to enable that. As I said it is a corporate role to try to enable the optics on some of that and governance was a part of that as well, as well as other indicators that come from finance and HR. **So it was to get a broader look at the challenges in the organisation. But, given the scale and size of it, I think there are certainly opportunities. And why I mention, perhaps, in my last comments there around the likes of, whatever it is called, quality improvement, steering group. Certainly I know when Dr. Khan was acting in the medical role, he says we could build this to become some sort of safety quality oversight group. And it didn't need to be producing just reports, it needed to be relationships, insights, putting things on the table and trying to make connections. So I think there is something more that could be done in that space**. Whether that could actually be replicated at other levels given the scope and span of the organisation into particular service areas, something like that I think would be useful.

What is the view of the SLT on this comment?

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What further realistic plans regarding safety and quality improvement can be moved forward into action?

3. Culture and behaviour

Q. Just last question. There was some discussion about letters being copied to patients. What's your view of that, because I was interested to see that you frequently copied your letters to patients –

A. Yes.

Q. But that wasn't commonly done?

A. Yes. It wasn't a practice that everyone done, in the same way when you were sitting in with various consultants at uro-oncology clinics, people work differently. Some people wrote down the majority of the consultation; others would have dictated that immediately after the consultation. So, people practised differently, but you had to be in the room to know what the practice was.

Q. I guess that's my point. Do you think it is important that patients do get a copy of their letter, is a more direct way of –

A. They are one of the main members of the team that's making the decision, they have to be engaged in it. Any virtual clinics that I am doing, they will get a copy of that letter.

How readily are patients in the Trust perceived by staff as being one of the main members of the care team?

Q. Do you feel that when you do raise concerns around that or any aspect, do you feel it should be the case that it's fed back down, if I can put it that way; that you are told, even in broad terms, of any learning from that?

A. Yes. I think it's part of the process; the process is cyclical. If it doesn't come back round and you don't know what happened, it's sort of -- it defeats the purpose, I think, because learning -- it's all about learning and being transparent and knowing what happened.

Q. Just on that point, there has been talk about the SAIs obviously yesterday. Was there any formal learning identified for the CNSes as a result of those, for example, nine SAIs?

A. I think, as I said, comparing the CNS role in terms of key worker then to now, absolutely. It's a more robust system, it's a more proactive system. There is now a person within Cancer Services that is in charge of audit, and they would send us a retrospective list at the end of every month of all the new diagnoses from that month. We appoint a CNS each month to cross-check that with the key worker activity so we can identify if indeed any patient doesn't have a key worker and rectify that.

An example of learning and action from SAIs being effective – such examples could be shared regularly throughout the Trust to evidence the value of a learning culture.

'we want to create a more restorative learning culture moving forward. I think for me the importance of establishing and addressing risk to prevent any harm, and how that has to be done robustly, cannot be understated how important that is. If that's managed well and robustly, then you can potentially then come to an agreement as to how to address issues and manage issues in a structured formal way but maybe not necessarily through, you know, formal sanctions'

Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT?

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Q. Another issue which has come through really in most of the MHPS witnesses was around a certain lack of transparency at the time that that happened. What I am talking about is nobody really knew much about the Oversight Committee; they weren't really sure what happened when matters were escalated up and senior people were talking about it. I think in your statement, you've emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing. I think the training that we have just rolled out has very much covered that in terms of making people aware of what the Oversight is, what the purpose of it is and what it's all about. But yeah, I think it's a journey about embedding some of that culture and some of those messages right across the organisation.

'Q. You have emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing.'

What measures are in place to test the current position in relation to transparency, fairness, and openness? How frequently is this audited?

Q. "What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?" And you say: "I do not think that management take concerns seriously within the Trust and often fail to act or do not communicate that they have done so. I have previously raised, for example, in regard to the duplicity" - is that duplication –

A. Yeah.

Q. - "of investigations and that hasn't been acted upon. When one raises an issue, usually a response is not received. "35.2. Many issues I raised in regard to radiological practice through the Radiology Clinical Director and the Radiology Service Manager which are not specifically neurological are not addressed by managers and opportunities for the improvement of patient care and efficiency are lost." You give examples of SPA entitlement for service improvements, and teaching. "Such issues are raised infrequently as I do not think time raising them is not well spent." Then at 35.3 you say: "There is scope for improvement in radiological practice. Managers need to acknowledge each and every issue raised with them and state how best the issue could be dealt with, rather than appearing not to engage at all." You finish by saying, "Areas of improvement should be discussed with clinical and nonclinical managers and a plan made to make improvements to the service." Does that reflect your experience over 15 or so years, doctor, that you are articulate in raising concerns from time to time about issues affecting your own practice, your service and its impact potentially on patients, but you seem a little despondent that the culture generally doesn't seem to direct responses by to you?

A. I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to. I tend to find that, in the Southern Trust, I think there are so many big issues,

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major issues, that managers are probably dealing with many of these in their limited time, particular clinical managers, the limited time for managers are dealing with these things. So, things that I raise that are comparatively minor are probably just ignored, because there's no time to deal with them. I think that's probably what happens.

Q. Apart from giving you responses, can you think of any ways, any vehicles, any structures that aren't currently in place that might, with little effort and little resources, be put in place to improve things?

A. I think the problem is that we have -- the supporting professional activities, which as you probably know, is part of the job plan or things other than clinical work, of which it's kind of recognised that 1.5 is the minimum, and that's really for personal revalidation and, more recently, is supposed to include some teaching, but it doesn't include service improvement. I think the Trust is very unwilling to give individual consultants additional SPA time for managing a service. So, any improvements that you wanted to do a service you would do in our own time. I don't think there's been -- there hasn't been much encouragement to give consultants additional time, certainly in radiology anyway.

'I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to'

What plans are in place to address lack of engagement and to boost staff morale by underlining the importance of listening and communicating clearly?

Q. Even so, you said a few things that indicate that the relationship with management, as you call it, wasn't fantastic. Who do you regard as management? Who is management? Do you mean the service administrators and people down that end? Do you mean the senior management of the hospital?

A. Well, the service administrators and then up to Katherine Robinson. Yes, that is who I see as my management.

Q. And that is where you feel that it wasn't very helpful. Do you think the Trust as a whole creates an atmosphere where all the staff feel valued?

A. Not particularly, no.

Q. Why do you feel that? What do you think the source of that is? I am sure they wouldn't set out to be like that.

A. I don't know how to describe or why it has went that way. I think everybody is just running about chasing their tail and nobody has time for anybody.

'Q. Do you think the Trust creates an atmosphere where all the staff feel valued?

A. Not particularly, no. I think everybody is just running about chasing their tail and nobody has time for anybody.'

Think about the importance of and how to 'be present and available' in interactions with staff amidst a busy workload.

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4. Communication

Q. You have mentioned about a concern that red flag referrals are prioritised and there is a danger that because of that, routine referrals are getting longer and longer with a concern that people are becoming more unwell, having originally been maybe allocated as routine?

A. Yeah.

Q. What's the situation with that now? Do you have any knowledge about how those people are moving along?

A. I think there's still an issue.

Q. Still a backlog?

A. Yes.

Q. But it's your evidence to the Inquiry that if there was that capacity in the CNS, that there would be greater movement along the journey for those patients?

A. Yes. It could only be a positive thing

What interim communication steps for engagement are operating with the lengthy waiting lists in the Trust?

Q. The note of the SAI indicates that the problem was with the clinical nurse specialist, that Mr. O'Brien had expressed concern about that, and the note reflects that he didn't understand the role of a nurse specialist. Just in relation to that SAI meeting note, does that properly in your view capture what you meant?

A. No. I have been misquoted. I've been -- I have been misrepresented.

Q. Well, what did you say and what message were you trying to impart to Dr. Hughes?

A. So, I would have said very similar to what I said in my Section 21. Aidan would have been very particular in his use of language and words, and I think it was just the "key worker" word that he didn't like. It's not -- I don't for one minute think he didn't understand what a key worker was, or indeed what a CNS was and what my role was, he absolutely did. I believe he did value that role. It's just he could have been very specific about his use of words and language and phrases.

Clarity around language and terminology used throughout the Trust will bring better cohesiveness and messaging.

Q. You have also been on this Task and Finish group. What have you personally learned from being on that?

A. There's a lot of wheels in motion.

Q. Yeah.

A. And sometimes the people on the ground don't get fed back to us as to where we are with things and what is happening.

Q. Because you mentioned a few things. Were the changes made quite quickly to start with? What was the pace? What was the feeling of that meeting; was there a sense of urgency? Or...

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A. I feel people wanted stuff to happen more quickly but perhaps the resources weren't there to enable that. But there definitely was willing, whether there were resources as timely as there should have been.

Q. Whose job did you see it to unblock those resources; where did you see that?

A. I saw that happening at a higher level than me.

Q. Did they explain to you how that actually all worked –

A. No.

Q. -- or was that a mystery?

A. Mystery. It was not explained.

Q. Do you think that's right, do you think it should be a mystery?

A. I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions. Yes, I think that could be important, yeah.

Q. Did you and are you taking all of that learning back to these consultant meetings and trying to tell people what's happening? Because the nine SAI Task and Finish group, I mean it's a big deal, isn't it, and it ultimately was a big part of matters of this public inquiry. Did you see it as your role to come back and tell everyone what was going on and were people interested, or did it fizzle a bit? I just get a sense from you that it's fizzled slightly.

A. Yes, I think that would be a fair comment to make. I know I would have mentioned it within our small team in passing but certainly not formally. But some of the consultants are on that Task and Finish group as well.

'I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions'

Taking time to explain clearly a process will reap the benefits of better engagement with it.

Q. If I could summarise. Where the SAI was bemoaning this disconnect between one service and another where it was saying there was a lack of support for the MDT, the response to that has been to carve out a specific role focused on those issues, and that's what Mrs. Muldrew is addressing?

A. Yes.

Q. Where the SAI complained, or concluded, that there was virtually no audit, no monitoring of how this MDT was performing across a range of issues, the appointment of Mr. Quinn is dedicated to that concern?

A. Yes.

Q. Are there any early indications of how all of these changes are bedding down and whether you are yet in a position to say whether noticeable positive changes have arisen?

A. Well, there has been some positive change in that even from the NCAT audit that was carried out on all of the tumour sites with the Clinical Leads, the information that was clearly coming out was that there was no -- for MDT principles around how an MDT should be carried out. We are now developing an MDT principles document, which clearly sets out what's required of an MDT; things like an MDT pro forma that's to be completed to bring your patient for discussion, which brings a much better, you

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know, information awareness around the kind of things that were going to be discussed at MDT. It's a minimum data set to bring your patient forward for MDT. That's been developed also in partnership with the MDT leads and chairs. A communication policy as well, where there was a felt need that we needed a communication policy. So, responsibilities for each member involved in an MDT process for what they should be doing pre, during and post-MDT in terms of communication out to patients.

What stage is the development of the MDT principles document and the communication policy at?

Going forward post Inquiry, it would be very helpful to oversee the streamlining of language and terminology, values and principles of all the Trust documents.

Q. Do you think that the poor communication allowed problems to exist and persist, such as the ones that the Inquiry are looking at? Do you think the poor communication from Urology towards Cancer Services assisted in creating an environment where problems were not dealt with?

A. I suppose I have used a couple of examples here that I was aware of.

Q. Well, you were aware of the issues around Mr. O'Brien and triage from 2015, I think? Do you recall that?

A. Yes. In regard to red flag triage, yes.

Q. I know that's not one of the examples that you've referred to but if I go back to my initial question. When you saw those emails -- and I'll give the Panel the note for the emails. 2015-2016, referring to Mr. O'Brien, referring to triage, referring to referral, referring to the build-up of patients who were not coming through the system and representing a blockage to get through the care pathway. Did you think that the failure for that information to be properly communicated to you allowed problems to persist in Urology?

A. Probably, in hindsight, if it had have been more joined up communication, that everything was together, it probably would have dealt with things at a much earlier time.

Lack of clear communication adds to a confused picture, delay in understanding issues and taking the appropriate action to ensure patient safety and care.

A. I think there seems to be a bit of a disconnect in what governance inspired to do and what is actually happening. It is just not achievable to have that gold standard.

Q. One of your reflections as well is that management needs to engage more with the workload. Was that a disconnect as well?

A. Very much so, yes.

Q. What could they have done about it, do you think? What should they have done about it?

A. Well, I think they just started to strip away any support we had.

Q. This is on the administrative side?

A. Yes. So we started off with four, I think four audiotypists; we ended up with one, and we were just expected to work harder and harder.

Q. You have reflected in your statement at WIT-76358 that the move to the Breast Service, I suppose, has led to an improvement in your working environment and you find it to be a more

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effective service. What are the differences that you are observing from a position as a medical secretary in that service by contrast with the Urology Service?

A. It is basically the difference in day and night.

Q. Could you give us one example of how things work better and are better for patients because you're able to do your job as a secretary in a better way to work?

A. Because you had more time to do it, more time to check on things. We attend the MDT meetings so you are very much aware of the cases that are discussed at MDT and you follow it up. It is just a pleasure to work in compared to urology.

It would be helpful for the SLT to continually shape an appropriate and empowering narrative around the realistic expectations of the workforce as it deals with a demanding workload and stretched resources.

Veryan Richards

18/7/2023

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Southern Health and Social Care Trust

Quality Care - for you, with you

AGENDA OF THE SEVENTH MEETING OF THE SOUTHERN TRUST EXTERNAL REFERENCE GROUP (STERG)

DATE: FRIDAY 29TH SEPTEMBER 2023

VENUE – THE LAW SOCIETY OF NORTHERN IRELAND BUILDING, BELFAST

AGENDA – MORNING SESSION		
10:00	Welcome and Apologies	Chair
10:05-10:10	Conflicts of Interest	All
10:10 -10:30	Updates from the meeting on 15th Sept 23 (briefing which provided by the SMT to the Trust Board)	Vivienne
10:30 – 11:00	Updates on the Leadership and Culture sub-Group	Hugh/Vivienne
11:00 – 11:20	What are the next steps	All
11:20 – 11:30	COFFEE BREAK	
11:30 – 12:00	Updates on Analytics sub-Group (next steps on finalising Trust's approach to analytics)	Simon Watson
12:00 – 12:30	Updates on Governance and Accountability sub-group	Robbie Pearson
12:30 – 13:00	LUNCH	

AGENDA – AFTERNOON SESSION		
13:00 – 13:45	Briefing on most recent review of the Public Inquiry Proceedings	Veryan
13:45 – 13:55	Any other business	All
13:55 – 14:00	Next Meeting – dates for remainder of 2023 to be agreed	All
14:00	CLOSE	

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Sixth Meeting of the External Reference Group

Date: Friday 29th September 2023 (10am – 2pm)

Venue: The Law Society Buildings, Victoria Street, Belfast, Northern Ireland.

Present:
Mary Hinds (Chair), Dr Maria O'Kane, Hugh McCaughey, Dr Simon Watson, Veryan Richards, Jane McKimm, Robbie Pearson, Heather Trouton, Vivienne Toal, Maria Siahaan (Secretariat).
Apologies: Margaret O'Hagan and Tom Frawley

Welcome :

Mary Hinds advised the meeting that in the absence of Tom Frawley it had been agreed that she would chair the meeting.

1.0 Apologies

The Chair opened the meeting by thanking everyone for attending. The Chair advised the meeting that she received apologies from Margaret O'Hagan and Tom Frawley, and noted that Hugh McCaughey will be joining online via Microsoft Teams.

2.0 Update from the Trust Board Meeting

Dr O'Kane thanked Vivienne Toal and Hugh McCaughey for their work on the Presentation for the Trust Board meeting. She believed that the information contained in the Presentation had "landed" very well with the Trust Board members. Vivienne Toal then elaborated on the critical areas covered in Dr O'Kane's Presentation to the Board.

- Dr O'Kane opened the Presentation by advising the Trust Board that on 15th September 2023, she would have been fulfilling the role of Chief Executive of the

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Southern Trust for 16 months. She then shared her experience and reflections on a range of examples from the "thousands" of episodes of care and interactions with patients and service users that have been delivered by staff during that time which she believed demonstrated both compassion and sensitivity. She emphasised that this in her view would represented the normal experience for patients in received of care from the Southern Trust.

- Dr O'Kane also highlighted some of the positive stories and compliments received through the Care Opinion portal. Some of the feedback she explained was related to the services provided by Obstetrics and also there were a number of examples from the Steps to Wellness Programme.
- Dr O'Kane had then updated the Trust Board on a range of awards that have been received by Southern Trust staff and services in recent months from external bodies. Examples she referred to included the outstanding success of Trust staff at the Royal College of Nursing NI Awards where the Southern Trust had received three first place awards and three runners up awards. She continued that The Trauma and Orthopaedic Service had recently received national recognition for the high quality information it provides to perspective patients in relation to joint replacement surgery. Craigavon Area Hospital had been placed within the 10 units that had been highly commended for their Professional Development, Obstetric training and overall performance.

- Apart from these outstanding achievements, Dr O'Kane had also explained that it was important to be aware that this award has been achieved against the backdrop of dealing with significant challenges that were affecting the Trust including negative publicity, industrial action and difficult staffing shortages.
- Dr O'Kane acknowledged in her Presentation, that the commencement of the Urology Services Public Inquiry in November 2020 represented a low point in the organisational life of the Southern Trust. Dr O'Kane explained that regrettably the well-being and safe care of Urology patients had not been given the priority it should have been.
- It is now essential that we demonstrate that these issues were being reviewed, identified and proactively addressed. It is for this reason she believed that the Inquiry presents an opportunity as well as a challenge for the Trust.
- In continuing her commentary Mrs Toal continued that Dr O'Kane also advised the Trust Board that she had commissioned an Independent Review of the "turnover" of General Physicians in Daisy Hill Hospital. Dr O'Kane advised the Board that it was clear from the completed review that the absence of a Strategic Plan to transform services at Daisy Hill Hospital was a significant factor in informing the decision of a number of the consultants to leave the hospital. She said that Dr O'Kane had advised the Trust Board that she now intended to share the findings of the review directly with the Consultants at Daisy Hill Hospital.

- Vivienne further advised that Dr O'Kane had indicated to the Board that the Findings contained in the Staff Survey platform would also be shared with everyone affected by the potential action that would now be developed from the insights emerging from the survey. Vivienne explained to the Meeting that there were three Questions contained in the Staff Survey, which she believed were particularly important for the meeting to note.

  1. Is the care of the Patients and Service Users in my Organisation its top priority?
  2. Would I recommend my organisation as a place to work?
  3. Would you be happy for your friend or relative to receive care in this Trust?

  Vivienne explained that Dr OKane had indicated to the Trust Board in her Presentation that the graphic charts contained in the Survey Report reflected that the staff responses to these questions (percentages) are slightly under the NI HSC average.

- Vivienne shared with the meeting the Findings from the Culture and Leadership Sub Group which Dr O'Kane had shared with the Trust Board. She explained that the Findings were derived from the meeting between the Senior Leadership Team (SLT) and a number of staff. The staff Dr O'Kane had explained to the Board, reflected that the Southern Trust needed to "draw a line in the sand" in relation to this very difficult and challenging period. The view of the staff was that the Trust needed to move forward to what had the potential to be a much more positive future. To build

such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust.

- Vivienne continuing with her account of Dr O'Kane's Presentation said that the Chief Executive had informed the Board that she had now asked Elaine Wilson the Director for Planning, Performance and Informatics to begin to draft a new Organisational Vision for the Trust that would be underpinned by a new 5 years Strategic Plan. She advised the meeting that the Chief Executive had asked the Trust Board to agree that these two critical pieces of work should be commenced immediately. She said that Dr O'Kane had emphasised to the Board that we needed to commit leadership to co-produce the Vision and Strategy by involving **all Stakeholders**.
- Vivienne advised the meeting that the Senior Leadership Team were now examining the development of the Principles that should inform how this important strand of work would be developed. She advised that in progressing this discussion that to date Senior Leadership had agreed the following Key Principles:
    - Safe and Quality Care
    - Investing our resources where they add most value

- A commitment to following through all actions that are agreed
- All underpinned by intelligent use of data

In closing her Report to the meeting Vivienne advised that Dr O'Kane had concluded her Presentation with the following two quotes:

"Those who cannot remember the past are condemned to repeat it."

"The first step towards getting somewhere is to decide that you are not going to stay where you are".

Reflecting on the Presentation, Vivienne said that she believed that the Presentation had been very impactful because it had been candid, open and honest. Robbie Pearson supporting this comment also reflected that the acknowledgement of past failures was very powerful. Both advised that in focusing on issues emerging from the Urology Public Inquiry there now had to be a clear commitment to Transparency and importantly that this commitment were evidenced in the Presentation. Robbie also suggested that the Leadership Team might consider including "Sustainability" as another important principle to be adopted by the Senior Leadership Team in moving these important issues forward. This was particularly relevant in light of the staff having expressed a clear view that the Senior Leadership Team needed to draw a line in the sand and move forward to a more hopeful future.

Dr Watson commenting that he believed the Urology Public Inquiry Proceedings had identified similarities and parallels with the other Inquiries that had been convened across

in NHS in recent years. He then advised that Healthcare Improvement Scotland (HIS) are currently investing in the development of an analytical tool to support management in the challenging task of ensuring greater safety of patients by identifying more reliable and sustainable approaches to ensuring safe care for all.

Action: Simon to share the Analytical framework with members

Hugh McCaughey said that he believed the Presentation was very well prepared and delivered. He said it provided a compelling narrative for the Trust Board membership. He believed there was a good balance in the information presented highlighting achievements while importantly acknowledging failures and ongoing challenges. He said it offered a very candid account while also demonstrating a clear commitment to improvement. He concluded his comments by suggesting that the most important audience for these messages beyond the Trust Board now are the staff working in the Trust. He said it was important to urgently deliver this message to staff but in doing so the leadership need to recognise the scale and the diversity of that audience. Therefore, he said it would be important to make the key messages more concise and accessible.

Dr O'Kane thanked the meeting for their comments and inputs. She said that through the Presentation she believed the Trust Board members had been given a candid and balanced account of the Key Issues that had been identified to date by the Inquiry and the resultant challenges that lay ahead. Concluding her remarks, she emphasised that there is still a great

deal of work to be done to reach a point in the Trust journey that the Senior Leadership now clearly aspired to.

Dr Watson responding to Dr O'Kane's reference to the essential change in the Trust Organisational culture that must be addressed was how leadership intended to effectively communicate a culture of "welcoming feedback" and "listening to staff" to critical behaviours that need to be established in the Trust if the culture change intended was to be achieved. As an example, he asked whether staff would have access to training session on how they might "speak up" or how to effectively articulate their concerns. Related to this critical behaviours he asked how can the Organisation be satisfied that at Senior and Middle Management Level that there is a commitment and ownership of these critical changes in behaviour.

In addition to this, he said that as part of the leadership challenge would be a commitment to demonstrate a capacity to listen importantly how would the management establish that we had the capacity and capability to be aware of what staff are communicating through the range of portals and opportunities available to them and then critically to demonstrate to staff that they had been heard?

Dr Watson advised the meeting that in HIS, they are currently working to develop a tool that would inform such judgements and evaluations.

Mary Hinds supported Dr Watson's comments said it is essential that we provide appropriate training that will enable those particularly in managerial roles to "**listen"** to staff.

Picking up on this point in relation to a change in organisational culture, Hugh McCaughey emphasised that it was vitally important to observe in management those characteristics that are evidenced not just, by what people say but also in how they act and conduct themselves. In this spirit, he shared with the meeting a quote that he had seen on the side of the Garrick building which he considered to be both inspiring and relevant for the leadership challenges that lay ahead.

"A nation that keeps an eye on the past is wise. A nation that keeps two eyes on the past is blind,"

3.0 Updates from Culture and Leadership Sub Group

- Identifying and agreeing the next steps for the ERG
- Developing and sharing the narrative that will be communicated to staff
- Developing and testing the engagement process that will be adopted in communicating with staff.

It was agreed that Vivienne Toal, Elaine Wilson and Hugh McCaughey should draft a map of a proposed engagement process. Vivienne also referred to the possibility of engaging with Trade Unions and the wider community of stakeholders as well as involving senior leaders (i.e. Band 7 above) in this critical process.

It was also important she said that the other Sub Groups were offered the opportunity to contribute to the testing and examination of the Engagement Process. Veryan Richards highlighted the importance of empowering staff at each Band/Level and not just more

"senior staff". She also indicated that we need to plan our engagement with staff at each level. Vivienne suggested that we can also consider establishing a new platform that might mirror the existing platform "Chat with the CEO" which would enable the Leadership to communicate as widely as possible the Trust's narrative to all staff.

Jane McKimm sharing an observation that she had developed through listening to the Public Inquiry Hearings said it was clear to her that frontline staff are the "heartbeat" of the organisation. She cited an example of a secretary at Band 4 having an extensive knowledge and understanding of each patient's treatment plans and therefore should be in a position to respond to non-medical queries from patients in an accessible way. In addition, she said a secretary could identify, if there are errors or inaccuracies within dictated "reports" from Consultants, secretaries could also identify gaps and faults in referrals for example. To this end, Jane expressed her view that it is very important for management to engage these frontline staff and make them feel "heard" and "valued" when they raise concerns or issues about their work with Supervisors.

Hugh McCaughey supported Jane's comments. He added that when staff feel they are being listened to, they would become real advocates by actively promoting the engagement plan.

Dr Watson elaborated on what he considered to be the real value of a listening organisation. In concluding his comments he said that there were key sources of critical information that we needed to focus on. In particular, he said there is a need for a much more sophisticated

approach to the analysis and interpretation of clinical data. He said that this was an area that would need an investment and expertise.

He also shared with the meeting who he believed were the critical audiences who must be engaged with if we were to be seen as authentic, these were:-

- the voice of patients
- the voice of the public
- the voice of staff

The plans for the culture and leadership group to meet with the quality and safety group had not materialised due to operational pressures.

Action: SLT to agree how they wish the coordination of sub group efforts to be taken forward

4.0 Updates from Analytics Sub Group

Dr Watson opening his report shared with the meeting the background to the analytical framework that is currently being developed by HIS. He continued his comments by quoting Robert Francis', the Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry who in his Executive Summary wrote: "The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent". Dr Watson said that this quote highlights the need to develop the processes and data that would offer a meaningful insight on how the implementation of recommendations

made by an Inquiry or Review were being proactively monitored. He explained that Steve Wilson from HIS is currently developing an analytical framework to identify "early warnings" of serious problems particularly in relation to the Quality and Safety of care.

10-1108_IJHG-10-20 21-0109 (1).pdf

Leadership Diagram.docx

20211119 SIHCG analytical framework

SIHCG Framework.pdf

Dr Watson then took the meeting through the slides that he had prepared. In his Presentation, he explained that the analytic framework is divided into 7 categories (Leadership, Culture, Governance, Financial Performance, Workforce, Professional Engagement and Clinical and Care Performance). The framework he continued can provide quality assurance, offer reliable early signals that may identify areas of error, and provide the person responsible for reviewing them with material that can inform a detailed analysis of this information.

Concluding his comments, Dr Watson advised that he can facilitate contact with Steven Wilson should the Southern Trust wish to have further discussion about the Framework.

Dr O'Kane thanked Dr Watson for sharing the Framework. She said she found the framework very useful, she believed it could provide a helpful toolkit for the Board as it could offer early warning signs of potential risks and challenges. Dr O'Kane added that she would ask Elaine Wilson, Director of Planning, Performance and Informatics to contact Dr Watson on how this matter could be taken forward by the Trust.

Actions:

- **To map out a system of "triangulations" that would facilitate the analysis of data**
- **to take forward an initiative on Data Analytics**

6.0 Updates from Accountability and Governance Sub Group

Robbie Pearson opened his update by emphasizing that it was essential that the Trust adopt the Champion Report in relation to Governance. He advised that he intended that the Sub Group would engage with the SLT and the Trust Board in the near future. In addition to these steps, Robbie identified the need to build a Trust wide learning system and importantly to identify how this critical work would be supported going forward. He also said that it would be important to allocate a management resource to support this work stream.

Dr Watson also commented that the Trust should consider the option of developing a management trainee scheme or a graduate management trainee scheme. In addition to this, he suggested the group should support an initiative to establish capacity to undertake this work including a "route map" that would inform the implementation and the timeframes for the implementation of the plan. Vivienne responding said that the number of training places in management is very limited. Veryan Richards suggested that it would be very important to develop a timeline for the program that is achievable and to map out a timeline that is realistic.

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Dr Watson alos comented that he felt it was important for the Trust to start addressing the issues identified now by the inquiry. Taking this two track appricah, looking to the futre while addressing issues of the past and present, would ensure the Trust are well prepared for the final report. This was supported by Jane and Heather who could see ow the inquiry were identifying practical issues that could be actioned before any final report.

Action:

- **Trust to consider a process addressing emerging issues.**
- **To identify a resource in the Trust that would be available to take the important work on a Accountability and Governance forward after the work of ERG is completed.**

7.0 Themes and Considerations for SLT- Veryan Richards

Part 4.0 Public Inquiry - notes and

STERG Themes and considerations for tl

Part 5.0 Public Inquiry - notes and

STERG Themes and considerations for t

Veryan began her Report by explaining to the meeting the themes that she had identified in reviewing the proceedings of the recent Hearings. She explained the themes contained in the Paper were in the following order: Leadership and Governance, Quality and Patient Safety, Culture and Behaviour and Communication.

1. **Leadership and Governance**

Training

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"What is the SLT's view on Datix training being mandatory for all staff on the frontline?"

"Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?"

Page 10 Public Inquiry Hearings Day 42 – 49

"the importance of training to a good standard to all those involved in job planning and drawing up professional contracts"

"Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers?"

Trust Improvement

Page 14, 15 and 16 Public Inquiry Hearings Day 50 - 57

"You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well. How can this narrative be reinforced throughout the Trust?"

"The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate. Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?"

"but the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have the families coming on board who were willing to influence the future was a really good piece of work. We have a statutory obligation,

actually, to involve patients' right from design, implementation and evaluation of all of our services."

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go through to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'.

What are the next steps to move towards this goal of inclusion, partnership and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'.

Page 18 Public Inquiry Hearings Day 42 – 49

"The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked?"

2. **Quality and Patient Safe**

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"Post inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care."

3. **Culture and Behaviour**

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"how readily are patients in the Trust perceived by staff as being one of the main members of the care team?"

"an example of learning and action from SAIs being effective – such examples could be shared regularly throughout the Trust to evidence the value of learning culture."

"Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT?"

4. Communication

none to note

8.0 Date of next meeting

The date of the next meeting was agreed for the 10th November 2023. It was also agreed that the meeting will be started at 9am in the Law Society NI to facilitate travel by those attending the meeting from Scotland. . It was felt that this may be the final or penultimate meeting of ERG, to be discussed with the Chair.

9.0 Any other Business

There was discussion within the group about preparation for ending of the formal ERG meetings circa the end of 2023. On behalf of the Trust Dr O'Kane agreed that a paper reflecting the learning to date and the approach to improvement would be presented by the Trust members to the other members of the ERG at the next meeting.

As there were no other business to be discussed the meeting then closed.

STERG – 29/09/2023 – agenda item

Suggested themes and considerations for the SLT – Days 50 - 57

The aim:

- to build public trust and confidence in patient safety and person-centred quality care
- to raise professional standards within the Trust
- to address and make provision for good staff wellbeing and morale.

Transcript notes and analysis

- to listen and identify some learning as the PI is in progress, to support Maria in helping her to keep in touch with the emerging themes and to assist the Trust in using this lens to consider modifying practice.

- to reassure the staff, patients and the public that the Trust is listening and is making efforts in real time to improve the standard of care for patients and raise the bar in terms of professional standards. Some of this intelligence gathering may already be happening within the Trust as well and it would be interesting to compare notes.

- we are not sure when the PI Report will be published with its conclusions and recommendations, in the meantime the Trust can be seen to be proactive.

STERG - the emerging themes from the PI transcripts.

- can strategy, practice and evaluation be considered in response and some guidance given on a possible route map for the next steps and potential medium-term goals?

(Note – please refer to the document Part 5.0 'Public Inquiry – notes and reflections' to give wider context to the points in the themes below. These papers have been circulate with 'Suggested themes and recommendations for the SLT')

THEMES

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

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1.Leadership and Governance

Tracking, clinical decision-making, and audit

Q. In that vein, a lot of people, mainly I think after your time, had said that there was a very big emphasis on performance and that data for performance was looked at very carefully, but that there wasn't much robust data to cover quality issues other than when things went wrong, and that, therefore, one didn't necessarily know, for example, if cancer peer review standards were not being met, or if people weren't following policy, or if people weren't using best Royal College guidance. Was that something you recognised in your time and did you have any views on that?

A. All that data was there. All the cancer review documents were there, again with clear action plans. All the RQIA inspections, announced and unannounced, were clear, they were always in Trust Board papers, they were in my directorate governance papers, the action plans against them were in directorate governance papers.

Q. I am talking more if you were asked what's the quality of clinical outcomes in Urology, would you have data to look at?

A. No, I wouldn't have at all. Whilst we as a Trust joined CHKS and we engaged in the process of contributing our data to CHKS, I think in my time it only got to maybe a divisional level, it didn't get to specialty level. There was a process of cascading, cleaning and assuring the data. Certainly I think there was a basket of 23 metrics that we were measured against, and we rated highly in the UK against that, but those were largely around performance and that's maybe where the perception has come from.

Q. I think that is what they said.

A. Yes.

Q. They said this is performance.

A. Yes. The audit of clinical practice and having an audit against that either locally or nationally, no, I felt that was a gap.

Is the SLT happy that there is now a high standard of robust data to cover quality standards across all the specialities? If not, as a priority, what immediate steps can be taken to address this?

Q. If we go to the Directorate Risk Register of July 2019 at WIT-94611. If I can read the extract from that rather than we all strain our eyes trying to find that. It says: "As of April 2018, there are 1,609 standards and guidelines identified on the Trust register. 74%, which is 1,193 of these, are applicable to Acute Services Directorate. Of these, 34%, 405, remain at a partial or non-determined level of compliance, with many identifying significant external barriers impeding the Trust's ability to comply." I think you have mentioned some of those external barriers are buy-in from GPs, and you have also mentioned, I think, the Board as well?

A. Yes.

Q. HSCB?

A. Yes, about implementing certain processes. You know, you were tried to waiting on those processes being fully implemented.

Q. From the figures provided in April 2018 to Dr. Khan's report eight months later, the figures have risen from 34% to 47%?

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A. Mm-hmm.

Q. Did you ever undertake a similar sort of analysis to find out what the standards and guidelines situation was while you were the coordinator?

A. I hadn't, no, but my standards and guidelines manager did do, and she would have produced reports for me and then for my senior colleagues as well every two weeks. These would have been discussed then.

Q. Would they have been discussed in percentage terms of the total not yet implemented, or partially complied or needing reviewed?

A. Yes.

Q. The figures that I am bringing you to from 34 to 47, do these sound about right in your recollection of the amount outstanding?

A. Yes.

What are the current figures?

Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly?

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback through the system. It was more difficult to do that for me with such a broad remit, so that's why the guidelines team were particularly good and particularly active at following through on that.

Is the system for guidelines monitoring fit for purpose and regularly audited?

Q. There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.

Q. The Panel has heard evidence about the fairly recent realisation of cancer tracking to maximise being able to follow. I think, the evidence is that there's still room for improvement; that that process is not a fail-safe either. Given that, the cancer tracking issue and the CNS issue, might the findings and recommendations from the nine SAIs more helpfully have provided systemic suggestions around care pathways generally that might have included CNS and less emphasis on the CNS providing the answer for all of those nine patients?

A. Yes.

'Q There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.'

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Is it still the case that various parts of the system are struggling to deliver successful care pathway oversight?

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern

Does the SLT consider 'the missing clinical audit' an area of concern? If so, what are the steps to address this?

Q. Okay. Thank you. You had a comment about deep-dives, and made a comment about not all are brave enough to do it. That's an interesting choice of words. What did you mean by it?

A. Again I am back to that expression I used there about lifting the stone and seeing what else. I think you should never -- especially when you have recurrent issues, say for example like triage and delays and patients who are not being seen in as timely a way as we could offer. I think hold on a minute, we need to have a deeper look here; we need to actually sample; we need to audit some of the work. You can't just accept, and we did in many ways accept he is a really good clinician and take that as read. We should be able to evidence that in this day and age. We audit our own performance and our peers. I think we should be able to do that and I think that takes bravery.

When there are recurrent issues taking a deep-dive approach to them is important, sampling and auditing some of the work. 'Lift the stone and see what else is under it.'

Can the SLT identify any current recurring issues in the Trust where this approach needs to be applied?

Quorate

Job description, appraisal, and handover

Q. Now, did Mr. Carroll give you a briefing as to what had occurred in the years prior to your taking up post that had raised governance issues?

A. Not with regard to Mr. O'Brien. He did give me a brief of the issues that were current, which were around the three sites, which was the Urology ward. There were a lot of risk issues in that ward at that time, and workforce issues, and a lot of quality indicators in terms of care. We put together a response to that with the corporate nursing team as well to try and stabilise 3 South. But that was the real emphasis for Urology in 9 June '19.

Q. So, the emphasis was on the immediate –

A. Yeah.

Q. -- issues that you were facing. Did Mrs. Corrigan ever raise the issues with you about what had preceded your tenure as regards governance?

A. No. Again, I believe that those were felt to be in hand at that point in time.

Q. Are you saying that with hindsight?

A. I am saying that with hindsight. I didn't know about them at the time, I wasn't sure of that. But as things emerged, that was my perspective, that they probably felt they were being managed.

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Q. Knowing what you know now, do you think that you should have been told?

A. Absolutely.

Q. If you had have known then, what would you have done to reassure yourself about what was in place to prevent any reoccurrences or to ensure good governance?

A. I would have wanted to understand what range of intelligence there had been, not just that led to the MHPS but before that. So, I would have wanted a chronological list of all of the issues that had been raised over years or all the concerns that had been raised over years, but in particular the MHPS and the recommendations from it, and the monitoring processes and the impact of those.

As one of the learning points from this Inquiry - what measures are in place to ensure a full handover process is seen as a priority for people taking up a new post?

Q. We know that Mr. Weir, by September 2018, had produced a job plan and left it with Mr. O'Brien

A. Yeah.

Q. -- to agree or disagree?

A. Yeah.

Q. It was never, ever finalised, it was never, ever signed off. Did you take any interest as Director of Acute Services in trying to drive that towards a conclusion?

A. With the job plan, no, I didn't, to tell you the truth. The job plans were very much the medical side of the house, the professional side. For some reason, though, I always had to sign them off at the end. I always felt uncomfortable because I didn't know what I was signing but the Director had to do it. But these were very much led by the Medical Directorate and not me.

Is it appropriate for the Director of Acute Services to sign off 'medical professional' job plans?

Trust Board

Silo mentality – segregation operationally as opposed to integrated working

A. Performance and governance are completely tied together. They are two sides of the one coin. They have to work together. When the pressures are higher, the governance has to be better, you have to consider it more. Who gets the last bed in the ED has to be around clinical priority and has to be based on good governance.

Q. "Better inclusion of non-clinical managers with clinical managers." You say that's been improved and we can ask Mrs. O'Kane about that?

A. Yes.

Is there now a good connecting structure in operation with non-clinical managers and clinical managers in all departments? Is this being monitored and where there are issues are they being addressed?

Priorities

Q. The review, what was the outworking of that in terms of how you were able to carry out your job effectively? You have mentioned the 2019 review. What improvements or did you see any improvements after that?

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A. Well, there was improvements from the viewpoint that we started getting moving through those current SAIs, and then getting those finished, completed and sent to the Board and to the families. It never really sat comfortably with me getting those reports out to families because I would have built up a rapport -- in my last job, I would have built up a rapport with families, they would have known him, they would have phoned me, I would have been able to contact them and say this is where we are at with the review. With these people, I was coming cold to them, do you know what I mean. The first thing they were hearing from me was a phone call, which was really difficult for them to take in, you know. We did a review of an incident that happened maybe two/three years ago and we were only completing it in 2019.

Good 'customer care' standards towards patients – should always be seen as a part of a deliverable care package and not an optional extra in healthcare. When was the last audit of this done in the Trust? What did the results show and what actions are planned as a result?

A. Oh, absolutely. On reflection, there's a lot of things that if I had have stepped back, took the time to step back and look at, you know, for example, one of the things, and I know we're talking about governance that always sort of was like a bugbear for a couple of the Heads of Service was the SAIs were done in isolation, which is fine. The recommendations came up and the next thing you got a list of 'These are the recommendations that you need to implement.' We never got a copy of the SAI. It's a wee bit like back to the MHPS. If you're given recommendations in isolation, but the biggest problem thing for me is, and it's come from this Inquiry, when I actually sit down look and all the SAIs and read them, the recommendations could be actually mapped across. And if we'd have done that at the beginning.

Mapping the Inquiry recommendations with the recommendations of other recent reviews and SAI's will be one of the first steps post Inquiry. This will contribute to assisting the Trust in shaping a firmer foundation, develop streamlined action points as well as the important task of building confidence with the public in the delivery of good and safe patient care.

Training

Q. In terms of staff -- I know you mentioned that the sister had meetings and there would be conversations around governance but, more widely, did you have a sense that staff across all disciplines, ancillary staff, had an awareness of their own individual responsibility around governance to alert the appropriate people if they had concerns?

A. I think the ward sisters had and the ward managers had. I would have done direct face-to-face training with them on Datixes, but –

Q. How often did you do that?

A. So that would have been done probably every few months. It would have been either me or Carly or David, the two Band 7s, that would have run that training with them.

Q. Just to clarify, Datix training every few months with staff on the ward?

A. Yes. Whilst they didn't get it every few months, they would have got it once, you were rolling out the training for staff to attend. It wasn't very well attended, you might have had maybe five or six people there at training.

Q. So was it optional?

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A. It wasn't in their mandatory training, and perhaps it should have been. It is in maternity, mandatory training for midwives.

Q. Do you think that would help if it was mandatory?

A. I think it would because when I first came into post, I think there was a negativity around putting in a Datix. It nearly seemed to be that you were reporting somebody if you put in a Datix. You know, in maternity, that was the case. I had to change the attitude to staff and say, you know, hold on a minute, this is not about a person or an individual, this is about a system and process, so we need to be looking at this, Datixes are not used as oh, I am reporting somebody because they did this and, you know, putting a negative slant on it. I would have seen Datix submissions as a positive because they were recognising there was a risk there, they were escalating the risk there and we were doing something about it.

What is the SLT's view on Datix training being mandatory for all staff on the frontline?

So where Tracey was saying Governance wasn't fit for purpose and it felt like she was saying there wasn't enough people -- it's not an add-on, it's an in the job/on the job role. And while they were writing the Datix, the on the job people, they just weren't following it through and addressing it, and that takes time and culture and support, and it felt -- it feels now, reflecting on that, it looks like it was too early then. To me, it's still an issue today. When I work with my teams, it's still an issue to have that challenging conversation with your consultant colleague, but we know that we have to do it and it's more instilled that it is required to be done and that's probably from all the learning that we've gained in the intervening ten years.

Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?

MHPS

Q. Now, there has been some evidence given to the Panel around the necessary confidentiality of the MHPS process and some of the perhaps barriers or challenges that puts up in relation to sharing of information, it's important for good governance.

A. Yeah.

Q. Do you have a view on the appropriateness of information not being shared to maintain confidentiality?

A. I respect confidentiality but I believe that when there are an operational team working, or there is an operational team working on issues that are referenced in that report as needing to be further addressed, and people referenced like the Assistant Director, I think they are entitled to have that information shared with them so that they can be fully informed and be part of that, and that wasn't the case. So yes, I do believe there should be a sharing with the appropriate people.

Confidentially vs intelligence and learning from the MHPS process – is there a guideline in place that addresses this? Does it need updating?

Oversight Group

Management

A.I have no problem with inquisition or curiosity. In fact, I would be known to be of that style myself so I have no problem with that. I agree with the Chief Executive, it's right that a Medical Director is

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inquisitive and holds people to account. From an Acute Assistant Director perspective, I believe that the style of previous Medical Directors had been as operationally facing or involved as Dr. O'Kane would have been. They would find it difficult to get used to where does the operational bit take over and where is the responsibility of the Medical Director, and I think there was some of that behind it. I do think there are different personalities in any team and there probably was a bit of feeling annoyed and maybe a bit defensive as a result of that, but that incident in 2019 just wasn't as clearcut as described there. With regard to the model within Acute, the model in the organisation for clinical and social care governance was devolved, and still is actually because it hasn't actually flipped yet. Therefore, the information that is held within directorates from a governance perspective is the same as the information that's held in Older People and Primary Care or Mental Health Directorate and so on. It isn't in the responsibility of one person to have that information. Anne didn't even work in Urology Services, for example, she was in the medicine side of the house. That information was shared at our governance meetings, at our Acute governance meetings. The actual collective leadership structure I talk about in my statement talks about the Clinical Director and the Divisional Medical Director and their professional accountability line to the Medical Director. So, there are a range of mechanisms to interact and get information, and a range of fora that allow us to share that information. There would have been no evidence, and no awareness certainly from my perspective, that anybody would have withheld or made it difficult to get information.

From a governance perspective - are there currently clear pathways to allow the maximum information flow in all parts of the system?

Q. You have mentioned about there being various people in your post prior to you taking that up. There was turnover at that level, turnover at Chief Executive level. Now, obviously some individuals like Mr. Carroll and Mrs. Corrigan were there for the duration of events as they unfolded from early 2012, 2014. What impact do you think the turnover of staff at a high level like that has on good governance management?

A. Very definitely, the turnover definitely affects our governance arrangements, and the styles definitely affect our arrangements in terms of -- I mean, if I use the example of Dr. O'Kane again. When she came in, right from April '19, she was very proactively following up issues of concern from a governance perspective that perhaps could have been dealt with at an earlier stage. But she was a very proactive mover and shaker in terms of clinical and social care governance. She'd also come from Belfast Trust and had experienced a different model of clinical and social care governance, so therefore she probably saw flaws in our system which I would imagine prompted the clinical and social care governance review. I think there have been significant changes made over her tenure to date that are about trying to improve some of those vulnerabilities and some of our systems and processes. So I think some of it is about style, but definitely an impact of change in personnel at the different levels.

Have all the recommendations in the Clinical and Social Care Governance review been implemented?

Q. Just to point more widely in relation to the relationship between HSCB - SPPG as it is now - what is the nature of that relationship, and do you have any views on how that relationship might assist better governance in a Trust generally?

A. Well, in many ways it was a holding to account relationship in that the services were invested in, we were the provider of those services and we were reporting on that. But where there were issues of concern or escalations, either we were escalating to the Commissioner or issues that the Commissioner wanted to discuss with us, there wasn't really -- there wasn't really much solutions coming from commissioning side of the house. You know, you would have been guided with some

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novel approaches that maybe we could take or whatever, but we weren't really getting much traction, especially with regard to backlogs and waiting lists and waiting times, despite efforts to try lots of different ways to bring that about. The relationship was respectful and proactive and we could have had discussions about new investments, so that was all very healthy. Some of the discussions around what else we could do and the holding to account bit were a bit frustrating because we didn't really develop new approaches. We might have had a bit of non-current investment or a contract development with the independent sector, there was always something we were moving forward, but we weren't really turning things around despite the two-way processes.

Is this still the case?

A. But I did act on that in terms of I knew the governance review had taken place from 2019. We were waiting on the outcome of that, hoping that it would give us some sort of acknowledgement that there was capacity issues for the volume and scale of what we were dealing with in Acute. I did put in post a Quality Improvement Project. To me, quality and governance are very interlinked, so our Quality Improvement Project dedicated some time to the Assistant Directors to actually look at some of the gap areas they were most worried about, like action plans, and implementing recommendations post serious adverse incidents, and dealing with some incidents on the Datix system.

Q. That's one of the things that Mr. Carroll actually refers to in this paragraph, the inability to deal with action plans, the implementation of recommendations following serious adverse incidents, or to deal with the volume incidents that require active management and the complex complaints that required attention.

A. Mm-hmm.

Q. Now, what was the scale? There's quite a breadth of governance concerns around that. Did you ever get underneath what the scale of all of that work was? For example, what were the number of complex complaints that required attention; what were the SAIs; which standing; what recommendations were awaiting implementation? What was the detail behind that?

A. So, we got that detail every month. If you notice in the Acute governance papers that came, we would have got how many complaints are outstanding, how many are awaiting answer, which Assistant Director is sitting with or which Head of Service? So we would have known through the Governance Coordinator where there was glitches in the system that we needed some action. When we had a Serious Adverse Incident Review, we did have an action plan that was pooled together with the Clinical and Social Care Governance Coordinator to outline the recommendations of that review. What we were missing was has it been actioned? Has it been implemented? When was it implemented? How can you evidence it was implemented? They weren't missing it all the time but we didn't have a clean sheet in terms of we had a thorough process end to end for that action plan and implementation process. So, that was the focus of me trying to put in place, number one, the Quality Improvement Project and some of the areas around that, but, more importantly, getting funding secured for a Band 5 Governance Officer for each of the Assistant Directors, who would be their person who would work with them and hold their hand to keep a bit of momentum going within the Directorate.

Q. Those posts were filled before you left, were you?

A. Yeah.

Q. Were they two Band 5s?

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A. No, there was four. There was one for each division.

Q. They actually tried to follow through on the outworkings because what this paragraph seems to suggest is the systems are effective in bringing the issues to the surface by and large –

A. Yeah.

Q. -- given that we are here, but that the actual remedial work and outworking of what's needed to make sure that doesn't happen again is the stage that has some hold-up?

A. Yes. The purposes change in learning. To bring about the change in learning needs capacity, and that's what we were missing. We had some capacity in different job roles. I mean, I think somebody said last week Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it. We were missing a wee bit of momentum. That's why both the quality project and the Band 5s for each AD, and now in place, were to try and accept that there was a reason to be kept awake at night and we needed to do something about it.

'So, we would have known through the Governance Coordinator where there were glitches in the system that we needed some action'

With a band 5 now in place for each AD – are there any remaining 'glitches' that need addressing?

'Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it.'

Q. If we could just go to the terms of reference of the review at WIT-35726. The purpose of the review, it's "Terms of Reference Southern Health and Social Care Trust Governance Review". It says: "The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on Patient Safety and that helps people learn. The objectives: The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like. It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach through the organisation**.** It will include a review of both clinical and social care governance. Specifically, the work will include gaining an understanding of the current governance structure and processes in place; meeting stakeholders to identify what works well and areas for improvement; undertaking a benchmarking exercise to identify best practice; review of existing and draft documentation, including a new governance assurance strategy. The outcome will be a written report outlining key findings from the review, and recommendations." The governance assurance strategy, did it ever come to fruition?

A. I don't believe I ever saw one.

Q. In relation to this clinical and social care governance review in September 2019, what was your understanding of the background of this particular report? Was this something that the Trust did every now and again or there was a specific reason?

A. There had been a couple of reviews in earlier years since the Trust had formed, I think it was 2012 and 2015 potentially. Again, I think it was following Dr. O'Kane joining the Trust, seeing some vulnerabilities, potentially assisting with the potential of a better model, actioned by the Leadership Centre. June Champion was the Leadership Centre author was carried out the review. She worked, in

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fairness, intervening teams and relevant stakeholders to make sure she put together a comprehensive report

The report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 Findings and Analysis, and are broadly categorised under the following themes: Work governance, culture of being open, controls assurance, risk management strategy, management of SAIs, complaints and legal services, health and safety, standards and guidelines, clinical audit, morbidity and mortality, learning for improvement, Datix, clinical and social care governance structures. A summary of the recommendations is provided in appendix 1."

Q. Now, your involvement was on the SMT in trying to implement some of the recommendations. You mentioned about the operational risk versus corporate. I wouldn't call it a struggle because I am not sure that's a word you would use but was there a tension between the competing expectations or demands that perhaps ultimately led to the delay or the failure to implement these recommendations?

A. Yes**.** I think the time-lag doesn't help when there's a review happens in August '19 and, a couple of years later, or three years later, we are still moving forward with it. You then have pockets of developments to try and strengthen where we are now as opposed to the root and branch review being implemented. However, I think changes that have been made have been felt and felt positively. Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you.

Q. So, there was a degree of flexibility built in?

A. Yes. We were evolving, we were learning on our feet and it really was governance in action, how do we keep this as safe as possible with patients at the centre.

Q. Do you think it might be helpful to have a toolkit for incidents like this where there are lists of suggestions, different routes, built in flexibility, a checklist of things to make sure they are done?

A. Absolutely.

Q. Would that be something that might assist?

A. I think because of the Belfast experience and because at the end of a lookback review, one of the stages is the outcomes and the recording of the learning, I think there's a natural opportunity there to learn and to share a lot of the tools and processes that we adopted.

Q. Giving the timing of this report and the September 2018 recommendation in the MHPS about an admin review, and this clinical and social care governance review then coming after that, was there any thought given that this was a possible vehicle by which that admin review could fall under this umbrella and perhaps gain some learning from that, given the independence of June Champion and, as you say, the requirement for the MHPS recommendation to be independent?

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Q. There was also learning over and above Urology Service in those. What was the position on the roll-out of those recommendations or their implementation by the time of your retirement; can you recall?

A. When I retired, there were nine out of the eleven delivered and the other two were embedded but subject to audit; we needed to evidence that they were effective. So all eleven are now implemented. I have to say that that process was extremely innovative because we had -- this wasn't about a Urology Department, this was about learning for the whole organisation in Acute Services. So, we had medicine, we had everybody sitting around that table taking responsibility because function of their MDMs, for example, was something that had read across. We had a really good process, and we had a subgroup and we had designated tasks that the different people around, say, job planning or audit, whatever, would work through and develop with the groups. But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work.

Alongside the learning from the SAI's, there have been several significant reviews in the Trust in the last 10 years, each with recommendations. Added to this will be the recommendations of the Urology Public Inquiry Report.

Going forward:

- what are the plans to review and bring some clarity, standardisation, and consolidation to all these recommendations?

- then to move through to systematic action and implementation?

- what is the SLT's view of developing 'a toolkit for incidents'

Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it.

A. Mm-hmm.

Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting?

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture standing back a wee bit, I think there's somebody thinking, no, there's a different way to do governance, I think, not just a series of tick box exercises.

How can the SLT shape the narrative post Inquiry so that this momentum can be maintained?

Q. Yes. Dr. Boyce has suggested that -- if we just pull up her statement, TRA-05849. If we just go to line 4, please. I'm asking her why you wouldn't take on this direct interfacing role with Trudy Reid, and you have given me an account this morning of why. Dr. Boyce's perspective on it was that you were overwhelmed with the post, it was a massive post, "and also there was maybe a level of inexperience in terms of governance, leading governance in a very big, very vast ranging Directorate." She says, "I think the fact that I was there and had already been doing it sort of allowed [you] not to maybe take it back fully." The downside of it, she explains, is that it made her nervous on your behalf because

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obviously: "Then Esther was going into Senior Management Team, the Corporate Governance meeting and so on, without that interface so I was always nervous about how she could then represent and talk about her risks and so on." Do you recognise that there was this risk of a gap if you weren't as fully committed to the governance aspects as Tracey Boyce says you ought to have been?

A -- So yes, I was uncomfortable and I felt extremely just unsupported in terms of -- you know, if you feel supported when you are in a swimming pool with rubber rings and everything and everybody takes that away, you feel a little bit adrift.

Are there any people in current senior leadership roles who are not carrying out their full brief?

'Q. The Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that'

Is this a trend that is still happening? If it is, how is it being addressed?

Q. And, in that role, what were the challenges? Was it a straightforward matter to implement these radical changes to how governance was to be done within the Trust?

A. No, it was really tricky. It was -- I mean, it was a bit like the performance era and that takes, it takes time, it takes consistency, it takes -- no, it was very difficult. Was everybody accepting of these processes? Did people want to add this on? I mean I have read in other evidence where in -- after my time in 2016/2017, they talked about giving additional PAs to consultants or 0.5 of a PA. We didn't do that at the start because we wanted to see: Can we buy you into actually this is part of your job role anyway? Now, there's a tossup between adding on a bit and paying you to do it, or you winning the hearts and minds and saying "This is part of my role anyway." I mean -- so, the whole thing just takes time to slot together, not just -- I mean, IT's not my thing, but, even that, but it was interesting reading people's statements about the use of IR1s and, you know, saying "Oh, well, I wrote the IR1" and it nearly felt like they came to an end-point there. No, the IR1 is to flag -- "I need to then talk with my line manager, they need to come back to me, we need to see what we're going to do about it." But they felt like they had discharged their duty just by doing it. So we hadn't got the culture there yet. It wasn't there yet**.** They hadn't the ownership.

It takes time for people to realise that governance is your business and somebody is not going to do it for you.

Is this understanding of governance widespread in the Trust today?

Trust Improvements

Q. Does that apply for the MHPS process as well?

A. So, we would never have known about an MHPS, definitely not. It wouldn't be something that would be shared at my level. It would be kept with a tight cohort of people.

Q. Does that apply even if the learning or some of the issues that arise through the MHPS have a direct impact on your role and governance and perhaps patient care? Are you not informed of anything about the outcome of an MHPS?

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A. Unless there is a staff member that has been -- their contract has been terminated, I wouldn't know.

Q. Did you ever share that or mention that to anyone and say is there any way we can get beneath some of the more formal procedures that actually can highlight aspects of governance that need improved? Were they conversations that were had at any level?

A. No, because I didn't know what I didn't know at that stage, if you understand what I mean. So, it wouldn't have been on my radar to ask that question.

Q. By the time you had left the Trust, was there any movement in thinking that that sort of issue needs to be looked at, that there perhaps is a wider benefit from a governance perspective in bringing other people inside the tent, as it were, so that learning in an anonymous context can be rolled out?

A. Not in that context. Having said that, I was aware of a Medical Director's office contacting me and saying, you know, has so-and-so -- is there any complaints or any SAIs involving this staff member? But they weren't -- you were just asked to check out if there was any incidences with that. There was no information coming back, if you know what I mean, to say look, this is what's happening in that case. It might have prompted you - that's only just before I left this started happening - that would have prompted you, oh, is there something going on? But you wouldn't have had any detail on that and you wouldn't have had any context where that's concerned, because very often the information was purely from they are revalidating, or it's for their appraisal; not necessarily that there's an investigation going on.

'Q. Do you think that there's a way of sharing information with you at your level as the coordinator, Governance Coordinator across Acute Services, that would allow you to carry out your role more effectively, assist in the protection of patients with a reduction of risk, and also anonymise sufficiently to maintain the confidentiality of the individuals involved?

A. I think so. I can see the benefits of it if you were aware there were other issues because then you are kind of joining all the dots, aren't you? You don't have all the dots to join otherwise.'

What is the current policy on sharing anonymised information and learning from MHPS/SAI's with the Governance Coordinator across Acute Services?

A. You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well because, very often, instead of looking at, well, that's a human factors issue, people still have that kind of blame 'oh, you never guess what so-and-so has just done. That needs to stop. For you to have openness and transparency and good learning coming through, you need to accept we are human, human factors, people make mistakes; this is the mitigation we put in place; this is the learning that we put in place so that the whole stigma of being involved in a serious adverse incident is removed. Because there is a stigma for staff that are involved in it, they are quite stressed about it and they think that people are pointing the finger at them. Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well.

'You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well'

'Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well'.

How can this narrative be reinforced throughout the Trust?

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Q. "I also believe there were too many individual processes, MHPS and/or insufficient joined-up thinking. For example the details of the MHPS process were kept confidential".

We raised that point before. The first point, there are too many individual processes?

A. It's not just MHPS; there's obviously nursing and midwifery processes as well. Any health professional, allied health professional, have their own professional bodies that they would have investigations through. Also, HR have another process for other staff as well. You know, you have got your conduct or your capability processes or your disciplinary processes and things like that. They don't necessarily all marry up and feed into each other. That's what I meant by that.

Q. Have you any suggestion as to what the answer may be or are you just identifying that those individual processes perhaps be joined-up thinking, and anything that would unblock that would probably be helpful?

A. Yes.

Q. Then you say at 22.6: "We should be an organisation with an effective corporate memory so that when an adverse incident happens, that learning is not only shared through the division or area of practice but extended to all areas within the Trust. Lessons must be learned by all teams, and action plans from recommendations should be kept live and revisited at least annually to prevent reoccurrence. Too often learning from adverse incidents is shared and there is some learning for a few years, then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems reoccurring." The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate.

A. Mm-hmm.

Q. But your suggestion is that when you lose people who remember things, everyone thinks they are starting again?

A. Yes. Yeah.

'The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate'

Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?

Q. You have said this previously but just to give you an opportunity to say anything else about it: "A deficit in one area of practice should provoke curiosity and require sampling of other areas of practice". We can see in the timeline there's a possibility of that thinking pre-MHPS, post-MHPS September 2019, 2016, 2017; there were signposts perhaps along the way. Do you acknowledge that that should have been the lens through which things were looked at various parts of this journey?

A. I am a great believer in always lift a stone, don't take it on face value, and I don't think we took that opportunity as an organisation early enough

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

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A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern. Also patient information and patient involvement. We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services. I think the Task and Finish work showed even when patients and relatives had been through a difficult time, they engaged with us, they trusted us to try and improve our services. I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public.

'But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work'

'We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services'

'I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public'

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go though to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'

What are the next steps to move towards this goal of inclusion, partnership, and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'

Q. Absolutely. Another thorny thing that's come through from a number of people, and it's on your Risk Registers at the Trust, is about standards and guidelines. Clearly a lot of bureaucratic things are involved when you try and make sure they have been read and the Department has looked at them. It would appear that there has been no systemic way of ensuring that when a standard and guideline is adopted, there's any kind of measures of whether people are actually using it. Is that correct?

A. I wouldn't say it's entirely correct. Caroline Beatty, who let the standards and guidelines work in Acute Services for many years, has now moved to corporate. She has moved to corporate because there was an acknowledgement that she had a best practice model - that was also acknowledged in June Champion's report - but that it needs to be corporate. A lot of standards and guidelines don't relate to Acute, but there's a lot that relate outside of Acute and there wasn't the same focus.

Q. But how would you know if a consultant wasn't following it?

A. The audit and the checking and the role of the change leads is critical here, for them to be able to evidence for us. I am back to the issue of clinical effectiveness and clinical audit and we need more of it.

Q. I think you would agree that we don't actually have any measures of the clinical outcomes in specialties, for many specialties. There are in some but certainly not in many surgical specialties.

A. Yeah.

Q. Has the Trust fully embraced that now, do you think? It's not very easy just to put it in if you recognise the deficit, but is there a full recognition of that?

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A. I think they are on that journey. I think they are starting to think even MDM outcomes for different specialties is part of that.

Q. But MDM, it's still the same thing in that you are following a guideline?

A. Yes, but I still think there's a piece of work to get us to a watertight place.

'Clinical effectiveness and clinical audit and we need more of it. We don't actually have any measures of the clinical outcomes in specialties, for many specialties'

This is key information that is needed for quality and patient safety – can this audit process be embedded across all specialities with a timeline for action?

Q. You understand that one of the focuses for the Panel is the governance system and processes that allow decision-making, I suppose, to be tracked back to origin. This seems to have been a fairly relatively important discussion that was going to slightly change the route by which triage was going to be approached, and certainly there's some contested evidence now around what was expected to be done. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely, because I know from the meeting with Mrs. Burns, I did put it in writing with regards to the plan with Mr. O'Brien not triaging. But I have looked back and I have never actually shared information with regards to the GP, the default of the GP prioritisation, which is now, you know, a regret. But then again, I don't think it was, you know, for me to do it because it wasn't my decision. It was a decision made by two assistant directors in discussion with a director, so I absolutely agree, we should have had minutes from that meeting, albeit even if it was an e-mail note.

'Q. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely'

Is the messaging clear throughout the Trust on the importance of documenting all decisions taken and circulating them to the relevant people?

Quality and patient safety

Q. Just a couple of clinical things. I was interested with your experience in the obstetrics and gynaecology life before the last job, and the comments you made on trigger lists and near-misses and things. Looking back with all your experience, how do you think we could use that, especially in urology but perhaps surgical disciplines?

A. Certainly I would feel in a specialty like surgery, you could have a trigger list as such that you can -- I mean, our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again. Then, from that then there's rolled out learning in theme of the week and things like that, you know, that is ongoing and is live and it keeps going. I can see how transferrable that is for Urology, looking at your near-misses. Your near-misses are a sure sign that your system is weak, and putting measures in place to see how you can prevent that happening because a near-miss one day is an actual event the next.

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'Our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again.'

Can this idea of a trigger list being used as an audit tool be applied to other areas of clinical practice in the Trust?

Q. Just before I move on, Patricia Kingsnorth had indicated that the staff turnover and the transient nature of staff in a Trust can cause concerns and challenges for good governance. Would that be a view that you would agree with?

A. Well, it's a view that I agree with but it's also evidence-based, so we know that where you have high turnover of people into an area, they may not be familiar with policy, with procedures; they may not be familiar with the working environment or the operating procedures; there isn't the same continuity of care for the patient. A lot of that translates into service delivery issues. There were issues with, for example, how we measure quality in the nursing care that we delivered, and there were a range of issues in poor performance that were directly linked to that high flexible agency and bank staffing. We were able to compare that with other wards where there were stable core staff and they weren't such an issue. The management styles, capability issues, there were a range of issues ongoing but very definitely linked to high turnover and workforce concerns in that ward.

How regularly is patient safety and the quality of care monitored and audited on wards that are experiencing a high turnover of staff?

Q. In the absence of any report or product that you can point to, and I have to say the Inquiry is unsighted on that, can I suggest to you that you did not, nor did the Oversight Committee, engage in any assessment of the risk to patients in terms of what had been uncovered?

A. I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly. A risk assessment at this point, sometimes you write a risk assessment to make sure you understand what risks are going to be, but at this point in time we knew exactly what the risks were.

Q. Did you? Because it wasn't until 2017, when the other clinicians in Urology sat down and began to look through the untriaged referrals, that a picture began to emerge that in excess of 20 cases, the referral into the system was wrong and triage would have led to an escalation of the referral from routine or urgent into red flag. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?

A. Until the consultants, which you say is January 2017. I wasn't, to be honest with you, sure of thatdate but that's when they started to do the waiting list initiatives and look at the triaging. The patients were then seen by them. Yes, you would be quite correct in saying that.

'A. 'I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly'

Q. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?'

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What learning can be taken from this (and actions if needed) to ensure that the principle of assessment of the risk to patients is always paramount in clinical practice?

Q. Do you have any observations as to the reluctance around that because it is a quite a good safety net?

A. It's a really good safety net and it's really interesting that you raise that because in my field now, we're in specialist palliative care - I'm the Director of Specialist Palliative Care - specialist palliative care is very much about the patient and family understanding where they're at.

Q. It is.

A. That there is, you know, active treatment to undertake and how are we going to see this through? So, we have regular debates in our governance forum about giving the patient and family the letter. My clinicians today are extremely reluctant about that.

Q. Why do you think that is?

A. Well, they tell me that it is because of some sort of protection for the patient and the family and from the clinical -- and I regularly tell them, 'If I am your patient I want to know every single detail for myself please.' So, they come from at it from, like, you know, we're protecting our patient but really, I think it's just the thought of getting used to actually saying out in black and white where you're out. They haven't just reached that point yet. And they are very good, my clinicians are very good at breaking bad news, they're very good at having those conversations but they still can't write it down.

Q. That's different from writing it, isn't it?

A. Yes, very.

This is an issue that has come up several times in the Inquiry – can the SLT clarify the guidance across the Trust on patients receiving letters after appointments recording their treatment discussions and plans?

Q. But at least from that time, you had on paper an identification that clinical risk was in your mind, would that that be fair?

A. That would be fair, yes.

Q. Given that, and your knowledge of that and your awareness of that and your operational head on, if can put it like that, was there ever a sense that you needed to speak to your medical counterparts and say, "This isn't just our problem operationally, it isn't a notes and records or a record-keeping problem, this actually has the potential for significant impact." Did anyone cross the potential divide and say, "We need your help sorting this out"?

A. From my perspective, I would have escalated and I would have had quite a number of conversations with regards to them issues with Mr. Mackle mostly so, and Mr. Young would have helped me out with sort of clinical issues that I would have felt that I wasn't able to address. To cross that, I didn't -- I don't believe I ever said -- it was quoted to me so many times by managers -- this is always an admin issue -- clinically, Mr. O'Brien is brilliant and we have no issues with it. Like, for example, Mr. O'Brien was his Clinical Director and one of his quotes is "If I had to come in, I would have had no issues coming in under Mr. O'Brien." So I think that clouded, wrongly, my judgement -- I have reflected on this -- in that I felt there may be an issue because nobody else did and that's my fault, I should have escalated it further. But it's one of those things that when I was escalating it or

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and thinking it and saying it in a letter and then it was removed, that it was me was thinking it was, where it really wasn't, if that makes sense? I'm probably not saying that very well.

Q. I think Vivienne Toal said something similar. She said "His excellence as a surgeon blinded us to the issues" -- I paraphrase her, but would that be a view you share?

A. Yes, yes. And I think it was everybody else sort of, you know, in and around and sort of up/out would have said that, that there was no issues clinically and it was all admin.

Post Inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

Q. Do you think that this particular example is something -- I don't mean the case, I mean the process -- the failure, and you might be right that it's relatively isolated, but is that something of such significance that it just has to be got right and, therefore, it has to be monitored?

A. It could be that, in hindsight, you could say that. But if you have -- if the vast majority are coming back and saying "Yeah, we do this" and there's peer pressure and we're saying "Tell your people you really must do it" and "Your CD and your AMD says you must do it" and "It's good patient care" -- "I don't know" is the answer. There's a line somewhere and in hindsight is a wonderful thing, isn't it.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

How operationally robust is the role of peer review and peer pressure in maintaining patient safety and quality standards throughout the Trust? How regularly is this audited?

3. Culture and behaviour

A. The issues of changing the behaviour of the consultant team to meet the required new-to-review ration of patients, and new clinic templates in Outpatient clinics to increase the day case rate and lower the inpatient elective workload and to meet the BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the the requirements for change tailored to each individual's practice.

A. You expect people working in the Health Service to automatically understand about safety and to learn whenever there are processes going on which are not in the best interests of patients as seen

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by most of the world. So, it is difficult managing somebody who has a view that whatever they are doing is the safest thing, despite the rest of the world disagreeing with that.

Are there any current areas in the Trust where there are difficulties in bringing about behaviour change?

A. I think the journey that we were on in terms of embedding the culture of if an incident occurs, recognise it as an incident, discuss it, report, let's learn from it.

Q. Yes.

A. That learning process, and making sure that the culture was around learning from an incident as opposed to let's hide it, we don't want to know about it or own up to it, that journey of opening the culture was a journey in progress. That's a really, really important organisational journey. That's what the core thrust of the corporate review of clinical and social care governance was about. I am sure you have heard about that and seen the documents around that. That was absolutely the core of what we were seeking to do. As you well know, it takes a long time to change a system. That required all of the staff working day in, day out in the wards and Outpatients in every which part of the hospital to embrace that culture, to recognise. I mean, there were still times when a senior leader, a senior clinician would come to me and say, 'by the way, I quietly want to tell you this has been happening for a long time, nobody has been prepared to own up to it but did you know', and you go gulp, deep breath time, 'right, what do we need to do'? So that's –

'The journey of opening the culture was a journey in progress' – post Inquiry, what does 'opening the culture' require at this stage?

- 'There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame.

- Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed?

A. An impression I formed, and information that other people gave me as well.

Q. Yes.

A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, it was very, very plain. I was bullied to within an inch...

- At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands.

- I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place

- Eamon Mackle told me they were drawing bets of how long I would last'

This narrative is now in the public domain and can be interpreted in several ways. How will the SLT address the themes that are raised in it on two fronts – for the staff in the Trust and for patients, carers, and the public interface?

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Q. Can I ask you this: Was it your sense that by the end of your time in the Acute Directorate, governance, in terms of its capacity and resourcing, was in a better place than what you found at the beginning, or was it treading water?

A. Ever so slightly. Every so -- well, we treaded water for a long time. It was ever so slightly better but, to be honest, whenever I left, anything was the last thing from my mind so I didn't even think about governance when I was going away. I was looking forward very much to working with Patricia Kingsnorth because she, to me, had exactly the same idea and I knew I could -- we could have -- and she was very proactive in Maternity. So, it was slightly better. Certainly the language that I used in my meetings about governance being important, and trying to bring on board. But, as I said to you before, you know, the culture was performance, performance, performance, and I don't know that I did very much to change that as an individual.

'The culture of the Southern Trust when I joined was performance, very much performance driven'

How would the SLT describe the current culture?

'There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so'

How can team working be enhanced in the Trust?

The biggest thing that was maybe just pie in the sky for me was changing the culture in relation to governance. Culture eats strategy for breakfast. If you are going to ask me what I learnt, that's the biggest thing.

'Culture eats strategy for breakfast'

Has the SLT adopted the priority of establishing a constructive and empowering cultural lens before delivering the detail of forthcoming strategy?

A. I believe in terms of communication, there were silos. In terms of management that would have been above me, people didn't necessarily follow their roles and responsibilities. That was actually a trend right across, and I would say that to you. Roles and responsibilities, for me, is every bit as important as following up a procedure. I need to know what my role is but I also need to know what your role is so that we don't overlap or I don't do your job, causing conflict and concern. There was an awful lot of dissatisfaction in that. I believe it's because people didn't know what their roles and responsibilities were and they just did whatever they thought on the day.

Q. Where do you see the responsibility for fixing that as lying?

A. Well, whenever it's a culture, it's very, very, very difficult to fix. It would needed to have come corporately from the top on down. It would needed to have been -- you see, you can't make somebody do something unless they believe it's right to do. You know, me making people believe, from my very, very small part I discussed it, discussed the importance of -- and it's not even hierarchy, it is just communication lines. I didn't mind talking to whoever in the canteen or whatever, but as long as the information that needed to be passed up and down went through the proper lines.

Recognising the key role of good communication flow throughout the Trust as a tool in changing the culture.

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Q. -- the understanding of what is to be done. I mean, does that -- I mean, looking back on it, do you think these what might be described as teething problems or difficulties were just inevitable, or was there training shortcomings in how the Trust went about it?

A. I don't think -- I don't recall the detail, to be honest, of the training and the rollouts. What my -- what I recall was, we were at a time when, you know, for example, 2014, Francis was -- they were accepting the Duty of Candour and it was so broad -- we still haven't got it in Northern Ireland! So, like, we were at a zero or minus starting point, so we were, like, building our culture. And it was very similar to the challenges that you faced at the start of the performance culture. And while people said the, you know, the written IR1s, you know, went into a black hole, that was great when they could say that. When it was popping up on their e-mail that they had an IR1 notification and needed to do something with it, clearly history tells us, for example, in 2014 there was a backlog of unopened IR1s! So it didn't change the -- it takes time to change their actions and their responses. You can put in all the systems you want, but you have to build a culture where -- and I think it was just very early in those days and it was very early in Northern Ireland as well -- across the UK because Francis was only just coming out and, if you look back now -- if you look at it with a 2023 lens, it's completely different. But that was a different time and we were learning different things, so I think -- I don't think that -- I honestly can't tell you the detail that went into the rollout. I mean, certainly we were writing -- "writing" is the wrong word. We were producing 450 IR1s a month across Acute in 2014 when I look at the reports, so I don't think we had any -- we didn't have -- obviously, the quality of those and what they were reporting, you could dive into that. But I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?". And you can put in the system, but it doesn't necessarily mean that people are going to change their role and responsibility and how they view it.

‘I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?".

‘A. It demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities.’

Is the current messaging in the Trust consistent, empowering and across the board when it comes to the requirement of a clinician’s individual responsibility, accountability, and action?

Q. And recommendation 4 related to the use of timely discharge letters?

A. Yeah.

Q. And she makes the point in 3 and 4 -- this is page 10: "We are relying on people to do the right thing, which is the weakest safety net..." -- and she asks the question: "Did the team consider anything stronger in terms of making sure this didn't happen again?" So, for example, alerts for unread Radiology reports/ monitoring of discharge letter performance. So at least one of those aspects, the Radiology is something, as I say, you were familiar with and the Inquiry is by now familiar with the history of that through a number of incidents and with a number of patients. Are you able to assist us at all -- I know the final report was signed off in August, you weren't there, but was there any attempt in your time to correct those two issues in the context of this case?

A. No, because, as far as I was concerned, we hadn't got the right conclusions yet, and you have to get the clinicians to own the conclusions. So I can't implement things like -- I can't -- you could -- you could try and tell them to do something about unread Radiology reports, but they would have to

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accept that and then go and do it. Monitoring of discharge letter performance is interesting and I think the concept of how much -- these are senior people, these are senior clinicians. Telling a patient -- telling a GP how their patient is doing and what's happening with them is probably, in my book, quite basic. Do you need me to check that you are doing that? At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"? And I guess these are senior people, they're senior clinicians, this is in the best interest of that patient in front of them and -- yeah.

Q. I suppose, what you're putting your finger on is the extent to which the organisation can afford to place certain issues on trust by reference to professional obligations?

A. Yeah.

'At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"?'

How is the SLT building this narrative into current culture?

Q. You also mention that there needs to be a clear management structure as there's no line of accountability for clinicians?

A. Yes.

Q. Would it be more that there is a line of accountability but that it wasn't actioned properly?

A. There was -- yeah, that's a fair point and I suppose listening to Mrs. Burns yesterday too, it was interested to hear that at that stage they were only all new and they weren't used to the challenge part of it. But I suppose it's something to ask the clinicians but I don't ever think they considered the clinical end as their managers. It was more to do with, you know -- like they nearly seen me not as their manager as such but as part of the team. I was the go-to person as opposed to, you know -- now, their job plans and their appraisals, etc., etc., I couldn't have become involved in and they would have pulled other people. I just think there's that disconnect for the clinicians, albeit the people who are in post, they don't seem to go to them.

How is the SLT addressing the ongoing need to facilitate a culture within the Trust based on respect for the different roles and responsibilities of all employees in the Trust in the delivery of quality care and patient safety?

4. Communication

The benefit of having the open door policy, having the senior clinicians dropping in and out, the benefit of walking the corridors, walking the wards and spending time with staff to listen. Now, not every member of staff would have opened up about things but many did. When you are walking around the hospital with a cup of tea in your hand, as I always did - it's one thing I haven't got here, is a cup of tea - a cup of tea in hand, it makes a deliberate statement, 'I want to have a chat'. I know people are busy and if you find there's something very serious to talk about, you come back and find a time to have that conversation.

Q. So visibility was a benefit in relationship building and confidence-building?

A. Very much so.

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What steps can the SLT suggest to encourage all members of the senior team to become more 'visible' and for the SLT to lead by example?

Q. You have said that this was one of the best serious incident investigations you have been involved in. What was about it that made you say that?

A. From a family engagement. I suppose that was my big thing with SAIs, was the whole family engagement bit. The early learning being shared as well as we were going along, because that information was being drip-fed. I can see the restrictions with this SAI very clearly with the benefit of hindsight, but at the same time, I mean, we did look at a systems approach, this wasn't about finger-pointing. This was looking at our structures in place and that's why I feel that was a really good SAI. I think the intention of the staff involved in the Review Team and the commitment that was there, I mean everybody worked so hard. At the same time, that feedback to families, keeping them in the loop, keeping them informed, to me that was an example of good practice of how to do it from a family engagement point of view.

Can this approach be applied to all future SAI's in the Trust?

'Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you'

One of the main ways of bringing people with you is to ensure there is quality and frequency of communication. Some thought needs to be given to this.

Q. Another thing that you talked about, I think, was the admin review. Now, having read the MHPS determination and the substance of it, it's quite clear that people have interpreted that external admin review as different things.

A. Yeah.

Q. If you'd interpreted it at the time and you'd read the statement that there were managerial failings and there needed to be external review, what kind of review would you have envisaged that to be? I know you weren't in charge of it.

A. I think we would have looked broader at roles, remits, responsibility, governance, actions, escalations, evidence of a concern materialising into some process.

Q. Yes.

A. It would have been bigger than is there triage happening or whatever. It would have been literally a root-and-branch review of how our systems working, and have we got the right balance between operational busyness and governing our systems and ensuring the patient is safe in our care.

Q. That's I think how many people would have interpreted that. Why didn't that happen, do you think? What was responsible for that inaction?

A. I think a ball was dropped. There was a recommendation that appeared to look like it was belonging to Acute but, in actual fact, it never said it belonged to Acute. It said independent but it had Acute in the middle of it, so I think somebody thought an Acute will deal with that and it wasn't dealt with. I think also the sharing with the operational team, I know Mrs. Gishkori had it, but Ronan had no idea that there was implications for him as Assistant Director, even for, you know, some of the oversight. I think it's back to the sharing appropriately, even of what had started as confidential type processes.

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Post Inquiry – it will be important to establish clear lines of communication for information flow and learning throughout the Trust. Also, to check that everyone has clearly defined roles and understands their responsibilities and accountability. Underpinning this will be the outlining of Trust values and principles and the strategic aims for the next five years.

Veryan Richards

16/9/2023

Received from SHSCT on 26/02/2024. Annotated by the Urology Services Inquiry.

EXTERNAL REFERENCE GROUP							
No.	**Date of Meeting**	**Action**	**Action Owner**	**Comment / Update**	**Status**	**Due / BF'd**	**Date Closed**
1	20/01/2023	Issue the completed Timeline to each member of the group	J King	**Update 10/03/23 -** Complete	Closed		10/03/2023
2	20/01/2023	Terms of Reference to be amended to include in Vivienne Toal's membership	M O'Hagan	**Update 10/03/23 -** Complete	Closed		10/03/2023
3	20/01/2023	Amend TOR to reflect Tom Frawley as chair of the ERG group	M O'Hagan	**Update 10/03/23 -** Complete	Closed		10/03/2023
4	20/01/2023	Amend TOR that the Group and individual members have access to Chairman of Trust	M O'Hagan	**Update 10/03/23 -** Complete	Closed		10/03/2023
5	20/01/2023	Contact Mary Hinds to brief her on meeting (as she was on leave)	M O'Hagan	**Update 10/03/23 -** Complete	Closed		10/03/2023
6	20/01/2023	Agree with the Chair a schedule of 'in person' meetings for 2023	J King	**Update 10/03/23 -** Complete	Closed		10/03/2023
7	20/01/2023	Invite Hugh McCaughey to become a member of the group	M O'Hagan	**Update 10/03/23** - Meeting between HMcC MOK and MOH on 27/ 02/23. Complete	Closed		10/03/2023
8	20/01/2023	Members of Panel to send Secretariat their five major themes that should be addressed in final report	All Members	**Update 10/03/23 -** Complete	Closed		10/03/2023
9	20/01/2023	Veryan Richards to produce a paper regarding themes arising from the Public Hearings	V Richards	Standing Agenda item	Ongoing	Update at each meeting	

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No.	**Date of Meeting**	**Action**	**Action Owner**	**Comment / Update**	**Status**	**Due / BF'd**	**Date Closed**
10	10/03/2023	4 Sub Groups to be convened led by an independent panel member and a member of the Trust Senior Management Team	S Austin, V Toal & H Trouton	**Update 21/04/23 -** Complete	Closed		21/04/2023
11	10/03/2023	Identify Trust membership of the 4 ERG sub-groups	S Austin, V Toal & H Trouton	**Update 21/04/23** - Complete	Closed		21/04/2023
12	10/03/2023	Information on SCRR process to be shared wi	M O'Hagan	**Update 21/04/23** - Paper to be drafted by MOH and tabled for information at meeting	Closed		02/06/2023
13	10/03/2023	Group to receive presentation on Magnet Hospitals	M O'Hagan & H Trouton	**Update 21/04/23 -** it was agreed this presentation would not take place as Trust does not want to pursure a uni-progressions approach to improving leadership and culture. H Trouton progressing conversation with Mersay care to understand their multi-professional approach	Closed		21/04/2023
14	10/03/2023	ERG to reevie presentation on "Culture"	H McCaughey	**Update 21/04/23** - presentation	Closed		21/04/2023
15	21/04/2023	Share TOR of 4-ERG sub-group with wider ERG group	S Austin, V Toal & H Trouton	**Update 02/06/23** - Complete	Closed		02/06/2023

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EXTERNAL REFERENCE GROUP							
No.	**Date of Meeting**	**Action**	**Action Owner**	**Comment / Update**	**Status**	**Due / BF'd**	**Date Closed**
16	02/06/2023	Trust to take forward the development of an Engagement Strategy and vision	Trust ERG members	**Update 29/09/23** - paper shared at Trust Board on 28 Sepetember and endorsement received	Open		
17	29/09/2023	Analytical Framework to be shared with group members	S Watson	**Update 09/11/23** - Actioned on 6 October - Complete	Closed		06/10/2023
18	29/09/2023	Trust ERG members to agree how they wish to continue with 4 subgroups following cessation of the ERG group	Trust ERG members				
19	29/09/2023	End of ERG support to Trust to be agreed and how the process and learning from having an ERG to be caputured in an end of term report	All Members				
20	29/09/2023	Trust that would be avaialable to take the important work on a Accountability and Governance forward after the work of ERG is completed	Trust ERG members				

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Southern Health and Social Care Trust

Quality Care - for you, with you

AGENDA OF THE SEVENTH MEETING OF THE SOUTHERN TRUST EXTERNAL REFERENCE GROUP (STERG)

DATE: FRIDAY 10TH NOVEMBER 2023

VENUE – THE LAW SOCIETY OF NORTHERN IRELAND BELFAST

AGENDA		
09:00 – 09:15	Arrival & Coffee	
09:15 – 09:20 **(5 mins)**	Start - Welcome and Apologies - Conflicts of Interest	Chair All
09:20 – 09:40 **(20 mins)**	Minutes of the previous meeting and matters arising	All
09:40 – 10:40 **(60 mins)**	Update on 4 Sub-Groups Inc. feedback meeting on 8 November 2023	Sub-Group Chairs
10:40 – 11:00 **(20 mins)**	COFFEE BREAK	
11:00 – 11:40 **(40 mins)**	Next Steps for Trust Engagement Plan	All
11:40 – 12:10 **(30 mins)**	USI / Lookback Review Updates	Jane McKimm & Margaret O'Hagan
12:10 – 12:40 **(30 mins)**	Reflections on Public Inquiry Proceedings	Veryan Richards
12:40 – 13:10 **(30 mins)**	Each Sub – Groups to advise on next steps	All
13:10 – 13:25 **(15 mins)**	Any Other Business	All
13:25 – 13:30 **(5 mins)**	Next Meeting in December 2023/January 2024	All
13:30	Close followed by Lunch	

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Seventh Meeting of the External Reference Group

Date: Friday 10 November 2023 (9am – 2pm)

Venue: The Law Society Buildings, Victoria Street, Belfast, Northern Ireland.

Present:
Tom Frawley (Chair), Dr Maria O'Kane, Dr Stephen Austin, Hugh McCaughey, Dr Simon Watson, Veryan Richards, Mary Hinds, Margaret O'Hagan, Jane McKimm, Robbie Pearson, Heather Trouton, Vivienne Toal, Maria Siahaan (Secretariat).

Apologies:
Elaine Wilson

1.0 Apologies and Minutes of the previous meeting

The Chair opened the meeting by thanking everyone for attending and noted that Elaine Wilson had apologised.

2.0 Minutes of the previous meeting and matters arising

Members approved the Draft minutes of the 29 September 2023 as an accurate record of that meeting.

Margaret O'Hagan advised the Chair that both herself and Maria Siahaan had now updated the ERG Action Log however she noted there are number of actions that cannot yet be recorded as completed. The Chairman confirmed that the updated Action Log will be included with the Minutes of the 10th November 2023 as Appendix A.

3.0 Update on 4 Sub-Groups including feedback from the Sub Gorups meeting on 8 November 2023

Received from SHSCT on 26/02/2024. Annotated by the Urology Services Inquiry.

Vivienne Toal advised the meeting that Heather Trouton had chaired the Sub-Groups on 8 November 2023. She explained that the meeting had been on a "virtual meeting". She advised that 20 colleagues from across the membership of the four Sub Groups had attended the meeting. She added that Elaine Wilson the Director of Planning, Performance and Information had been also joined the meeting. At the outset of the meeting, Heather Trouton said she had shared information detailing the Programme of work undertaken by the External Reference Group (ERG) she had done this she said by taking the meeting through Presentation she had prepared. She said she had explained to the meeting that the purpose of the ERG is to fulfil the role of a "Critical Friend" by providing independent challenge and support to the Chief Executive and Directors who were leading the Southern Trust's Improving Organisational Effectiveness Programme. She explained she had advised the Sub Groups representatives that the central aim of this Programme is to improve organisational health, maximise safety, quality and the experience for patients / service users and staff by identifying areas of concerns highlighted by the Inquiry into Urology services. Heather continued that she also explained to the meeting that the External Reference Group (ERG) had identified four themes which had led to the formation of the four Sub Group:

- Patient Safety and Quality, this Sub-Group led by Heather Trouton and Mary Hinds

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- Governance, this Sub-Group led by Dr Stephen Austin and Robbie Pearson
- Data Analytics, this Sub-Group led by Dr Stephen Austin and Simon Watson
- Culture and Leadership, this Sub-Group led by Vivienne Toal and Hugh McCaughey

Heather advised the ERG that the Trust representative who had led each of the Sub Group had then provided the meeting of 8th November with updates on the progress of each of the Sub Group. She also informed the ERG that during the meeting she had asked asked Vivienne Toal to share with the Sub Groups the "compelling narrratie" the Chief Executives had presented to the Trust Board. Vivienne informed the ERG that she had elaborated on the information contained on each slide of the Chief Executive's presentation to the Trust Board.

Following the Briefing on the work of the ERG, to the Sub Groups Elaine Wilson was invited to make her presentation on the proposed approach to the Development of the Trust Vision and related "Five Years Strategy". Heather informed the ERG that Elaine had shared with the meeting the following key points:-

Strategy Development – some Guiding Principles.

- All stakeholders must have a clear understanding of the proposed Vision – what will be the same/what will be different.

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- The strategy must be co-produced with staff, patients/users, carers and other key stakeholders supported by plans: Financial; People; Operational; Digital
- There must be a commitment to and ownership of the process by all involved.
- "Engagement and Buy-in" would be central

Strong Leadership - would be critical and the Process must

- Initiate and secure engagement early and be constant and consistent in the messaging
- Achieve 'buy-in' by clinicians and secure their ongoing engagement – throughout the process
- Demonstrate active listening – 'You Said, We Did'
- Be informed by identifying and responding to what Patients and Service Users Value – A Citizens Panel?
- Facilitate Mega Panels to engage many voices?
- Develop regular touchpoints, milestones and have an ongoing evaluation of progress being achieved throughout the process.

Vivienne then shared with the meeting comments and suggestions she had noted both in the discussion following the Chief Executive's presentations to the Trust

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Board and also the discussions following Elaine's presentation to the meeting of the members of the Sub Groups.

In these comments, reference was made to the need to ensure staff across the Trust were effectively involved in a structured engagement process. Heather commented that a well-developed communication process would be essential to underpinning a successful Engagement Process.

- It will also be important she said to make the engagement with staff timely relevant and meaningful in order to maintain and sustain interest of all who need to be involved.
- The comment was also made that it may be beneficial to embed these principles in the current/existing projects that are underway in-house. It was also suggested that the messaging to staff should reflect that these activities are not a new initiative or another project initiated by the Trust. They are in fact another phase of the existing project.
- It was commented that Dr O'Kane's presentation particularly the slide relating to Trust's Principles makes no reference to working with staff members to ensure safe care and improving quality. Both Vivienne and Heather suggested these principles should be added alongside any other comments received from staff and other stakeholders during the Engagement Process. However, it is important they said to remember that we need to keep the Principles

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limited in number so that they are impactful and more likely to secure people's attention.

- The meeting was advised that there was a query from one of the Sub-groups members regarding the 'change model' that would be adopted to facilitate the development of the Co-production Approach. Vivienne commented that in that in preparing for the development of the Trust Strategy suggested they should refer to the document: McKinsey Organisational Health: A fast track to performance improvement model.

Veryan Richards commenting on Elaine's Presentation made the following points:-

- Having a timeline/route map would be a helpful visual in enabling stakeholders to have a realistic expectation around timescale and thus assist those involved to stay on the same page in order to ensure we participate in the journey together.
- There has already been a lot of thoughtful reflection/discussion and consultation over the past year in the Sub-Groups and in the SLT. She said there comes a point when we need to show courage and belief in our learning processes and move to an **Action Phase**
- It would also be important she said to maintain momentum or we will lose some stakeholders along the way

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- Veryan continued that while there seemed to be agreement on moving on from Sub-Groups working towards establishing an advisory "Steering Group" it would be crucial to ensure that there is a representative from all of the key stakeholder groups on the Advisory Panel including patient/carer representation.
- Veryan said that the three Principles that were highlighted in Dr O'Kane's presentation to Trust Board are excellent statements of intent and importantly she believed they would also be measurable. Instead of adding more principles (there could be many and for example could include Sustainability and Transparency), it might be preferable however she said to take each of Dr O'Kane's Principles and develop a short paragraph which would elaborate on each Principle. She continued that thought needs to be given on how to measure and evaluate each Principle and how frequently a measurement will be made during the implementation of the project.
- Veryan emphasised it would be essential to develop clear and concise messaging with an empowering narrative. Define terms and concepts so that everyone has a shared understanding – "streamline messaging".

Communication therefore would be key as well as developing clear communication channels. This she said could go quite a long way in helping to agreeing/delivering the Vision.

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- Veryan acknowledged there was an appropriate recognition that the analysis that informed the Vision was based on evidence but she also advised that it would be critical to consider and agree the Values that would inform the Trust's approach. This narrative, she suggested was currently absent from the meetings and discussions that had taken place to date as far as she aware.
- Veryan concluding her comments said it was essential that a "protected resource" is agreed to support the process and also that an updated narrative was developed on the Trust's Website. For example, she suggested Dr O'Kane's presentation to the Trust Board could be shared with staff by uploading it to Trust's website.

2.0 Next Steps for Trust Engagement Plan

As an outcome of the meeting of the 4 Sub-Groups, both Heather and Vivienne advised that there is they believe a genuine consensus around the 4 Sub-Groups that an Internal Reference Group (IRG) needs to be established going forward to provide the necessary Updates and information on the process in a structured and evidence based format. It was also suggested that an IRG could fulfil a critical role in monitoring the progress of the implementation of the Engagement Plan. It was agreed that if an Internal Reference Group was established it should have a schedule of meetings across 2024.

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Heather said she would welcome suggestions from the existing members if they consider additional representatives from different departments across the Trust should be invited to join the proposed IRG. She said if an Internal Reference Group was established we need to understand the implications of that decision for the current Sub Group structure?

During the discussion that followed Vivienne's presentation of Elaine Wilson's 'Five Year Strategy Development', one particular slide which referred to 'Building Carefully Together'. The slide indicated she said that more than one stakeholder will be involved in the implementation process. Both Simon and Robbie commented that there is a risk in creating a 'Mega Panel' that there would be a particular challenge in being clear about who would be centrally responsible for undertaking the Project. It would therefore be essential if a 'Mega Panel' was to be created to agree Terms of Reference for such a panel that would describe its role its objectives and its accountability.

Hugh McCaughey commenting suggest that he would advise that the Trust should also consider the role of the 'Community of Leaders' Forum, which could have responsibility for developing the Values the Trust would wish to adopt and inform its approach when undertaking the engagement plan with staff and public.

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Hugh also shared with the meeting the 'Quality Management System' flow chart as a further additional option for informing the approach the Trust could adopt in developing the Engagement Plan.

How to move beyond quality improvement projects
BMJ 2020; 370 doi: https://doi.org/10.1136/bmj.m2319
(Published 27 July 2020) Amar Shar

Mary Hinds commented that she believed it made good sense to establish an Internal Reference Group (IRG). However, she emphasised that the group needed to be chaired by a 'qualified person' that had both experience and expertise in fulfilling such a role. She said that the individual must be able to capture and articulate the concerns, queries, comments and suggestions from the members of the IRG in order to establish and importantly maintain its credibility both inside and outside the Trust.

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Heather Trouton concluding the discussion said that it would be very important to have agreed process and procedures to support the IRG. This would ensure she said that we are not missing critical perspectives and concerns from across all stakeholders.

4.0 USI/Lookback Review Updates

Update from Urology Lookback Review, Margaret O'Hagan explained to the meeting that up to today's date approximately 50 patients from Cohort 2 have completed their Lookback Review journey. Of those 50 patients 23 have been assessed as presenting "No Concerns" in relation to their Urology care. Therefore, their episodes have been discharged from the Urology Service and the Lookback Review database. The remaining 27 patients are proceeding to the next stage of a Lookback Review some of these patients are due to be seen by the Independent Consultant Urologist at the Review Clinic to be advised of the outcomes of their reviews. Margaret further advised the meeting that the Review Team satisfied that the Lookback process had been implemented efficiently. Margaret advised that the overall Cohort 2 Urology Lookback Review process would be completed by the end of January 2024.

Jane McKimm then provided the meeting with updates from the Public Inquiry, she explained in relation to the Inquiry Schedules, that the week commencing 4 December will be the last week of Inquiry Hearings for the current year - 2023. The Hearings she advised will be convened again on the week commencing 9 January

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2024 when further details of the Inquiry timetable will be uploaded on Urology Services Inquiry Website.

5.0 Reflections on Public Inquiry Proceedings

Veryan Richards shared with the meeting her notes and reflections the detailed of which referred as Appendix B on this minutes.

NB: Comments in blue types are Veryan's views on what she considered the Trust Leadership should be demonstrating and will be addressing.

6.0 Individual Sub Groups proposals for next steps

Data Analytics

The Data and Intelligence Group has met on a number of occasions to develop the key strands of a future Data and Intelligence Strategy for the Trust. The Group explained that their approach was rooted in themes that emerged from the clinical issues that were being identified in the Urology Review. The meeting was also advised that the themes emerging from the wider analysis of the External Reference Group had also been considered in the approach taken; in particular, they need for a strong, respectful and collaborative organisational culture. The final recommendations in the paper shared at today's meeting were reflect all these considerations and the wider landscape of Healthcare, and including some projected future needs of the Trust and the Public it serves.

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Analytics Sub Group recommendations

We recommend that the Trust commissions a formal strategic plan for data and intelligence that should include consideration of the following five key areas

1. Supporting continuous improvement in clinical and care processes.
2. Create a warning system to identify emerging Clinical Care or Clinical Governance concerns.
3. Empower patients through information sharing to support better self-care
4. Deploy 'machine learning technologies' to support business and clinical activity
5. Create formal collaborations with strategic partners from other sectors, critically Academia

Analytic Sub Group conclusions

There is never an ideal time to embark on a new data and intelligence strategy. Nevertheless, the lessons emerging from the ongoing Public Inquiry and need to develop a culture built on team working, leadership and governance all require intelligence insight and knowledge to inform action and importantly to evaluate progress. As the saying goes, 'In God We trust, all others bring data'. Furthermore, the world is at a crossroads in the current information age and organisations that do not plan now may be limiting their influence over the future. The Sub Groups

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believes these are compelling reasons for the Trust to develop a new Data and Intelligence Strategy.

The five key ambitions outlined above represent specific themes that have emerged in various discussions. They are not intended to be an instruction or requirement for the Trust. The Sub Groups commands them as key strands of a new strategy. They should prompt discussion in the wider consultations required for strategic planning and it is expected by the Sub Group that they may be supplemented, or replaced, by alternative or additional ambitions or objectives.

Finally, consideration should be given to the integration of the recommendations from this Group with those from other Sub Groups and their work streams of the wider External Reference Group.

Governance and Accountability

Robbie Pearson advised the meeting of a number of key points pertaining to Governance and Accountability that his believe it would be beneficial for the Trust to consider:

- 'Triangulation of systems' to facilitate the analysis of data and perhaps a call for greater use of 'soft intelligence'
- An integration of learning systems to be put in place going forward. In particular, the Trust should consider adopting 'A Framework for Measuring and Monitoring Safety' this Robbie explained was an approach which was

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developed on behalf of the Health Foundation by Professor Charles Vincent and which could be used as a Reference Document by the Trust.

- Robbie in his comment reflected that in his experience the Trust Leadership should consider that curiosity is necessary to continue driving continuous improvement
- A twin-track approach is necessary to ensure that health and social care services can deal with immediate pressure as they emerge

Dr O'Kane responded to Robbie's comments and advised the meeting of some actions that already been taken by Southern Trust in relation to improving its Governance. She advised that the Southern Trust have approached NHS England and the Care Quality Commission (CQC) particularly in relation to the Governance for delivering the policy 'Joint Priorities Matter'. She further advised that apart from the above approach, the Regulation and Quality Improvement Authority (RQIA) has undertaken a review of Southern Trust Urology Services and the related Lookback Reviews, it is expected that the final Review Report will be published in December 2023.

Robbie commented that in relation to establishing an effective governance system, the Scottish Government had recognised the need to ensure that the governance arrangements in NHS Scotland were fit for purpose and importantly also keeping pace with changing policy including the current challenging financial environment.

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In response, he said the Director General for Health and Social Care in Scotland had commissioned a Review of Best Practice in Healthcare Governance. The outcome of the review was a development of a **Blueprint** for an effective governance system that would be adopted across NHS Scotland. He continued that this Blueprint for Good Governance was published in January 2019, NHS Boards have been adapting this model to match the needs to their organisation in responding to the challenges currently being faced by the NHS in Scotland. Robbie had shared the link to enable the members to download the digital copy of this Blueprint for the Trust to consider whether it I possible and appropriate to apply any of this analysis in the Southern Trust.

https://www.gov.scot/publications/blueprint-good-governance-nhs-scotland-second-edition/

7.0 Any Other Business

As we are approaching the end line of ERG, Tom Frawley asked Jane McKimm and Veryan Richards to work together to produce a report to would summarise the many issues that have covered and importantly the key learning that had been identified through the ERG process.

8.0 Next Meeting

All members agreed to have the last ERG meeting on Friday 19 January 2024 at Law Society NI, Belfast. Dr Watson and Mr Pearson will join the meeting virtually, Veryan Richards will attend the meeting in person.

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STERG – 10/11/2023 – agenda item

Suggested themes and considerations for the SMT – Days 58 - 63

The aim:

- to build public trust and confidence in patient safety and person-centred quality care
- to raise professional standards within the Trust
- to address and make provision for good staff wellbeing and morale.

Transcript notes and analysis

- to listen and identify some learning as the PI is in progress, to support Maria in helping her to keep in touch with the emerging themes and to assist the Trust in using this lens to consider modifying practice.

- to reassure the staff, patients, and the public that the Trust is listening and is making efforts in real time to improve the standard of care for patients and raise the bar in terms of professional standards. Some of this intelligence gathering may already be happening within the Trust as well and it would be interesting to compare notes.

- we are not sure when the PI Report will be published with its conclusions and recommendations, in the meantime the Trust can be seen to be proactive.

STERG - the emerging themes from the PI transcripts.

- can strategy, practice and evaluation be considered in response and some guidance given on a possible route map for the next steps and potential medium-term goals?

(Note – please refer to the documents Parts 3.1 and 3.2 'Public Inquiry – notes and reflections' to give wider context to the points in the themes below. These papers have been circulated with 'Suggested themes and recommendations for the SMT')

THEMES

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

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1. Leadership and Governance

1.Tracking, clinical decision-making and audit

Q. Under the key duties, the first key duty, perhaps, importantly, is, you were to "Take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and they are providing timely assurance and alerts to both the service director and the organisation." We get a sense of how you found the ground, so to speak, within your Section 21 statement. I suspect you are going to tell us today that your ability to provide the kind of assurance that things were operating at a sufficiently high standard of compliance was not, despite your best efforts, was not available to you because of resource issues?

A. Yes. I couldn't have provided an assurance in the organisation that all aspects of clinical and social care governance were robust within the Acute Directorate. There was a very small and limited team available, at times it was me and one other part-time person, so things in relation to audit for assurance wouldn't have been robust at the time. And there was an internal audit report that highlighted that the Audit Committee hadn't met for some time within the Acute Directorate and then that was one of the actions that I put in place to try and make the system more robust and try to provide a form of assurance to the Acute Director and, therefore, SLT.

What is the current standard of auditing across all aspects of clinical and social care governance? Where standards are low or the auditing process not taking place - what actions are planned to address this? Is this a standing item on the SLT agenda?

Q. -- to implement actions around standards and guidelines. You talk, at paragraph 3.126 of your statement, about establishing a forum encompassing lead nurses, midwives, allied health professionals, radiography to ensure that the actions needed to implement standards and guidelines was shared and embedded with frontline staff?

A. Yes.

Q. Were those initiatives that you took forward?

A. Yes. So whenever I went into the acute governance role the worry was that the recommendations stopped at a certain level and sometimes what you find within governance is it doesn't filter down to the wards and departments. So this was our attempt to make sure that the lead nurses and midwives and AHPs were fully appraised and involved in developing the actions from the recommendations.

Q. One of the things I suppose you had a concern about, as reflected in your statement at paragraph 3.96, was that it wasn't always possible to provide assurance audit that guidelines that I suppose had been adopted by the Trust were actually being adequately implemented by frontline staff?

A. So to provide assurance you need to try and develop an audit and make sure that the audits are completed to identify that all of the actions are taking place and within the Acute Directorate there wasn't the resource to be able to sufficiently do that. For some standards and guidelines there were very robust audits but for others there weren't.

Is this forum still operating? Are resources being identified to support the auditing process to ensure that there is implementation of all the actions at ward level?

Q. Is there anything in the system, either for you or for the consultants, that flag up when results have been sitting a while or waiting or if there is any delay in look at them?

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A. I know the secretaries, they would, if a patient has been seen in an out-patients clinic and they are having an investigation, they are put on to the patients administration systems as what they call DARO which is discharged awaiting results. This is placed on the PAS. The secretaries would run reports then monthly and this will show if there is any outstanding results that needs to be actioned. So the secretaries could contact the consultants or even myself, if I have requested anything or if there is results available they could contact me.

Q. Now you speak about DARO at 14.3 and you say that the CNSs don't have access to the DARO functions?

A. No, that's for the secretaries would have access to that.

Q. Do you think that it would improve follow-ups if you did have access? Give us a bit of background to that, why you have said that?

A. I think it would improve my follow-up. You know, if nurses had, maybe, or Nurse Specialist had access to it we could be notified if there is results outstanding or if the result has become available. It would probably be around the same as what NIECR or Sectra would be and it could notify us if we have put in a request and results are available.

Is this a suggestion that could be implemented?

Q. Was it your experience at the time, or has it been your experience since, that perhaps consultants who are more senior, who are more used to their own way of doing things, find it difficult either to be challenged or to adjust their practice to reflect advances?

A. So, I think that at the heart of safe consultant practice is good team working, and that working in a functioning team where there's a built-in peer review, essentially. I think when you work in isolation, there's a risk that you develop practice that maybe doesn't follow best practice or best guidance or, you know, keep up to date with current best thinking.

The importance of clinicians seeing themselves as an active team member where there is a built-in peer review approach operating.

A. So, my reading of that was that we knew that the tracking only went to first diagnosis. We understood, we discussed that that was a problem. It would have been much better if tracking was extended beyond that and resourced beyond that. But it wasn't, because we'd already explored that. Dr. Hughes was coming from a perspective, as I understand it, that he had been a medical director in another Trust and he had also been, I think, a NICaN lead at one point in time. And he should have been very well aware that tracking in the Trusts here was only resourced to first definitive treatment. Now, he may have made different decisions in the Western Trust as to how to resource their tracking, and he may well have done that, I'm not aware, but I think that's where he was coming from. I've maybe lost the second point. Oh, yeah, the quality assurance about whether MDT outcomes would have been adhered to. So, at the time, as a group we would agree the MDT outcome for each individual patient. That would be spoken out loud in the room, the tracker would record that, and then the tracker would type that information into CaPPS, usually at a later time, and that would be provided to the person who Chaired the meeting to review the outcomes as they had been recorded for factual accuracy. And once that had been agreed, that would go back to the tracker to be circulated out to the whole MDT and that would then allow the CaPPS letters to be generated to the GPs and they would be posted out to the GPs. So, that's how that happened. So that was that bit of quality assurance to make sure that the outcomes were correct as discussed at the meeting. Now, it comes then to whether or not individual clinicians adhered to the outcomes when they met the patient. We

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now have in place, in very recent times, less than the last 12 months, support available within cancer services whereby we run a random audit of whether or not outcomes have been adhered to. That information is brought back to the MDT and shared with the MDT. I also receive that report as the lead clinician, and if there are cases that don't appear to match what the outcome was, then those cases are addressed on an individual basis.

Has the effectiveness of the tracking system recently been audited in all specialities in the Trust? Do steps need to be taken to improve the system?

2. Quorate

A. Yes. So, there is an issue about how quoracy is counted, okay? And I'll explain that in a moment. But we now have the situation where we have two radiologists, and that has helped a lot. We are also in the position where we have a single clinical oncologist linking in from Belfast, and her attendance is probably in the order of high 70s to 80%. We have two medical oncologists, one who usually physically attends the meeting and the second person links in by video. So, those aspects have improved. However, when you count quoracy, you have to count all the core members. And if one of those core members is absent, you're not quorate that week. So, as you can see from the top line there, on that particular week there was no clinical oncologist. So, technically we are not quorate. Quoracy has never really been an issue for pathology, urology, clinical nurse specialists, and the tracker, the coordinator. So really the quoracy issues lie in radiology and oncology.

Q. And, of course, one always will anticipate that there will be a meeting here and there where one of those disciplines can't attend.

A. Yeah.

Q. And you've explained the setback that that causes in terms of some cases. Because, as you say, you don't necessarily need an oncology discussion around every case, or for that matter a radiology discussion around every case?

A. That's correct.

Q. But I'm just trying to assist the panel to gauge where we're at now in 2023.

A. We're in a stronger position, but we are reliant on a single clinical oncologist. And if that person is sick, or that person takes leave, then we don't have their valuable input

Quoracy is an issue that has come to the fore several times in the Inquiry. Is there any further guidance that the SLT can give on the challenges of meeting the quoracy standard?

3. Job description, appraisal, and handover

Q. You say in your statement that you didn't receive a handover as such?

A. No.

Q. Is it right?

A. That's correct. Dr. Boyce would have been supporting the Director at the time but there was no formal handover from a previous sort of full-time coordinator.

Q. Just in terms of the importance of a handover, Patricia Kingsnorth, when she gave evidence she said from a handover point of view, you handing over to her as you were exiting you were able to give

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her 45 minutes of a handover. First of all, are handovers important in your view? And the handover that you provided for Patricia Kingsnorth, was that adequate?

A. Handovers are important. And I think in retrospect 45 minutes probably wasn't enough. Although I was there on the end of the phone or if she needed any other guidance or support at the time.

The importance of setting time aside to complete a full handover.

Q. So, you make the point that you're the subject of appraisal for the purposes of validation, and it's said on a number of occasions, so I get the impression that you think it important to say it repeatedly that this is not a performance related review, and in answer to other questions you make the point that consultants are outside of the performance management loop. Tell me about your thinking on that. Are you suggesting in those answers that you think it would be a good idea, in light of experiences within urology services at the Southern Trust, and perhaps elsewhere, for you and your colleagues to be subject to some form of performance management?

A. Yeah, I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.

Q. You refer to it as, I don't think I need to bring that up on the screen, it's paragraph 47.2. You seem to value the opportunity, if it had stayed like this, for a confidential reflective exercise in professional development; you see advantages or benefits in that. But what you say is that the process has now morphed into something akin to bean counting - my words - it's a formulaic capture of documents - your words?

A. Yes. I think bean counting is equally good as a descriptor.

Q. So, moving from the positive side of that spectrum to the negative, why was this opportunity for reflective discussion around professional development, why was that useful and what has it now become?

A. So, when I first became a consultant, the appraisal process was between two peers and was largely a discussion, and you felt that you could have a confidential discussion about the challenges that you faced, the difficulties that there were, perhaps share the successes that you'd had, all of that kind of thing. Now nobody's really interested in that. They just want to make sure that you meet all the domains that the GMC have set out, that all of those -- in our Trust they use an electronic method for capturing all of that, I think it's common across Northern Ireland, and, you know, as long as you've got a tick in every domain, that's really what it's about. You know, you can see from the spread of specialties that have been my appraiser, many of them don't have that much insight into my specialty. Maybe I don't have that much insight into theirs. So, you know, there's something of questioning the value of that conversation. They don't have the performance data, they can't possibly meaningfully interpret the performance data in the different specialty, you know. How would, for instance, an emergency medicine consultant interpret the data of a surgeon? It's difficult for them, I would think. It would be difficult for me to interpret the outcomes of their work. I don't do their job.

Q. So, if, as you imply, it is, to use another metaphor, a box ticking exercise, are there implications of that if, for example, the practitioner has some frailties or –

A. So, a point that was made to me by Robin Brown, who was at one time CD for urology quite some years ago, and more laterally has been one of the senior members of the revalidation team, he said

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to me "I'm not looking for all the good points in your appraisals. What I'm looking for are the little indicators that there are problems", and I think that's largely what it has become, and it may be very difficult through this appraisal process for the Trust to actually pick up where there are problems. Not too many people present warts and all in their appraisal, I would suggest.

Q. And your seeming endorsement of some form of performance management, whether integrated within the appraisal process or standing separately from that –

A. I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.

Q. Knowing what we know, and there may be a bit of a debate about what precisely we know has emerged out of urology services in the last few years, particularly arising out of the processes relating to Mr. O'Brien, do you see in that particular context a specific merit around performance management or –

A. Yes, I do. Because I think if you identify these things at an early point and they're out in the open, then it allows the team to, first of all, identify and name the issue and, secondly, then to think of ways that the team can address the issue together. It means a more consensual collegiate way of working, you know. So I think there are merits to that.

'I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.'

'I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.'

What is the view of the SLT on this approach and suggestion?

4.Trust Board

Q. So if you could wave a magic wand and resources weren't an issue what would you like to see happen in terms, first of all, generally in governance and more specifically what do you think is the one thing that would help prevent something like this inquiry happening again?

A. I think resourcing the teams appropriately, having sufficient resource to, both - at all levels, so making sure we had the right resource to make sure that the clinical workload was doable, having the resource within the operational teams to make sure that there was managerial time to make sure that actions were taken. From a clinical governance team it's making sure that the right number of people with the right skill set, the right training, the right time were available to review the incidents, take forward the proactive work, the education, the training, the audit, the triangulation of information,

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having data analysts that can actually really delve into information and show it in a meaningful way and having IT systems that mean that information isn't a challenge of going to lots of different systems to try and pull it together.

This reply could be a useful comment to feed into the discussions on outlining the vision for the next chapter in the Southern Trust.

5. Silo mentality – segregation operationally as opposed to integrated working

6. Priorities

Q. Last one. I mean if a member of the Trust Board came to you when you are in your governance role and said 'How can you assure me that your consultants are following up to date standards and guidelines? What assurance can you give me?', what would you have said to them?

A. I would have highlighted the challenge of the resource that we had to do it. I can't remember the exact numbers back then, but now there are over 3,000 guidance. 2,800, all of them are applicable to the acute service. They don't come with funding.

Q. But will you be able to assure him is what I am really saying?

A. No.

How is the SLT addressing the miss-match between no available funding and assuring your consultants are following up to date standards and guidelines?

7. Training

Q. And within your role, I suppose, specifically of governance. It is notable as against SAI investigations you haven't felt able to say anything in terms of strengths?

A. The challenge at the time was significant. There was a large backlog of SAI reports. They weren't able to be progressed in a timely manner. And the patient and family engagement isn't what I would have wanted for those patients and families.

Q. Yes. You point out the core weaknesses: "Staff do not have sufficient training to make them confident with the SAI process, particularly for chairs of SAI panels and it is difficult releasing staff to attend SAI meetings." That's difficult to your staff or operational staff?

A. Operational clinical staff.

Q. Yes. Is that then pointing in the direction then of particular problems with the SAI process? Was it almost facing a situation of near collapse because of these problems or is that too strong?

A. Collapse is maybe strong but there was a significant backlog of SAIs, I think at that stage probably about 33. The small team, myself and one other at the time, it was a challenge for us to be able to support all of the chairs, help draft the timelines, help with drafting the reports, supporting the chairs and supporting the members of the panel. And again to getting the teams released to have the meetings in a timely manner and support them in writing, you know, finalising the reports, it was a huge challenge at the time.

Is there currently adequate time, training, and resource now in place for staff conducting SAI's? If not, what is the plan to address this?

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A. That I think is really relevant to this process? It mentions training and support. Prior to me undertaking those SAIs, I did not have any training. So, I recall being asked by Eamon Mackle to Chair the first, chronologically whatever the first SAI was that I did.

Q. That was –

A. I can't recall which one it was.

Q. Yeah.

A. But I sat in the office reading the e-mail and I thought "Am I really ready to do this? Do I really know how to do this?", and I batted that back to Eamon in a conversation and it was kind of - the answer wasn't "you'll be grand", but it was to that effect.

Q. Yeah. I was going to ask you about the training, and maybe that was a convenient but accidental point to stop on.

A. I've subsequently had training.

Q. Yes. You outline in your statement, 19.4 for the panel's reference, that you completed training in structured clinical record reviews in 2021.

A. Yes.

Q. As well as root cause analysis training.

A. Yes.

Q. The Inquiry is very interested in the nuts and bolts that make up the aspects of the SAI process. Training in 2021, you did your first SAI, so far as this Inquiry's concerned, in 2015?

A. Yes.

More evidence from the Inquiry about the need for proper training before taking on roles that relate to patient safety and quality care. Is this aspect now being audited?

Q. There is training associated with Datix or for users of Datix, is that primarily targeted at those with investigation responsibilities?

A. There are two levels of training and they were instigated by the Directorate Governance Coordinators at certain points. There was training in relation to general governance which would have touched on the Datix system. And then there was also training in relation to someone who is investigating a Datix incident and how they work their way through that process and what elements they should consider in their investigation. That was sporadic in its nature. And in my current role now since 2019, whilst in 2019 there were a number of sessions organised but when Covid kicked in then those were put on hold. So training now is just on an ad hoc, on request basis.

Q. And it is not mandatory for Datix users?

A. It's not mandatory, no. But it's something that I feel that should be mandatory. It's an IT system that's used by the Trust and I think that that system should be supported with appropriate IT training.

Does the SLT agree that it would be appropriate for all clinical staff to have mandatory training in the most recent Datix system?

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Q. What is the buy-in with consultants in all of that? Do you work parallel with them to identify training and deliver it or is this nurse-led training?

A. The consultants, yes, do buy in with the training. I think the consultants would value if they do do the basics first. And they would like the nurses to look at where service provision is, where there is a need for the service. Yes, they are very open and managers are very open if there is any specific training that needs, such as if they need to be sent for a flexible cystoscopy course or if they need to be sent for the non-medical prescribing, the consultants are very supportive. And also the Nurse Managers would be, there would be support from the Nurse Managers as well. There is also training at present for myself and that would be for the transurethral laser ablation. A girl had come out to assess the Urology Service and they had recommended that this would be an ideal opportunity for the Urology Nurse Specialist to be trained.

Q. What stage is that at? Is that something there has to be separate funding sought for or what way does that work?

A. There will be funding for the equipment and there will be funding for training. The company will provide training and myself and Jenny, who will be trained in this, will be sent to centres in England to be trained up and to assess for the transurethral laser ablation. We will also have consultants will assess our competencies and we will probably have sign off competencies to be able to do this procedure.

Q. But your view is that the Trust are motivated for this to go forward?

A. Yes, to bring this forward. Because this will reduce patient waiting time. If they have small bladder cancer reoccurrence, rather than be on a waiting list we can provide this nurse-led service. Also, there are maybe patients who are not fit for general anaesthetic, so we can provide the service for those group of patients.

Has the funding stream been identified for this training? Have staff been released to access the training?

Q. So if we move to the preceding page, TRU-303440. And this is an email sent to you from Patricia Kingsnorth, who we know is the Head of Governance. She sends it to you and copies Martina in and Fiona Reddick. And she says: "Hi Patricia, many thanks for agreeing to assist with the SAI process. We have a number of cases to be discussed and will measure them against the existing pathway. Can you be available to meet with the review team on Thursday, 10th September at 9:30am in the meeting room, Trust headquarters." And signs it off, "Many thanks, Patricia". So that was the start of your involvement in the process?

A. That's right.

Q. And that was the first meeting that you attended, that was your first introduction. I just want to ask you in general terms, we have looked at the notes and we have looked at the minutes and we have discussed this, in relation to your introduction at the meeting, did anyone set out your role and what was expected of you and what you brought to that particular process in relation to the make-up of the team?

A. No. I never had any information of what my role was to be with the team. I gathered that because I had experience of a urology CNS from another Trust, and a lot of experience, it was to sit on to see if there was any key worker involvements. But I was never given any task to say this is the expectation we would like you as being part of the Panel for the SAI process.

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Q. When you say key worker involvement, was it indicated to you that that was the purpose for you being involved, was the key worker issue?

A. No, I don't think it was the purpose of why I was involved. I think it was the purpose because of my experience and what I could bring to the SAI. But there was no criteria or no particular road plan was given to me.

Q. Did you have any knowledge at that meeting or after of the terms of reference of the SAI?

A. There was no terms of reference was formalised at the first meeting. But terms of reference was formalised following that first meeting. And they were written both by Patricia Kingsnorth and Dermot Hughes.

Q. Did you have any input into those terms of reference?

A. I didn't, no.

Q. Do you recall those terms of reference Doctor 1?

A. Yes, the terms of reference were referred to Doctor 1.

Q. Now you had no previous knowledge of SAIs or you had never been previously involved in any?

A. No, I had no knowledge of SAIs. I wasn't involved in any or I had never been the subject of an SAI. I never had any training either with an SAI. However, I do note that my role was just to sit on the Panel. It wasn't to be a chair or a governance part of the SAI. But no, I had no previous experience.

Q. Just so we get a feel of it. Something that we're not familiar with, but the SAI, was there a feeling that everyone was an equal member of the team and everyone brought a different lens to it or what was your feeling about it?

A. My feeling about the whole team, I wasn't given -- only my -- I felt that I didn't have a lot of input into the team. I would have liked to have maybe had more of an input. Such as with my experience and my experience of being a key worker and an experienced Urology Nurse Specialist, I felt my input would have been better if I could have liaised with families and with patients along with Dermot and Patricia Kingsnorth. Because I could have maybe found out more information, I could have spoken to the patients, I could have found out -- because the particular issue and it would tend to be that there was no key worker involvement, I could have maybe spoken to the families and maybe found out more specific information. My role really was to look at the likes of the patient administration system, the appointments process, the DARO, the protective review, but it was never anything such as, you know, being involved with the patients or the families.

Q. So it was more data-led?

A. It was more data-led.

Q. You were good for figures rather than facts of processes?

A. It was more of timelines, you know, timelines of patients' appointments and was there a key worker at that clinic and when was the patient seen, was there a letter typed for that particular episode, that was more of my involvement.

Q. Now you have been through that process as a team member, do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?

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A. I think it would be useful if training was to be advised for anybody who wishes to sit on an SAI process. Also, too, it would appreciate what type of SAI is it, is it a Level 1 or 2 or 3. And also, too, what each team member brings to the SAI, such as the chair of the SAI or the governance person of the SAI. But I do think it would be a very useful training for anybody who wants to sit on an SAI process is to do the two-day training.

'Do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?' What is the SLT's view on mandatory training?

Q. Now in relation to your involvement in the SAIs, is there anything else you would like to add that might assist the Panel in considering whether the effectiveness of SAIs generally as a governance tool or what you think, as having been on a team, might help beyond what we have already discussed, is there anything further?

A. I feel, obviously, training is very important for the SAI. I think even informing a person what the SAI is about. When I attended that meeting on 10th September, looking at the SAIs then I realised or worked it out that it was about Mr. O'Brien. I think it is good to be notified what the SAI is about because I did find the SAIs was very, very comprehensive and very complex. A lot of it was very emotional because a couple of the patients did -- I felt was very emotional about a couple of the SAIs. And I think, too, counselling, if somebody could maybe be very upset with regards to an SAI, because a patient could have catastrophically been harmed and maybe counselling may be something to consider.

Q. Some sort of outreach around patients who have been involved in that process?

A. Sorry?

Q. Some sort of outreach in relation to patients who might have been affected by the SAI process itself?

A. Yes, for the patients been affected by the SAI process. And also staff as well, staff could value from counselling.

Is support offered currently to patients and staff affected by the SAI process?

8. MHPS

Q. Tracey Boyce has said in her evidence to the Inquiry that there was this disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team and she says from what I understood at the time they had to be kept totally separate. However, with the benefit of hindsight, she thinks that a joint approach would have been beneficial. So, for example, the SAI concerning patients, the five patients, might have been expedited rather than taking the guts of three years. A more of a joined-up approach would have led to a more efficient and perhaps a more universal learning. Do you have any view about that?

A. My understanding is that the two processes sit separately, one is in relation to the professional management of the doctor, the other is in relation to learning from a clinical incident. I think as a governance coordinator you are aware of lots of very confidential, very sort of information and it would be good to understand other processes that are going on within the Trust to help triangulate all that information and perhaps share between the two processes so that you have got a very robust rounded learning from what was happening at the time.

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Is it still the case that there is 'a disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team'? Is there a move towards triangulation of information?

Q. You've also mentioned in your statement that the guidelines were a way of effectively encouraging good practice, because they would be audited, and you thought that that would allow then perhaps any issues to rise up to the surface.

A. Yeah.

Q. That was one of your motivations as well.

A. Yeah, retrospectively, it would have been good to audit. There are many audits it would be good to do, and particularly from an MDM perspective, you know, there are a number of things we would like to look at. I think it would have taken probably precedence in moving the service forward more than Bicalutamide 50, but actually, yes, it would have been good to take it to a year time point after the guidelines to see were they being complied with.

Q. I mean, you know, if I asked you the question "How do you know people are adhering to all the guidelines?", how would you know?

A. I think when they come for their opinion and you're seeing a trend of non adherence, that's the flag for concern.

Q. But there's no systematic look at that, you don't think?

A. No.

"How do you know people are adhering to all the guidelines?" Is there now an auditing system in place that measures adherence?

9. Oversight Group

10. Management

Q. Another feature of some of the cases that we'll look at shortly is, I suppose, the delay from - let me not call it a delay - the passage of time between incident and final report. Obviously you have a lot of steps in the middle, you have to assemble the material, get the timeline, get the screening done and then research, interviews, analysis, drafting, maybe multiple drafts, lots of steps till you get to the final report. Some cases have taken three years to produce an outcome, again can you, in the generality, not necessarily referring to any particular case, but what is the problem there in realising the prompt delivery of an SAI outcome?

A. I suppose that's one of my sort of greatest regrets, that many of the SAIs took such a long time. It was essentially resource, resource of the governance team, myself and a small team, the number of SAIs, the complexity of some of them, the timelines, then diary management, sometimes getting a Chair. So if you start from the initial, we screen, we have to decide there is an SAI, we have to decide who the panel is, who the Chair is. There were challenges in always getting chairs, particularly if there was an external Chair required. Then organising the meetings, getting the diaries aligned. If we had to interview individuals in relation to the SAI it was getting their diaries aligned as well. So steps, small steps all along the way all slipped over time and unfortunately and regrettably the SAIs took too long.

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Q. Yes. I suppose more often than not you're looking to an experienced clinician to Chair an SAI?

A. That's correct.

Q. Perhaps a clinician with other clinical and governance commitments; was that part of the problem, getting clinicians, who are no doubt to be thanked for putting his or her hand up to do the SAI when it is undoubtedly something that they maybe wouldn't necessarily have wanted to do? Is there a solution to be found? Have you thought about whether there is a better way of doing it, rather than calling ad hoc on clinicians out of the blue, perhaps, to become involved?

A. So the clinicians all have very busy clinical schedules and they did the SAIs within that diary commitment that they had. So that is why one of the governance structures looked at having some time set aside for people to be -- for chairs to have that half PA a week to help facilitate governance and SAIs. The other element was to have professional chairs, for want of a better phrase. And the Trust now does have some people who Chair SAI meetings, that's their -- that's what they do, they have the time and the commitment to be able to do that.

Q. Because if we start with the principle that the SAI review is taking place in order to provide learning and an opportunity to do better in the future in respect of, for example, a clinical issue or a behavioural issue or a technical issue, whatever it might be, the learning obviously has to take place in a considered environment, you don't just rush out with the conclusions right away, it has to be considered and thought about. But three years down the line or two years down the line is, would you agree, not much benefit if there is a real problem there that needs addressed?

A. They do need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So two years is too long.

‘Conducting SAI’s need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So, two years is too long.’ With the learning from this Public Inquiry on this matter – how is the SLT responding?

Q. -- inefficiency, that there is also an aspect of individual working styles and differing case mix. So: "If a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters, then inevitably the waiting list will grow more quickly than that of a colleague who lists chronologically."

A. Yes.

Q. Was that a problem?

A. It's still a problem. Because, you know, if you look at our current waiting list, the patients who are waiting longest are waiting for bladder outlet obstruction surgery, there is the occasional Nesbit's that's waiting. So clearly other cases have been picked ahead of them. I didn't make the comment when you put up the data of the waiting lists, by the way, but if you look at that in great detail you'll see that there are differences across the team.

Q. Yes.

Is there clear guidance on surgeons choosing to take cases in a chronological order? How regularly is this audited?

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11.Trust Improvements

Q. Ultimately it seems to come to this, you use this word which we're hearing a lot about, triangulation, "triangulation of risks was therefore challenging". You seem to put a lot of store by the need for good data access and good data analysis; why was that? Why is that?

A. Very simply, it's really challenging to identify risk when you can't see it from the different systems all aligned. So you may have a large amount of information but to identify from one system to another to another and pull that all together is really, really challenging and without being able to pull the information together you don't get the overall picture and, therefore, you can't see the overall risk. So some of the issues that had been identified, you know, with good data systems may have been easier to identify. But again it's as good as the information we put in so, therefore, making sure that your staff have the appropriate training to make sure that they know how to identify risk, how to fill in an information form so that you have got a clinician name to identify if it's a clinician or identify if it's a specific issue in relation to a medication or the sort of recording of the deteriorating patient, all of that is really, really vital to be able to really identify the risks that we have.

Q. Do you know whether - obviously long out of the job you were doing in Acute Directorate - do you know whether the picture has changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?

A. It is still a significant challenge. The systems haven't changed that much. If you look at the demonstrations of the new Datix system that's available, you can put everything from your incidents, complaints, litigation, safeguarding, audit, recommendations, everything can go on it and be potentially triangulated and have reports coming out of that. So we don't have the most modern version of that. In relation to audit, again we need to continue to develop a system to put our audit recommendations on. And data analysts are really challenging to employ and we have a very limited team of probably one person. And again even having IT specialists who can put applications across data to, such as one of the click applications that will pull information from one or two systems into a report that is pictorial, for example, again there is a challenge with being able to resource those people within the organisation.

‘Has the picture changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?’

What needs to change in the immediate, mid, and long term to confidently triangulate risk issues within the Trust?

Q. It's been suggested to the Inquiry that perhaps the most significant impediment to moving SAI cases forward is the availability of the lead responsible officer on the review, who is inevitably a clinician?

A. Yes.

Q. And usually a busy, committed clinician; is that something that is just inevitable or are there ways of driving momentum and encouraging expedition that you have now recognised that perhaps weren't a feature of some of the cases we have seen?

A. Yes. Well, I think when you're using a working clinician, that will increase the length of time, because if they have not got protected time to carry forward this SAI review, we are really depending on their clinical commitments and trying to fit this in around that. What we have been doing since 2019 is doing a lot of the preparatory work, in that we are writing the timelines, we're making the packs. So we're doing some of the groundwork for the Chairperson in advance of the first meeting. Obviously

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they'll still need time to prepare for the first meeting and review the information that they have available. But I find that that can quicken the process.

Is there now in place the provision of protected time for the Chairperson of an SAI panel?

Q. So, you are reflecting back out of your own experiences of Chairing or leading three SAIs, and more widely, is that fair?

A. Yes. So, my own experience is that they do take too long. And for the reasons I've outlined, I think that is not helpful. Because if there's quick learning needed then you're not getting that out there as it should be, you know, across the organisation. Secondly, when an SAI report comes down through the governance structure to the M&M patient safety meeting, for instance, what you get is basically a set of recommendations. It's often very difficult to contextualise those recommendations, to put them in a scenario where the people in the room understand, you know, this is what has happened and this is why we're making these recommendations. And another problem that I think with the recommendations is that I may Chair an SAI, Mr. Haynes may Chair an SAI, Mr. O'Donoghue may Chair an SAI - and this has happened in our department - and we all make slightly different recommendations on the same kind of core issues. I think it would be better if the SAIs are conducted by a team of people who have knowledge of what other recommendations are being made, so that there is a consistency in the recommendations. So, it is not infrequent when you are drafting the agenda for the patient safety meeting to have several SAIs coming down through the governance team, and really we don't have time to fully consider all of the recommendations and all of the nuances arising from those SAIs. So, there are other ways of sharing that information. You know, you can do case review type presentations at M&M meetings or similar learning events, and I know that that's used in other specialties. And it's probably more effective than just providing us with a summary of recommendations.

Has there been a recent review of how effective and efficient the structure is in running an SAI Review, its recommendations and cascading the learning? Have the suggestions in the witness's response in the above paragraph been considered?

Q. I'm sure the Inquiry is interested in, I suppose, the nature of the governance relationship between these two centres. In essence it's one patient, and while they're going to different facilities, they probably think, right, globally this is my care package, so they will want, I suspect, to be assured that if things go wrong on either side of those centres that it's being well managed so that you are alerted in Craigavon if Belfast thinks things are not as they should be and vice versa. Is that a relationship - is the relationship one that works in that way?

A. I don't think that there is enough sharing of information across the cancer network here. I think that -- I can't recall what's been provided on a unit basis from the centre data demonstrating timelines and pathways. I can't recall that for either bladder cancer or prostate cancer. We've had a recent exercise whereby all of those units providing kidney surgery have participated in a project. So I have participated in that at Craigavon on behalf of our Trust, and my colleagues in Belfast and Altnagelvin have participated as well, and I think the Ulster. So that's the kind of work that we need to do. So, I think it's somewhat frustrating to hear things being thrown back at the units when, indeed, the communication coming the other way from the centre could be better.

Are there current plans in place to continue to develop collaborative relationships and roll out continuity of care pathways across different centres?

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2. Quality and patient safety

Q. I was just going to ask that. Was audit not viewed or how did things become so skewed that audit wasn't viewed as an integral part of quality improvement?

A. It should be. But the resource went to focus on quality improvement training, supporting the quality improvement as opposed to supporting the audit element of that.

Are all elements of quality improvement being addressed in the Trust now?

Q. Yes. When you talk about risk in this context, I suppose the risk that follows from being unable to proactively pursue governance issues, spell that out for us, what does proactivity mean in this context? Can you give us an example or two and what risk flows from the inability to pursue it?

A. So if we take some of the elements of governance. If we are looking at SAI reports, having them be able to be addressed and identify learning at an early stage and the recommendations be implemented and audited just to ensure that they were appropriately implemented is one risk. So delay in learning; delay in implementing recommendations; the inability to audit to provide assurance; to ability to provide frequent and robust training to teams in how to complete a Datix appropriately; how to identify risk; how to mitigate that risk again was another challenge and would have been a risk.

Q. Was it the case that, although you're talking the language of risk to Mrs. Gishkori, that while sympathetic, she didn't appear to be able to provide complete solutions, she talked about some initiatives that were tried, but did she appear to get it, that there was real risk here?

A. It would have been really challenging for her not to have got it because when you bring the number of outstanding SAIs, when you highlight the inability to audit to the level that we would have wanted to, it would have been really difficult for her not to have understood that risk. The challenge of providing the staff would have been a challenge from a financial perspective. But, again, how that was escalated outside and up to SLT I'm not fully aware of.

It is a key message in ensuring patient safety to listen well and pick up messages.

Q. Do you think the Trust continues to remain vulnerable to an inability to bring together different strands of information, some might call it intelligence, around the practitioners who may be putting patients at risk?

A. I think, because of the systems that we have in place at the minute, the Datix system, while it has improved, the ability to triangulate all the information is still a challenge. And again without good data analytics to help pull all the reports together, to evidence the trends, it could remain a challenge and does remain a challenge.

What immediate steps are being taken to provide good data analytics to mitigate the risk to patients?

Q. A couple of things, well first of all if I can just ask you about Datix. It has been updated but you're not on the newest system, why is that? Is that a resource issue?

A. I would imagine so. I can't say for definite but I would imagine that is, and there would be a cost associated with that as well.

Q. The new Datix that is currently in operation, is it any less cumbersome to input the information than the previous one?

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A. Not really, no.

Q. So would you accept then that in some ways it is perhaps not fit for purpose?

A. Yes, you could say that it is not fit for purpose.

Q. I mean, obviously the easier it is for people to make a report –

A. Yes.

Q. -- the more likely they are going to do it and if they are put off by a cumbersome system that requires a lot of training and that isn't particularly user friendly then it's not really going to be the most effective system, is that fair?

A. That's a fair point. But on reflection you still need to capture the key essence of what the incident is in a factual and concise manner.

Q. I accept that entirely. But if you're having to tick a box, if you're logged out after a certain period of time, then those are things that surely with the IT skills that people have nowadays could be improved?

A. Could be rectified, yes, I agree.

Is the current Datix system user friendly? If not, what can be done to rectify this?

A. So, I think the key to managing patient safety concerns is appropriate escalation. So, I think if a trainee was raising a concern with a clinical supervisor or educational supervisor about a patient safety concern, I would expect the CS or AES to raise that with the Clinical Director of the service and then escalation as appropriate. So, to me, it comes back to the heart of how you manage clinical performance concerns and about early -- you know, if there is escalation, that it's dealt with appropriately, people in senior positions respond to that appropriately and investigate it appropriately.

Q. And in these particular examples, rather than generically, what would be best practice to happen, given the information that I've read out, the information you've provided to the Inquiry? If this were the case and you had spoken to Mr. Young, do you consider that these are cases that should trigger an approach by him to act accordingly to perhaps explore your concerns to speak to Mr. O'Brien, to speak to a colleague? Do you think these pass the threshold for necessitating some governance action?

A. So, I would have expected him to have a conversation with his Clinical Director. And, you know, these were patients who were on the ward, these were patients that he would have been aware of, you know, on the joint ward rounds. So, irrespective of whether or not he remembers me talking to him about it, he would have had sight and visibility of these patients.

Q. And also would it be right to say irrespective of whether you're right or not in your concerns, there's an obligation?

A. Absolutely.

'So, I think the key to managing patient safety concerns is appropriate escalation'

Do all the staff in the Trust have a clear understanding of the appropriate escalation process? This is an important strand of practice that keeps patient safety to the forefront.

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Q. But in terms of what should be done around reviewing that case for learning –

A. Yeah. I mean I think what they saw demonstrates is that the number of people involved in this discussion didn't adhere to process. The process was to report this as an IR1 and allow that process to run its course. In parallel, the patient could be seen clinically and treated.

Q. Yes. One of the things that's probably overarching a lot of what we'll discuss in the course of today is the, I suppose, the appetite for challenge and the - how that feeds in to the safety culture. I pick that example. I suppose you would agree with me that it doesn't reflect well on –

A. I think there's an initial misstep of not doing the IR1. If you had done the IR1 at the very beginning you wouldn't have this issue of the round-robin discussion going on, it would have gone through the correct process.

How can the importance of reporting an incident, where appropriate, as an IR1 be understood, re-enforced and engaged with as a positive step in maintaining a safety culture throughout the Trust?

Q. Yes. I think you referred yesterday, or I referred you to the point you make that patient outcomes and the data around that is now perhaps more very recently beginning to be used, is that the kind of stuff that's –

A. Yeah. So I think there are other specialties that we can learn from. Orthopedics have had patient related outcomes for a long time, and I think that that's something that we could definitely, as a specialty, adopt and adapt to our needs. You know, the Trust could invest in very simple things like surveys of patients to ask them what has happened every time somebody comes into the hospital, you know. How was your experience? Did you have a complication? Well, the patient is going to tell you if they had a complication. So there's a very easy way of picking up morbidity, you know. There are other safety systems that other Trusts that I have worked in have used such that you cannot get to theatre if your VTE assessment is not completed. You cannot prescribe medication on the system unless you have put in the patient's weight and their VTE status. So, these are safeguards that are built into the system to allow safe practice.

Are comprehensive patient surveys been routinely used in all the specialities in the Trust? If not, are there plans to introduce them, audit them, and share the learning?

Q. I mean, do you have a sense, as the lead of the MDM, that while systems are always vulnerable to human error, that safety nets, if I can describe them as that, are as robust as they need be, or do you have any lingering concerns that keep you awake at night in this context?

A. At this period of time in 2018, we didn't have resource to properly audit and quality assure what was happening, and we had flagged that up as a concern. We now do have that resource. So as I spoke about earlier today, we run a check on random cases every month to ensure that outcomes are actioned.

Is there regular monitoring and awareness across the Trust on how effectively its ‘safety nets’ are functioning? How quickly is there a response when vulnerability is flagged up? Has this been recently audited?

3. Culture and behaviour

Q. And a lot of the things you mention are the outworking of clinical governance, the end product, coroners and medical negligence, civil claims, learning from perhaps the wrong end of the telescope.

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Do you consider that there is -- well, what part do you think that culture in a place has to play in both the triggering of governance and the effectiveness of any action taken?

A. I'm going to answer the -- in answering the question it's quite complicated, but in 2018/19 in Belfast, I brought in a system based around the measurement and monitoring of safety, and it was based on a document written by the Health Foundation in 2013 by Charles Vincent. And basically, it turns your organisation into a problem sensing organisation, where you ask really profound questions, like: Are you safe today? Are your systems reliable? Are you learning from past harm? Are you looking forward to see where there's going to be issues? And we've adopted that in Belfast as a way of thinking and about how we problem sense, and I think that you're right, you have to learn it from harm, but it is - it tends to be reactive. What we try to do is shift that thinking into how can we make sure we're safe today? So the out-workings of that are daily safety huddles, right the way up to executive team, ehm, weekly huddles where divisional teams come together and they review all their safety data from the previous week and look to, you know, is there any immediate learning? Is there anything that needs to be raised as a concern?

Because I think I said earlier on, at the heart of any safe system is staff feeling safe to raise concerns and be open, and be open when things go wrong, and when things do go wrong, that they will feel safe and that they won't feel that they're going to be blamed. Because we're all human, we all make mistakes, and it's important that we accept and acknowledge that we will make mistakes. But it's how we learn from it. And I think how we make our clinical governance even better is how we focus on how we learn, because that can be difficult sometimes to make sure that you put systems in place that engineer a change.

On a scale of 1 to 10 what is the SLT's estimate of where the Southern Trust is at in terms of it being 'a problem sensing organisation'? How can this approach be fully interpreted and applied across the Trust?

Q. Now, you spoke to Mr. O'Brien and he mentioned that he had discussed this case with a urologist in the United States of America. I don't suppose you remember the name of the urologist?

A. No, but his response stuck in my mind. Because, you know, I remember asking him and I remember him saying somebody else had raised this as an issue and he had spoken to somebody in the United States of America who said in the circumstances it was a reasonable course of action.

Q. And he didn't say who the other person was who had also perhaps shared your views, who had expressed the same view?

A. No. I mean, I think that, I suppose I felt brave challenging him and I got an explanation back which was, it was difficult to argue with.

Q. And you don't recall - you can't say whether you spoke to Mr. Young about this issue or not? You just don't recall?

A. So, undoubtedly, you know, because of the joint ward rounds, I would have expected that Mr. Young would have been aware of some of these patients. And when I did raise concerns with Mr. Young, as I've said in my statement, his response was "That's just Aidan".

Q. And what did you take that to mean when he said that?

A. It's hard to know how to interpret it. But I felt I was speaking to another consultant and raising an issue and that was the response. And, again, you look back and you think 'I'm a second year trainee, I

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don't know everything about urology, I'm working with senior consultants, maybe they think this is acceptable'.

The importance of addressing the cultural power imprint/imbalance in clinical teams, particularly in terms of delivering safe patient care.

Q. And do you think that the culture within an organisation and within departments, and even within clinics, has a part to play on whether people feel comfortable raising governance issues?

A. I do. Yeah, I do. And I think looking back, you know, when I think when I arrived here from London I didn't know anybody here, I was very, you know, not quite isolated, but certainly didn't know how things worked. So that takes a while to get - not just to understand the governance structures, but also to understand exactly, as you say, the culture. Just coming in from it cold, it takes a while to understand the culture.

Q. And the two parts of that maybe are the confidence of the person who needs to speak about something and also a listening ear or a willing recipient of that information?

A. Yes, both of those things, exactly, yeah.

Q. What would make it easier, in your view, for junior colleagues, or indeed any colleagues, to raise concerns such as this?

A. Yeah, I think first of all, it is a culture where everything gets discussed in a friendly, non-confrontational manner, and essentially just leading from the front as a more senior consultant now, I certainly would encourage open discussion in our peer chats when we're discussing patients, and we try not to have a hierarchical approach to that, but we do bring -- I have a lot of experience now, so I bring that to the table. But we really try and create a culture where junior members of staff feel empowered, and that's really just by having a friendly attitude to how we operate.

Q. And have you had to talk to colleagues over the years informally about issues maybe just that you needed clarity on or were concerned about? Have you had experience of that?

A. Sure. Certainly as Clinical Director that would be a weekly occurrence, yeah.

Q. And as Clinical Director, is that something that, in your experience, has brought about the necessary change, or have you had to then instigate formal governance processes?

A. There have been occasions where formal governance processes were required. But as I say, for the most part a more informal discussion solved a lot of things.

The importance of senior consultants 'leading from the front' in developing a friendly, non-confrontational tone in open and transparent discussions. Establishing a culture of listening and empowerment of junior staff.

Q. Do you think it should be mandatory that patients are copied in to all letters?

A. I think that's becoming the culture now. I have some issues regarding certain circumstances, especially where the patient has got very short survival who don't want to know about that.

Q. Yes.

A. So there are some challenges. But overall, yes, I think patients, and patients, with the new IT systems coming, will have full access to their health records. So I strongly support that.

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Q. What do you think the barriers to that have been?

A. I think cultural and paternalistic approach to medicine over the years. "Doctor knows right".

One practical way of moving the provision of medical care on from a paternalistic approach will be to provide patients access through IT, to their medical notes and copying them in to the letters relating to their care.

4. Communication

Q. We had a patient come to the Inquiry to give evidence, his name is Patient 84. You can see, if we just bring it up on the screen, PAT-000225, he directed a complaint to the Trust on 19th September 2016. Without going into all of the fine detail, this was a case where there were -- a complaint where there was a number of issues but primarily and at the heart of it it was a patient who had a stenting procedure. The stents had to be removed. The patient had been given the understanding that they would be removed by a certain date and that date moved and moved and moved until he got into some considerable medical difficulty, had to be admitted to hospital with infection, had to be re-admitted and was not, as you might expect, terribly happy with his treatment, leading to this complaint. And you were at that time responsible for managing or coordinating complaints and we can see, for example, PAT - well it's three pages further on at 228 - we can see that your first step, I suppose, is to send out what I take to be a pro forma kind of response which might be politely described as a holding response or an acknowledgment?

A. An acknowledgment of complaint, yes.

Q. Yes. This was one of these cases where you were unable to comply with the 20-day aspiration. A number of holding letters were issued over the following months, leading to a substantive response on 1st December. If we could have that up on the screen please, PAT-000231. That would have been signed off by Mrs. Gishkori. Now, if we scroll down through it. Just further on down, on to the next page perhaps. When this patient came to give evidence, and indeed in subsequent correspondence in response to this output, he took exception or he explained that he took exception to how his complaint had been dealt with and what was particularly sore with him was that his perception was of being made to feel guilty about complaining because - and he drew this or he was caused to feel this - because he was told that, in essence, the service is struggling to meet demands and cancer patients have to come first, if you like, and that's perhaps contained within that paragraph, commencing: "Mr. O'Brien confirms that ideally patients who have a stent inserted should have this removed and have this performed within four to six weeks later. However, the demand on the urology service is unrelenting, with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway." Just to show you how it was expressed by the patient when he came along to see us, if we go to TRA-00094. He came along at the opening week of the Inquiry and he says that, just scrolling down, he says: "Obviously, when they brought in the cancer patient stuff and, you know, while obviously I have sympathy with them life threatening conditions and things but that wasn't I suppose - you shouldn't be made to feel guilty." In other words, he took it as why are you complaining, there are people worse off than you. Did you draft the letter?

A. The information contained in the letter would have been a direct lift from the information provided by the service area. Having read that now again, I accept that the patient would be annoyed by the content of the letter and I am sorry for that. I can understand where the patient is coming from. I think the attempts to explain the pressures on the urology service have not been communicated as well as they maybe could have been.

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Q. I suppose linguistically it's a difficult balancing act, you perhaps want to communicate something of an explanation as to why the treatment has been delayed?

A. Yes. Yes. And that explanation had been given to various other patients who were waiting as well.

Q. Yes. I think what you are acknowledging this morning is that, from his subjective perspective, it's understandable that he would feel annoyed?

A. Yes.

Q. And maybe there is a learning here in terms of how you convey the message?

A. Yes, exactly.

Treating each patient with dignity and respect includes attention to the quality of communication - a key component in delivering person-centred care.

Veryan Richards

26/10/2023

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Themes and considerations for the Southern Trust Senior Leadership Team

This document:

- is a streamlined version of several papers presented at the Southern Trust External Reference Group meetings 2023/2024 covering the court transcripts of the Northern Ireland Urology Public Inquiry

- provides context to the 'USI learning – 19th January' document

- can be used as a reference tool and contribute to the development of a new vision and strategy

Note – The Inquiry has raised points of learning, observation, and challenge during the Public Inquiry Court hearings. These points are grouped into themes, accompanied by the relevant court transcript text giving rise to some questions and comments for consideration (some points were raised several times and are included to demonstrate some of the common themes)

Structure

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

1. Leadership and Governance

Tracking, clinical decision-making and audit

A. Trust lacks an effective system to manage and track the administrative working of clinical decision making. Nobody could be assured that the service was being delivered safely in the absence of tracking and audit.

This also applies to monitoring the delivery of quality care. There are weaknesses in both the governance of the organisation and in elements of clinical care

There is a need for better tracking – the role of co-ordinators.

Trusts failure to carry out some of the recommendations from the March 2017 investigation

Is this still the case?

A. Clinical audit was not a strong feature in the Southern Trust. The line of sight from the Boardroom to the bedside should be clear in a high functioning system – this was not the case in Urology

A. We did not have consistency in the team – one reason for missing things

Is there a robust system now for the learning from SAI's to be monitored and actioned?

A. Dr Hughes findings/recommendations – some were being addressed before Covid.

Are they continuing to be addressed now?

What is the current monitoring system to check that private patients are not being bumped up the NHS list?

Are pre-op assessments being audited now?

What is the Trust policy on minuting meetings – which meetings?

…….

Q. Might it have been something that the medics involved in both the work to prepare for the Return-to-Work Plan and looking at the work that had completed in June 2017, might it have been something that they noticed and could have adapted the plan to reflect?

A. Yes. I think because the people that would have been seeing -- as in medics -- would have been seeing patients without that information on them, if they had escalated then we would have known, but nobody every said there was -- at that stage, in between the '17 and, sort of, '19, that there's letters missing. An in-patient discharge wouldn't be so bad because obviously there is electronic discharge from the ward so the juniors would have done that, it would be signed off. It was more to do with the day cases. They weren't dictated on, but nobody every said they were missing. It's one of those things, unless you're told, you don't really –

Q. Does it go back to your point that this was an opportunity at this point to perhaps delve a little bit more deeply into what was happening as regards Mr. O'Brien's practice and also procedures in place? Do you see that as a missed opportunity now?

A. I do, yes.

Q, Does that also reflect the tradition, if I can call it that, that you spoke about earlier of when people raise issues, nobody generally comes back to tell them how they was resolved?

A. That's correct, yes.

Note the importance of regular monitoring of process being carried out efficiently and where possible build in a practice of 'closing the loop' on raised issues.

Q. Was the barrier to that not having a specific Deputy Medical Director who could devote themselves to that? Was the barrier cultural? Your mechanics seemed to be working fine but meaningful discussion was not necessarily available for us to look at.

A. That's a very good question. The mechanics at the time I was there did work very well. Actually we knew when people were being appraised. We had almost 100% compliance. We did have a fairly advanced quality assurance check on appraisals, that the right questions were being asked. What we didn't have was a matching up of agreed specific clinical data that was agreed within teams that were relevant to them. It was too much left to the individuals to bring data themselves. So for peer comparison within urology, for instance, that was not robust enough. Part of that would have been simply the culture within Northern Ireland medicine. There has been a lot of resistance to introducing that type of data on a systemic basis. But I have no doubt that having someone assigned with a dedicated role as a Deputy Medical Director, for instance, with that as their role would have been very helpful. That's what I was trying to achieve. I don't think that by itself would have changed the culture but it would have been very helpful.

'What we didn't have was a matching up of agreed specific clinical data that was agreed within teams that were relevant to them. It was too much left to the individuals to bring data themselves. So for peer comparison within urology, for instance, that was not robust enough.'

Has this now been tightened up?

.....

Q. These are general questions really based on your experience as a manager in the Trust. Just to start with, in your role as Assistant Director did you get any regular reports that provided any kind of range of metrics about the performance of outpatients generally? So I'm thinking about time to first appointment, time to follow-up, dictation times, workload by consultant, complaints, patient feedback. Was that ever pulled together so that you could look at it by speciality and see what was going on?

A. I suppose the short answer is no. That level of detail we didn't -- was not provided.

Q. Would that have been helpful?

A. Absolutely, yes.

Are the measures now in place that capture this range of metrics?

Q. I know the Inquiry has heard evidence around specific charts and tracking in relation to Mr. O'Brien, but from a departmental position would you agree that the validation and the tracking of charts was something that was ongoing over the years during your tenure?

A. Yes. We tried -- we tried to keep our housekeeping up-to-date but unfortunately, due to staffing levels, if anything was to fall, it would be that where the core business would be to get the chart for the patient. But these things would have been put onto the work plan because you didn't want them to fall off the radar and they could be reviewed and what can we do. And if you couldn't do everything, at least can we try and do a few things every year.

Q. Was it because of the vulnerabilities of human nature that the chart issue - and we'll see it when you're raising it with your managers later on - just didn't go away?

A. Oh yeah. It was ongoing.

Q. Right up to 2019?

A. Yes.

Q. By the time you left, the situation would have been -- was it the same; was it enhanced?

A. No, there were always issues with tracking. The system, the patient administration system, it's an old system and there is no flexibility within it and it is very reliant on human input. Before I had left, I put in a business case for iFIT and that actually is where you have a label with a chip in it and that's attached to a chart and it's all wifi driven. If you are taking the chart from one area to the other, the wifi picks it up and actually updates the code. So, you don't need that manual input and you would know then when a chart has moved from one location to the other. The business case was passed and it was waiting for money and then Covid hit. But iFIT is actually being implemented very shortly within the Southern Trust, which will be fabulous and will resolve the tracking issues.

Q. Who will be able to provide us with more up-to-date information on that? Would that be Anita Carroll?

A. Yes.

How is the implementation of iFIT going? Has adequate training been given to all staff involved in using this system?

Q. Tracking of patients charts on PAS. "Would you please remind all your staff that it is absolutely crucial that every chart is tracked when moved from one location to another. Recently, due to a chart not having its tracking codes updated, a patient's operation was cancelled. The chart was later found in a different service and in a different building. The consultants have stated that from now on if the chart is not available, they will not operate on the patient. "If you take a chart, you must track it to the new tracking code. If you don't have access to pass to do this, then you must leave a message for a member of staff from the area that you have taken the chart from giving them details of where the chart is going and asking them to track this for you. This is not just a request to help staff when looking for charts, but this has a direct impact on the care we are providing to our patients. No chart, no surgery, no appointment. Would you please circulate to all your staff". You sign that off. I don't think you could have been much clearer in that email in setting out the repercussions of -- and you have provided evidence there that someone actually missed an operation, a booked operation, that was cancelled because of that?

A. Yeah.

Q. Was that the first time that you were aware that an operation was cancelled or was there something about that that triggered this email?

A. No, that would have been a specific event where the operation was cancelled. I had explained before there if there was a chart missing, about the Records member of staff would have looked for it, the supervisor, the manager, they really did do everything that they could to get the chart. For this to happen, you know, they would have taken it very badly. It would not only have upset them but also they would have wasted so much time. It just had to be spelt out. You know, look, it's not -- sometimes when you talked about tracking a chart, that it was just that's Records having a bit of a moan.

Q. Is that what you felt?

A. Sometimes, yes. It was a bit of a moan, that's them moaning again. So this was, look, it's not just us moaning, this actually happened, a patient was prepared for their surgery; they came in today and it was cancelled because somebody hadn't tracked the chart properly.

Q. So, this is the real life consequence for that?

A. Yes.

Q. If I understand what you are saying correctly, your experience was that at times people were a little lax or a little indifferent to attempts to track charts?

A. Yes.

Q. Was that because it was such a common problem?

A. I just don't think sometimes people saw the importance of it. "Sure I'll take that chart and I'll leave it back", and then you forget to leave it back and then something else happens. Sometimes the admin processes just weren't taken -- weren't followed as well as other processes might have been.

Q. Do you think there was - and disagree with me if you do disagree - do you think there was a lack of respect for aspects of your work or the admin process, that people just didn't give it the due diligence it deserved?

A. Yeah. I think it was that it wasn't given the due diligence.

Q. Do you think there was any impact on the culture towards charts and admin, because there didn't seem to be any sanctions for people who were perhaps a bit - I want to say lackadaisical because I can't think of the word that is not lackadaisical - but who were a little bit casual in their use of charts? There was nothing done if you didn't bring your chart back home or put it in the library or code it properly, so perhaps a failure to sanction was a bit of an acquiescence?

A. Yes, and sometimes I think we could have been a victim of our own success. We would have done KPIs out, and like I've said, Craigavon library alone would have been pulling 19,000 a month but our percentage rate of charts would have been 99.5% availability. That would have been an average. So, we did get an awful lot of charts but the staff really worked hard to make sure that they did that. Maybe if we just hadn't searched and searched and searched and that percentage had went down, maybe then people would have taken notice because there could have been more noise in the system.

Q. And more impact?

A. Yes.

Q. So your diligence was your downfall in some respects?

A. Yes.

Post Inquiry – consider fresh and innovate ways to encourage everyone in the Trust to value and respect all the roles and functions needed to deliver safe care and quality care for patients.

Q. Now, you have also said in your statement that more auditing is a must, and there's a lot of focus in the Trust on targets, performance and bed management, and that those issues - I presume you are speaking historically - those issues distract you from governance?

A. Yes.

Q. And therefore governance was not always the primary focus?

A. Yes.

Q. Is that still your view of the way things are run at the moment?

A. Yes, but I think there's a real willingness to change. And I think that's come out because of the Inquiry.

…….

Q. Could I just bring you then to the overarching SAI report. If we go to the section on governance and leadership, WIT-84302. It says in the third bullet point, it largely repeats the sentiment we've already seen, that: "There was no system to track if recommendations were appropriately completed". Can you see the sense, from a tracking perspective and from a patient's safety perspective, of having a tool, whether it is a live tracking device or whether it's some form of audit to be in place, to bring the monitoring of the treatment further along the line?

A. I can definitely see the benefits of it. If it was properly resourced and the functionally within CaPPS expanded to allow you to track a patient through -- say, they had a bladder cancer through maybe multiple occurrences or stuff like that, there definitely would be a benefit for the patient.

Q. In light of what we heard from you in evidence earlier this morning, would I be correct to form the impression that given the resources that you had at that time within tracking, it wouldn't have been feasible to do much more given the resources you had?

A. I would agree, that's totally right. The tracker were under immense pressure with increased workload. They were struggling to track what they were commissioned to track, you know, 31-day and 62-day to first definitive, let alone a whole patient's pathway for years.

How are the realistic expectations of staff working in the Trust set, monitored, reviewed, and adjusted?

Q. The incident report which I showed you there, the essence of it was that it appeared that a direct referral had been generated in your place in the Southern Trust but hadn't been received or dealt with in Belfast, and it took a GP to write in a year later and raise the alarm. Can you help us to understand what might have gone wrong there?

A. I suppose because -- I don't know the case exactly but I suppose one thing that could have went wrong is they had hormones commenced, their first definitive, then oncology referral was generated from the Southern Trust. Therefore, because they have been closed in CaPPS, they wouldn't have been tracking that to see that they had got the referral. It's the only explanation that I can give.

Q. But again, not knowing the case –

A. Yes.

Q. -- and I know we're in a sense speculating, but in terms of any case going that route, you've outlined the kind of correspondence that must be generated –

A. Yep.

Q. -- at your end, at the Southern end?

A. Yep.

Q. If that is not responded to for whatever reason, Belfast Trust have a computer problem or somebody is not doing their job properly or whatever it might be, what is the alarm bell in that situation; what is the safety net?

A. In my time I don't believe there was a safety net there, but looking back now, there needs to be one, you know, to follow up those patients that aren't being actively tracked. But once we have done our -- to me it is with the consultant, the patient is the consultant's responsibility. Because oncology referrals would also have been generated, it just wouldn't have been say a CaPPS oncology referral, most consultants would have followed that up with an actual written letter to oncology that maybe contained more information on that referral than the CaPPS referral.

Is there a safety net in place now for patients who are not being actively tracked?

Q. At WIT-80977, you are referring to the lookback exercise in relation to the role of the Cancer Tracker and the benefits of tracking patients past their first appointment. Is that improved, in your experience? I know the Panel heard the Cancer Tracker evidence this morning, but from your experience is that system in any way better for you?

A. I think there is still improvements to be made on it. I'm not sure if they are still funded to only go to that point of first definitive treatment. But there certainly is more engagement in relation to the audit processes.

Q. Now, you've said, looking back in your statement, that you didn't think governance arrangements were fit for purpose, and. Is that something that you still feel –

A. I felt from the outset when the Mandeville Unit opened, you know, where people went for cancer treatment, there was no footprint at all for Urology within that setting. I found that strange. It removed the opportunity of meeting on the corridor or seeing the door open in an office where you could put your head in and say 'any progress with, you know for example, the advertisement for the CNSs, or any new equipment requirements. We didn't have that. They were in their corridor and we were in ours and the two never passed, except there you would have seen these people at the AGM or MDT. There wasn't engagement all the time. We would have worked closely with the cancer trackers and red flag team. They would have been in and out of the unit so we would have significant engagement with them.

Q. Is that the situation now; is it still that disconnect?

A. There is more to do. I thought about these just recently. We are as a team improving and striving to continue to improve. I have no doubt the cancer team is doing that and others,

'The findings indicate a disconnect between Urology MDT and Cancer Services management'

'We just haven't had the opportunity yet to come together and say what all has been achieved thus far, and collectively how much further can we go.'

Has the SLT checked recently on the connecting progress between Urology MDT and Cancer Services?

Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently?

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of pathway tracking that was alluded to in the testimonies yesterday but, to the best of my knowledge, that isn't currently in position at present.

Q. And do you think that would be a good idea?

A. Absolutely.

Note the improvement in the provision of a key worker for patients with a new diagnosis.

Has the SLT knowledge of how ready is the system to address 'whole pathway tracking'?

Q. Thank you. In terms of the key challenges that remain to be addressed arising out of the recommendations, you have highlighted already the difficulty that might affect more Trusts than the Southern Trust in dealing with the tracking issue. Is that the key challenge or the most difficult recommendation to comply with?

A. I think actually the whole thing around the audit of MDT, I'm not sure that any Trust is resourced to provide the level of audit that we would like to do. In regards of assurance around processes and systems of the MDT, and we have talked about it as a group of cancer operational managers, that it is

definitely something that we would all like to do; we just haven't been resourced to do it. I know Southern Trust has gone at risk to appoint our two posts in, and we will see the benefit of all those posts in time. But it's at starting point, and we certainly would like to do much more audit than what we currently do. In particular around the key worker side of things, we also would like to audit and ensure that the key worker, in relation to those recommendations, they are actually doing what we say they are, you know, in that they are allocated, they have provided the information and those kind of things. We are not just resourced yet to do that.

Are there any interim audit measurements in place on the placement and effectiveness of the key worker role?

……

Q. In that vein, a lot of people, mainly I think after your time, had said that there was a very big emphasis on performance and that data for performance was looked at very carefully, but that there wasn't much robust data to cover quality issues other than when things went wrong, and that, therefore, one didn't necessarily know, for example, if cancer peer review standards were not being met, or if people weren't following policy, or if people weren't using best Royal College guidance. Was that something you recognised in your time and did you have any views on that?

A. All that data was there. All the cancer review documents were there, again with clear action plans. All the RQIA inspections, announced and unannounced, were clear, they were always in Trust Board papers, they were in my directorate governance papers, the action plans against them were in directorate governance papers.

Q. I am talking more if you were asked what's the quality of clinical outcomes in Urology, would you have data to look at?

A. No, I wouldn't have at all. Whilst we as a Trust joined CHKS and we engaged in the process of contributing our data to CHKS, I think in my time it only got to maybe a divisional level, it didn't get to specialty level. There was a process of cascading, cleaning and assuring the data. Certainly I think there was a basket of 23 metrics that we were measured against, and we rated highly in the UK against that, but those were largely around performance and that's maybe where the perception has come from.

Q. I think that is what they said.

A. Yes.

Q. They said this is performance.

A. Yes. The audit of clinical practice and having an audit against that either locally or nationally, no, I felt that was a gap.

Is the SLT happy that there is now a high standard of robust data to cover quality standards across all the specialities? If not, as a priority, what immediate steps can be taken to address this?

Q. If we go to the Directorate Risk Register of July 2019 at WIT-94611. If I can read the extract from that rather than we all strain our eyes trying to find that. It says: "As of April 2018, there are 1,609 standards and guidelines identified on the Trust register. 74%, which is 1,193 of these, are applicable to Acute Services Directorate. Of these, 34%, 405, remain at a partial or non-determined level of compliance, with many identifying significant external barriers impeding the Trust's ability to comply." I think you have mentioned some of those external barriers are buy-in from GPs, and you have also mentioned, I think, the Board as well?

A. Yes.

Q. HSCB?

A. Yes, about implementing certain processes. You know, you were tried to waiting on those processes being fully implemented.

Q. From the figures provided in April 2018 to Dr. Khan's report eight months later, the figures have risen from 34% to 47%?

A. Mm-hmm.

Q. Did you ever undertake a similar sort of analysis to find out what the standards and guidelines situation was while you were the coordinator?

A. I hadn't, no, but my standards and guidelines manager did do, and she would have produced reports for me and then for my senior colleagues as well every two weeks. These would have been discussed then.

Q. Would they have been discussed in percentage terms of the total not yet implemented, or partially complied or needing reviewed?

A. Yes.

Q. The figures that I am bringing you to from 34 to 47, do these sound about right in your recollection of the amount outstanding?

A. Yes.

What are the current figures?

Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly?

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback through the system. It was more difficult to do that for me with such a broad remit, so that's why the guidelines team were particularly good and particularly active at following through on that.

Is the system for guidelines monitoring fit for purpose and regularly audited?

Q. There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.

Q. The Panel has heard evidence about the fairly recent realisation of cancer tracking to maximise being able to follow. I think, the evidence is that there's still room for improvement; that that process is not a fail-safe either. Given that, the cancer tracking issue and the CNS issue, might the findings and

recommendations from the nine SAIs more helpfully have provided systemic suggestions around care pathways generally that might have included CNS and less emphasis on the CNS providing the answer for all of those nine patients?

A. Yes.

'Q There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.'

Is it still the case that various parts of the system are struggling to deliver successful care pathway oversight?

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern

Does the SLT consider 'the missing clinical audit' an area of concern? If so, what are the steps to address this?

Q. Okay. Thank you. You had a comment about deep-dives, and made a comment about not all are brave enough to do it. That's an interesting choice of words. What did you mean by it?

A. Again I am back to that expression I used there about lifting the stone and seeing what else. I think you should never -- especially when you have recurrent issues, say for example like triage and delays and patients who are not being seen in as timely a way as we could offer. I think hold on a minute, we need to have a deeper look here; we need to actually sample; we need to audit some of the work. You can't just accept, and we did in many ways accept he is a really good clinician and take that as read. We should be able to evidence that in this day and age. We audit our own performance and our peers. I think we should be able to do that and I think that takes bravery.

When there are recurrent issues taking a deep-dive approach to them is important, sampling and auditing some of the work. 'Lift the stone and see what else is under it.'

Can the SLT identify any current recurring issues in the Trust where this approach needs to be applied?

.....

Q. Under the key duties, the first key duty, perhaps, importantly, is, you were to "Take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and they are providing timely assurance and alerts to both the service director and the organisation." We get a sense of how you found the ground, so to speak, within your Section 21 statement. I suspect you are going to tell us today that your ability to provide the kind of assurance that things were operating at a sufficiently high standard of compliance was not, despite your best efforts, was not available to you because of resource issues?

A. Yes. I couldn't have provided an assurance in the organisation that all aspects of clinical and social care governance were robust within the Acute Directorate. There was a very small and limited team available, at times it was me and one other part-time person, so things in relation to audit for

assurance wouldn't have been robust at the time. And there was an internal audit report that highlighted that the Audit Committee hadn't met for some time within the Acute Directorate and then that was one of the actions that I put in place to try and make the system more robust and try to provide a form of assurance to the Acute Director and, therefore, SLT.

What is the current standard of auditing across all aspects of clinical and social care governance? Where standards are low or the auditing process not taking place - what actions are planned to address this? Is this a standing item on the SLT agenda?

Q. -- to implement actions around standards and guidelines. You talk, at paragraph 3.126 of your statement, about establishing a forum encompassing lead nurses, midwives, allied health professionals, radiography to ensure that the actions needed to implement standards and guidelines was shared and embedded with frontline staff?

A. Yes.

Q. Were those initiatives that you took forward?

A. Yes. So whenever I went into the acute governance role the worry was that the recommendations stopped at a certain level and sometimes what you find within governance is it doesn't filter down to the wards and departments. So this was our attempt to make sure that the lead nurses and midwives and AHPs were fully appraised and involved in developing the actions from the recommendations.

Q. One of the things I suppose you had a concern about, as reflected in your statement at paragraph 3.96, was that it wasn't always possible to provide assurance audit that guidelines that I suppose had been adopted by the Trust were actually being adequately implemented by frontline staff?

A. So to provide assurance you need to try and develop an audit and make sure that the audits are completed to identify that all of the actions are taking place and within the Acute Directorate there wasn't the resource to be able to sufficiently do that. For some standards and guidelines there were very robust audits but for others there weren't.

Is this forum still operating? Are resources being identified to support the auditing process to ensure that there is implementation of all the actions at ward level?

Q. Is there anything in the system, either for you or for the consultants, that flag up when results have been sitting a while or waiting or if there is any delay in look at them?

A. I know the secretaries, they would, if a patient has been seen in an out-patients clinic and they are having an investigation, they are put on to the patients administration systems as what they call DARO which is discharged awaiting results. This is placed on the PAS. The secretaries would run reports then monthly and this will show if there is any outstanding results that needs to be actioned. So the secretaries could contact the consultants or even myself, if I have requested anything or if there is results available they could contact me.

Q. Now you speak about DARO at 14.3 and you say that the CNSs don't have access to the DARO functions?

A. No, that's for the secretaries would have access to that.

Q. Do you think that it would improve follow-ups if you did have access? Give us a bit of background to that, why you have said that?

A. I think it would improve my follow-up. You know, if nurses had, maybe, or Nurse Specialist had access to it we could be notified if there is results outstanding or if the result has become available. It would probably be around the same as what NIECR or Sectra would be and it could notify us if we have put in a request and results are available.

Is this a suggestion that could be implemented?

Q. Was it your experience at the time, or has it been your experience since, that perhaps consultants who are more senior, who are more used to their own way of doing things, find it difficult either to be challenged or to adjust their practice to reflect advances?

A. So, I think that at the heart of safe consultant practice is good team working, and that working in a functioning team where there's a built-in peer review, essentially. I think when you work in isolation, there's a risk that you develop practice that maybe doesn't follow best practice or best guidance or, you know, keep up to date with current best thinking.

The importance of clinicians seeing themselves as an active team member where there is a built-in peer review approach operating.

A. So, my reading of that was that we knew that the tracking only went to first diagnosis. We understood, we discussed that that was a problem. It would have been much better if tracking was extended beyond that and resourced beyond that. But it wasn't, because we'd already explored that. Dr. Hughes was coming from a perspective, as I understand it, that he had been a medical director in another Trust and he had also been, I think, a NICaN lead at one point in time. And he should have been very well aware that tracking in the Trusts here was only resourced to first definitive treatment. Now, he may have made different decisions in the Western Trust as to how to resource their tracking, and he may well have done that, I'm not aware, but I think that's where he was coming from. I've maybe lost the second point. Oh, yeah, the quality assurance about whether MDT outcomes would have been adhered to. So, at the time, as a group we would agree the MDT outcome for each individual patient. That would be spoken out loud in the room, the tracker would record that, and then the tracker would type that information into CaPPS, usually at a later time, and that would be provided to the person who Chaired the meeting to review the outcomes as they had been recorded for factual accuracy. And once that had been agreed, that would go back to the tracker to be circulated out to the whole MDT and that would then allow the CaPPS letters to be generated to the GPs and they would be posted out to the GPs. So, that's how that happened. So that was that bit of quality assurance to make sure that the outcomes were correct as discussed at the meeting. Now, it comes then to whether or not individual clinicians adhered to the outcomes when they met the patient. We now have in place, in very recent times, less than the last 12 months, support available within cancer services whereby we run a random audit of whether or not outcomes have been adhered to. That information is brought back to the MDT and shared with the MDT. I also receive that report as the lead clinician, and if there are cases that don't appear to match what the outcome was, then those cases are addressed on an individual basis.

Has the effectiveness of the tracking system recently been audited in all specialities in the Trust? Do steps need to be taken to improve the system?

……

Q. So the -- just so I'll be clear on your answer. You carried out the triage at the point of vetting the referral letter, you also took a clinical view whether tests were required, and dependant on the results of those tests the categorisation may have changed?

A. That's right, yes. Yeah. Like you know especially for those with like, if we mark it as a routine one, then I don't want this patient waiting for the CT results, which could be something different, marked as routine, 1 but I want to see the CT report, and then, if needed, to upgrade, yes.

Q. And was that the way triage was done when you arrived at Craigavon, or was that a system that was introduced while you were there?

A. As I told, initially we were just doing normal triaging, like marking as routine or urgent. We would not be investigating. But I think the advanced triaging started a bit later.

Q. And was that something that all the consultants -- was there a view taken that all the consultants would approach it that way, or was it really up to each individual clinician as to what approach they took?

A. I think this was the policy we agreed within the Department. So I presume every consultant was doing it .

Q. And do you know when that policy came in?

A. I'm sorry not exactly when.

Q. But your recollection is that there was a view taken that that is the way in which triage should be carried out?

A. I felt that it's the better way like, you know patients, rather than waiting for months and months to have a clinic visit, and then to ask for an investigation. So I think this advanced triaging speeded up the process of investigations.

Q. I suppose I am trying to get to -- there's two issues really. The first is what you did as a clinician, and you have explained that. And the second issue is trying to establish if advanced triage, as it's referred to, was a policy, or a conscious decision made by the Trust at some point. So I think I understand your position at the moment to be that you considered advanced triage to be the most appropriate way for you to assess patients for prioritisation, but the second element of that I just want to make sure your evidence is clear, was there a decision collectively made that advanced triage was to take place in the way you have described?

A. Yes.

Is the advanced triage approach to assessing patients for prioritisation an agreed and recommended approach? Are there Trust guidelines on triaging red flag, urgent and routine referral cases?

Q. If a patient wants to remain on the Bicalutamide 50 monotherapy, and I know this patient did and you referred him on to Mr. O'Brien to discuss that, as he was his patient, the patient said to you "I want to stay on this", and you know that it's outside the licence conditions, and the risks we discussed earlier, what would be your response to that?

A. As I told, nobody should be on this monotherapy because there's no -- absolute no indication at all for this treatment. So I would explain to the patient that it's not the conventional treatment, it's not indicated, so the appropriate actions will be, there are other choices, like patient could be on active surveillance, depending on the stage and, you know, Gleason score, whether these categories. So other treatment options are either active surveillance, or curative treatment, or watch/waiting, depending on the staging and grading of the prostate cancer.

Q. So you would provide the patient with information to explain to them why it wasn't appropriate?

A. Yes, absolutely.

Q. Would you continue to prescribe it to them because of their belief that it was helping them when clinically that isn't an evidenced based belief?

A. No, I wouldn't personally recommend to continue. Yes.

Q. Now, you obviously felt that there was, the issue was dealt with at the MDM. You raised it as an issue. Mr. O'Brien said he would go and review the patient. And you formed a view that you didn't need to take the matter any further?

A. That's right, because I thought this is the first case I came across then. So I thought it was properly addressed at that point, like this.

Post Inquiry, would it be a reasonable outcome for the SLT to underline the message that all prescribing in the Trust should remain, where possible, within the licenced requirements?

Q. I think it's Recommendation 5, if we scroll back up. So it's talking about -- yeah, it's talking: "This will be achieved by appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance." Is that what's not in place?

A. I think we're still only funded to first treatment.

Q. And is there agitation or advocacy around this?

A. Yep.

Q. As far as you know?

A. This has been spoken about for a long time. It is known to the people who lead our cancer services that this is appropriate.

Q. What would be the utility of it from your perspective? Can you paint for us some examples of where you see the potential for patient safety or patient risk if this isn't in place?

A. It's hard to think of examples straight off the top of my head, but there are some cancers that we survey or monitor for very long periods of time, bladder cancer would be one example. Some of the prostate cancers, fall into that category. So those would be the patients I think who would benefit from that process. It would be very resource intensive. You know, the trackers are currently tracking perhaps 700 live cases. So that's a lot of people to keep an eye on. If we went to the whole of pathway tracking, that number would invariably increase, and if we had some form of tracking mechanism for all those patients who were on forms of monitoring and surveillance, my own personal workload of cancer patients probably comes into the range of three or 400, minimum. So you multiply that out across the team, you can have an idea of how many patients we're talking about.

Q. In terms of -- you mentioned a moment ago that there's now I suppose better accessibility to the cancer side of management, whereas it was painted in fairly bleak terms within the SAI reports. There was talk of a disconnect between the MDT and cancer side, and I think you've echoed that in your Section 21 statement. In what ways has that connection been "enhanced" probably isn't the right word if there was not much there to start with?

A. I think the key appointments have been those of Angela Muldrew and Mark Quinn, because they are then able to work with the MDTs across all the different specialities to provide the kind of audit

support and back office support, if you like, for the activities that we undertake. Secondarily, we have a new cancer service's CD. He's a medical oncologist. He happens to attend our MDT, which from my perspective is great because I have a direct line of communication, and that has given a new impetus to improving the governance and oversight of all of the MDTs. So you'll be aware that there was a piece of work following this report from Dr. Hughes that was undertaken by Dr. Tarek, who was the AMD for this service, and out of that then there has been lots of new changes, and I would say certainly in my experience with the Urology MDT, improved support for us.

'Recommendation 5 "This will be achieved by appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance."

To what degree has this recommendation been implemented and embedded into practice? What are the next steps to take to achieve this recommendation?

Q. Do you see a role as well for the CNS nurses in terms of, if you like, superintending the process to ensure that the care that perhaps was suggested or recommended by the MDT isn't forgotten about or isn't taken off in a different direction?

A. So I don't think they have a specific role in being the watchman, but they have definitely a role, as all the members of the MDT have, in ensuring that appropriate care is delivered to the patient, and they have clearly a role in advocating for the best interests for their patients as well.

Q. Just finally in terms of Mr. Young, were the comments that were being made to you in the context of his stone clinics or was it cancer care?

A. I've no knowledge of his stone clinics.

Q. I'm talking in terms of what the nurses were saying about his use of them?

A. So Mr. Young, when I first arrived, would have had a cancer practice alongside other aspects of his practice. In later years he has withdrawn from the cancer practice. So, I think what I am reflecting is when he was doing an Outpatient clinic in the Thorndale Unit he may not have had the CNS in the room for all of the consultations. He may have, and I am presuming this, he may have used them at other times, he may have asked the CNS to see the patient, I just don't know, you will have to ask Mr. Young how he practised that. But it is my understanding that the nurses would not have been in the room for the whole clinic in the way that they would have been for mine.

Q. In terms of what has come after these revelations, has work been done to reinforce amongst your colleagues the primacy or the importance of the key worker role in both cancer and benign care, where the patient wishes to have them?

A. I think as consultants we all accept the importance of the CNS role, and we try to involve the CNSs in - I think they're in nearly every aspect of what we do in an Outpatient setting, both benign and malignant, or cancer.

'Has work been done to reinforce amongst your colleagues the primacy or the importance of the key worker role in both cancer and benign care, where the patient wishes to have them?'

When was the last audit done on the availability of CNS nurses to meet the request of patients to have one accompany them on their treatment pathway? What did the audit show and have there been any subsequent actions?

Q. Just stopping there for a moment, in relation to triage as it currently is -- I know we've have confined it to 2019 -- currently, what's the position regarding triage? Is that something that is manageable and managed by the consultants at the moment?

A. Well, we did advance triage in 2019. It's no longer completely advance triage now. But, yes, I still fulfil all the triage would be in the on-call week.

Q. And when you say it's not advanced triage now, has the system changed again somewhat since 2019?

A. It has, yes. So we used to do advance triage for a lot of the patients, especially the red flags and the urgents, and even just for some routines to try and prevent them from having an appointment if they're not required. Given, however, there is very much a lack of consultants and the backlog, in doing advance triage at current, what that then does is if you have a hundred patients to triage and say you do a hundred scans, when are you physically going to follow those up? It's not physically possible, at present, to do advance triage in the way we used to do it.

Q. And that's because of the numbers, the staffing numbers?

A. That's due to staffing, yes.

Hopefully, with the three new consultants arriving in spring 2024, it will be possible to increase advance triage again.

Q. "what appears to have gone wrong is failings in a process, a process of ensuring that concerns of staff shortages from a doctor and nursing perspective are addressed to provide suitable care, a process of ensuring that regular audit of processes is undertaken and disseminating to the department. Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided." Now, your experience has focused on the staffing issue that you consider were the contributor during that period of time. The Inquiry has heard evidence more broadly. But the mention of the audit, the regular audit of processes, what's your understanding now of what the audit of processes are that are undertaken that would provide some reassurance about the non-reoccurrence of the issues that we have been discussing?

A. Well, it's probably best to split that between benign and then cancer because I can speak of my experience of being with the MDM, the audit processes that are now in place are very reassuring -- they are reassuring to many parties, to patients, but also to as yourself, as a clinician, you want to know that what you are doing is right, and what you're doing happens, and so there is an audit process in place to make sure the decisions that are made are undertaken. There are audit processes to show that are the right number of people at meetings and, if not, why not? So audit is massively important.

'Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided'

Moving towards a high standard of auditing throughout the Trust should enhance safe and quality care for patients, and give assurance to staff and the public.

Q. "The urology MDM was under-resourced for appropriate patient pathway tracking. The review team found that patient tracking related only to diagnosis and first treatment. That is the statutory targets of 31 and 62 days. It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care." The point that's being made there is that this MDT, in terms of its governance, did not have a facility that scrutinised the progress of the patient along the care pathways. So if delays in referral happened, for example, it wasn't spotted. If referral didn't happen, it wasn't spotted. Can you help us with your own experience, particularly in the public

sector in the NHS. Was there good governance, and was that governance around ensuring that patients got what they were expected to get in terms of treatment?

A. Well, in general they did but I think you have to recognise that the system is overburdened, it's swamped. I think I read that Mr. O'Brien's hospital was getting 160 referrals a week, urology referrals a week, and we'll come on to talk about triage, I'm sure. Of those 160 patients referred in urology, at least half would have cancer. That's 80 patients that need to be discussed every week, and you have a waiting list that's getting longer and longer and longer. Inevitably, delays will come because patients are not coming in to be treated, and you have emergencies pouring in through the Accident & Emergency Department. Inevitably in such an overloaded system, you are going to get delays. It is really hard for individual clinicians to look after their individual patients, or build in systems in a hospital whereby these sort of errors that we're seeing in these cases are bound to occur. I'm afraid COVID had compounded that enormously. It is a system right across the NHS, not just in Northern Ireland, where we're seeing the system is overloaded. Clinical Nurse Specialists will help; a really active MDT with a full complement of different specialists will help, but inevitably some cases are going to get delayed and lost in the system because there's too many patients.

Q. Yes. In your experience would an active, job-specific tracker assist in the process of ensuring that care was delivered appropriately and on time?

A. Yes. You could call a tracker an MDT coordinator, because it's so difficult for the individual clinicians when they have to operate and do Outpatients and dictate on their clinics, and so on and so forth. To try and to keep track of all your own patients is almost impossible. I think one or two of the cases illustrate maybe Mr. O'Brien didn't prioritise some of the really urgent cases as well as he could have done. The patient with the penile cancer, for example, was rather slow; methodical but too slow in the way it was dealt with. An MDT coordinator with a specialist nurse badgering and liaising directly with the patient would definitely have improved the situation.

Is the role of a job-specific tracker/coordinator in MDTs clearly defined? How realistic is the provision of a tracker in MDT's?

……..

Q. Do you accept that this was a period of time where the information was there, people knew what was going on and there was a failure to grapple with the patient risk issue that was at the heart of this?

A. 2016 was very important. I agree fully with what you're saying. There was a missed opportunity there. I don't think we realised the volume of what we were talking about but, certainly, here's a further example that should have been escalated. It's only been picked up whenever the patient is coming through the system again. So it's knowing -- it's getting ahold of those untriaged letters was the crux of the point.

Q. But it was perfectly obvious to some, wasn't it?

A. Yes.

Q. You might say it wasn't perfectly obvious to you, but if the letter has not come back, there's a way of tracking that isn't there?

A. Yes, it is via the booking office, not knowing it's coming back

Q. As clinical lead, you didn't take this forward?

A. Well, these are the minutes of the meeting and I had thought that they had gone higher. It wasn't me taking the minutes. I had thought that they had moved on but I have been told that they weren't.

Q. I suppose if you, as clinical lead, are not going to bring this issue forward, whose responsibility should it be?

A. I thought these sorts of minutes go to -- if we're taking a minute from the departmental meeting, it goes to Martina Corrigan and I would have thought that, you know, it would go up the chain from there. I didn't take it to the AMD or any level like that. These were discussions that we had on that day and taking them further, I'm not aware. Apologies.

Q. Just to reconcile that from a position where a failure to triage had caused considerable difficulty, of which you were aware, for a large number of patients and here you have a meeting which is getting close to looking at those kinds of issues through the lens of you clinicians, some of you are struggling with the whole concept. Surely, recognising the problem, there was an onus on the clinical lead to take these matters forward and make sure they were addressed?

A. I accept that.

Is the SLT confident that clinical leads in the Trust are following through on their reasonability of checking that issues discussed and that are to be escalated higher at departmental meetings have actually done so?

Q. Now, you observe in your statement -- maybe just bring it up, WIT-103617, paragraph 6. So you personally discontinued the use of glycine when the new resective scope system was on site. And you understood, next paragraph, the other urologists had also changed to the saline system. Why did you change? Did you feel it was an obligation to change given the direction signaled by the Chief Medical Officer's office and the adoption of a policy by the Trust?

A. Yes. It was a directive. But, in saying that, having used the use of glycine for 25 years and well used to it, I observed that this was coming through as a safer option. It was easy to learn and, as a comment, that the use of the cut and the diathermy were not quite as good as the glycine, but was a fair swap because of the safety issue.

Q. You go on to reflect there, paragraph 6.9, that you were aware, and we've seen the emails, that Mr. O'Brien did not like the saline system, he regarded it as an inferior system. You personally thought he needed a further period of time to get used to the saline system. It has only come to your knowledge recently that he never did convert to using saline and continued to use glycine. How was it not obvious that he had failed to make the transition?

A. We all operate independently. I don't go to Mr. O'Brien's theatre list. I don't think any of the rest of us go. We all have our theatre days, and there's very little overlap. I had thought that, and again hadn't heard until I directly asked the question from theatre, had he actually moved over. So I thought that we were –

Q. When did you ask that question?

A. Very, very recently.

Q. Yes. Of course, upon the purchase of the equipment it might be suggested that clinical lead or perhaps the clinical director would assemble the team and say, right, we have the equipment, you know the policy, you know our expectation, I expect each member of the team to enter into a

commitment to use it, because it is safer, it has been directed upon us by the CMO. Was there no such conversation or communication with Mr. O'Brien?

A. I think there was the expectation that he would move like the rest of us too. I don't remember him informing us that he had not moved over. I agree, it's a question maybe I should have asked. This is a theatre directive as well. It's not just me in the department –

Q. Of course?

A. -- it's not just me in the department asking the question. There's CDs and AMDs. I'm not entirely sure if they knew Mr. O'Brien hadn't moved over either.

Q. We can see, if we bring it up briefly, it's the policy or the directive coming down from the CMO at WIT-54052. Under the heading of "monitoring", it is said that the Trust's audit department will need to monitor that the recommendations are implemented. An audit would have revealed outliers in terms of the expected practice, enquiries aware of no contemporaneous audit. Was this matter audited?

A. Not to my knowledge.

Is the SLT confident that the system that is now in place to monitor the directives from the CMO that come with recommendations of being audited, is functioning well?

Quorate

Quite a few MTD meetings were not quorate.

Do the services that are currently provided meet the professional assurance and standards and regional guidelines? Good audit and data collection are necessary.

The importance of MDT meetings being quorate – with the right expert representation.

How is this system monitored?

Western Trust 98% quoracy at MDT meetings – not the same in the Southern Trust.

How is this measured now and what is the figure?

……..

Q. You do mention as well in your statement about the MDMs and the quoracy issue. We have heard something about that yesterday and have and will do from other witnesses. Your experience that was if there wasn't quoracy, then at times patients discussed at regional meetings. Can you just explain that, how that came about?

A. If there wasn't a radiologist on hand and a decision was pressing or was time-sensitive and needed to be made, that patient could have been added on to the regional meeting. It's not that they -- if we'd had a radiologist, that wouldn't have needed to have happened, but that's on occasion what did happen in order for the patient to proceed down their pathway.

Q. You have said that can lead to a delay in decision-making. Was that because of the infrequency of the regional meeting or because of some other reason?

A. Because the regional meeting is for specific cases that need to be discussed there. Had we had quoracy within our MDM, some of those cases that were discussed there perhaps wouldn't need to have happened there, so it's maybe putting stress on another MDM when it was really our responsibility to have a quorate MDM to have them discussed there.

Q. In practical terms, if a radiologist was absent locally and there was one available regionally, they could use their expertise?

A. Yeah, on occasion.

What percentage of patients currently are discussed at regional meetings due to lack of MDT quoracy in the Trust?

Q. The second point is the quoracy is low due to low clinical oncology and radiology attendance. It had been, in October 2017, 25% attendance and it was now 11% by May 2018. You say that only five meetings were quorate throughout 2017 and it is perceived that this has decreased even further. "Therefore, more patients are not benefiting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision-making process and treatment. 3. Long waits for routine referrals. Due to increasing number of referrals, services concentrating resource on meeting red flags and urgent demand. Routine referral waiting times have increased from 52 weeks to 128 weeks, present day. Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded." The Inquiry has heard evidence that routine referrals, sitting back, not getting priority because of the red flag in urgent referrals, posed a risk to patient safety. I presume that's something that you would agree with?

A. Yes.

Q. In relation to the quoracy, you have identified there delays in decision-making processes in treatment. So, the level of oversight that perhaps is anticipated by full attendance at MDT for Cancer Services is absent if quoracy is not met and the right people aren't round the table?

A. That's right.

What are the 2022/2023 quoracy figures for MDT meetings in Urology and cancer?

……

A. Yes. So, there is an issue about how quoracy is counted, okay? And I'll explain that in a moment. But we now have the situation where we have two radiologists, and that has helped a lot. We are also in the position where we have a single clinical oncologist linking in from Belfast, and her attendance is probably in the order of high 70s to 80%. We have two medical oncologists, one who usually physically attends the meeting and the second person links in by video. So, those aspects have improved. However, when you count quoracy, you have to count all the core members. And if one of those core members is absent, you're not quorate that week. So, as you can see from the top line there, on that particular week there was no clinical oncologist. So, technically we are not quorate. Quoracy has never really been an issue for pathology, urology, clinical nurse specialists, and the tracker, the coordinator. So really the quoracy issues lie in radiology and oncology.

Q. And, of course, one always will anticipate that there will be a meeting here and there where one of those disciplines can't attend.

A. Yeah.

Q. And you've explained the setback that that causes in terms of some cases. Because, as you say, you don't necessarily need an oncology discussion around every case, or for that matter a radiology discussion around every case?

A. That's correct.

Q. But I'm just trying to assist the panel to gauge where we're at now in 2023.

A. We're in a stronger position, but we are reliant on a single clinical oncologist. And if that person is sick, or that person takes leave, then we don't have their valuable input

Quoracy is an issue that has come to the fore several times in the Inquiry. Is there any further guidance that the SLT can give on the challenges of meeting the quoracy standard?

Job description, appraisal, and handover

It was noted, more than once, that there is an issue with having proper job handovers.

Q. Can you recall receiving a hand-over from the outgoing Clinical Director?

A. No, I did not receive a hand-over.

Q. Just so we are perfectly clear, there was no orientation, say, from the Associate Medical Director, the Medical Director, the Assistant Director?

A. No.

How is the Trust monitoring the importance and delivery of the hand-over process?

Has guidance now been implemented throughout the organisation?

Has the job planning and appraisal system been over hauled?

Is it correct throughout the Trust – you are assigned an appraiser, an independent person who is not within the speciality?

Quality of care and patient experience is key in appraisals

…….

Q. Could I put it into these words and you can tell me whether you agree? You were seeing a situation where operational and clinical managers were alleging shortcomings on Mr. O'Brien's part. You were also seeing or hearing about successful appraisal, if I can put it in those terms, and revalidation. Your questions, presumably, were in circumstances where this clinician is said to have significant shortcomings in his practice, is our system of appraisal working appropriately or effectively. Is that what you wanted to look at?

A. I suppose it's even before that. The link of appraisal into the job planning and also beyond that, of linking appraisal into performance, management, clinical governance, all of that needed to be looked at. There was kind of joined-up working between the so many elements of professional governance and clinical governance which we are aware now were not as robust as they should be. I was trying to indicate that although it's not an immediate issue which is obvious now, but in my experience -- I was heavily involved in appraisal and revalidation and job planning in my directorate, and I found it a very

useful tool to be able to identify, to support, to make sure that the safety element is there. That was the thinking in my mind at that point in time.

Is the system of appraisal working effectively now?

……..

Q. When Mr. O'Brien took those two months out to do his appraisal during the investigation, did you ask to see the appraisal, as a matter of interest, which was happening in the middle of the investigation? It might have been quite enlightening.

A. No, I didn't ask for appraisal to be seen. I was interested in the appraisal and revalidation purely because when it come to me -- this information came to me essentially at the beginning of the investigation, that Mr. O'Brien was successfully revalidated and had appraisals. I was interested to know what was the process behind it and how was that not linked, why it wasn't linking to his job plan and other elements. I was interested in the bigger picture of the appraisal feeding into the professional governance, the revalidation, and also the job planning going into the whole process of not necessarily identifying just the identification of concerns but also supporting the doctor, making sure these are professional governance arrangements, and why they have not been coming together.

Q. Then there was a delay in the job plan as well. That never came through, I think; is that correct?

A. Unfortunately, I understand it never came through. It was progressed to the level to Mr. O'Brien for agreement but I don't think it was completely agreed and signed off from both parties.

Has the Trust recently reviewed its policy on appraisals, job plans and revalidations?

……

Q. We will bear that reflection in mind and explore it for what it means shortly. But can you tell me from an organisational as well as an individual practitioner's perspective, what is the importance of job planning, in your view?

A. I think it's really very important. It's the key contractual document that should be a partnership approach between the consultant and the Trust to identify the supporting mechanisms that are needed to allow consultants to deliver the work. It's an opportunity for them to discuss with their clinical manager what is expected of them and what they will need to enable them to deliver that for the year ahead. So, it's very much a performance management type of tool in the sense of having those meaningful discussions to decide how is it possible to deliver the work that has been assigned, and it should also then feed into demand and capacity information so that that's driving the job planning discussions.

Q. You mentioned demand and capacity. Is job planning a tool which can address that issue?

A. I believe it has the potential to. I think that's the original intention of it in relation to it should commence with a review of what the service needs to deliver for the year ahead, with the service. That should be considered and then designed into individual or team job plans with job plan objectives to align, taking on board what supportive resources or supporting mechanisms a consultant may highlight at those meetings that are needed to deliver the service. It allows then the service to ensure that objectives are aligned and job plans are aligned with the direction of travel that the service has to deliver and commission to.

Currently - how streamlined is the flow from individual job planning to the objectives and direction of travel that the service has to deliver?

Q. I suppose, used properly, job planning, if it's actually done, will leave the employee, the clinician, with an understanding, and the manager would have an understanding, as to what's expected, and failure to deliver on what is expected will lead to questions or challenges being posed; is that fair?

A. That's fair, yes.

Q. It provides a basis upon which inquiries can be made?

A. Absolutely.

Q. Those inquiries could potentially lead to a disciplinary route; is that fair?

A. Yeah, potentially, yes. I mean it's a contractual document so it's a contractual requirement on both parties to participate in it.

Q. Equally, in some cases the failure to deliver on objectives within a job plan might raise a wide range of other issues, the need for help or assistance?

A. Absolutely, yes.

Q. It may lead to conclusions in relation to how well the service, how well the employer is assisting the employee, supporting the employee to deliver on the plan. But it's important to have that baseline, isn't it?

A. Very important, yes

Taking time to establish a clear baseline for the contractual document between the employee and the employer is key to understanding and delivery.

Q. Okay. You described very eloquently potential uses of job planning?

A. Mm-hmm.

Q. The challenges, which I think many Trusts face; you would not be alone in that?

A. Yes.

Q. Again, have you an agreed strategic approach to this for the future led by a senior doctor who is saying this is what we are doing?

A. I think that's what we are moving towards. We have had early discussions with our local negotiating committee that this is the area we want to focus on, and our Medical Director is fully behind that and that's the direction we are going.

Q. Have you ever used job planning as the tool you described it could be used as the basis for disciplinary action, if somebody is not fulfilling their job plan? Has that ever been done actually?

A. Not to date, no

Q. Has it ever been done the other way around, to say this consultant can't fulfil their job plan and they need support?

A. Yes. No, I think that does happen, you know, in terms of some of those areas which are very good at job planning. I think our focus is we want to get back to the importance of a job plan meeting and actually having a face-to-face meeting.

Q. Have you actually taken a consultant to say you are not fulfilling your job plan, this is a problem, you have to do something, we have to do something together?

A. Yes. No, we haven't got to that stage, no.

The importance of having a face-to-face job planning meeting

…….

Q. Now, did Mr. Carroll give you a briefing as to what had occurred in the years prior to your taking up post that had raised governance issues?

A. Not with regard to Mr. O'Brien. He did give me a brief of the issues that were current, which were around the three sites, which was the Urology ward. There were a lot of risk issues in that ward at that time, and workforce issues, and a lot of quality indicators in terms of care. We put together a response to that with the corporate nursing team as well to try and stabilise 3 South. But that was the real emphasis for Urology in 9 June '19.

Q. So, the emphasis was on the immediate –

A. Yeah.

Q. -- issues that you were facing. Did Mrs. Corrigan ever raise the issues with you about what had preceded your tenure as regards governance?

A. No. Again, I believe that those were felt to be in hand at that point in time.

Q. Are you saying that with hindsight?

A. I am saying that with hindsight. I didn't know about them at the time, I wasn't sure of that. But as things emerged, that was my perspective, that they probably felt they were being managed.

Q. Knowing what you know now, do you think that you should have been told?

A. Absolutely.

Q. If you had have known then, what would you have done to reassure yourself about what was in place to prevent any reoccurrences or to ensure good governance?

A. I would have wanted to understand what range of intelligence there had been, not just that led to the MHPS but before that. So, I would have wanted a chronological list of all of the issues that had been raised over years or all the concerns that had been raised over years, but in particular the MHPS and the recommendations from it, and the monitoring processes and the impact of those.

As one of the learning points from this Inquiry - what measures are in place to ensure a full handover process is seen as a priority for people taking up a new post?

Q. We know that Mr. Weir, by September 2018, had produced a job plan and left it with Mr. O'Brien

A. Yeah.

Q. -- to agree or disagree?

A. Yeah.

Q. It was never, ever finalised, it was never, ever signed off. Did you take any interest as Director of Acute Services in trying to drive that towards a conclusion?

A. With the job plan, no, I didn't, to tell you the truth. The job plans were very much the medical side of the house, the professional side. For some reason, though, I always had to sign them off at the end. I always felt uncomfortable because I didn't know what I was signing but the Director had to do it. But these were very much led by the Medical Directorate and not me.

Is it appropriate for the Director of Acute Services to sign off 'medical professional' job plans?

……..

Q. You say in your statement that you didn't receive a handover as such?

A. No.

Q. Is it right?

A. That's correct. Dr. Boyce would have been supporting the Director at the time but there was no formal handover from a previous sort of full-time coordinator.

Q. Just in terms of the importance of a handover, Patricia Kingsnorth, when she gave evidence she said from a handover point of view, you handing over to her as you were exiting you were able to give her 45 minutes of a handover. First of all, are handovers important in your view? And the handover that you provided for Patricia Kingsnorth, was that adequate?

A. Handovers are important. And I think in retrospect 45 minutes probably wasn't enough. Although I was there on the end of the phone or if she needed any other guidance or support at the time.

The importance of setting time aside to complete a full handover.

Q. So, you make the point that you're the subject of appraisal for the purposes of validation, and it's said on a number of occasions, so I get the impression that you think it important to say it repeatedly that this is not a performance related review, and in answer to other questions you make the point that consultants are outside of the performance management loop. Tell me about your thinking on that. Are you suggesting in those answers that you think it would be a good idea, in light of experiences within urology services at the Southern Trust, and perhaps elsewhere, for you and your colleagues to be subject to some form of performance management?

A. Yeah, I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.

Q. You refer to it as, I don't think I need to bring that up on the screen, it's paragraph 47.2. You seem to value the opportunity, if it had stayed like this, for a confidential reflective exercise in professional development; you see advantages or benefits in that. But what you say is that the process has now morphed into something akin to bean counting - my words - it's a formulaic capture of documents - your words?

A. Yes. I think bean counting is equally good as a descriptor.

Q. So, moving from the positive side of that spectrum to the negative, why was this opportunity for reflective discussion around professional development, why was that useful and what has it now become?

A. So, when I first became a consultant, the appraisal process was between two peers and was largely a discussion, and you felt that you could have a confidential discussion about the challenges that you faced, the difficulties that there were, perhaps share the successes that you'd had, all of that kind of thing. Now nobody's really interested in that. They just want to make sure that you meet all the domains that the GMC have set out, that all of those -- in our Trust they use an electronic method for capturing all of that, I think it's common across Northern Ireland, and, you know, as long as you've got a tick in every domain, that's really what it's about. You know, you can see from the spread of specialties that have been my appraiser, many of them don't have that much insight into my specialty. Maybe I don't have that much insight into theirs. So, you know, there's something of questioning the value of that conversation. They don't have the performance data, they can't possibly meaningfully interpret the performance data in the different specialty, you know. How would, for instance, an emergency medicine consultant interpret the data of a surgeon? It's difficult for them, I would think. It would be difficult for me to interpret the outcomes of their work. I don't do their job.

Q. So, if, as you imply, it is, to use another metaphor, a box ticking exercise, are there implications of that if, for example, the practitioner has some frailties or –

A. So, a point that was made to me by Robin Brown, who was at one time CD for urology quite some years ago, and more laterally has been one of the senior members of the revalidation team, he said to me "I'm not looking for all the good points in your appraisals. What I'm looking for are the little indicators that there are problems", and I think that's largely what it has become, and it may be very difficult through this appraisal process for the Trust to actually pick up where there are problems. Not too many people present warts and all in their appraisal, I would suggest.

Q. And your seeming endorsement of some form of performance management, whether integrated within the appraisal process or standing separately from that –

A. I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.

Q. Knowing what we know, and there may be a bit of a debate about what precisely we know has emerged out of urology services in the last few years, particularly arising out of the processes relating to Mr. O'Brien, do you see in that particular context a specific merit around performance management or –

A. Yes, I do. Because I think if you identify these things at an early point and they're out in the open, then it allows the team to, first of all, identify and name the issue and, secondly, then to think of ways that the team can address the issue together. It means a more consensual collegiate way of working, you know. So I think there are merits to that.

‘I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.’

‘I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team,

what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.'

What is the view of the SLT on this approach and suggestion?

……

Q. Could I bring you to a reflection from Mr. Glackin around the appraisal mechanism. If we go to WIT-42316. If we go to the top of the page. He expresses the view that the appraisal process has morphed from a confidential reflective exercise in professional development between two professionals which, elsewhere in the statement he welcomes and, like you, found extremely useful, but it has, as he says, morphed into a formulaic capture of documents, such as reflection on complaints, records of continuous professional development, through evidence a recommendation for revalidation by the Trust's responsible officer. In other words, I think he agreed with my re-characterisation that that is either bean counting on box ticking. I forget the metaphor I used. But I think the point he's making is quite clear. Has that become your experience, that there has been a change in the character of the process, or do you still remain relatively content that it is a positive experience?

A. Well, I can probably only speak from my experience. I mean there certainly is where you're collecting all the documents, but they're essential because they're evidence of engaging in various activities to support your practice. I mean, I have had confidential discussions, I've reflected with my appraisers, and so it hasn't been my experience. Perhaps I had a good experience, but it -- and I found it -- and I put a lot of work in and, as a result of that, I try and achieve everything that I've set out to do for the following year. It does set -- it does give you a focus of where you want to go. So I found it useful.

Q. Have your appraisers been external to Urology?

A. One of them was internal, it was Mr. Young, but the other three them were external. One in Radiology, A&E, and aesthetics, so I've had four.

Q. Is there something, if you like, to be preferred from using a person from another discipline to conduct the other?

A. I think it is probably a good idea in that they can be, certainly, more objective. You know, if I'm a colleague of yours, I mean you mightn't be as hard on me as perhaps somebody else might. I'm only surmising.

What is the current guidance on using an external appraiser for appraisals? How practical would it be to make this a desirable requirement?

Q. In terms of the handover, we've obviously got a picture of turnover amongst the consultant staff, particularly during those years until perhaps relatively recently when things may have settled down to a degree. To what extent is the handover problem well addressed at this time?

A. There is still no policy in place, to the best of my knowledge in the Trust, describing how this process should be managed. Within our own department what we have been doing, we've had a number of locums in the last few years and we've had other members of staff retire. So, for instance, from the cancer perspective, those patients who are coming to MDT where it is clear that that person has retired or left the Department, those cases are shared out formally and they're handed over to a new

named consultant. From a results perspective, when somebody has left employment of the Trust, we have agreed to share out the results of those people and divide the workload between the existing consultants.

'Q. In terms of the handover, we've obviously got a picture of turnover amongst the consultant staff, particularly during those years until perhaps relatively recently when things may have settled down to a degree. To what extent is the handover problem well addressed at this time?

A. There is still no policy in place, to the best of my knowledge in the Trust, describing how this process should be managed'

Is this still the case?

Q. ''custom and practice went unchallenged with respect to the timeliness of correspondence, triage, monitoring of volumes of activity and chronological listing of cases for theatre." So is part of your concern here in terms of what we learn from all of this is that, as I think we discussed on the last day, performance management, more focused performance management is key to getting at the problems at the earliest possible stage?

A. I think we need performance management. I think we also need openness and transparency in terms of job planning and what people are delivering and what they're expected to deliver. You know, practice. Even amongst a small team like ours, we all have sub-specialist interests and, you know, it may not be possible for us all to see equal numbers of patients, but we should be expected to deliver a reasonable volume of work, and that should be agreed, and we should be monitored to ensure that that's happening, you know. I think, you know, timeliness of correspondence and completing triage in a timely manner, all of that stuff should be formally agreed, it should be, you know, recorded in a job plan, and it should be recorded in a policy for the Trust.

A clinician recognising the constructive role of performance management and the need for openness and transparency in job planning, what people are delivering and what they are expected to deliver – suggesting that this should be a Trust policy. What is the SLT's view of this suggestion?

Q. Yes. I wonder is your slight awkwardness or discomfort around this reflected in something Mrs. Corrigan has said, if I can ask your comments on this -- if we go to WIT-26304 and at I think it's paragraph E, she's reflecting some learning arising out of, if you like, all of this. She says: "In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. For clinical staff, they need to know who this is and what authority they have as their accountable..." -- and I think that should say "manager". "It is my observation that there wasn't a clear line of accountability of management while I was in post. So whilst the consultants were directly accountable to their responsible officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a clinical lead, Mr. Young, and whilst I believe it was understood that he should be managing the rest of the urological consultants, Mr. Young never had an actual job description outlining what this should entail and, from my recollection, only got 0.5 of a PA to be the clinical lead, so I don't believe that he ever felt that this was his role, although this would be a matter best addressed by him." And here we are! It's set up for your comment, I think. She's speaking in tolerably clear terms, but, to paraphrase, is she echoing something of what you've just recently said, that, really, you didn't accept that you were the manager of these collection of Consultant Urologists in the kind of sense that she's describing -- that is with authority, telling them to pull their socks up if they needed to pull their socks up, and...

A. That's spot on. It's a small group. It's a small team. It's very important to get on to make the thing -- to make the work gel, to make the whole as a unit gel. So it's hard if it's -- if you're put on the spot. If someone needs to be put on the spot, that's fairly obvious, but, you know, I felt a bit pressurised on that front and I thought it was an unfair ask, if you want to put it that way.

Q. Yes. Plainly, you took the role on in or about 2000, give or take?

A. Yes.

Q. It's in much different-looking shape than it was in 2014 when you have five or six consultants, albeit for a short time, as we discussed earlier.

A. Yeah.

Q. Do you feel that the expectations that came with the job changed throughout that time?

A. Well, like most things, they change as they move on. I mean, I saw the role as a service-driven, sort of organisational job. I would have represented the unit at such things as our THUGS Committee -- that's our theatre users group! So I would have represented our unit for that to report to the Committee on what we wanted from Urology, and maybe backwards from that Committee to the rest of the team. I saw my role as leading on if there was any sort of major sort of project to get through, that would have been -- for instance, actually setting up the ICATS service on the 2009 process of how we're going to get this into the unit; I sought -- there was the saline resectoscope issue -- I sort of took charge in trying to process that, to make it happen, and maybe facilitated the departmental meetings. But, again, that was trying to get people to get round the table. And, again, I might have sort of managed the staff grades in a little bit more detail, albeit that the staff grades contract, their next in charge was actually the CD, I believe; it wasn't me.

Q. Yes.

A. Although I took control of it.

Q. Yes. And, in many ways, your pre-empting -- I'm not criticising you, by any means -- some of the bigger ticket items we'll explore through your evidence to see how they managed and to see how they both reflected on your role and how what they say about, I suppose, governance in general. Just before I leave what Ms. Corrigan has said, and it's up on the screen, she adds the sentence that she felt or she feels it was unfair, in any event, to have peers attempting to manage peers, as these were their colleagues and it was hard to hold them to account when they were of the same grade. So I think that's echoing at the very heart of your discomfiture –

A. Yeah.

The importance of post holders having a full description and understanding of their role with a clear line of management accountability. How is this monitored?

Q. Let me pick up on some of that. This was in part about changing culture, it was getting the system of appraisal in the mainstream. As you say, 40 to 60 percent, you got it up to close to 100 percent. At that level it was a success. I suppose if this Inquiry is looking at, I suppose, methodologies or instruments by which a Trust can pick up on doctors in difficulty, doctors not performing as they are expected to, if that's one of the Inquiry's interests, the Inquiry, at least going back to the early days of appraisal, the Inquiry would be wrong to think that appraisal was focusing robustly or rigorously down on that kind of issue. It wasn't about that, really?

A. No, and there's been criticism from the BMA and others since then where appraisals have been in some Trusts used more for performance. That, I think, isn't the right way forward. There has to be, if you like, a back-up to say, well, we're also going to look at your performance and adherence to guidelines and, you know, what we want you to do as an employee. This is about you telling us how you want to get better and can we help you.

Q. Right.

A. So it couldn't really -- I think there's a gap there in terms of performance management.

Q. Yes.

A. I tried to introduce it at the AMD level. What I said to all the AMDs was I want you guys to come up with your own performance targets for every year.

Q. We'll come to the AMD. Let's just step into this training document as a source to help us understand aspects of the appraisal process. If we go to WIT-25882. I think you've said in your evidence earlier the doctor's role includes identifying an appraiser for him or herself so they, in a sense, at that time got to select. It's for the doctor, at least in part, to identify factors that may inhibit performance. Of course, you say it was intended as informative as opposed to performance management. We see in Mr. O'Brien's case that he was appraised by his peer, Mr. Young, who was also clinical lead for five continuous years. Whether the purpose of the scheme is formative as opposed to management performance, that's not good governance, is it?

A. No, but it's a start because previously there would have been no requirement, really, to engage in appraisals. It was a start. There was a debate at the time as to whether or not a doctor should be appraised by someone from the same specialty. But what we tried to do as we moved on was to train professional, if you like, appraisers who could do that. I was in favour of that because my appraiser as an Associate Medical Director was Paddy Loughran, who was an anaesthetist, so I had to explain to him what I was doing in psychiatry, which is no bad thing. I believe the Trust now allocates appraisers, and I think it is changed every so often to keep things fresh. So, that wasn't ideal.

Q. As it says there, they have to identify factors that may inhibit performance.

Does the SLT think that the current appraisal system is fit for purpose? When was it last audited?

……

Q. Maybe it comes back to something you said on the last occasion, about, I suppose, a sense of awkwardness or reluctance to be able to challenge a peer about an obvious shortcoming in his practice. We've seen how in the past you've helped out, I suppose, rather than have a confrontation.

A. Yes.

Q. This was clearly a time for a confrontation, was it not, whether you to him or by escalating it to a clinical director, so that this could be finally resolved?

A. Yes, that's a fair comment, as a peer-to-peer that I could have, I should have. On reflection that's a very valid comment. But, having done this before and offered help and received, you know, it may have been more appropriate that somebody much higher than myself was actually doing that. And, potentially as a friend and a colleague, yes, I potentially could have

Could this point be a topic covered in all yearly appraisals for consultants in the Trust?

Q. So he is setting out in this form -- you'll recognise the format -- he's giving, in these boxes, details of his work. In terms of details of any other clinical work at 2.5 he tells you how triage red flag referrals when urologist of the week. It doesn't appear that that's interrogated in any way. Indeed it's a feature of the appraisals, and we'll look at these this afternoon, that his problems with triage are not addressed through this process. It is perhaps not obvious now, maybe with some hindsight, that he is telling you that he doesn't triage anything else apart from red flags?

A. I have gone over these appraisals and what's written in this first section is often a copy from the year before and it's only in recent times, when I have reviewed the whole document, that I saw that one line.

Q. It stood out for you as well?

A. Well, I have had to read the document several times. It's only in recent times that I've -- I saw that one sentence. Having done appraisals before, I accept that.

Could this text be used as an appraisal training example and learning point from the Inquiry?

Trust Board

Mr O'Brien's case was not discussed at Trust Board level until 2020. There is a space at the end of the Board meeting for AOB to raise concerns. Clinical risk was raised by Mr Haynes in 2019 but it did not come to the Board. Chair of the Board only had knowledge of SAI's via Dr O'Kane's report in September 2020. Governance connectivity and debrief were not rigorous in 2018/2019.

Are the processes and use of procedures operating effectively now with operational, clinical, and social care governance?

Q. An early alert was sent to the Department of Health in July 2020. The Trust Board was not notified until 27th August - there was a delay – why?

Was this the Trust trying to manage bad news?

What is your response to this?

A. It is a fair reflection to note that it was not a regular occurrence for information that was discussed at committee level to have any detailed conversation at the Trust Board.

…….

Q. "The document is not clear and at times we got completely muddled as to what their role actually is and how far they can go when contacted by a doctor through a process." I think you've just said, is that related to the O'Brien/Wilkinson experience?

A. Yes. Absolutely. I think Mr. O'Brien's expectation of the role of the designated Board member was not maybe something that was the same as our expectation.

Q. Unmoored from the O'Brien case, and based on your general experience in this area, and knowing perhaps the limitations of NEDs, no matter how enthusiastic or experienced they might be, what would you be telling the Department if they were listening to you? Is the appropriate role for a NED in terms of the relationship with the practitioner on one level, and in terms of their relationship with their fellow Board members going in the other direction?

A. Personally, I'm not sure there is a need for it. We certainly don't have it in any other, you know, non-medical staff group. However, I think the issue around maintaining the momentum is important, but I'm not sure that that necessarily has to be the role of a non-Executive. I think there are other ways to ensure that there is momentum maintained and maybe part of that is through the arrangements we have and the reporting through to a Governance Committee or onwards to Trust Board. But I just think that this is something that muddies an actual process. I'm not sure that it is terribly helpful. I think in fairness to a practitioner they might have an expectation, that is that they will step in and actually do something different.

Is there currently a clear understanding of the role of NED's within the Trust? Also, the role and expectation of a designated Board member?

……

Q. "I received broad general training on the MHPS Framework. The role of the designated Non-Executive Director was unclear and was highlighted as such by the trainer who, on several occasions, stated that the role was indistinct and that the Department of Health had been asked on several occasions for clarification but none had been provided." So, what did you take in respect of MHPS specifically and the training around that? Did you feel that it was beneficial, did you feel it gave you an understanding of your responsibilities?

A. I took away a general understanding of the role of the Non-Executive Director as the designated person, but in terms of the detail as to how they would actually carry out that role, I was still unsure of that role. With regards to the way in which it was actually delivered, there was an overriding comment made that, look, the role of the NED, if I can use that phrase, the role of the NED is indistinct; you have to search for it and you have bring it together, and this is what we have done for this level of training. At that stage I had no knowledge that I was going to be asked to undertake this role, so I was content that it was okay at that high level of understanding. On reflection now, I know that it wasn't sufficient.

Q. Do you feel it was part of your role to provide support to Mr. O'Brien? For example, sort of from an employer relations perspective or from a comforting perspective or beyond the role that you have described there, did you feel that formed part of your role as the Non-Executive Director?

A. I think this is one of the issues with the role of a nonexecutive director, is finding the word that best describes what the nonexecutive director will actually do as a designated person. I don't want to be pedantic about it but support can mean different things to different people. That's why I think there needs to be some sort of guidance material which describes the activity of the nonexecutive director. It could be supporter, it could be inquirer, investigator, it could be so many other things. But that wasn't clear within the guidance material, nor was that intimated to me. Whether or not Mr. O'Brien interpreted it in a wider degree, I can't stand over how he interprets that. I can give him what the guidelines say. But as unpacking that statement, that's most important.

More clarification and guidelines are needed on the roles of the non-executive director and the designated non-executive director.

Q. I suppose what I'm asking is were you accepting at face value that the Trust was telling you it's going to take longer than the four weeks and whenever that kept getting extended, did you just accept that?

A. Yes, because what else -- this is a -- what else was I to do? Was I to investigate that? Was I to bring people in and investigate that? Is the investigative part of the nonexecutive director a key aspect of it? If it is, then I doubt whether or not a layperson is the person to carry out this role.

Q. Who do you think then would have been more appropriate?

A. Someone placed within the health system, who is well trained. Because it is a well -- I believe now it's someone that needs to be well-trained, and needs to know the structures and processes within the nonexecutive director role. That person needs to know what he or she can or cannot do and what is expected of them.

What is the SMT's view on this?

Q. I think just to wrap up this bit about the board. Again I can be corrected if I am wrong, but it seems like the Trust had received a confidential update on 27th January regarding Mr. O'Brien's exclusion. Then it appears that the board isn't told anything until the Early Alerts in and around September 2020; is that right?

A. That's correct.

Q. So they hadn't been informed of anything in the interim?

A. No.

Q. Do you think that there's a governance failing in that?

A. Yes. Put simply, yes. But I think that the Trust was operating on what had been previous practice, and I can't verify that because I was only fresh into the Trust at that stage but that seems to me the way it was done. There's no doubt about it, that the board needed to be kept more informed, even at a general level, as to the progress of this investigation.

Is there more clarity now about the Trust Board being kept in touch with progress in an investigation?

……

Q. Mr. Devlin refers to reports that are sent up to the Board from the committees in his witness statement. He says that it is a fair reflection -- sorry, in evidence he said that it was a fair reflection that reports from committees aren't generally the subject of great debate or input at Board level?

A. Yes.

Q. Would that have been your experiences also?

A. It would. I think what the non-executive director members and the Chair of those committees would have brought for noting, you know, there would have been an update, maybe a verbal update on just what the last meeting had been about, et cetera. But I suppose the assumption was that's why you had the committee, the committee to do the work and to do the challenge, the discussion on behalf of the wider Trust Board. So, I would have said there wouldn't have been a lot of time spent on those at Trust Board.

Q. It seems that there was a slight shift, you have said, about the assumption in that assumption. Mr. Devlin states in his evidence: "It was not a regular occurrence for information that was discussed at committees to have any detailed conversation at the Trust Board." Then he goes on to say: "We did in probably October and November 2021 then begin to have a conversation about risk appetite and about what the process should be for escalating from committees to the Board."

A. We did.

Q. Given that was only in 2021 and given the historic nature of the issues before the Inquiry, do you think that conversation should have been happening sooner?

A. I think that's a fair comment.

Is the SLT confident that the Trust Board is now receiving and reviewing all the relevant reports and papers in accordance with the Trust's brief?

……

Q. So if you could wave a magic wand and resources weren't an issue what would you like to see happen in terms, first of all, generally in governance and more specifically what do you think is the one thing that would help prevent something like this inquiry happening again?

A. I think resourcing the teams appropriately, having sufficient resource to, both - at all levels, so making sure we had the right resource to make sure that the clinical workload was doable, having the resource within the operational teams to make sure that there was managerial time to make sure that actions were taken. From a clinical governance team it's making sure that the right number of people with the right skill set, the right training, the right time were available to review the incidents, take forward the proactive work, the education, the training, the audit, the triangulation of information, having data analysts that can actually really delve into information and show it in a meaningful way and having IT systems that mean that information isn't a challenge of going to lots of different systems to try and pull it together.

This reply could be a useful comment to feed into the discussions on outlining the vision for the next chapter in the Southern Trust.

Silo mentality – segregation operationally as opposed to integrated working

Q. SAI's seem to have been dealt with in silos – in different directives – not shared or given oversight by the Medical Director.

Is it possible to evidence that this is now different so that confidence can be developed?

A. There was not a corporate approach to Clinical and Social Care governance – there was a Directorate approach.

Has this changed?

A. There were also cross-site governance issues

What, if any, are the current cross-site governance issues – what plan is in place to address them?

A. There was a disconnect between the Cancer Service and Urology, they were not communicating with each other.

There is a need for more integrated working and joint ownership – how is this principle being filtered through the organisation?

……..

Q. You say in your conclusions towards the bottom of 912 for you, 01923 for us, that these are what you regarded as systemic failures by managers at all levels, both clinical and operational, to deal with those matters. What did you mean by "systemic" in that context?

A. I suppose the operational team and clinical teams -- the operational and clinical management teams provide the governance, the professional governance assurances. So, what I meant was that there must be failings at many levels in order to reach to this stage, both operationally and professional governance point of view. I was aware that these issues were raised at multiple times and they were not addressed by professional, clinical, medical and operational teams. So there must be -- I was trying to explore there must be other reasons and I wasn't finding that in the report. Therefore, I requested that there needs to be a further in-depth analysis investigation by the team which is independent, and they can do independent assessment and they should provide for learning for the organisation to go forward. That was my thinking, I suppose.

Q. Can I trouble you for an example of what you might have been thinking about, perhaps, for example, triage. You would have observed from your reading of Dr. Chada's report over a period of time, going back several years, triage was an issue being raised both clinically and operationally by management, but the issue was never resolved to the satisfaction of management so that a default arrangement was put in place whereby if triage wasn't performed, then the patient was placed on a waiting list in accordance with the general practitioner's designation. If that's a useful example, or pick another example of what you would seek to communicate in identifying this concern.

A. I suppose there were many examples, but more troublesome for me at that point in time was I could not find a valid reason that these issues were raised on multiple occasions and they were not addressed, so there might be a system-wide failure to get to that point. I was really troubled by thinking what's going wrong? Why is the system not working? There is a professional governance structure, there's a clinical governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.

‘I was aware that these issues were raised at multiple times and they were not addressed by professional, clinical, medical and operational teams’

‘There is a professional governance structure, there is a clinical governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.’

Have new lenses been applied by the Trust to monitor the safety netting so that there is concrete evidence that the safety of patients can be guaranteed?

Q. It's been quite clear from the people we have spoken to that although all the managers, medical and operational, were trying to do their best, there was a little bit of confusion at times as to who was doing what. So, the doctors tend to leave most things to the operational managers because they are so busy but when there's an issue with a doctor, it has to be managed by a doctor. It's my impression that this isn't as functional as it might be. Would you agree with that in terms of what you have seen for this Inquiry, and is it a more general problem in the Trust, or what do you think?

A. I do think that there was confusion about lines of management and who was to manage that area. I think that is an issue when it comes to senior clinicians and consultants in particular. There does seem to be this lack of clarity about what areas should be addressed by non-clinical managers and what areas need to be addressed by managers. I would completely agree with that, and I think

improvements in that have been made. I'm aware that -- I mean we did this investigation under Maintaining High Professional Standards, and we wrote out to people and said to them this is what we are doing. I'm not entirely convinced that people always knew what that meant, and particularly non-medical managers. However, it was explained to them. I think non-medical managers are anxious about managing doctors.

Q. And what's the solution to that?

A. I think there has to be a closer working with non-medical and medical managers. I think the problem, looking back from my time as a medical manager, the problem is you are not actually given enough time to do the medical management role because you are trying to manage performance but you are also trying to manage other governance issues, you are trying to manage SAIs, you are trying to go to 101 meetings, you are looking at service development, you are looking at quality improvement. You have two sessions a week perhaps and you are trying to do too many things in that short space of time. You try to do those to the best of your ability, usually outside of work time. So I think more time, more protected time to properly engage in management is, I think, required.

What consideration is being given to provide adequate time for more aligned working between non-medical managers and medical managers?

Q. You talk, helpfully I think, that categorisation of the initial concern can make a significant difference to how a case progresses with the distinction between capacity with options for assessment and remediation and conduct which can lead to disciplinary. If Simon Gibson, you say, did not know about any capability, clinician capability concerns in September 2016, that avenue under the MHPS Framework effectively disappeared. As I say, we're going to go on just in a moment to look at the issue of screening and the availability of, if you like, soft intelligence or soft information. What you may not know is that Simon Gibson is asked to perform this screening exercise effectively off the back of the March 2016 letter which identified the four issues that were rehearsed to you.

A. Yes.

Q. Is there a problem, or can you help us in trying to assess whether there's a problem, in that he gathered the information for that screening report –

A. Yes.

Q. -- by speaking to operational management. He was feedings back to this group that I've called the Oversight Committee, and there was no intervention, no contribution from clinical colleagues of Mr. O'Brien, I think it's fair to say. So, the Associate Medical Director was not brought into that loop; the Clinical Director wasn't brought into that loop; the Clinical Lead was not brought into that loop; none of his colleagues who don't hold managerial roles but are on the medical side and are senior clinicians were spoken to. Is that the kind of information that needs to enter into the system at the earliest possible stage in order to get the categorisation correct?

A. I think that's reasonable. Yes. Simon went to the operational managers because that's Simon's world. Simon is an operational manager, do he went along and he would have got the feedback around delayed triage, the things causing bother to the operational managers. You're absolutely right, if he had gone along to the medical colleagues, he would have probably got a different bit of feedback. He might have got some of the same stuff but he would also have got a more nuanced feedback on capability. I suspect if a medical person had been asked to do the screening report, it would have probably looked a little bit different because they would have gone to the medics. So, you're absolutely

right, and I think that's a reasonable observation, that, you know, somebody should have asked his medical colleagues.

Note the importance of gathering screening information from both the medical and operational strands of the organisation.

Q. We looked through the email, the two emails that you have indicated the patient risks specifically. Anita Carroll, Heather Trouton, Martina Corrigan are all sighted on those, and thereafter Debbie Burns told you to stop filling in Datixes. Would it be unfair for me to characterise it as being slightly disingenuous for Anita Carroll to say acquiesce to that direction, nothing is being done, when actually she is one of the people that could have done something?

A. But she did escalate.

Q. Did she ever speak to Mr. O'Brien?

A. No, but that wouldn't be how we worked. We worked probably in silos. It wouldn't have been for her to speak to the consultant, it would have been the AD for that area to speak to the consultant. Just as if there was an issue with one of my ward clerks on the ward, I wouldn't have expected another Head of Service to speak to them, I would have wanted to have been informed of that issue and then I, as the Head of Service for that area, would have spoken to that person.

Q. The Inquiry has heard evidence and likely will hear more evidence about those twin tracks of governance and accountability, clinical and operational, if I can use those shorthands. Is this a real-life example of one of the disadvantages of there being twin tracks when trying to deal with problems that actually cut across both?

What current advice is the SMT giving to the organisation when problems arise that cut across the twin tracks of governance and accountability, clinical and operational?

Q. In relation to that, you may have heard Mrs. Forde saying on Tuesday about the silo of line management, operational and clinical; very rarely they seemed to communicate across the barricades, as it were. Was that your experience, that there was a silo in the way things were managed or communicated up and down admin lines or clinical lines?

A. Very much so, yeah.

Q. Do you think that contributed to issues either not being identified, not being addressed and/or getting worse?

A. Yes.

More evidence of silo perception and working – presenting higher safety risk for patients

……

Q. And why is it that escalation is regarded as a substitute for action. Now I don't expect you have to have the total solution to that, but do you have any reflections as to why that's the case, other than the extreme work pressure, which we have heard about and which is acknowledged and the complexity of the organisation, is there anything else, do you think, that's fundamentally responsible for the fact that a number of things don't seem to have filtered up to the right people?

A. Yes. There's probably something in the space and it's very much in the governance space, I guess, people being very clear on what their roles and responsibilities are and it's not necessarily somebody

else's responsibility. So whether there is a diminution of people's understanding of what each person is responsible for and what you are certainly responsible for as a leader, I don't really have the answer to that. I do think, as you have articulated quite well, I suppose probably my own assessment and my own experience. Like I said, I would reiterate the fact that I do think it's not just as simple as saying culture, I think there is more to it than that. And I do believe there to be subcultures, but clearly it's a leadership challenge at all levels.

Q. So, in that vein, there is my impression, and I think we have heard evidence that people have concentrated very well in their areas –

A. Silos.

Q. -- of the different committees and in their professionals areas, so you can call it silos, you can call it all sorts of things, but it doesn't seem to be integrated governance in action as far as the evidence we have heard. So what discussions have been had at Board level about how to make a more integrated approach to performance, et cetera, a reality, because it's another thing that's easy to say and difficult to do. My question is around does the Board regularly discuss this, has it discussed it, did you have any contribution to that discussion and, in that regard, what did you regard your role as a Board member in terms of facilitating the difficult discussions underneath some of these issues?

A. Okay.

Q. So that's quite a broad area.

A. There's quite a lot there, yes.

Q. It's about integrated governance and how you as a Board member can execute your responsibility for everything, it's not just within your portfolio?

A. Sure.

Q. And whether the Board in a wider sense really grasps the need for that given the breadth of the issues you are facing?

A. So if I start with thinking about the intent of the Performance Committee, for example.

Q. Yes.

A. The intent behind the Performance Committee was to consider performance in a broader optic, and not just about –

Q. The numbers?

A. -- the targets et cetera. So when we would have had a session on cancer or whatever, I mean the Board determined whatever area to drill down into in a deep dive type thing, it was an opportunity then as Board members to really get under the surface of some of those things.

Q. Did you, do you think?

A. No, I think we made a start. I think we did make a start. What I can say as a member of the senior -- here's how I measure that: As a member of the senior management team those meetings started in October 2019 and at every meeting I learned something. I think that is a measure of what I wasn't otherwise finding out some way else. So there was an opportunity for people to talk people into the other issues they were facing within their services et cetera. So I think that could be part of the solution certainly going forward.

'But it doesn't seem to be integrated governance in action as far as the evidence we have heard'

On a scale of 0 – 10(being fully integrated) where does the SLT rate the current level of integrated governance?

……

A. Performance and governance are completely tied together. They are two sides of the one coin. They have to work together. When the pressures are higher, the governance has to be better, you have to consider it more. Who gets the last bed in the ED has to be around clinical priority and has to be based on good governance.

Q. "Better inclusion of non-clinical managers with clinical managers." You say that's been improved and we can ask Mrs. O'Kane about that?

A. Yes.

Is there now a good connecting structure in operation with non-clinical managers and clinical managers in all departments? Is this being monitored and where there are issues are they being addressed?

…….

Q. Do you think that's the main problem, that they don't have the time, the expertise, the training, the support to do it, or is there something else behind this? I mean you talk about back channel communication. We've heard it from other people about various things: hierarchy, silos, secrecy, fear, mistrust. These are not good words, and nobody in these roles would set out to be like that, I'm quite sure. So what do you think the problem was? And while you're answering that, have there been attempts to improve on it, do you think, or how does it feel from a practising clinician point of view?

A. I don't think the people who are asked to take on those roles are provided with adequate training and support. I don't think they have enough time in their week to deliver that workload. It's not really something that I have ever aspired to be.

'Hierarchy, silos, secrecy, fear, mistrust' – these are words that have been noted from witness statements in the Inquiry – does the SLT have a feel for how relevant are they today in the experience of staff in the Trust?

Priorities

Mr Devlin looked at organisational priorities – not MHPS.

A. It was not on my list of major issues; I was focussing on the areas that I saw on building the organisation

How would you describe the balance now in addressing the organisational priorities and the MHPS?

A. SAI's in 2019 were not drawn to my attention – I would have expected issues of patient safety to have been raised with me

If this is correct – why didn't this happen? Is there some learning here?

……

Q. Does it surprise you that more information didn't come into the whistle blowing framework about the concerns that we are now beginning to hear about?

A.I think it shows we have a lot of work to actually do. Does it surprise me? Possibly. I think we were in a situation where so many people knew for so long and, for some reason, those concerns weren't resolved at the earliest possible stage. I think what we have now to do is significantly more work around enabling people to be more comfortable about actually raising concerns. This is a long-term piece of work and it is a journey that we're on to try and ensure that individuals are raising those concerns in the best interests of patient care. It is absolutely an actual journey that we're on around raising that openness, and when there are concerns being raised that people take action. I mean, that is something more down the organisational development side of my role that we absolutely need to pay a significant degree of focus to moving forward.

'This is a long-term piece of work and it is a journey that we're on to try and ensure that individuals are raising those concerns in the best interests of patient care. It is absolutely an actual journey that we're on around raising that openness, and when there are concerns being raised that people take action.' How is this message being kept on the front page of the Trusts delivery priorities?

…….

Q. And one question the Inquiry would have to consider is why those concerns weren't uncovered earlier as part of the MHPS investigation, which took place over 18 months. An angle which could be taken might be that the parameters of that investigation, the terms of reference were set too narrow from the start. That in effect the Trust were only looking at what they knew, as opposed to establishing or satisfying themselves that there's no patient safety concerns or any further patient safety concerns and NCAS advice may have played into that. What do you say in response?

A. Well, I wouldn't really agree with that because I'm still back to the point of, you know, they did come to a conclusion that the matter should go to a conduct hearing which would have given them an opportunity to draw a line under it and presumably monitor Dr. O'Brien's performance to ensure it didn't happen again. I mean, if patients were still being harmed, that's a completely separate issue and we need to look at why the restrictions that were in place weren't sufficient to prevent that. If you're saying to me that patients continued to be harmed whilst this investigation was going on and after it concluded, obviously that's a huge problem. The biggest problem is why were the restrictions removed? The problem had never been addressed. They never got to a conduct hearing. They never really got to an acknowledgment that there was anything -- I mean I don't think Dr. O'Brien acknowledged that he accepted the findings. You know, in those circumstances, how was he continuing to work without some sort of supervision in place? That, for me, is the biggest issue.

With the knowledge that some patients had come or could potentially come to harm - was there supervision in place from 2017 onwards monitoring Mr O'Brien's practice?

Q. You've more experience than most of dealing with the MHPS Framework given your unique enough position. You obviously heard some of Dr. Fitzpatrick's reflections earlier. Does the process or does the framework work? Can it work? What might need to change in order to make it more effective?

A. I think there's a number of problems with MHPS. I think there's great difficulties in Trusts in managing concerns. I mean, we've seen this a few times now. You know, you pointed out earlier -- and it is something that we address in case investigative training but it's not getting any better. They don't have people freed up really, they add it on to their day job. I think they're completely -- I think the

situation in which the Health Service in isn't going to make it any easier any time in the near future. As you can see, this was taking up an enormous amount of time.

Q. Those issues you describe, I don't personally have a view on it and I'm not expressing the Inquiry's view by any stretch, are they issues with the framework itself, are they issues with almost the structures, the funding or the infrastructure around the framework in how it's implemented?

A. I think there are problems within MHPS but I think there are problems within organisations as well. I think there are difficulties -- there's a lot of tick boxing goes on in the Health Care system at the moment. I think there's a real nervousness around managing performance concerns. You're dammed if you do and dammed if you don't. There's real concern. I see it as people doing things just so that though can say they did them. It has become increasingly bureaucratic, and that has an influence on patients as well in that the time taken to do everything is hugely extended because of the need you are making sure that you're adequately covered, that you're not exposing yourself to risk. I think there's a lot of -- there's a huge amount -- I don't even know how you begin to fix it.

Q. That's probably not welcome news to the Inquiry at this stage.

A. I know but it's true

While considering the bigger picture, are there any quick win ways that can help the Trust manage this tension so that the wellbeing of staff and of patients can be upheld?

Q**.** I've just have got two short questions, hopefully. I'm still struggling slightly with the classifications of shortcomings and just two things with respect to, firstly, the dictation and, secondly, the triage. We know Mr. O'Brien could do it but he on occasion didn't do it. How do you classify that as capability or performance or something different and how do you work that out?

A. Well, I think if you have the ability to do something and you don't do it, that's a conduct issue. So, as I understand it, Mr. O'Brien didn't really agree with the triage that was a put in place but he was instructed that that was to happen but he didn't want to do it like that, so that led to the backlog. So it was as a direct result of decisions he was making about how he behaved. So I viewed that very much as conduct.

Q. What's the place of mitigation there, pressure of work, and things, would that change?

A. Yeah, I agree entirely with that. I think that was -- you know, there were mistakes made there about not freeing him up to do it. But I think even -- when it was drawn to his attention, you know, and it had become a big issue, that was the time that he could really have, even for himself he could have stopped -- I imagine if he had told the Trust I'll stop doing X, Y and Z, to do that. There would have been very little they could do about that. But he didn't. So I think that had he -- you know, I realise he did a huge amount of work and a huge amount of hours but he wasn't following specific instructions and he didn't make any -- well, he used to get the better for a while and then slide back which sort of as well implies conduct. He could do it when he had to but he couldn't consistently do it, probably because he didn't believe in it.

The importance of identifying and immediately dealing with a conduct issue

……

Q. Now, I asked you before the break about learning, and I think it was my word to say there was ad hoc learning from the SAIs**.** I just want to indicate from your witness statement that you are a member

of the Task and Finish group. You refer to this at WIT-85936 at paragraph 20.5. This was a group established in 2021 to action the outcomes of the Urology SAI recommendations by the Trust?

A. Yes.

Q. Is this a way in which learning comes back out through the formal system to the CNS, or does the learning sit within the group?

A. So, in a way it's turning the learning into an action that results hopefully in an improvement. Myself and Kate - I think it's myself and - no, myself and Patricia - are within that Task and Finish group. But as for updating the CNSes per se, no, that isn't part of the remit of that group.

Q. So when it's tasked to action the outcomes of the recommendations, how do they do that?

A. So, I have been involved with the service user group. There's going to be a survey as to what information and role they expect within their journey, and we are looking at the information that's given. Out of also this Task and Finish group, I think that is where the additional audit resource has come from in terms of us now having a list each month of the new diagnoses and being able to cross-reference those. So there has been good that has come out of it, but there's more to be done.

How robust are the plans to cascade and embed the learning from the Urology Public Inquiry throughout the Trust so that a similar statement 'there was ad hoc learning from the SAIs' will not hold true?

Q. Yes. To try to summarise your experience over the last 10 or 15 years in performance –

A. Mm-hmm.

Q. -- in measuring performance and trying to assess what flows from it and what can be done about the difficulties and pressures faced, is it the reality that demand has outstripped, and continues to outstrip, the capacity to address the needs of patients in your local population across SEC as well as Cancer Services?

A. Yes, that's a fair enough reflection. It's not unique to Urology, it's actually the case for a number of the specialty areas.

Q. The Trust recognises that this places patients at risk and has communicated that to the Commissioner?

A. Yes.

When the Trust last communicated to the Commissioner that demand continues to outstrip capacity

In Urology - what was the response?

.....

Q. The review, what was the outworking of that in terms of how you were able to carry out your job effectively? You have mentioned the 2019 review. What improvements or did you see any improvements after that?

A. Well, there was improvements from the viewpoint that we started getting moving through those current SAIs, and then getting those finished, completed and sent to the Board and to the families. It never really sat comfortably with me getting those reports out to families because I would have built up a rapport -- in my last job, I would have built up a rapport with families, they would have known

him, they would have phoned me, I would have been able to contact them and say this is where we are at with the review. With these people, I was coming cold to them, do you know what I mean. The first thing they were hearing from me was a phone call, which was really difficult for them to take in, you know. We did a review of an incident that happened maybe two/three years ago and we were only completing it in 2019.

Good 'customer care' standards towards patients – should always be seen as a part of a deliverable care package and not an optional extra in healthcare. When was the last audit of this done in the Trust? What did the results show and what actions are planned as a result?

A. Oh, absolutely. On reflection, there's a lot of things that if I had have stepped back, took the time to step back and look at, you know, for example, one of the things, and I know we're talking about governance that always sort of was like a bugbear for a couple of the Heads of Service was the SAIs were done in isolation, which is fine. The recommendations came up and the next thing you got a list of 'These are the recommendations that you need to implement.' We never got a copy of the SAI. It's a wee bit like back to the MHPS. If you're given recommendations in isolation, but the biggest problem thing for me is, and it's come from this Inquiry, when I actually sit down look and all the SAIs and read them, the recommendations could be actually mapped across. And if we'd have done that at the beginning.

Mapping the Inquiry recommendations with the recommendations of other recent reviews and SAI's will be one of the first steps post Inquiry. This will contribute to assisting the Trust in shaping a firmer foundation, develop streamlined action points as well as the important task of building confidence with the public in the delivery of good and safe patient care.

…….

Q. Last one. I mean if a member of the Trust Board came to you when you are in your governance role and said 'How can you assure me that your consultants are following up to date standards and guidelines? What assurance can you give me?', what would you have said to them?

A. I would have highlighted the challenge of the resource that we had to do it. I can't remember the exact numbers back then, but now there are over 3,000 guidance. 2,800, all of them are applicable to the acute service. They don't come with funding.

Q. But will you be able to assure him is what I am really saying?

A. No.

How is the SLT addressing the miss-match between no available funding and assuring your consultants are following up to date standards and guidelines?

……

Q. Did you make those suggestions in any formal or informal way to those who were making decisions?

A. I did, actually. I think I must have said that and that's why I still remember it, but not in a formal way because we were never asked about any formal. It's only in the meetings I might have discussed that, that this is the way it should be.

Q. Do I take it from your answer that you didn't feel that you had been engaged with properly in relation to the review, the regional review?

A. The majority of the review happened without us present. We were only present on a meeting with Mr. Mark Fordham, which you might have some notes of the minutes of the meeting. That's the first time I recall. It was quite a feeling for me, in a way, that, yes, we are meeting and we thought, my understanding is when you meet you discuss the things. But the way it came across on to us, I was the junior most fellow so I kept quiet for the majority of the time, but the way it comes to us was entirely a one-way traffic, this is the things that has to be done.

'One-way traffic' – is it possible to currently identify areas in the Trust where staff feel their voices are not being heard and that the imprint is still one of 'one-way traffic' as opposed to collaborative discussion and decision-making?

Q. What I want to ask you about is your sense that you were reassured that safe systems were in place. As a practitioner, did you have any sense of being supervised, scrutinised, in terms of the work that you delivered, the actions that you took in relation to patients?

A. Well, in that if I caused a problem to a patient, I was aware that that would be discussed, either at a mortality or morbidity, so that would be investigated, so I was aware that that would be policed. I was aware that, you know, that I was policed that I was seeing -- although it was pre-booked for me, that I was seeing a certain number of patients in clinic. That I was -- I think probably, I'm not sure, probably in those days, I think it's -- I don't think paperwork results were policed that closely, as far as I remember, I can't remember. But I think they -- I think the word there is "seemed". It seemed, rather than me actually knowing.

Q. I quite take the point that if your actions, or actions of a colleague led to disaster, or led to injury, you would expect to be held to account, because that's a very visible evidence of something that has perhaps gone wrong. But you make the point that at that time I was aware that there wasn't any great scrutiny of results sign-off. You probably, if you had thought about it, would you have recognised that while systems were in place to spot that, triage wasn't being done, it wasn't always being done in a timely fashion. Ultimately enforcement action around that was less than optimal. You would, as we'll see when we look at some of the other incidents that arose, you would have seen that a failure to dictate, following a clinical encounter, wasn't particularly well-monitored and due, and Mr. Haynes, for example, I suppose stumbled upon it isn't the right word, but you became aware of it as opposed to some system of superintendence or governance becoming aware of it. Just some examples to set against your view that you felt reassured**.** Do you now, upon reflection, see holes in either the system of governance and/or the appetite for enforcing good governance when problems were identifiable?

A. Absolutely. I mean sitting here now, I can't say I was happy with -- I could be happy with how things were done then. I suppose, with regard to results, because in those days I wasn't signing results in NICER, I depended on my secretary who has been with me a long time and is very diligent, and she made sure I had all the paper copies and ensured that they were all signed-off. So I was dependent upon a good secretary.

'Q. But you make the point that at that time I was aware that there wasn't any great scrutiny of results sign-off. Do you now, upon reflection, see holes in either the system of governance and/or the appetite for enforcing good governance when problems were identifiable?

A. Absolutely'

When problems are identified now in the delivery of safe clinical care, how quickly is good governance applied? Where does accountability sit in finding a solution/resolution?

Q. If we could have up on the screen, please. WIT-50524. At paragraph 8.1, Mr. O'Donoghue, you explain that you strived to provide, along with Mr. Young, and no doubt other of your colleagues, to provide an excellent and efficient service for patients. How was that possible in terms of the excellence and efficiency of delivery. How was that possible when you see the state of the waiting lists and what lay behind the waiting lists?

A. I think on reflection, "efficient" is probably a bad choice of word. Excellent, in my eyes, I provide the best service I could, so I think it was excellent in that sense, but "efficient" perhaps shouldn't be in there.

Q. I suppose there's two ways of reading that. As you suggest, you did your level best to provide an efficient and excellent service but the Service itself, in terms of its efficiency and excellence was okay for those who got in the door, but it wasn't by any other definition an efficient or excellent service if you're waiting for more than a reasonable period?

A. Absolutely. I did my best with what I had, but I think if you were looking at it objectively, it certainly wasn't efficient. But I worked hard or I do work hard.

Q. Yes. You have explained to us that there were these recruitment issues and the Trust worked, as best it could, to try and fill the void with locums on the consultant end. Ultimately, you know, there are insoluble problems or at least problems that are difficult to get around on the recruitment side. You have reflected to us the efforts on the part of The Trust to innovate to some extent with the modernisation programme, and you gave examples of that, and the expansion of nursing services and the scope of nursing practice. Still and all, we're left with waiting lists the size of which we've just explored and no doubt the impact of COVID has been far from helpful.

How can the SLT actively support the Trust's clinicians as they aim to deliver safe care for their patients while at the same time psychologically experiencing the pressure of long waiting lists for consultation and treatment?

A. So I think, you know, for Mrs. Burns to give evidence and in the email statements to say that we were passing the buck, is clearly wrong, it's not in keeping with the activity that went on after this, and I think I was making the point to her, because the SAIs are not just about what happens in Urology, they're about what happens in the wider organisation, and that's why we structured the recommendation in that manner. The second point in her evidence then, if you have -- and if we perhaps go back to her evidence where she quotes the number of outstanding reviews, if you wouldn't mind showing that?

Q. Yes, it's in the transcript of her evidence. It's at TRA-07064, towards the bottom of this page. If we go down just there. Yep.

A. Okay. So I would ask the question: If you are receiving a performance report with 20,000 people on it overdue their review, would you not be digging into that a little bit further to understand who those patients are? What their clinical priority is? Would you not be asking your ADs and your heads of service to give you a clear understanding of the clinical risk involved in this situation? It's not good enough to say that you've got 20,000 people waiting, you need to know what's happening. We knew what was happening in Urology, that's why we did the uro-oncology review list, that's why we created various categories for the Outpatient reviews, so that we could in some way try to manage and mitigate the risk.

'I was making the point to her, because the SAIs are not just about what happens in Urology, they're about what happens in the wider organisation'

Post Inquiry – this is an important point to underline when the Report comes out so that learning can be maximised across the Trust.

Q. And in your experience of MDM attendance both during that particular period -- I know it's late on in our time, in our timeline, but what was the process or what did you understand to be the process or proper procedure, if there was to be a deviation from a previously agreed MDM proposed plan?

A. Well, it's paramount that if anyone deviates from a plan that's been discussed amongst a large group of experts, that that should be represented. You can't single-mindedly go off on a deviation from it. And so I would expect anyone who had then subsequently seen a patient who then the plan could potentially change, to represent that patient.

Q. So, for example, if an agreed plan was a certain form of treatment and the clinician then subsequently performed some tests and they came back that may have changed his view as to the appropriateness of that treatment, rather than just then make that decision, is it the expectation currently, or has it always been in your mind, that that should come back to the MDM for discussion?

A. It should have come back to the MDM for discussion and that's the way I would view it from an obvious standpoint of you've gone to a meeting to make a plan, you've gone away, something's changed -- well, you bring it back.

Q. And within that context, is it your view that the MDM plan is a proposed one, based on what is presented at the meeting at that point, but that it should always come back for collective endorsement?

A. If the plan is going to change beyond the proposed treatment or plan to something completely different, then it has to be re-presented.

Q. Is there any -- is there another perspective on that, that the MDM is a recommendation that the clinician then discusses with the patient and, together, they then decide what the best outcome is, given the patient's views?

A. Completely. So it's patient-centred care and we can only do recommendations to patients. But if a patient or a clinician then decide to go along a completely different path, it needs to be brought back because the reason being is if the patient decides on a different route, is there an alternative option which may even be better or enhanced, even if they don't want to go a recommendation. So it's not about just accepting "Okay, that's fine, go that way" -- it's about bringing back and going "Well, they want to do this -- what does everyone think? They want to do it, fine, but can we recommend anything else as well?". So it's the ability to bring back to discuss for the benefit of that patient. But, fundamentally, it's the patient's decision.

Q. So it's drawing on the expertise of the other members of the MDM. So, for example, if a patient doesn't want a proposed form of treatment because of side effects and that's brought back, an oncologist may say "Well, actually, here's another option -- if that's the worry for the patient, this may negate that worry" -- is that an example of what you're saying would be the benefit?

A. Completely.

‘So it's the ability to bring back to discuss for the benefit of that patient. But, fundamentally, it's the patient's decision’.

What plans are in place to audit whether the policy/principle of 'shared decision-making' is being implemented and embedded into clinical practice across the Trust? Where it is found to not be taking place, what are the next steps to address this?

Q. Another thing which has been of interest is in relation to the way things operated at the Southern Trust, and to some extent more broadly in terms of governance, but also whose role it is to spot things that are going wrong. Could you give me your view of the importance of the collegiate atmosphere amongst the consultant body in a department with respect to keeping patients safe? What has been your experience of (A), the importance and (B), the results when that becomes dysfunctional?

A. Well, it is crucial, really. I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet because it is so difficult. Some people are very difficult to deal with, especially senior surgeons perhaps. In quite a few units we've seen around the UK, interpersonal rivalries develop, and one surgeon will say to the nurse on the ward, "I would never have done that operation and my colleague can't operate for toffee", something like that. Then that can get out control and sort of vendettas develop. You are dealing with human nature. But when problems arise, they need to be addressed. Most hospitals now have -- it used to be three wise men but now I'm not sure, that system is out of date now. But the equivalent of that, sort of troubleshooters. In this case I think the troubleshooters should have gone in there, shaken the system up and devised better ways of doing things.

'I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet because it is so difficult. Some people are very difficult to deal with'

Are there any red flag warning signs and issues that are currently being swept under the carpet in the Trust today? What are the SLT's plans to address them?

Training

There are considerable issues in having AMD's who are full clinicians with a fulltime clinical role – resulting in lack of time to fulfil demands of ADM role. Are the current AMD's in a balanced role?

A. I was unaware of the MHPS process until the Public Inquiry

Q. Were you conscious, in 2017, when you gave your statement, that you were contributing to an MHPS investigation?

A. No, I wasn't

This is quite alarming – are you sure that your current senior staff in the medical and operational management teams are up to speed on all the relevant documents and training?

A. People had a very superficial understanding of how the MHPS process operated and what help could be obtained from it

Is there good training across the board in place now so that this statement is no longer true?

Are all the doctors practicing within the Trust up to speed on the training programme about good practice when dealing with private patients?

Q. Did you feel confident that you had a sufficient knowledge of the guidance and sufficient training to be able to discharge that role? (being appointed to be the Case Investigator into Mr O'Brien)

A. No. I don't think that -- it's okay doing courses, but you know, you do a course and three years later you've never put it into practice.

We'll all sign up for courses and do this, and do that, and management training and whatever, but it has to be close to the time. It has to be -- and then you do it and then you probably need somebody to be alongside you to direct you and help you do it. You cannot go into these things with one course or one lecture or a half-day, and then away you go. It's just not the way to do it.

There is some learning here about accessing timely training when being asked to carry out specific roles – how is this currently being prioritised and monitored?

The Chair raised the issue about leadership roles e.g., Assistant Medical Director – a specialist job which most professionals are not adequately trained for.

Is adequate training in place for leadership roles now?

A. I think that for something as fundamental as MHPS and the Trust Guidelines, just to fire out guidelines and maybe to train one or two people misses the whole point. It is important that every permanent medical employee is aware of the guidelines, aware of the process, and gets training in it so they understand what they are facing into if they are subject to either informal or formal, what their rights are and what the correct process should be.

Q. In terms of how that could be achieved?

A. Well, there's mandatory training. Every year we had fire training, every year. And the fires didn't change from year to year. Every year we had infection control training and, again, that didn't change from year to year. But something as fundamental as this I think it should be provided to all new starts within their first year and then it should be renewed at least every three year. I think it should be mandatory. This is their employment. It is expected of them. How they should behave. I think it's important.

What is the Trust's view on mandatory training and it being renewed every three years?

……

Q. Would you have appreciated when making these appointments that Dr. Khan and Mr. Weir were without training, at least at the point of appointment?

A. Yes. This was a widespread issue within the Trust. There were very few people who had appropriate training.

How is this being addressed and monitored.

On appointment does the Trust know an accurate summary of the training already completed by the appointee?

Q. Is there a need for Trusts to build capacity, familiarity, and a degree of, I suppose, comfort with these processes among medical leadership so that those charged with these key responsibilities are able to do them, I suppose, more efficiently and with less stress?

A. Yes. Absolutely. It's a major issue, I think, in processing these investigations. I have to say I struggle to think of anyone who would have been comfortable with this particular one because it was quite

complex and difficult. But, as a general theme, there are very few people who would have extensive training who are doing these investigations frequently enough. It is not just about training, it is then about updating your experience and keeping abreast of developing issues. You may be fully trained, carry out one investigation, then not be asked to do another one for a couple of years. So that's a major issue. My own personal belief is there needs to be extensive training of a bank of People within the province.

'It is not just about training, it is then about updating your experience and keeping abreast of developing issues' Can this comment be fed into the current training policy of the Trust?

A. From an Employee Relations point of view, we have reflected on, not specifically Mr. O'Brien's case but including Mr. O'Brien's case, on a range of feedback we've had over many cases where individuals feel that those supports are really a tick box, they're not really supports that are helpful. You know, that has been a theme of feedback that we have heard in a number of cases. As a result - and, as I say, not specifically related to Mr. O'Brien - but as a result of a number of cases, we have moved to the position of developing an Employee Relations guidance note for, primarily Employee Relations staff and Medical HR staff and, I suppose, investigators and service managers, that sets out a range of supports that need to be offered to individuals, which is much broader than here's Occupational Health or here's Inspire and Carecall.

Q. When was that guidance note issued?

A. That was last year. So that was 2022 that that guidance document has eventually gone through SMT and is now part of our processes.

We've tried to address that within this document to say that there needs to be an identified point of contact, probably from somebody in a line management role, to provide that support on an ongoing basis to ensure there are regular updates and that there are contacts made just as a check-in in terms of how are you feeling, how are things going for you, how are you feeling, and we built that into this new guidance note.

What is the plan to monitor the effectiveness in practice of this new guidance document?

A. I mean, ideally where you want to be with this is you would like to have these people who undertake these roles trained at a very close time to the point at which they undertake the role. In practice again, that's very, very challenging because you don't know when cases are going to land. You don't know, you know -- so from 2017, and we had a fairly substantive cohort of individuals who attended that training, probably very many of them had never undertaken the role of Case Manager or Case Investigator since, so it becomes almost a bit defunct. Then it's about, right, okay, we need to identify somebody for these roles and you're going back to either people who have been trained but trained quite a period of time before that, or you're trying to get formal training in place. So it is challenging, there's no doubt about that. I fully accept what you're saying in terms of you are doing that internally and that refresher piece, there is that danger. Absolutely.

Q. The other side of that coin is the individuals who are being asked to take on the role of Case Investigator and Case Manager are full-time employees with very busy practices –

A. Absolutely.

Q. -- who don't have time, one would assume, to look at the fine detail of the MHPS framework or the Trust guidelines, so a refresher at the point of need might be something that the Trust considers to be entirely appropriate. My question was merely aimed at if the person doing that in future –

A. Doing that. Yes I accept that.

'I mean, ideally where you want to be with this is you would like to have these people who undertake these roles trained at a very close time to the point at which they undertake the role'

'a refresher at the point of need might be something that the Trust considers to be entirely appropriate'

Is the Trust considering the principle and practicalities of doing this?

Q. You talked about medical managers not being properly trained to deal with MHPS, for example. I just wondered what your view would be to a regional team of people and bringing people externally in whenever one of these issues arrive so it would take pressure off the Trust internally in terms of its resources. If you had, if I can use the term, a flying squad to come in.

A. Parachuted in. Yes, and I suppose we have chatted about that even in relation to the training of the Case Manager and the Case Investigator, training, and if that was regional training and if that was run more often. I think if you take investigators in who are unknown to the practitioner, it makes life a whole lot easier because you are asking people who are working alongside, in some instances, to investigate colleagues or investigate people that they know and have to work with. So, that's challenging within itself. They don't build up an expertise, they do it so infrequently. So there is absolute benefit, I think, in terms of having a pool of people who build that expertise and go around and do those types of investigations. I can't see how else you would do it efficiently because internally within the Trust, the challenge is there's not enough of these cases for anybody to build expertise, and the capacity issues and the relationship issues and all of those things impact on that. So, taking somebody completely independently in, I think is -- yes.

What is the SMT's current view on this? If in agreement – how realistic is this approach in today's climate?

Q. How useful do you think training is; how important is it for people taking on roles such as the role you took on? And have you any reflections to offer the Inquiry about how medical managers - because it is typically medical managers who take on these roles - how should they be prepared by way of training or familiarity with the processes? How should that be done if the Inquiry were thinking about making recommendations around that?

A. Training, in a way, is also very important but I think that developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training. Training is one part of the expertise but there should be further elements to this whole, I say, a suite of tools available to people who are going to do the MHPS role. No doubt training is very important, and the right training for the right time.

'Developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training' Is there provision now to extend the scope of the training to include these elements?

……..

Q. Okay. Just in terms of your training, as you say you probably had done more of these cases than many in the Trust. In terms of training, it seems to be that there is a lack of expertise and a lack of continued knowledge and continued training, even aside from when you are being asked to do one of these things. We are looking at how the whole system could be improved. I wondered what your view

would be of having a regional pool of medics who come in to do these investigations? I mean, I was struck by your comment that no consultants will do these any more. So, how can that be addressed?

A. I completely agree that I think there needs to be a pool of expertise so that you are repeatedly exposed to this and repeatedly doing this, because you learn every time you do it.

Is the Trust planning to develop 'a pool of expertise'?

Q. Okay. That's interesting and helpful, thank you. Just one other thing. You talked about the impression that you formed. Impressions are formed on a cumulative basis. I take it was just an overall impression as a result of all you heard from everyone you spoke to?

A. Yes, and I suppose that's exactly what I was trying to say. It was information from witness statements; it was information from e-mails; it was information from the documentation I was provided with before; it was information from the meetings with Mr. O'Brien himself and trying to plan and trying to organise those meetings. You just form -- you stand back and you form an overall impression, you know. You walk away and you think this is my impression of something. It's never something that's formed in a single contact or a single moment in time. It's always something that's much, much wider than that.

An interesting scale – views, impressions, facts – can value be applied to all three components?

Q. In broad terms can you help us with this: In terms of MHPS, how well do you think the Trusts in Northern Ireland are served by the training provision that's available? Is there room for improvement around that, or can training be over-emphasised in terms of its importance to the safe conduct and the safe operation of the MHPS arrangements?

A. I think training is critical. Training is very important, and it needs to be the right training. A lot of it is even just around allowing medical managers and others to discuss how they would implement MHPS and what would they do. We use a lot of case studies to say, well, what would you do in this situation? That was always very interesting and people learned a lot from that. So yes, training is critical. Another thing is just because you went through a training in whatever it was, March '17, doesn't mean that in March 2023 you are still up-to-date and sorted in terms of conducting an investigation. There needs to be -- and that's probably an area where we don't do enough of, is coming back and reviewing it. It's okay if you have been doing investigations constantly since 2017, you probably reasonably up to speed, but quite frequently people do this course and three years later someone asks them to do something and they have forgotten everything they learned.

The importance of checking in with up-to-date training when participating in an investigative role in informal and formal investigations.

Q. I suppose that's the point. We've observed in earlier stages of evidence, operational managers seeking informally to orchestrate change or remedial action in terms of Mr. O'Brien's practice going back some years, triage being the most prominent example. But nobody actually, until 2016 in all of that, nobody actually sitting down with him, meeting and I suppose making him understand why these rules of practice are important and requiring him to comply.

A. I take your point, yes.

Q. Nothing had changed by reference to this particular example by the time you came into the role?

A. No.

Q. Why is that? What is the culture that is existent at the time? I suppose you may say this is a relevantly small issue, and I'm sure the Inquiry might accept that, but what is the difficulty that causes you to fail to sit down with the clinician and say listen, you have to do something different?

A. I suppose it's complex. If it was easy, we would fix it. In terms of the life of anybody working in hospitals, there are many, many, many challenges that you face on a daily basis. I suppose everybody is guilty. If the issue isn't sorted there and then, it tends not to be completed, the loop tends not to be completed because there's something else very quickly falls in behind it. If Mr. O'Brien was the only thing that occupied my life, that would be one thing, but it wasn't. There were many other challenges, not least, you know, Dr. McAllister's state of the nation was only a small part of the challenges which we faced on a daily basis in the health service. Two months of my working life each year was taken up on the role of the Assistant Director of the Week, where I stopped doing my AD of the week role and I was occupied looking after flow. That was one full week every six weeks. So, if you didn't sort out the problem at source there and then, unfortunately to get back to it, sometimes it never happened because there was just so much more to be done with the resources that we had. Every morning we came in and we were faced with overwhelming patients in ED, trying to find the beds for them. Part of my role in finding the beds was, well, what surgery can we proceed today with. That is endless and draining. So, plenty of challenges.

'So, if you didn't sort out the problem at source there and then, unfortunately to get back to it, sometimes it never happened because there was just so much more to be done with the resources that we had.'

It is difficult with major time pressures and lack of resources to think clearly, pick up on important issues and prioritise – is there training that staff can easily access that will build skills to assist them in these situations?

Q. I just want to highlight some of the issues or some of the provisions that the Trust required throughout the years. On the first page - just move down slightly - you will see the headline. The title of this is the Policy For the Safeguarding, Movement and Transportation of Patient, Client, Staff Trust Records, Files and Other Media Between Facilities. You will see the publication date there is August 2006. This is really one policy captures all. The introduction states 1.1: "The aim of this policy is to ensure that staff safeguard all confidential information whilst travelling from one facility location to another during the course of their working day". Then we see at "It is the responsibility of all staff to familiarise themselves with the contents of this policy". If I can just stop there and ask you about that issue. Were you aware of these policies being made available to staff, any staff or medical staff?

A. No.

Q. No. Do you remember if there was any training given to staff around the requirements of these policies?

A. Not that I am aware of.

Q. Would it be the case that if there was training around records and charts and movement and transport and storage, that it would likely have to come from your department?

A. Because that encompasses all of the health, not just health records but all records, I would have imagined that would have come from information governance.

Q. And did you ever know them to provide any training on these issues?

A. Not that I can remember.

Q. Did you ever attend any?

A. No.

Q. Now, you'll see the guiding principles then at 2.1. It states: "Everyone working for or with the HPSS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to patients and clients and to his/her employer. This applies equally to those, such as students, or trainees, on temporary placements". 2.2: "Staff must notify their line managers immediately on suspicious of loss of any confidential information". If we go over the page. 2.3. "Managers must ensure staff are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information". Were you ever aware during your time in charge of records of anyone being disciplined for breach of confidence, or for the way they have handled or stored charts or records specifically for that purpose?

A. Not disciplinary action. We may have spoken to some of our staff. Like, say you have been going along a corridor and you might have seen a trolley of charts left unattended, so you would have spoken to that individual. But in my area, nothing that led to disciplinary

Policy For the Safeguarding, Movement and Transportation of Patient, Client, Staff Trust Records, Files and Other Media Between Facilities 2006

Has this policy been reviewed and updated? Is training now being given to all the staff that this policy applies too?

Q. Do you think it would be a good idea if there were specific training programs or continuing professional development points, or some way in which the Trust could bring home their policy aspirations to people who actually operate - I don't use that word medically - who actually work in the Trust so that they better understand their obligations and their responsibilities?

A. Yes. I think we could improve the training aspect. We do have e-learning for some of the things but maybe more specific training on this. Or, you know,

Q. By the time you left in 2020, did you have any knowledge of any training that was in place at that point such as that?

A. No. No.

Q. Just the main point from that, I suppose, from your perspective as a manager was that you instigated the request rather than it being something that was available

A. Yes.

Q. And there may be changes now, you just don't know, I suppose, having left?

A. No. make sure it is included in the junior doctors' induction.

Is training regularly provided so that staff fully understand their obligations and their responsibilities?

Q. Just in relation to learning. Again for the Panel's note, that's dealt with at your witness statement WIT-60390, and over the page 60391. You have sentences of self-reflection, I think, in your statement where you have said you need to be more proactive and less reactive; you need more staff to audit so errors can be picked up. One of the things you have said and I wonder if you could just explain why

you think this might be helpful, that there's "no governance forum where admin managers can engage with clinicians about administrative issues, and this should be encouraged".

A. Yes.

Q. I know there was a meeting with the consultants at one point when they called to discuss the systems, but that wouldn't be something that the admin would be able to call a meeting with the consultants to attend?

A. We can call all we want but nobody would turn up, so...

Q. So what you are advocating for in that sentence is the possibility of everybody getting together to iron out issues or to identify how systems might be better improved?

A. I think admin on the whole has no centralised forum to air concerns, thrash out different things or whatever, that there are medics also at. I remember back, and I am talking early '90s, there used to be an old, what was called then the Medical Records Committee. It didn't deal with medical records as physical charts, it dealt with the wide-ranging issue of admin. We hadn't had that so I believe that is very much needed. There's probably a perception in the Trust that the Heads of Service for each area deal with all of those sorts of things, but I think their roles are too wide. I think admin needs a section on its own for governance, and for the right people to be added and for us all to thrash things out. That's my opinion.

Q. I suppose that's more focused when you look at the number of people that are under your remit. You have 200 people who do such vital work at that level of the Trust. Then that sort of forum, you think, might prevent either issues arising, or short-circuit what needs to be done to fix things?

A. Yes.

Q. Do you think there's a good enough understanding among clinicians about how your systems operate?

A. I think each clinician will have a very good understanding of how each of their secretaries work. How other things operate, no, I wouldn't be so sure.

Q. Would they be aware that the secretaries really answer to you rather than them?

A. I am not so sure about that.

Q. Helen Forde, when she gave evidence, I had asked her whether she was involved in training doctors around charts and tracking and the issues around that. Do you have any involvement in dealing with medics or training with them?

A. No, but when Helen drew up that document, she did speak to me. A couple of things then that I had wanted to say were on that document, if you like. So I didn't do the work, she done the work, but it was a joint kind of thing, if you know what I mean. We would have worked quite closely together.

Q. Your input - and I know Helen has retired - but the input of people from Medical Records into training for the doctors as they join the Trust, you think if that was formalised as a mandatory session that that would help inform people's use of systems?

A. It would, but let's tackle our current people, never mind new people coming in. I would be thinking along those lines.

Q. So bring them in for refreshers?

A. Yeah.

Is there currently provision for a 'refresher' training session for clinical staff on administrative processes e.g., charts, tracking. pathways?

……..

Q. Your view that it's an important tool, or potentially important tool, together with something like appraisal which may allow the Trust to better understand what's going on in a clinician's practice, the challenges he or she is facing, issues that perhaps lie beneath the surface which have not yet been identified, all of those things are potentially discoverable through a good, robust job planning process?

A. Mm-hmm.

Q. The fact that this was let sit for so long and never delivered, does that perhaps reflect a failure to understand on the part of medical management the potential wins or gains that can be achieved through good job planning?

A. I think that's fair, yes.

Q. Is there any ongoing work, or any work in light of what we know happened in Mr. O'Brien's case, around job planning?

A. Yeah. There's constant work with job planning in terms of working with our local negotiating committee and providing training sessions, and lots of things to try and see how we can support clinical managers because it is an important task, but also ensuring that it's a doable ask for them. But yes, we are trying to put a lot of effort into -- because job planning is also a tool to attract doctors to the Trust, and to use as a retention tool as well. So, we are looking at how job planning can be used imaginatively. It's a professional contract between consultants and their Trust, but to use it in a way that we can actually use it as a retention tool and an attraction tool as well. We are looking at it from all of those aspects.

The importance of training to a good standard all those involved in job planning and drawing up professional contracts.

Q. Why do we have a situation where, from some witnesses who put their hands up to do a medical management role, whether it's clinical director or associate medical director, why does it appear, at least in some situations, to be the case that senior medical managers are coming in when they don't have the right amount of time available to them, haven't had training, obviously are unable to attend important meetings –

A. Mm-hmm.

Q. -- why does that continue to be a problem and one which, if I may say so, the Trust has just had to tolerate or accept?

A. I think the difficulty is medical management posts are not commissioned, they are not funded, they are not resourced. The responsibilities, I think, have extended significantly in recent years as a result of, you know, all of the different processes that are put in to manage and that they are responsible for and the demands on the service. Our workforce plans, I don't believe, have taken into account, I suppose, the fact that we need clinical managers leading and that, therefore, then takes them out of their clinical practice. I think the demands on the hospitals are so significant that that's a very challenging thing to do. But if it was properly commissioned and resourced and training associated behind it, then I think you would get individuals who are -- you know, we are seeing now adept fellows

is a thing which has been established where junior doctors are taking time out of their training scheme to buddy up with a line manager and work on leadership projects, which is a really good positive step forward we wouldn't have had in the past. So that gives an introduction to management, but that probably needs to continue and have the opportunity that you are not just a consultant one day and clinical director the next, but there's actually a formal process and career path for clinical managers to follow

Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers?

Q. You also mentioned that there are no standards for a clinical leadership but there are standards, aren't there? The GMC sets out standards. There's the Federation Medical Leadership and Management Standards; there's a range of competencies. Is the Trust attempting to bring some formality to those competencies in in its training programme, or is this also still work in progress?

A. Yeah, I think that's something that's being considered in terms of some of these development programmes for clinical management leadership structures. That has been covered in previous leadership training programmes. I think when you have a cohort of staff and changeover of medical managers, it has to be ongoing continuous thing.

Recognising that there will always be an element of staff changeover - are systems lined up and the training in place to make sure that all new staff are up to speed with the relevant standards?

A. At that stage there was no corporate programme for training staff on incident reporting, risk management, because if you don't train staff on how to report an incident, you get a lot of unnecessary work later on, you know, if they grade something either catastrophic that wasn't; or vice versa, you can miss the importance. The coordinator should also have a role in terms of themeing your incidents that are coming in, and really pushing near miss reporting. We just weren't doing any near miss reporting at that stage. You want to get your near misses reporting done because that's your opportunity to fix systems before there's harm done. That wasn't happening; there just wasn't the capacity to do it.

How widespread in the Trust is training for staff on incident reporting and near miss reporting?

Q. Again, the system for spotting what the Trust has called irregular prescribing, is it down to the alert pharmacist on the ward spotting the problem or is there a more sensitive way that these kinds of issues could be spotted if they were to occur again?

A. Unfortunately, at the minute it is still down to alert staff, whether it is the pharmacist or obviously the nursing staff or other medical staff. Our prescribing system in Northern Ireland based on wards and medicines administration system is paper-based, so there is no way of sitting back and having an overview. Now, I'm sure you have maybe heard already from other witnesses about Encompass that is coming. It's unfortunate. Back in 2015, I was sitting on a working group. They were going to introduce electronic prescribing and medicines administration system to all Trusts back, I think, 2015. In 2015/2016 that work was stood down because they thought at that point Encompass was going to come quite quickly and there was no point in investing in a standalone system when a bigger system was going to knock it out, you know, knock its position. So, that work was stood down. Today, we still have a paper-based system until Encompass starts in the South Eastern Trust later this year. If you have a full electronic prescribing system administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It

would allow you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having alarms ringing, shall we say, that there was something unusual happening.

With the Encompass system being introduced later this year in the Trust, have training opportunities for all staff using this system been mapped out ensuring that the training is accessed before its introduction?

……

Q. In terms of staff -- I know you mentioned that the sister had meetings and there would be conversations around governance but, more widely, did you have a sense that staff across all disciplines, ancillary staff, had an awareness of their own individual responsibility around governance to alert the appropriate people if they had concerns?

A. I think the ward sisters had and the ward managers had. I would have done direct face-to-face training with them on Datixes, but –

Q. How often did you do that?

A. So that would have been done probably every few months. It would have been either me or Carly or David, the two Band 7s, that would have run that training with them.

Q. Just to clarify, Datix training every few months with staff on the ward?

A. Yes. Whilst they didn't get it every few months, they would have got it once, you were rolling out the training for staff to attend. It wasn't very well attended, you might have had maybe five or six people there at training.

Q. So was it optional?

A. It wasn't in their mandatory training, and perhaps it should have been. It is in maternity, mandatory training for midwives.

Q. Do you think that would help if it was mandatory?

A. I think it would because when I first came into post, I think there was a negativity around putting in a Datix. It nearly seemed to be that you were reporting somebody if you put in a Datix. You know, in maternity, that was the case. I had to change the attitude to staff and say, you know, hold on a minute, this is not about a person or an individual, this is about a system and process, so we need to be looking at this, Datixes are not used as oh, I am reporting somebody because they did this and, you know, putting a negative slant on it. I would have seen Datix submissions as a positive because they were recognising there was a risk there, they were escalating the risk there and we were doing something about it.

What is the SLT's view on Datix training being mandatory for all staff on the frontline?

So where Tracey was saying Governance wasn't fit for purpose and it felt like she was saying there wasn't enough people -- it's not an add-on, it's an in the job/on the job role. And while they were writing the Datix, the on the job people, they just weren't following it through and addressing it, and that takes time and culture and support, and it felt -- it feels now, reflecting on that, it looks like it was too early then. To me, it's still an issue today. When I work with my teams, it's still an issue to have that challenging conversation with your consultant colleague, but we know that we have to do

it and it's more instilled that it is required to be done and that's probably from all the learning that we've gained in the intervening ten years.

Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?

……..

Q. And within your role, I suppose, specifically of governance. It is notable as against SAI investigations you haven't felt able to say anything in terms of strengths?

A. The challenge at the time was significant. There was a large backlog of SAI reports. They weren't able to be progressed in a timely manner. And the patient and family engagement isn't what I would have wanted for those patients and families.

Q. Yes. You point out the core weaknesses: "Staff do not have sufficient training to make them confident with the SAI process, particularly for chairs of SAI panels and it is difficult releasing staff to attend SAI meetings." That's difficult to your staff or operational staff?

A. Operational clinical staff.

Q. Yes. Is that then pointing in the direction then of particular problems with the SAI process? Was it almost facing a situation of near collapse because of these problems or is that too strong?

A. Collapse is maybe strong but there was a significant backlog of SAIs, I think at that stage probably about 33. The small team, myself and one other at the time, it was a challenge for us to be able to support all of the chairs, help draft the timelines, help with drafting the reports, supporting the chairs and supporting the members of the panel. And again to getting the teams released to have the meetings in a timely manner and support them in writing, you know, finalising the reports, it was a huge challenge at the time.

Is there currently adequate time, training, and resource now in place for staff conducting SAI's? If not, what is the plan to address this?

A. That I think is really relevant to this process? It mentions training and support. Prior to me undertaking those SAIs, I did not have any training. So, I recall being asked by Eamon Mackle to Chair the first, chronologically whatever the first SAI was that I did.

Q. That was –

A. I can't recall which one it was.

Q. Yeah.

A. But I sat in the office reading the e-mail and I thought "Am I really ready to do this? Do I really know how to do this?", and I batted that back to Eamon in a conversation and it was kind of - the answer wasn't "you'll be grand", but it was to that effect.

Q. Yeah. I was going to ask you about the training, and maybe that was a convenient but accidental point to stop on.

A. I've subsequently had training.

Q. Yes. You outline in your statement, 19.4 for the panel's reference, that you completed training in structured clinical record reviews in 2021.

A. Yes.

Q. As well as root cause analysis training.

A. Yes.

Q. The Inquiry is very interested in the nuts and bolts that make up the aspects of the SAI process. Training in 2021, you did your first SAI, so far as this Inquiry's concerned, in 2015?

A. Yes.

More evidence from the Inquiry about the need for proper training before taking on roles that relate to patient safety and quality care. Is this aspect now being audited?

Q. There is training associated with Datix or for users of Datix, is that primarily targeted at those with investigation responsibilities?

A. There are two levels of training and they were instigated by the Directorate Governance Coordinators at certain points. There was training in relation to general governance which would have touched on the Datix system. And then there was also training in relation to someone who is investigating a Datix incident and how they work their way through that process and what elements they should consider in their investigation. That was sporadic in its nature. And in my current role now since 2019, whilst in 2019 there were a number of sessions organised but when Covid kicked in then those were put on hold. So training now is just on an ad hoc, on request basis.

Q. And it is not mandatory for Datix users?

A. It's not mandatory, no. But it's something that I feel that should be mandatory. It's an IT system that's used by the Trust and I think that that system should be supported with appropriate IT training.

Does the SLT agree that it would be appropriate for all clinical staff to have mandatory training in the most recent Datix system?

Q. What is the buy-in with consultants in all of that? Do you work parallel with them to identify training and deliver it or is this nurse-led training?

A. The consultants, yes, do buy in with the training. I think the consultants would value if they do do the basics first. And they would like the nurses to look at where service provision is, where there is a need for the service. Yes, they are very open and managers are very open if there is any specific training that needs, such as if they need to be sent for a flexible cystoscopy course or if they need to be sent for the non-medical prescribing, the consultants are very supportive. And also the Nurse Managers would be, there would be support from the Nurse Managers as well. There is also training at present for myself and that would be for the transurethral laser ablation. A girl had come out to assess the Urology Service and they had recommended that this would be an ideal opportunity for the Urology Nurse Specialist to be trained.

Q. What stage is that at? Is that something there has to be separate funding sought for or what way does that work?

A. There will be funding for the equipment and there will be funding for training. The company will provide training and myself and Jenny, who will be trained in this, will be sent to centres in England to be trained up and to assess for the transurethral laser ablation. We will also have consultants will assess our competencies and we will probably have sign off competencies to be able to do this procedure.

Q. But your view is that the Trust are motivated for this to go forward?

A. Yes, to bring this forward. Because this will reduce patient waiting time. If they have small bladder cancer reoccurrence, rather than be on a waiting list we can provide this nurse-led service. Also, there are maybe patients who are not fit for general anaesthetic, so we can provide the service for those group of patients.

Has the funding stream been identified for this training? Have staff been released to access the training?

Q. So if we move to the preceding page, TRU-303440. And this is an email sent to you from Patricia Kingsnorth, who we know is the Head of Governance. She sends it to you and copies Martina in and Fiona Reddick. And she says: "Hi Patricia, many thanks for agreeing to assist with the SAI process. We have a number of cases to be discussed and will measure them against the existing pathway. Can you be available to meet with the review team on Thursday, 10th September at 9:30am in the meeting room, Trust headquarters." And signs it off, "Many thanks, Patricia". So that was the start of your involvement in the process?

A. That's right.

Q. And that was the first meeting that you attended, that was your first introduction. I just want to ask you in general terms, we have looked at the notes and we have looked at the minutes and we have discussed this, in relation to your introduction at the meeting, did anyone set out your role and what was expected of you and what you brought to that particular process in relation to the make-up of the team?

A. No. I never had any information of what my role was to be with the team. I gathered that because I had experience of a urology CNS from another Trust, and a lot of experience, it was to sit on to see if there was any key worker involvements. But I was never given any task to say this is the expectation we would like you as being part of the Panel for the SAI process.

Q. When you say key worker involvement, was it indicated to you that that was the purpose for you being involved, was the key worker issue?

A. No, I don't think it was the purpose of why I was involved. I think it was the purpose because of my experience and what I could bring to the SAI. But there was no criteria or no particular road plan was given to me.

Q. Did you have any knowledge at that meeting or after of the terms of reference of the SAI?

A. There was no terms of reference was formalised at the first meeting. But terms of reference was formalised following that first meeting. And they were written both by Patricia Kingsnorth and Dermot Hughes.

Q. Did you have any input into those terms of reference?

A. I didn't, no.

Q. Do you recall those terms of reference Doctor 1?

A. Yes, the terms of reference were referred to Doctor 1.

Q. Now you had no previous knowledge of SAIs or you had never been previously involved in any?

A. No, I had no knowledge of SAIs. I wasn't involved in any or I had never been the subject of an SAI. I never had any training either with an SAI. However, I do note that my role was just to sit on the Panel. It wasn't to be a chair or a governance part of the SAI. But no, I had no previous experience.

Q. Just so we get a feel of it. Something that we're not familiar with, but the SAI, was there a feeling that everyone was an equal member of the team and everyone brought a different lens to it or what was your feeling about it?

A. My feeling about the whole team, I wasn't given -- only my -- I felt that I didn't have a lot of input into the team. I would have liked to have maybe had more of an input. Such as with my experience and my experience of being a key worker and an experienced Urology Nurse Specialist, I felt my input would have been better if I could have liaised with families and with patients along with Dermot and Patricia Kingsnorth. Because I could have maybe found out more information, I could have spoken to the patients, I could have found out -- because the particular issue and it would tend to be that there was no key worker involvement, I could have maybe spoken to the families and maybe found out more specific information. My role really was to look at the likes of the patient administration system, the appointments process, the DARO, the protective review, but it was never anything such as, you know, being involved with the patients or the families.

Q. So it was more data-led?

A. It was more data-led.

Q. You were good for figures rather than facts of processes?

A. It was more of timelines, you know, timelines of patients' appointments and was there a key worker at that clinic and when was the patient seen, was there a letter typed for that particular episode, that was more of my involvement.

Q. Now you have been through that process as a team member, do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?

A. I think it would be useful if training was to be advised for anybody who wishes to sit on an SAI process. Also, too, it would appreciate what type of SAI is it, is it a Level 1 or 2 or 3. And also, too, what each team member brings to the SAI, such as the chair of the SAI or the governance person of the SAI. But I do think it would be a very useful training for anybody who wants to sit on an SAI process is to do the two-day training.

‘Do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?’ What is the SLT’s view on mandatory training?

Q. Now in relation to your involvement in the SAIs, is there anything else you would like to add that might assist the Panel in considering whether the effectiveness of SAIs generally as a governance tool or what you think, as having been on a team, might help beyond what we have already discussed, is there anything further?

A. I feel, obviously, training is very important for the SAI. I think even informing a person what the SAI is about. When I attended that meeting on 10th September, looking at the SAIs then I realised or worked it out that it was about Mr. O'Brien. I think it is good to be notified what the SAI is about because I did find the SAIs was very, very comprehensive and very complex. A lot of it was very emotional because a couple of the patients did -- I felt was very emotional about a couple of the SAIs. And I think, too, counselling, if somebody could maybe be very upset with regards to an SAI, because

a patient could have catastrophically been harmed and maybe counselling may be something to consider.

Q. Some sort of outreach around patients who have been involved in that process?

A. Sorry?

Q. Some sort of outreach in relation to patients who might have been affected by the SAI process itself?

A. Yes, for the patients been affected by the SAI process. And also staff as well, staff could value from counselling.

Is support offered currently to patients and staff affected by the SAI process?

…….

"The post of specialty lead is a taster role for those who want to try medical management out. The post may become a stepping stone to a wider management role or may prove to be as much as the post-holder wishes to take on for a longer period." So you stopped at that rung in the ladder. You didn't use it as a stepping stone to elsewhere –

A. Correct. I didn't want to climb up the management level.

Q. Yes. In terms of the role, were you remunerated for it?

A. Yes. I was given 0.5 PA.

Q. Did that adequately reflect the time that you devoted to the responsibilities of the role?

A. I don't think so.

Q. Were you supported administratively or otherwise in the role?

A. My secretary did any typing that I needed.

Q. In terms of, if you like, training for the role, support in that direction, did you ever receive any specialty lead specific training?

A. No. I trained myself and to what I thought was needed.

Q. Were you given any guidance as to what might be needed?

A. No. But I also wasn't told that I was doing something wrong, if you know what I mean -- if I was going up a wrong pathway, that's what I'm trying to say.

Q. Over the years -- and it was 20, approximately, years for which you held the role –

A. Yes.

Q. -- did anybody at any point press the pause button with you and say "You're doing this particularly well, but you're not doing this particularly well"? Any meetings of an appraisal-type nature focusing on specialty lead?

A. No.

Has there been a recent audit of all the posts in the Trust that require/should require training and if corresponding appraisal of the post holder has taken place?

How frequently is such an audit carried out? Have actions from the previous audit been implemented?

Can the SLT assure the public that there is a high standard of training and appraisal for all its clinical and management staff?

A. One of the things we did achieve is to regularise the M&M Chair position into an appointed position, interviewed for competitively, appointed and given half a PA a week, a small amount of time but, nevertheless, previous to that the M&M Chair had been a volunteer. I also thought that was a very good idea as a way of introducing newer and younger consultants to medical leadership. Because my idea of that medical leadership, which I tried to explain many times, is not about being the most senior doctor, it's about making things happen, making good things happen. So we did that and I was very pleased with that.

Are there currently good and accessible pathways for newer and younger consultants to gain training and experience in medical leadership?

Q. It is no doubt very difficult, to coin a phrase, to teach an old dog new tricks, if that's the sense of what you're communicating –

A. Yes.

Q. -- about him in terms of the use of the word "idiosyncratic". Is there a responsibility on the part of clinicians to move with the times to try to embrace new practices and new ways of doing things?

A. I think, yes, ideally that's what should happen. I think the key relationship in urological surgery is the consultant surgeon and the patient. I think that there is a sort of tryst between the patient and the urologist. When things go wrong, it is the urologist that gets criticised. I think over the passage of time we've seen more and more people deployed into the team who facilitate - the nurses, the radiologists, the radiotherapists, medical oncologists, etcetera - but the key relationship is that urologist with the patient. Some more senior urologists have been understandably reluctant to let go of their own special management of the patient; they feel uneasy about delegating their care to nurses who may have a slightly different view. You know, there's a sense of wanting to keep the patient to yourself because you're the one who carries the can, really. So I do understand where Aidan is coming from, but I don't think it helped his practice.

Q. Yes. I mean that sense that you've picked up on of keeping ownership of the patient, would you regard that, certainly in 21st Century urological medicine, as a bit of a blind spot?

A. It probably is, yes. I think what we've seen is the development of all sorts of individual specialties within urology - stones, cancer. I mean, in my case I only looked at prostate cancer patients in the last five/10 years in my practice. You do need the assistance of other people because you no longer have the necessary knowledge. You can understand why some people feel reluctant to delegate or to hand over the ownership of the patient. I think that's what happened in Aidan's case.

Where best could effective discussions take place around the idea of 'ownership of the patient' in clinical practice?

MHPS

Q. Is there then a possibility of looking at having external people dealing with MHPS procedures? Would that be a good idea?

A. It would be a -- if you were asking me what one thing would you want to change in the system, it would be that one thing when it's a complex -- I mean there might be times when it's, you know, when it's better not to do that. It's degrees of difficulty. When it is complex and sustained over a period of time and despite previous efforts over many -- you know, a long period of time, and it's quite systemic, then, yes, external -- to me external review or external process has to be the most objective way to deal with this and to deal with it as quickly as possible.

Does the SMT think this would be a good general principle to apply going forward – having external people dealing with MHPS procedures?

Q. Maybe we can just formally bring this to the screen. WIT-33938. At paragraph 29.2 you say that: "On reflection, I do recognise that the screening of concern stage should have been undertaken by the Clinical Manager rather than myself." And that your actions were outside the agreed guidelines.

Can you guarantee that all the current investigations in the Trust are operating within the agreed guidelines and the MHPS?

……..

Q. Just in summary form, for the Panel's note, WIT-26299 to 301, you have set out what you consider to be failings generally –

A. Yes.

Q. -- in your Section 21. You've indicated you felt there was a lack of respect for non-clinical managers in doing this role?

A. Yes.

Q. Is it still the situation at the moment? Do you know if non-clinical managers are still expected to undertake this kind of oversight and monitoring role?

A. With being out of the role now, the operational role since June 2021, I couldn't comment on that at all.

Q. Was it up until that point, June 2021?

A. Up until that point, yes.

What would be your assessment now regarding respect for non-clinical managers taking on roles in the delivery of MHPS?

Q. In your witness statement, for the Panel's note at WIT-26315, you expressed a view that you don't think that Mr. O'Brien should have been allowed back to work so soon and you called that a mistake. Can you give a bit of context to why you have that view?

A. It's just back to what I had said previously. This is in hindsight, I didn't say this at the time, but it is a reflection when I was doing my Section 21, I think the investigation should have been a wee bit further. At that stage it hadn't even really started. I think there needed to be more of a -- you know, to extend it to talk to the likes of the people I'm saying there to say what other areas do we need to look at. It was a decision made inside a confined group of people without actually expanding it out. It's a bit like everything -- just back to what I said there, you know -- any of the rest that go through disciplinary, they would be properly investigated before allowed back to work.

There is the principle of equity and due process being equally applied to all undergoing a disciplinary process and a return-to-work plan – this seems to not have been the case with Mr O'Brien.

Q. The doctor who is under discussion, what is the appropriate point to tell him or her that there are issues being discussed both within the organisation, obviously, and externally if you are seeking advice from NCAS? Mr. O'Brien obviously was wholly in the dark about these meetings, the September meeting, the October meeting?

A. Yes.

Q. Only on 30th December is he told about this long-running process?

A. Yes. In fairness to the clinician it should be whenever there is a case being discussed. I mean, back in September, you know, I think the appropriate point in time at that stage was to be flagging to him in September that, you know, the Medical Director, Director of HR, you know, and the Operational Director had an awareness of this and there was a screening done. Yes, absolutely, September time, in fairness to the clinician.

Is this now standard practice?

Q. It would have been as simple as: Mr. Gibson, you said this to NCAS, what did you mean by it and who told you about it? And a judgment then could have been made about whether further questions were merited outside of the room amongst fellow clinicians perhaps or within the service.

A. Yes. That's correct. I think there is learning from that in terms of ensuring that at every meeting -- and I think, I mean that's absolutely what we have now in terms of a proper timeline of cases and attachments of NCAS advice and attachments of legal advice, so you have the whole picture when you come to discuss a particular case. That's what was missing here.

Is there monitoring evidence that this is now the case?

Q. Finally then, you described the improvements in MHPS reporting. I think, you, yourself, suggest that's the tip of the iceberg, really, in terms of understanding all the informal issues and all the improvements you need to make. So I think from what you said that's been helpful in terms of increasing the discussion engagement at Governance Committee and, hopefully, at the Board in due course. Have you seen any other improved engagement that fits along with the Just Culture kind of idea at Board level as a result of the work that you have had to do for this Inquiry and the work that others have had to do. Have you seen anything else filtering through that would be helpful for us to know about?

A. I think from a Board perspective, I mean there's very much that openness. There's the openness to bring problems at a much earlier stage and I think that is very much welcomed. I mean inevitably across different services, even Acute Services, there is issues and it is very much a full disclosure, there's an openness, there's engagement at an early stage to say "this is what we're dealing with". The discussion is had. There's the challenge there. There's the follow-up there. I suppose I'm seeing more of that.

A key message that should remain on the front page of Trust business - 'There's the openness to bring problems at a much earlier stage and I think that is very much welcomed'

Q. Have you anything to suggest to the Inquiry in light of your experience about how a Trust operating within the rubric of MHPS can ensure that when issues such as those that were raised in 2016 and into

'17, how they can be translated into Terms of Reference which encompass other areas of the practice that perhaps aren't known?

A. I suppose, looking at this e-mail, which I've never seen before, but looking at this e-mail and the case that you have outlined in relation to the retained swab, I suppose I would have assumed that when one was screening, one would have looked at adverse incidents, never events, things like that that had occurred in the past, I would have made that assumption. But I do have to preface that by saying I have no experience of screening, I don't know if there are limitations to time frames. I really don't know how screening happens and, therefore, I really don't feel I am the best person to comment on that.

Is there clear guidance in the Trust on a thorough screening process before the Terms of Reference for an investigation are agreed?

'I believe there is an element of lack of clarity within the framework but also lack of clarity within the roles and responsibilities among various peoples. There is a designated director, nonexecutive director, as well, and there is a Case Manager, and then there's a Case Investigator who is doing the case, who is trying to explore what's happening. I believe there needs to be much more clarity in roles and responsibilities'

Q. I think we spoke earlier about the issue of dedicated time and just to perhaps go back on that again. Is it your view that an MHPS investigation of any complexity does require dedicated and focused resource, both in terms of the Case Manager and the Case Investigator, and perhaps also the HR support, in order to ensure that the process works itself through in the most efficient manner?

A. Yes.

'I have reflected on the overall MHPS process and I think this is one of the improvements we should make as a healthier system. These types of investigations require quite a lot of input both from the clinicians and from the HR point of view, and requires additionality. Therefore, it has to be recognised as an additional piece of work, and additional time and resources should be put in place'.

……..

Q. Just finally from my perspective. You've offered some reflections on the MHPS process generally and your role in it. One of the things you've said in your witness statement -- this is at page 903 of your bundle, not the core. WIT-31999. You say at 23.1 that on reflection in your view, the MHPS process could have been more proactive. Proactive in that context means what? Proceed with greater expedition or efficiency?

A. I suppose I was thinking on my experience and my reflection since then. The MHPS process was implemented and there were a number of elements. My reflection was that all of them or most of them contributed into the MHPS process; the framework document itself, then how it was implemented in the informal stages, the formal investigation, and post determination, but also how the resources were allocated, what was provided, what was the training element, the experience, the expertise going forward, the interaction or the interface of the Trust own going into the MHPS Framework, that was all part of my thinking. In terms of proactive more towards clarity of the framework or the document or the policy, but also clarity of roles and responsibilities, clarity of entry and exit points in the process, and clarity of taking it forward. That's what I meant by proactive.

Q. I'm glad I asked because there was more to it than simple efficiency. It's a wide-ranging concern you have. You go on to point out the absence of dedicated resources, and you give the example of

your own role as case manager being an add-on to your other day jobs, which were more than one, as we know. Anything further you wish to add to that?

A. I think the dedicated time or protected time is vital in terms of doing these investigations. We know now it took much, much longer and it's still was going on and on. It was initially thought to be for a few months. I was already doing a busy clinical practice but also in a managerial role. Then I took over the Interim Medical Director role, which was also very busy, without any proper induction or hand-over. So, I felt that in my particular role as case manager, it took a significant amount of my time, not only just the time but also it had a greater impact on other elements going into the clinical and my managerial roles. So, I felt that what needs to be put in place if this is to be done in a correct way.

Is protected time now a standard provision for those carrying out a specific investigating role?

Q. Also within this document he is explaining his commitments to the Urology MDT and MDM. He is putting this to you as a context for the work which he is doing and by way of explaining how there weren't enough hours in the day to do the work, all of the work that was expected of him. Do you accept that this wasn't appended to your report?

A. Yes, it wasn't appended.

Q. And it wasn't otherwise referred to in your report?

A. Well, the document isn't referred to but the additionality of his work is referred to in the report.

Q. In what way?

A. In his respondent statement that I think we just referred to there, Mr. O'Brien indicated that he was doing significant additionality in relation to his work, and was doing extra clinic -- extra theatre sessions.

Q. Yes. That was his statement where it's referred to?

A. Yes.

Q. Why didn't you append the evidence, this example of evidence provided by Mr. O'Brien to your report?

A. Because I think -- I felt that including it in the statement, that this was the mitigation that he was putting forward, was sufficient. I didn't feel that it was -- I felt the point of mitigation that he was making was something that can be made to the Case Manager, it wasn't one of the Terms of Reference. Therefore, my view was it wasn't necessary for that to be appended. There were, as far as I knew, lots of appendices as it was already, so I didn't feel that it was necessary.

Q. You are describing a conscious thought process to deliberately leave this out of –

A. Yes. I didn't include it. I didn't feel it was necessary to include it.

Q. So, Mr. O'Brien is setting out mitigation for the alleged shortcomings in which he is working, and of all of the evidential pieces that you are provided and you append to your report, you decide to leave this one out of account?

A. I think there were other pieces of evidence that Mr. O'Brien provided in relation to some of his private patients, for example, that I just felt it wasn't necessary. It was included in his statement that he was doing a lot of additionality. I felt that doing additionality, whilst I understand why he did it, it was still my view that he had a responsibility to do the job that he was asked to do.

Q. Is there anything in your report that suggests that you took into account the content of this document?

A. I considered Mr. O'Brien was a very busy man who opted to do surgery rather than do his administration. The issue in relation to most of the Terms of Reference were in relation to the administration of his -- in relation to his work.

Q. You didn't consider it to be unfair not to include this evidence?

A. I did not.

The importance of fair and accurate contextual representation in investigations.

Q. Just coming on to one of the things that you have been asked about extensively. I am not going to go into the detail, you will be relieved. But private patients, the issue of transfer between the NHS and private practice is always fraught with difficulty and most Trusts have a policy that says if you see them privately, and you want to see them in the NHS for any reason, you have to transfer their care to the NHS, and you shouldn't be transferring them back and forth as you wish, and that must all be documented. Now, whatever is the case with the private patients in this situation, I can't see evidence that all of that happened robustly. My question to you is, is that a general problem in the Trust, do you think? Have you got any awareness of that? Do people pay enough heed to the rules and regulations around this, because it is quite clearly set out in the GMC guidance that you mustn't give private patients an unfair advantage. Have you any comments about that?

A. I think managing private patients in the Trust has become a much more robust system latterly. I think there have been times in the past, particularly historically, where the Trust would not have had robust systems in place because a lot of consultants wouldn't have been involved with private practice; some people were seeing people outside of the Trust. So I do think there probably weren't robust systems in place historically. I believe that's not the situation currently.

'I believe that's not the situation currently'

Is this an accurate statement?

Q. Because obviously, doctor, where we had in this case a lengthy investigation, it took some 18 months to bring it to a conclusion, and where it didn't identify the kinds of shortcomings that were to come to life in 2020, the public will obviously be concerned about the MHPS process and whether it is fit for purpose for discovering these kind of things. Or perhaps the reflection is the MHPS is only as good as the people using it and if they don't take effective stock at the beginning, then it's not going to deliver the kinds of outcomes that are important from a Patient Safety perspective.

A. Absolutely. MHPS is a flawed process; there are many flaws in it. We could sit down and have a long discussion about how it could be improved. At the end of day, it is a process and if we don't follow it, it's not much use at all. So, it's not rigorously followed. It also doesn't replace common sense. You know, you still need to apply common sense occasionally. You know, yes, there are terms of reference and investigators are expected to stick to the terms of reference but that doesn't mean they can't listen to anything that's told to them.

As MPHS is currently being revised – is all the learning from the Inquiry relating to MPHS being fed into the process? What are the plans to update and roll out training for all staff on the revised MPHS?

Q. Yes. My other point is when you are speaking about your initial discussion with the senior decision-maker, i.e. preferably the Medical Director, once that had been done and you'd sorted out an action

plan, do you think you would have had to have spoken again with the Medical Director, or would someone like a clinical director who has more operation knowledge of the problems would be a good person to talk to? I suppose what I'm asking does it always have to be the most senior decision-maker or can you go down the sort of food chain later?

A. I think that's probably reasonable. Certainly at the beginning, we need to have a discussion, I think, with somebody who can take decisions and decide the way forward. Yes. When you are just monitoring progress, I suppose you could, as you say, speak to someone whose a bit more operational, with the proviso that if we say, hold on, there's a big decision to be taken here, it's not working, you can go back up the ladder

There is a relevant place for gathering monitoring information in real time at 'the coal face'.

……..

Q. Now, there has been some evidence given to the Panel around the necessary confidentiality of the MHPS process and some of the perhaps barriers or challenges that puts up in relation to sharing of information, it's important for good governance.

A. Yeah.

Q. Do you have a view on the appropriateness of information not being shared to maintain confidentiality?

A. I respect confidentiality but I believe that when there are an operational team working, or there is an operational team working on issues that are referenced in that report as needing to be further addressed, and people referenced like the Assistant Director, I think they are entitled to have that information shared with them so that they can be fully informed and be part of that, and that wasn't the case. So yes, I do believe there should be a sharing with the appropriate people.

Confidentially vs intelligence and learning from the MHPS process – is there a guideline in place that addresses this? Does it need updating?

……..

Q. Tracey Boyce has said in her evidence to the Inquiry that there was this disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team and she says from what I understood at the time they had to be kept totally separate. However, with the benefit of hindsight, she thinks that a joint approach would have been beneficial. So, for example, the SAI concerning patients, the five patients, might have been expedited rather than taking the guts of three years. A more of a joined-up approach would have led to a more efficient and perhaps a more universal learning. Do you have any view about that?

A. My understanding is that the two processes sit separately, one is in relation to the professional management of the doctor, the other is in relation to learning from a clinical incident. I think as a governance coordinator you are aware of lots of very confidential, very sort of information and it would be good to understand other processes that are going on within the Trust to help triangulate all that information and perhaps share between the two processes so that you have got a very robust rounded learning from what was happening at the time.

Is it still the case that there is 'a disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team'? Is there a move towards triangulation of information?

Q. You've also mentioned in your statement that the guidelines were a way of effectively encouraging good practice, because they would be audited, and you thought that that would allow then perhaps any issues to rise up to the surface.

A. Yeah.

Q. That was one of your motivations as well.

A. Yeah, retrospectively, it would have been good to audit. There are many audits it would be good to do, and particularly from an MDM perspective, you know, there are a number of things we would like to look at. I think it would have taken probably precedence in moving the service forward more than Bicalutamide 50, but actually, yes, it would have been good to take it to a year time point after the guidelines to see were they being complied with.

Q. I mean, you know, if I asked you the question "How do you know people are adhering to all the guidelines?", how would you know?

A. I think when they come for their opinion and you're seeing a trend of non adherence, that's the flag for concern.

Q. But there's no systematic look at that, you don't think?

A. No.

"How do you know people are adhering to all the guidelines?"

Is there now an auditing system in place that measures adherence?

…….

Q. Can I ask you to reflect, in light of the support that Mr. Suresh appears to have received, in terms of Mr. O'Brien's practice - and we're going to look at a number of issues, and perhaps you can only address the issue generally at this point, because much depends on the gravity with which the issue is understood from a patient safety perspective, there's obviously whether there's full knowledge around the issue - but in terms of looking back on Mr. O'Brien, he came through an MEPS process and then there was a return to work plan, and I know from what you've said that that was largely hidden from his colleagues. Do you think, from a team perspective, Mr. O'Brien could have been better supported with the practice difficulties that he faced?

A. Yes, and I've said so in my statement. I think it would have been much better if those issues, and I realise there are sensitivities around some of them, but certainly I think if the medical managers had of discussed with us as a team of consultants the particular issues, and allowed us to understand the breadth of issues, but then also to formulate a support plan, a network, if you like, as to how Mr. O'Brien could return to the team and practice safely. It would also have given us greater oversight going forward as to when, if there were any dips in performance, or non-adherence to agreed behaviours, then we would have been able to identify that at an earlier stage.

Q. We'll maybe unpack some of that as we go along. What do you identify as being the, if you like, the block or the obstacle that was in place that prevented the development of that kind of approach?

A. So, I had no knowledge or part to play in the return to work plan. That was developed without input from the whole team. It was developed, as far as I understand, from the medical management side

and with some input from the Head of Service, from what I've read subsequently. So those people held that information. It wasn't shared with us. I think if we had of been aware of what they were monitoring and how they were addressing any shortcomings, then we would have been in a position to assist.

Taking these comments on board – has there been a discussion on what a full range of consultation looks like before developing a supportive return-to work plan?

Q. We have been discussing the MHPS process and what recommendations that we might make, and I'm just wondering what your view might be about that. Do you think there is a role for a specialist team to do this kind of work?

A. You can't tag this on to the work of a CD. It was very difficult at the best of times but for all of 2012 I was utterly overwhelmed by two smallish -- no, two normal -- if you like two normal MHPS ones and a massive one that went on a year and involved challenges from the legal profession, which took me a year to do because of all the challenges. But it can't be done on the back of a CD role. It has to be a team. It also should be a very experienced team, and it shouldn't be people who know each other. That's not great, either. The suggestion, obviously, is that it should be retired people. I think -- well, I won't be doing any.

This issue of adding to the already demanding clinical role - engagement in the MHPS process has been raised several times in the Inquiry. What is the current thinking on the MHPS process being carried out by an experienced team preferably whose members are not currently employed be the Trust?

……..

Q. I suppose my question's perhaps a little bit broader than being specific to your assistance that you provide. Do you see any merit in the Trust having a formal or a structured approach to new consultants to allow them to understand exactly what's expected from them in their role, as regards, for example, administration, discharge, the processes by which they engage with wider ancillary staff within the Trust?

A. So, again, when I started in Belfast Trust, that there was a programme of training as a junior consultant. But that only happened after I was appointed and then it was, I think it was like one day of training per month for the first six months - I think it was called the CLIME sort of training, C-L-I-M-E. I can't remember what that stands for. But that was sort of part of being a new consultant, how you were introduced to the governance structures and how the Trust expected you to run your practice. But certainly, bringing that into higher training so that when they start that they have a better idea of what's expected I think would be beneficial.

Is there a formalised, structured training in the Trust around what's expected of and from registrars and new consultants in relation to their role?

Oversight Group

Q. There has been a lot of mention of the Oversight Committee in the discussions that we've had. What was your understanding as AMD of the actual role, purpose, status, hour, of that Committee? Was it something that everybody understood well or?

A. No, not at all. It was basically -- it wasn't really a committee

Q. So it was -- how did you see it then? Can you give us your view of how that operated?

A. This was a committee that looked at Maintaining High Professional Standards, GMC issues, and it was the Medical Director and it was the HR. The HR role, as I understood it, my experience of HR is they don't take responsibility. They give advice, they give you options, and then you make the decision, and then they ensure that due process is followed, ostensibly so it is fair but really so there is no chance of any comeback in any appeal or legal process. Then there's a Director from whatever division is involved. But these are medical issues so the divisional director really has less of a call.

Q. So as Divisional Medical Directors it is my understanding in looking at the minutes that there was no attendance at these meetings even when it involved something in your division; is that right?

A. You mean for me?

Q. Yes?

A. No.

Q. So it was done without you?

A. I was never involved, ever, in Oversight Committees. That was always at Director level.

Q. What's your view of that? The appropriateness of that?

A. Totally inappropriate. But you need to have -- if you're going to have a Clinical Director there, they need to be someone who is prepared to be robust and to be prepared to be robust. I think for a Clinical Director it would be difficult. I think for an AMD it would be easier.

Is there currently an Oversight Group/Committee? If so, what is its purpose and what roles make up its members? Is there a transparent operating process?

Are steps being taken to make sure the current operating structures within the Trust are clear to all who work in the Trust?

…….

Q. It was the role of the Oversight Group to ensure that that was done in a way that was consistent, fair, transparent. It was a quality control type function as opposed to an investigatory screening or decision-making function?

A. That's how it was envisaged, yes.

'It was a quality control type function as opposed to an investigatory screening or decision-making function?' Is this still the understanding of the purpose and function of an Oversight Group?

Q. But one argument may be that the terms of reference are an issue for the Human Resource Manager and the Case Manager rather than as a collective approach by the Oversight Group. Do you have any views on that?

A. I suppose what I would say around even the Oversight Group and the matters of roles and responsibilities and the function and how the Oversight Group functioned, while it's documented there, there were probably varying views in terms of what actually in practice was the role of that group. So, what I understand in terms of this is that the clinical manager, in terms of the individual who ordinarily would become aware of the concerns and raise the concerns, in this instance that role essentially was a number of people, including probably the Medical Director, who was becoming aware of issues coming out of the SAI. So, that nice clean process of who identified the concern, who screened the concern, who then was the commissioner or the decision-maker around the need to go

forward with a formal investigation, in this instance that was, in my view looking back over the documents, probably more the Oversight Group at that particular point in time. Because those decisions around needing to exclude was happening with the Medical Director, I suppose taking advice of the HR Director and involving the Operational Director. In terms of how terms of reference, I suppose, should go forward, I'm not sure that the Case Manager in practice has done that. Should they do it? Quite possibly.

Q. Is it possible that your answer could be interpreted as saying that the collective expertise of the Oversight Group would be beneficial in informing terms of reference?

A. I think in practice that is how it operates. These matters are difficult, they are complex, they are challenging to start off on that track. It generally is the collective experience of a number of folk in terms of trying to get this on to the right path as such. So I think, yes, the answer to that is yes, it's generally a collective input from a number of people who have a level of expertise.

How is the Trust addressing and improving the need to have a clear understanding of the roles, responsibilities, and lines of communication in the carrying out of informal and formal investigations?

Dr Swart -Q. Another thing that comes out when you listen to the various witnesses is there was very poor knowledge about the workings of the Oversight Group amongst quite senior medical managers. It seems to me it was shrouded in secrecy which is actually the opposite of what people are aiming for these days. Is that a fair observation? Was that by design or accident?

A. I think it was a fair observation at the time but I'm not sure it was by design. I think it was more that over the course of those years between 2010 and up to the point at which, for example, Mr. O'Brien's case commenced in 2016, there was probably a handful of cases. There wouldn't have been huge numbers. The involvement of the Oversight kind of progressed in terms of what their role was. I don't think there was any deliberate intention to keep that shrouded in secrecy, but the numbers of individuals across the organisation who would have had a touch point with an MHPS process was very limited. So, it just wasn't known.

How are the principles of transparency and role clarity applied to Oversight Groups now?

……..

Q. Yes. We know, and perhaps it is more for Dr. Lynn to comment upon, that the Oversight Group made a decision at its meeting on 22 December to exclude for the duration of the investigation, as it was described in their decision. That was to be subsequently revised. The second part of their decision was to have a formal MHPS investigation. But then the advice was sought; the advice was then sought from her on 28th December. In general, while there's nothing to prevent that approach, you consider that to be the wrong way round and unhelpful?

A. I would agree. It is the wrong way around, it is unhelpful. What's the point ringing us (NCAS) if you want us to rubber-stamp a decision you have already taken.

Q. Now, there is a relatively complex evidential picture in terms of what happened next. I don't particularly need to go into that with you and it might be unfair to ask you to comment, but it is the case that no contact was made with Mr. O'Brien in respect of those issues until December, and late December, 2016. I don't wish to build in the complex ingredients to what was going on on the ground but, in general terms, where there are shortcomings or perceived shortcomings in a practitioner's practice, whether that's a conduct issue or a capacity or capability issue, and where the Trust has sought advice from you, or NCAS in general, it would be good practice, would it not, to advise the

practitioner that these engagements are happening so they are no longer behind the scenes, they're upfront and direct with him?

A. I absolutely agree. As I think I may have said earlier, in later years we actually wrote specifically in our letters, we put in a phrase which said 'please make sure you share this with the practitioner', because we were come to a realisation that that wasn't happening in many cases, and it clearly didn't happen in this case. It is a sort of fundamental principle of justice that if you are being accused of something, you have a right to know what it is and who is accusing you. So yes, they should be involved early and informed of their ability to phone us. Quite often we would find out that that had happened because the practitioner would phone us and we'd have a chat. Yes, it was disturbing to discover that Mr. O'Brien didn't know anything about this until quite sometime later.

'It is a sort of fundamental principle of justice that if you are being accused of something, you have a right to know what it is and who is accusing you. So yes, they should be involved early and informed of their ability to phone us.'

Does the SMT agree with this principle and having the willingness to apply it going forward?

Q. Could I put a perspective to you which goes something like this: Mr. O'Brien is, it appears, plainly in the dark that all of these events are taking place behind the scenes in respect of him. These matters directly concern him. On the one hand, we have NCAS advising that Mr. O'Brien needs significant support to be able to address these matters, and these matters are allowed to drift with no action being taken, no discussion with him. Then we get to the Oversight Group meeting on 22nd December, taking a decision to have a formal MHPS investigation and exclusion of him - and views may differ about his response to the letter of 23rd March - but he has not been engaged to do anything about his shortcomings and he has not been provided with any support to address his shortcomings. Is he entitled to feel aggrieved about that, in your view?

A. Yes. With hindsight, absolutely. I mean, the whole process of any dispute or any member of staff who is underperforming, or viewed or deemed to be underperforming, is about two-way communication. So yes, with hindsight Mr. O'Brien should have been spoken with, should have been advised of what was happening; what had happened and what was happening.

How would the SMT assess itself now on its ability to engage with both parties in timely, meaningful communication when it comes to an informal and formal investigations?

Management

Q. The criticism that emerged from MHPS, that there were systemic failures at all levels of management across a range of issues – was that conclusion drawn to your attention on a formal basis?

A. No

Q. There was a recommendation that there should be an independent review of management actions in this context. Were you interviewed or spoken to in the context of that review?

A. No

How is the learning and actions from Reviews, both internal and external, currently being monitored throughout the Trust – are you happy with the robustness and effectiveness of this system?

A. Mr O'Brien's secretary had not been escalating information. Secretaries can be loyal to consultants.

How is this being addressed?

A. A significant amount of our time at managerial meetings were spent on performance, to meet targets etc. This misses other important aspects like the quality of output.

Would this be an accurate reflection of managerial meetings now – is this being monitored?

How would you describe the current relationship between medical management and operational management?

…….

Q. Now you have said in one of your statements at WIT-26290, just for the Panel's note, that you felt there was an overreliance on you as you had an already demanding operational day-job and that the system failed when you were on sick leave, seemed to fail when you came back as well, but do you feel that you weren't supported in trying to take on this role as well as all the other things you had to do as Head of Services?

A. I suppose I'm the sort of person that just says, probably, yes, and just gets on with it. I do think there was always an overreliance on me in the sense that everybody perhaps used the working relationship that I had with Mr. O'Brien to get things sorted rather than people tackle it because we did get on -- we were amicable to each other. I could never change him because he was sort of very set, stubborn in his ways. With regards to support, I probably -- it's my own fault, I probably didn't reach out for, you know, to say; "I'm struggling with this", I just did it. I had a demanding job, would have worked easily 15 hours a day, and then on call, acute on-call on top of that, but, you know, always tried to get it done. So from my point of view, I probably didn't reach out and ask for support, but I do think there was an overreliance on me, on reflection.

Effective line management includes checking on the wellbeing of staff.

The importance of clear messaging being actioned through the appropriate channels.

A. I had to trust my colleagues, that's what they were there for. I had to trust my AMDs, my ADs, the Clinical Directors below them. They had a job of work to do. I was doing loads –

Q. You also have to manage them, Mrs. Gishkori.

A. Yes. Yes.

Q. You have to, because you're at the top of pyramid, say to them –

A. Operationally, yes.

Q. -- you have to say to them, do you not: 'Listen, this is a doctor who appears to be struggling. His struggles are causing potential harm or patient risk. I want this addressed, and I want it addressed quickly, and I want you to report to me with how it has been resolved'. At no point did you receive assurances of that nature; is that fair?

A. Only after September Oversight Meeting. That was whenever I really took the issue into my own hands to try and sort it out.

The monitoring of good quality and patient safety clinical care can be missed in a healthcare system where professional working relationships are 'sticky', good governance can suffer as a result. Awareness of these issues should be regularly scanned for and discussed. Team building exercises built into strategy.

A. I suppose in my mind, at what point does the MHPS procedure start? It could have been there wouldn't have been any further investigation after the Oversight, but with hindsight and looking back, yes, I think that's a fair point, that the local clinician being involved at the start would have been more likely to have that information to hand. I think that's correct.

Note the importance of gathering information from all relevant sources at the early stages of an investigation

A. On a human nature I have had to investigate colleagues, it is a very uncomfortable place to be and you have to put aside your personal relationships and go on your professional training. But it's a difficult, it's a very difficult thing to do. But it is a core part of the Clinical Director's job. It would have been normal practice in our Trust from the Clinical Director to have been the case investigator.

Q. If you are putting your hands up to take on the role of Clinical Director and receiving the salary or the pay, really it comes with the territory, difficult though it is.

A. It does. Mr. Weir had done this before and done it very well. I appreciated his reluctance, but I was, at that point, convinced that the best person to conduct this investigation was someone with local knowledge of the team.

Recognising the difficult challenge of investigating a colleague – be careful to put in adequate support for both the investigator and the person who is being investigated.

Q. Just on that. You can develop your answer, but if you could answer these as you go. What do you put that down to the fact it was allowed to drift through informal channels for so long? Was it deference to Mr. O'Brien and a reflection of how he was viewed as an experienced practitioner who was a good surgeon, an excellent surgeon, perhaps, and these issues were perceived as being more on the administrative side and not likely to cause too much harm to patients?

A. I think that's part of it. I think also a reluctance for people to put themselves in the firing line of criticism by a very senior colleague is part of it as well. Perhaps a lack of experience and knowledge of the potential remedies that might have been available. As I've said in my statements earlier, that there was a great lack of knowledge amongst even the senior medical staff around MHPS and other processes and how they would function. So certainly an education component to how that could be improved. There was some experience in the Trust in the past, as I now know, some of these issues had been escalated but they hadn't been addressed formally. So there was a feeling of what's the point of doing that again? That's part of the reason, I think, why people were reluctant to escalate, because they had seen it hadn't worked in the past.

Q. Maybe that's a bit too oblique for me, what do you mean by that?

A. In years gone by some of these issues, as I now know, had been raised at different stages but they didn't seem to have been brought to a conclusion or definitively addressed. I think there was knowledge within the system and within the teams that had happened, so what's the point in trying again? I think that reflects a naïvety and a lack of knowledge about potential remedies that can be very effective when implemented properly. That's where we'd like to be. I think earlier intervention would have potentially fixed these issues at an early stage and prevented us getting to this stage. In my experience, it is always a mistake to not intervene formally in these type of situations because they always get worse, they virtually never get better.

'I think earlier intervention would have potentially fixed these issues at an early stage and prevented us getting to this stage. In my experience, it is always a mistake to not intervene formally in these types of situations because they always get worse, they virtually never get better'

What is the SMT's view on this comment?

Q. Job planning has been mentioned by quite a few people. I've looked at quite a lot of the information. It doesn't seem to me that the Trust job planning process included, as mandated, team objectives and individual objectives, and any kind of capacity information built in. Is that correct? Or was that a place where that happened?

A. I think that is largely correct.

Q. Why was that then?

A. Well, I think it was one of the things that had been allowed to slip. We had a quite highly developed electronic system for the application of job planning.

Q. I've seen it. I've had to use it.

A. I'm not sure it was that helpful, really, because it did away with some of the face-to-face interactions where you can have a more meaningful discussion around that. There was a review of job planning just before I left. We were doing a lot of work around that at the time. We had a job planning task force looking at various different ways to improve the process and to improve the outcomes from it. That was still ongoing as I left. We had had a specific issue within Surgery, actually, because of the multiple changes again of the leadership roles in that Department, and the surgical job planning was probably the worst area in the Trust. There were other areas where it was quite good and regularly done and meaningfully done. But I personally don't know that the electronic system we had was really much of a help. In some ways it was a hindrance.

……..

Q. Let's just come to Mr. O'Brien in a moment. In terms of management, Dr. Khan, if I can ask you this: Who do you think bears the lion's share of responsibility for this omission to effective monitor over a period of months?

A. I suppose it falls to many people. On reflection, the action plan was heavily reliant on one person and that should be a broader, much more robust monitoring of arrangement for the action plan. I believe without anyone's intention, it fell through the system in terms of monitoring when one person who was mainly responsible was off sick for a period of time.

'On reflection, the action plan was heavily reliant on one person and that should be a broader, much more robust monitoring of arrangement for the action plan'

Is there currently Trust guidance on effective monitoring arrangements of action plans in informal and formal investigations?

Q. But just on the role of NCAS, did you find that Dr. Lynn's input was helpful and - a second element to the question - were you, in a sense, of the same mind with regard to the particular importance of an action plan?

A. I did, I did. At that point in time I discussed with Grainne about how it can be challenging in terms of having a right kind of a balanced action plan, and how can we ensure -- therefore, she indicated we

have a team where we can help you, we can advise you, the Trust, in terms of putting together the action plan. So I must say I was very much encouraged to involve NCAS in forming the action plan.

Q. We can also see from her advice that she recognised in what you were saying the fact that a conduct issue had arisen and that a formal conduct process was likely. I know that ultimately Mr. O'Brien disagreed with that and presented a different analysis for the purposes of his grievance. Just to be clear, did you interpret Dr. Lynn's advice as indicating to you that a conduct approach in lightly of the findings of the investigation that you were reporting to her could be recorded as appropriate?

A. As part of putting together my determination, yes, I did obviously receive the advice and I considered that. That was my own conclusion anyway. But as part of that, yes, NCAS advice was very comprehensive and it was very useful in that regard.

Note – the constructive role and input of NCAS

Q. What, from your perspective, were you seeing when reading this about the shortcomings of medical management? What should they have been doing but weren't doing?

A. I suppose my experience as Associate Medical Director before and as part of the Interim Medical Director, I was mindful of the shortcomings in the succession planning, the resources, the roles and responsibilities of all of that. That was the reason why one of the three key priorities I took as part of the Interim Medical Director was to start a process of looking at the professional governance structures in the Trust and the whole medical leadership structure. As part of my role as Interim Medical Director, we produced a paper to the Senior Management Team, SMT, for reviewing medical management or medical leadership structure. The other element was about the whole Clinical Governance and how it fits into the bigger picture of governance structures and supporting the clinicians and managers. But also highlighting and raising and providing the assurance to the system was also something I was mindful of and entrusted at that point in time. Therefore, I started another piece of work which I put in the statement report.

Has the learning from these documents been integrated into the working of the governance structures?

Q. Isn't that the very point? You were convinced, you tell us, by Mr. Young's analysis performed in 2017, yet, two years earlier, armed with the e-mails that Mr. Haynes sent through, it appears that although he had knowledge as a senior manager, he didn't perform any analysis, and yet you have managed to find your way to conclude that senior managers appear not to have known if private patients were an issue**.** Is this again, Dr. Chada, a failure on your part to follow this issue through to a proper conclusion and, in doing so, appearing to reach a conclusion that really wasn't consistent with the evidence that you received?

A. I think, as I have said earlier, it was a lengthy and complex investigation with lots of information and audit sheets and copies of patient lists and a lot of paperwork. I didn't feel that widening that further was necessary because I felt that the information that I had to draw those conclusions -- as I have said, I felt that the information I was being given was that up to this point when it was formally sat down and looked at, that it was more hearsay, that there was an explanation for when patients were moved. I felt there was a lot of confusion about when patients were added. I felt for those reasons, it was reasonable to accept that the Trust weren't clear and, therefore, that idea of knowledge as opposed to hearsay, that's the difference.

Q. So –

A. That's my view. I accept the Inquiry might view that differently.

'Is this again, a failure on your part to follow this issue through to a proper conclusion and, in doing so, appearing to reach a conclusion that really wasn't consistent with the evidence that you received?'

Knowledge vs hearsay.

Q. In terms of Dr. Khan's determination, you were in a sense a stranger to that. You weren't provided with a copy of it, it wasn't discussed with you, you had no input into it for obviously correct reasons. I think you have expressed the view that it might be of some assistance to know what determination was being reached and the view that has been taken of your report?

A. I think I raised that -- I was trying to be helpful to the Inquiry bearing in mind the Inquiry's Terms of Reference, and I have raised that in my Section 21 response. I just think from a learning point of view, you know, doctors audit regularly and we are expected to audit regularly and to consider what it is we do and what the outcomes are. Therefore, if one of your roles is to be a Case Investigator, for example, knowing how that report has been received and what action has been taken on foot of that report, actually I think is a learning opportunity rather than for any other reason. It's not that I should have any input into the Case Manager's determination, I appreciate that's completely separate and should be, but it's really about getting that feedback so that, if you are asked to do this again, that you can improve and you can consider the areas that perhaps could have been done better, or if questions are raised at a later stage about the investigation, that you actually get some feedback about right, okay, you know, I could change that part of my practice**.** Because it's about improving. So it was an issue about improving performance really, not just for me but for any Case Investigator.

The principle of 'closing the loop' where possible can provide good learning and improving practice opportunities. Alongside building and valuing teamwork.

Q. Whenever you say you were asking orally for updates, what would have encouraged you? Did you have a regular timeframe in how you sought an update? How would you have managed it from your own perspective?

A. I would have been looking roughly for monthly updates because I wouldn't have wanted it to be extended over that extended period of time. I needed to have a handle on where the investigation was. So for that reason, you probably can see there is a pattern to those e-mails that are coming through, and they are generally on a monthly basis.

Q. Do you feel that you should have done something more formal than perhaps raising it orally, as you have described?

A. If I was doing this again, I would have been looking for regularised meetings with HR, with the Case Manager, with the Case Investigator. I know Siobhán would have been, as it were, second-in-command, so Siobhán would have done, I think, a regular meeting, a formal meeting on a monthly -- if it could be arranged, bearing in mind -- but I think that's part and parcel of the learning that comes out of this, that as a non-executive director, it would have been good to have those formalised meetings, to sit down and seek, well, where are the hiccups in the process.

Q. At the time, and, as I say, we are talking now about in and around March 2018, over a year since the investigation started, at the time did you not think we need formalised meetings or we need something to formalise this to try and combat the delay?

A. Honestly, no. That was not within my mindset at that time. I thought that by contacting and meeting with both Mrs. Toal and with Mrs. Hynds, that we were tackling that particular issue

'If I was doing this again, I would have been looking for regularised meetings with HR, with the Case Manager, with the Case Investigator.'

Would the SMT consider introducing this idea more formally?

Q. Thank you. I can identify with a lot of your views and recommendations having had the privilege of multiple interactions on most of these things. It is my observation, particularly in the Southern Health Care Trust, that there was a huge fear in relation to managing doctors, some of it because they had this view that everything had to be done under MHPS; rather a lack of understanding about what I would call normal medical management. Much like in the old days, you just called someone into your office if you were Clinical Director and said come on, we can't do this, and if they don't do it you write them and email, a letter and help them do it, you don't think you have to go down a big framework. But it is still management. Now, I don't think there's a good understanding about this, certainly at the Southern Healthcare Trust at the time this happened and probably in other institutions. Whose role is it to deal with this in your view? Where does the responsibility lie and is it a combined one, and is that something that NCAS could help with since you see what happens when it goes wrong?

A. Yeah. I mean, one of the problems is the way we get into medical management, which is usually by accident. There's not really a lot of lot of -- in recent years, the faculty of medical leadership, or whatever they're called, and other people have provided a bit of training, but there's precious little training out there for people to be medical managers. You're absolutely right, they sort of get scared by processes like MHPS. It's not helped by defence organisations who scare them as well. They don't realise, as you say, you can apply common sense and just do it. Quite often - I mean back to what I think I said earlier, particularly with conduct issues - the best advice I can give is just do what you would do if it was someone else. What can we do? There needs to be training. Whether that's for NCAS to provide or somebody else, I'm sure NCAS, if you asked them nicely and paid them enough money, they would do it.

Q. Do you think it would be helpful to have a warning in the MHPS Framework to say 'by the way there is normal medical management'?

A. That wouldn't go amiss. That wouldn't go amiss.

Q. Because actually the number of times people, in any experience, would come to me and say we have doctors, we have to use this, and I would say no, it's common sense.

A. I agree with you.

Can the SMT give some guidance on the place and use of 'normal medical management'?

A. Now, I do appreciate Dr. McAllister in October, and then Mr. Weir, both went off on sick leave, and maybe with hindsight that was a missed opportunity to sit down and have a discussion about Mr. Weir's plan and the possibility or the reality would it ever be -- would life be given to it, and should we have a rethink and revisit the decision of the September Oversight Committee meeting. But that never -- and that's just me with hindsight. But those discussions never took place.

How does the SMT monitor the situation when those in senior positions involved in investigations are off sick?

Q. Of course. The point, I suppose, I'm asking is if Mr. O'Brien sees 12 patients at a clinic at the SWAH on a Wednesday afternoon but only two or three letters are dictated and come back to his secretary, what is she to do with her knowledge that he hasn't dictated on the remainder?

A. So, my expectation is that she would speak to Mr. O'Brien and say the clinic in SWAH, of the twelve patients seen, you've only dictated on three, where are the other nine? Then there would be an outcome from that. If there was no outcome, then I would expect her to have escalated that to her services administrator.

Q. If he's telling her, for example, I don't need to dictate on those now, they're not urgent or whatever, there's no expectation that she should take that anywhere else; her relationship is with Mr. O'Brien?

A. Well, yes, and I don't underestimate the relationship between the consultant and the secretary but also she has a responsibility to escalate to her superior, not least because if she's not dictating Mr. O'Brien's work, what is she doing.

Recognising the important working relationship of trust between the consultant and their secretary, how will one of the messages from this Inquiry be underlined - advising secretaries of their responsibility to escalate to their administrative line manager issues that do not meet the guidelines?

Q. You have said in your statement at paragraph 26.3 that Mr. O'Brien instructed his secretary not to use DARO. Was that something that was reported to you or did Noleen Elliott tell you that directly?

A. Noleen Elliott told Colette McCaul, who was her line manager at the time, and Colette McCaul then told me.

Q. Was there an expectation that Noleen Elliott - we discussed this slightly earlier - would follow the guidance that DARO was the system in place? Or was there an expectation that she would use systems to better reflect the clinic practice of her consultant?

A. Well, it's a very tricky one but I believe the secretary should be listening to us because we are the admin people and you should be following your instruction from us. However, I understand it's very difficult because she worked very closely with the consultant; you see them as 100 times more important than we will ever be. But you have to follow process and you report to us.

Q. But did Noleen Elliott have any appreciation, as reflected in your statement, that to not do that, not to follow DARO, may result in tests being not followed up, results not being followed up or patients coming to harm? Do you ever get the sense that she was aware that that was a potential?

A. She may not have thought of it that way.

Q. Did you know her to have any workaround? If she wasn't going to use DARO under the direction of Mr. Mr. O'Brien, did she develop any other system for keeping an eye out for tests that needed done or results that needed followed up?

A. Not that I am aware of.

Q. So, as far as you are aware, by not using DARO, there was no system in place between her and Mr. O'Brien and the patients that were seen by him for monitoring follow-up with tests or results?

A. As far as I'm aware.

Q. Now, she did then start to use the code?

A. Yes.

Q. How did that come about, that she was able to comply with it? Was that a conversation with you?

A. I'm pretty sure I had a conversation with her and told her that she had to take her instructions from us, which is not an easy conversation to have but it's the way it is.

Q. I think you have said in your statement at WIT-60388 that you spoke to her on at least two occasions?

A. Yes. I definitely remember, but I have no evidence, I definitely remember 'you need to listen to us when we tell you'.

Q. Was the second occasion because she didn't listen after the first one?

A. Possibly. I can't totally remember.

The need for regularly messaging and empowerment of staff (both clinical and administrative) to operate within Trust Guidelines and processes.

Thank you for your very clear statements today. Two things, really, jumped out at me. One was your statement that "consultants are a hundred times more important than we will ever be". The other one was "we had no significance". Now, I think that's quite worrying, especially from someone who clearly has passion for their job. What do you think the root cause of this is, and do you have any suggestions as to what should be done about it? Because all the evidence, Patient Safety evidence, internationally shows that having strict hierarchies where people feel unimportant isn't good for safety. Can you just give me your thoughts on the basis of how that felt and what you think should be done.

A. Our structures relating to admin are weak and they don't really have a position in the Trust, in my opinion. Now, this is my opinion.

Q. That's what I am asking. Yes, that's fine.

A. I think until admin be given their place, their rightful place, it will not change.

Q. What does that feel like as a member of staff? What impact have you seen on that feeling?

A. Well, I actually think it's got worse over the years. I actually think admin did feature quite a bit years ago, it's actually gone downhill. But it's very disappointing. Some days I wake up and I think, well, I am coming to the end of my career so whatever they like.

Q. Does it cause problems with recruitment and retention of staff, does it cause increased sickness rates, mental health issues? Have you seen any of that or are people just grinning and bearing it?

A. I think there's a lot of grinning and bearing it.

'Our structures relating to admin are weak and they don't really have a position in the Trust'

What is the SMT's view on this statement?

.....

Q. You speak about learning and improvement in your statement. We don't need to go to it but it's at WIT-85932. You have given some bullet points of the way in which communication and action planning could be improved. Some of these focused particularly on practical application of your skills to the system, if I can put it like that. You have said that one of the ways in which the system could be improved is to enable clinical nurse specialists to have access to a managed DARO list. Could you just explain that a little bit?

A. So, this is a list that secretaries hold for the consultants. I think the actual terminology is Discharging Awaiting Review or Outcome. These are patients waiting scans or a blood result to come back. I'm thinking more of this in terms of my nurse-led work as a safety net for that. At present, I don't have any way of monitoring, apart from me keeping it all on a spreadsheet and revisiting it every week. If I have ordered a scan for a patient, currently the radiology scans don't come back to the nurse that ordered them, they will come back to the consultant. They don't populate in my ECR automatically for sign-off. I now have it set up that my PSA bloods come back to me, so I don't have to go, and not waste time but use time to find them. They are populated on a list, a sign-off list that I can just go to, but the same doesn't happen for the scans. It's just another layer of safety that could be there and prompting me that to look for that.

Q. So you might order the scan as such but the result goes back to the clinician?

A. Yes.

Q. Would it be something that might assist if the result were to go back to both you and the clinician?

A.Yeah.

Is this an idea that the SLT agrees with, if so, what are the steps to implementation?

Q. Just in relation to the concerns overall, you say that you feel "I should have been made aware of the aforementioned governance concerns within Urology." Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

A. Absolutely, and then there's a balance to be struck.

Q. But if you had have known about issues sooner, what difference do you think it might have made?

A. For a start, you would have had more of an awareness. Referring back to the two cases that we discussed, I think I would have handled those very differently had I had an awareness that there were issues in and around those processes.

Q. And handled differently how?

A. I would have went to my lead nurse and my Head of Service also.

Q. So, you would have escalated the issue?

A. Yes.

'Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

Absolutely, and then there's a balance to be struck'

How does the SLT define this balance and then communicate it throughout the Trust?

Q. How would you explain that? Is that explicable, that issues would be troubling management for, let's call it several years, and yet nobody saw fit to elevate it on to a formal process until 2016? How is that explicable? Does that tell us that managers didn't understand? Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated? What's your best assessment?

A. Potentially a factor of all of those, I think. I mean they were aware there was a Medical HR Department, so I think that that shouldn't have -- we should have been contacted, and I don't know the reason why we weren't. I think there's some work we need to do in changing that culture, that you know maybe there's a feeling if you contact HR, they're going to escalate things to a formal matter whenever it's not necessarily about that. You know, there's lots of positive things that can come from an MHPS process, it's not a negative thing. There's lots of supportive measures that can be considered; there's lots of structure and framework that can be put around to support individuals to get an early resolution. I think there's maybe a fear that if you tell HR, that it's like pressing the button, a nuclear button, and things will be escalated. Maybe that's what we need to ensure is not engrained in thinking. I'd like to think that's not a case now, we are contacted very regularly by our clinical managers about issues just for advice and reassurance in terms of how they are handling things. But maybe back then, there was more fear around that all.

'Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated?'

Is there an element of fear that still exists in the Trust when it comes to dealing with the shortcomings of some clinicians?

Q. I was going to start with that one. Just following on from that, is there a single person in the Trust who is leading any sort of, you know, big idea, innovative approach to recruitment for medical staff specifically? Where does that sit?

A. Well, it probably sits within our HR Director's remit in terms of, you know, we do have recruitment campaigns –

Q. But have you got a big strategic idea –

A. Yeah. I think it's something we are looking at.

Q. That the Board is involved in? I mean, this is a Board issue really?

A. Of course.

Q. It is so significant. Is that there or –

A. We have it listed on our Corporate Risk Register in terms of our ability to recruit medical staff.

Q. Have you got somebody saying I am in charge of this?

A. Yes. Possibly not.

Is there a plan to have a lead in the Trust with this responsibility?

Q. The other thing that has come out is a sort of secrecy and mystery and all of that, but also a reluctance to manage doctors, not just not to ring HR, which you have described as perhaps due to fear of process. I am presuming you are implying that HR is trying to be less scary in that regard?

A. Yes.

Q. But there also seems to be a general reluctance for doctors to manage doctors, for managers to manage doctors. Is that something you have observed, and why do you think that is?

A. Yeah, I think it probably has been something -- I guess medical staff are -- they are so used to being autonomous workers and independent workers. But it's difficult. I mean, it's not something that I think

-- I think it's a journey that we are on in terms of ensuring that they are managed in the same way as anyone else would be managed, and I think that's important.

Q. Do you think that's improving? A. Yes, I definitely do.

Note - the importance of continuing this journey of consistency, transparency, fairness, and equality with all the staff in the Trust.

Can I just be clear because it's perhaps my misunderstanding of the language used here, but it seemed to me that you talked a lot about escalation. To my mind, escalation is where you move something up to somebody more senior so that they can do something about it. Sending it back to the head of service, to my mind, is really not escalation. Is that not just sort of, well, you know, this is your problem, you need to deal with it?

A. Do you mean the head of service within the specialty?

Q. Within Urology, yes.

A. Generally, whenever I was escalating any issue, that would have gone through to the operational support lead, to the head of service and the assistant director within that area.

Having raised an issue to be escalated in the correct sequence, what is the guidance on action when the issue remains on this person's desk and goes no further?

Q. "What we really need in the Trust is the recruitment of a radiologist with an interest in general urology, someone that can partake in the GU Service and attend and take the MDT. The only way to achieve this is to make a real attempt to recruit by putting out interesting job plans that offer more than the bare minimum, mentions of flexibility, offsite SPA, more than 1.5 SPAs, recruitment and retention premia. I remain unclear why the Trust does exactly the opposite and how it expects to recruit in the circumstances, which leaves me, as a sole practitioner, which is not safe and not recommended by the College." So you're explaining yourself in fairly strident terms.

Q. Did you ever get direct feedback yourself on this point that you're making, that we need to, as an organisation, make the role more attractive, to be more proactive in our recruiting strategy?

A. No, I don't think so. I think this was something that I suggested a number of times over the years and I didn't get any feedback.

How does HR review the quality of its recruitment strategy and content of job adverts?

Q. The inquiry has heard some evidence about I suppose the difficulties faced by medical managers, those in the AMD, CD Clinical Lead cadre; busy clinical practices but also a heavy job description that goes with these managerial roles?

A. Very much so.

Q. Any particular reflections to offer on how that might be done better?

A. Again, I suppose it came back to when I put the proposal in about giving protected time for, particularly, clinical staff to focus on governance. I would still have that opinion, either that or maybe outsource some of it to - what I am doing at the moment - recently retired people who are still experienced enough that they can bring their recent knowledge to Chair SAIs and take that pressure off Trusts. But I think the Assistant Directors were slaughtered at the time, and they still are in terms of their workload. So things like this were a tiny -- I know they weren't -- in terms of significance, they

weren't tiny but in terms of their massive workload. Also, the Assistant Directors as well would have been carrying a one-in-six on-call rota on top of their day job. In terms of the operational management of the hospital and the out-of-hours and weekend period, there wasn't such a thing as compensatory rest for that level of staff. It was massive. Even though, yes, for those poor patients, it's a huge impact, in terms of the daily workload, trying to find time to focus and keep on top of meetings and things, it was just huge for the Director and the Assistant Directors as well.

Q. Is there a sense or do you have an experience of is it left to those in operational management to give informal nudges to clinicians to get things done, and get things done better if there were shortcomings, but really it's up to the medical management, the AMD, to take more decisive action if the operational managers are not able to achieve a successful outcome, and at least exhibited through interactions between some medical managers and Mr. O'Brien, there has been a slowness about taking robust action so that things are allowed to drift. Is that part of a culture that you recognise more generally?

A. I wouldn't call it a culture as such but it is probably a symptom of how job plans and things are arranged in terms of obviously the medical staff, their focus is their patient-facing activity. Obviously the operational staff see the issues starting, and they see -- the admin team and the governance would have known that maybe a panel wasn't meeting, so they would have nudged. Actually if then there was some reason that there was a decision not to meet, they couldn't make the consultant meet or run that panel, because they weren't in any sort of line management control. So it had to go back to the medical management line if the nudges weren't working.

Q. Yes.

A. So, it was out with their scope of control to make it happen

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What are the criteria for the SLT in considering the potential for outsourcing some of the Trust's work to ease the pressure on workload?

Does the view 'I think the Assistant Directors were slaughtered at the time' hold true in the Trust currently?

The Panel have heard some -- as you say, the Chief Executive post was a position held by numerous people over the years. Did you think that was a particular cause of concern for you as a director?

A. Oh, it definitely was. I mean, of course it is. The senior team needs -- for me, it was about trying to redefine. You know, I changed what I did. I think I mentioned in my witness statement as well in terms of trying -- as each Chief Executive comes in or is trying to navigate their paths, their vision and how they wish to have things done, a director with the responsibility for planning and performance et

cetera, I would have been working differently and trying to drive forward the vision of the Chief Executive and work closely with the Chief Executive. So, that was a challenge. It was a challenge also because it wasn't just Chief Executive changes. You'll have heard from some of the other evidence, I am sure, but we did have changes to our senior team in terms of creating a new role in the Director of Nursing, and different things that were shifting. For the matters pertaining to this Inquiry, the assistant director team and the Acute Director was a very stable team as in it hadn't changed over that period of time, but there was a lot of change and movement within it. I mention also that within the Governance team, and I think Tracey Boyce's evidence yesterday alluded to that in terms of quite a lot of changes in that as well. So, all of those changes do make it more difficult. There has been a lot of expertise lost and experience lost.

Q. It is also the case that some of the changes brought about by new Chief Executives can also be beneficial?

A. Oh, absolutely

The senior team in the Trust has seen significant personnel role changes in the last ten years with the potential loss of corporate memory. How is the SLT addressing the challenges in nourishing and establishing stability and consistency in senior post holding going forward?

Q. When they are on their third or fourth time ringing up, what kinds of things did they say to you?

A. Well, a lot of it was frustration. It was frustration too on my part because there was nothing we could do. I think they accepted that, that it was out of our hands.

Q. Was there ever a time, for example, when you could liaise with some of the nurses or someone else to talk to them, because a lot of them would have had quite clinical complaints, I would think, and they would need someone to talk to. Were there any discussions about how that might be managed within urology, as far as you were aware?

A. We were never actually advised that we had the nurses there for a backup. That was never something that I was aware of, and I don't believe any of the other secretaries ever transferred to the clinical nurse specialist.

Q. What do you think; do you think that would have been helpful?

A. Well, I know now that that is expected and, yes, it would be very helpful. But at that particular time, those clinical nurse specialists were up to their eyes with work so they didn't need patient calls as well. You know, they were under-resourced as well.

What is the view of the SLT on CNS's being available to support secretaries when patients are frequent callers?

Q. "This incident demonstrated that the secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every attendance on a timely basis. I would have expected that Noleen Elliott, Mr. O'Brien's secretary, would have been following up with her consultant Mr. O'Brien to advise that he had not dictated on clinics. Also I would have expected that when she was aware of delays in dictation, she would have brought that to the attention of her service administrator, Andrea Cunningham. If this had happened, this would have been apparent on the backlog report and would be visible to myself", and those others she mentions. Do you accept that criticism, that this was an aspect of your role that you should have been performing?

A. Not really, no. As I said I looked -- I believe that that backlog report was a secretarial backlog report. I was never told that I was to highlight the backlog of a consultant on that backlog report. There was that mechanism of that 3D report that was already in the system for the service administrator to see what was outstanding.

Do all the secretaries in the Trust have a complete understanding of the full purpose and requirement of the Backlog Report?

Katherine Robinson is reporting to Anita Carroll, "see the attached list". "This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome to some of these patients. There is a risk that something could be missed so I am escalating to you although I know that a lot of the time Mr. O'Brien knows himself what has to happen with patients. Unfortunately this was not highlighted on the Backlog Report."

We have just looked at an example of what a backlog report looks like. "The secretary assumed we knew because there has always been issues with this particular consultant's admin work from our perspective. As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality. The secretary also advised that at present Mr. O'Brien is working is some of his backlog admin report as he is off recovering."

'As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality'

How regularly is the Backlog Report being monitored for adherence?

Q. If that patient had been on DARO, the service would have had visibility of the fact that results had come in from radiology; isn't that right?

A. That's right, yes.

Q. And would have had visibility that those results hadn't been actioned because the case still remained on DARO?

A. Yes. So our service administrator -- the narrative, should that person have been on DARO, how I would have validated that DARO would have been "result with Mr. O'Brien to see and action". Now, that happened on a regular basis but our service administrator never came back to say why has this not been actioned, so I'm not sure whether it would have went anywhere. All right, it would have been noted on the DARO but whether those sorts of things were ever actioned, I am not concerned -- I am not convinced that they were.

Is the monitoring of DARO a watertight system in practice?

Q. Yes, but what I'm saying is regardless of whether the patient is on a tracking system, if you as the secretary see something untoward in the result, do you have any role - I am thinking here from the perspective of an additional safety net - to get the thing moving with the cancer tracker?

A. No, no. No role, if that's what you are saying.

Q. You had no role in that respect?

A. No. I never referred anything to the cancer tracker for MDT discussion.

Post Inquiry – will there be a refresh on the role and responsibilities for all secretaries within the Trust?

……..

A.I have no problem with inquisition or curiosity. In fact, I would be known to be of that style myself so I have no problem with that. I agree with the Chief Executive, it's right that a Medical Director is inquisitive and holds people to account. From an Acute Assistant Director perspective, I believe that the style of previous Medical Directors had been as operationally facing or involved as Dr. O'Kane would have been. They would find it difficult to get used to where does the operational bit take over and where is the responsibility of the Medical Director, and I think there was some of that behind it. I do think there are different personalities in any team and there probably was a bit of feeling annoyed and maybe a bit defensive as a result of that, but that incident in 2019 just wasn't as clearcut as described there. With regard to the model within Acute, the model in the organisation for clinical and social care governance was devolved, and still is actually because it hasn't actually flipped yet. Therefore, the information that is held within directorates from a governance perspective is the same as the information that's held in Older People and Primary Care or Mental Health Directorate and so on. It isn't in the responsibility of one person to have that information. Anne didn't even work in Urology Services, for example, she was in the medicine side of the house. That information was shared at our governance meetings, at our Acute governance meetings. The actual collective leadership structure I talk about in my statement talks about the Clinical Director and the Divisional Medical Director and their professional accountability line to the Medical Director. So, there are a range of mechanisms to interact and get information, and a range of fora that allow us to share that information. There would have been no evidence, and no awareness certainly from my perspective, that anybody would have withheld or made it difficult to get information.

From a governance perspective - are there currently clear pathways to allow the maximum information flow in all parts of the system?

Q. You have mentioned about there being various people in your post prior to you taking that up. There was turnover at that level, turnover at Chief Executive level. Now, obviously some individuals like Mr. Carroll and Mrs. Corrigan were there for the duration of events as they unfolded from early 2012, 2014. What impact do you think the turnover of staff at a high level like that has on good governance management?

A. Very definitely, the turnover definitely affects our governance arrangements, and the styles definitely affect our arrangements in terms of -- I mean, if I use the example of Dr. O'Kane again. When she came in, right from April '19, she was very proactively following up issues of concern from a governance perspective that perhaps could have been dealt with at an earlier stage. But she was a very proactive mover and shaker in terms of clinical and social care governance. She'd also come from Belfast Trust and had experienced a different model of clinical and social care governance, so therefore she probably saw flaws in our system which I would imagine prompted the clinical and social care governance review. I think there have been significant changes made over her tenure to date that are about trying to improve some of those vulnerabilities and some of our systems and processes. So I think some of it is about style, but definitely an impact of change in personnel at the different levels.

Have all the recommendations in the Clinical and Social Care Governance review been implemented?

Q. Just to point more widely in relation to the relationship between HSCB - SPPG as it is now - what is the nature of that relationship, and do you have any views on how that relationship might assist better governance in a Trust generally?

A. Well, in many ways it was a holding to account relationship in that the services were invested in, we were the provider of those services and we were reporting on that. But where there were issues of concern or escalations, either we were escalating to the Commissioner or issues that the Commissioner wanted to discuss with us, there wasn't really -- there wasn't really much solutions coming from commissioning side of the house. You know, you would have been guided with some novel approaches that maybe we could take or whatever, but we weren't really getting much traction, especially with regard to backlogs and waiting lists and waiting times, despite efforts to try lots of different ways to bring that about. The relationship was respectful and proactive and we could have had discussions about new investments, so that was all very healthy. Some of the discussions around what else we could do and the holding to account bit were a bit frustrating because we didn't really develop new approaches. We might have had a bit of non-current investment or a contract development with the independent sector, there was always something we were moving forward, but we weren't really turning things around despite the two-way processes.

Is this still the case?

A. But I did act on that in terms of I knew the governance review had taken place from 2019. We were waiting on the outcome of that, hoping that it would give us some sort of acknowledgement that there was capacity issues for the volume and scale of what we were dealing with in Acute. I did put in post a Quality Improvement Project. To me, quality and governance are very interlinked, so our Quality Improvement Project dedicated some time to the Assistant Directors to actually look at some of the gap areas they were most worried about, like action plans, and implementing recommendations post serious adverse incidents, and dealing with some incidents on the Datix system.

Q. That's one of the things that Mr. Carroll actually refers to in this paragraph, the inability to deal with action plans, the implementation of recommendations following serious adverse incidents, or to deal with the volume incidents that require active management and the complex complaints that required attention.

A. Mm-hmm.

Q. Now, what was the scale? There's quite a breadth of governance concerns around that. Did you ever get underneath what the scale of all of that work was? For example, what were the number of complex complaints that required attention; what were the SAIs; which standing; what recommendations were awaiting implementation? What was the detail behind that?

A. So, we got that detail every month. If you notice in the Acute governance papers that came, we would have got how many complaints are outstanding, how many are awaiting answer, which Assistant Director is sitting with or which Head of Service? So we would have known through the Governance Coordinator where there was glitches in the system that we needed some action. When we had a Serious Adverse Incident Review, we did have an action plan that was pooled together with the Clinical and Social Care Governance Coordinator to outline the recommendations of that review. What we were missing was has it been actioned? Has it been implemented? When was it implemented? How can you evidence it was implemented? They weren't missing it all the time but we didn't have a clean sheet in terms of we had a thorough process end to end for that action plan and implementation process. So, that was the focus of me trying to put in place, number one, the Quality Improvement Project and some of the areas around that, but, more importantly, getting funding secured for a Band 5 Governance Officer for each of the Assistant Directors, who would be their person who would work with them and hold their hand to keep a bit of momentum going within the Directorate.

Q. Those posts were filled before you left, were you?

A. Yeah.

Q. Were they two Band 5s?

A. No, there was four. There was one for each division.

Q. They actually tried to follow through on the outworkings because what this paragraph seems to suggest is the systems are effective in bringing the issues to the surface by and large –

A. Yeah.

Q. -- given that we are here, but that the actual remedial work and outworking of what's needed to make sure that doesn't happen again is the stage that has some hold-up?

A. Yes. The purposes change in learning. To bring about the change in learning needs capacity, and that's what we were missing. We had some capacity in different job roles. I mean, I think somebody said last week Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it. We were missing a wee bit of momentum. That's why both the quality project and the Band 5s for each AD, and now in place, were to try and accept that there was a reason to be kept awake at night and we needed to do something about it.

'So, we would have known through the Governance Coordinator where there were glitches in the system that we needed some action'

With a band 5 now in place for each AD – are there any remaining 'glitches' that need addressing?

'Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it.'

Q. If we could just go to the terms of reference of the review at WIT-35726. The purpose of the review, it's "Terms of Reference Southern Health and Social Care Trust Governance Review". It says: "The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on Patient Safety and that helps people learn. The objectives: The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like. It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach through the organisation**.** It will include a review of both clinical and social care governance. Specifically, the work will include gaining an understanding of the current governance structure and processes in place; meeting stakeholders to identify what works well and areas for improvement; undertaking a benchmarking exercise to identify best practice; review of existing and draft documentation, including a new governance assurance strategy. The outcome will be a written report outlining key findings from the review, and recommendations." The governance assurance strategy, did it ever come to fruition?

A. I don't believe I ever saw one.

Q. In relation to this clinical and social care governance review in September 2019, what was your understanding of the background of this particular report? Was this something that the Trust did every now and again or there was a specific reason?

A. There had been a couple of reviews in earlier years since the Trust had formed, I think it was 2012 and 2015 potentially. Again, I think it was following Dr. O'Kane joining the Trust, seeing some vulnerabilities, potentially assisting with the potential of a better model, actioned by the Leadership Centre. June Champion was the Leadership Centre author was carried out the review. She worked, in fairness, intervening teams and relevant stakeholders to make sure she put together a comprehensive report

The report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 Findings and Analysis, and are broadly categorised under the following themes: Work governance, culture of being open, controls assurance, risk management strategy, management of SAIs, complaints and legal services, health and safety, standards and guidelines, clinical audit, morbidity and mortality, learning for improvement, Datix, clinical and social care governance structures. A summary of the recommendations is provided in appendix 1."

Q. Now, your involvement was on the SMT in trying to implement some of the recommendations. You mentioned about the operational risk versus corporate. I wouldn't call it a struggle because I am not sure that's a word you would use but was there a tension between the competing expectations or demands that perhaps ultimately led to the delay or the failure to implement these recommendations?

A. Yes**.** I think the time-lag doesn't help when there's a review happens in August '19 and, a couple of years later, or three years later, we are still moving forward with it. You then have pockets of developments to try and strengthen where we are now as opposed to the root and branch review being implemented. However, I think changes that have been made have been felt and felt positively. Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you.

Q. So, there was a degree of flexibility built in?

A. Yes. We were evolving, we were learning on our feet and it really was governance in action, how do we keep this as safe as possible with patients at the centre.

Q. Do you think it might be helpful to have a toolkit for incidents like this where there are lists of suggestions, different routes, built in flexibility, a checklist of things to make sure they are done?

A. Absolutely.

Q. Would that be something that might assist?

A. I think because of the Belfast experience and because at the end of a lookback review, one of the stages is the outcomes and the recording of the learning, I think there's a natural opportunity there to learn and to share a lot of the tools and processes that we adopted.

Q. Giving the timing of this report and the September 2018 recommendation in the MHPS about an admin review, and this clinical and social care governance review then coming after that, was there any thought given that this was a possible vehicle by which that admin review could fall under this

umbrella and perhaps gain some learning from that, given the independence of June Champion and, as you say, the requirement for the MHPS recommendation to be independent?

Q. There was also learning over and above Urology Service in those. What was the position on the roll-out of those recommendations or their implementation by the time of your retirement; can you recall?

A. When I retired, there were nine out of the eleven delivered and the other two were embedded but subject to audit; we needed to evidence that they were effective. So all eleven are now implemented. I have to say that that process was extremely innovative because we had -- this wasn't about a Urology Department, this was about learning for the whole organisation in Acute Services. So, we had medicine, we had everybody sitting around that table taking responsibility because function of their MDMs, for example, was something that had read across. We had a really good process, and we had a subgroup and we had designated tasks that the different people around, say, job planning or audit, whatever, would work through and develop with the groups. But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work.

Alongside the learning from the SAI's, there have been several significant reviews in the Trust in the last 10 years, each with recommendations. Added to this will be the recommendations of the Urology Public Inquiry Report.

Going forward:

- what are the plans to review and bring some clarity, standardisation, and consolidation to all these recommendations?

- then to move through to systematic action and implementation?

- what is the SLT's view of developing 'a toolkit for incidents'

Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it.

A. Mm-hmm.

Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting?

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture standing back a wee bit, I think there's somebody thinking, no, there's a different way to do governance, I think, not just a series of tick box exercises.

How can the SLT shape the narrative post Inquiry so that this momentum can be maintained?

Q. Yes. Dr. Boyce has suggested that -- if we just pull up her statement, TRA-05849. If we just go to line 4, please. I'm asking her why you wouldn't take on this direct interfacing role with Trudy Reid, and you have given me an account this morning of why. Dr. Boyce's perspective on it was that you were

overwhelmed with the post, it was a massive post, "and also there was maybe a level of inexperience in terms of governance, leading governance in a very big, very vast ranging Directorate." She says, "I think the fact that I was there and had already been doing it sort of allowed [you] not to maybe take it back fully." The downside of it, she explains, is that it made her nervous on your behalf because obviously: "Then Esther was going into Senior Management Team, the Corporate Governance meeting and so on, without that interface so I was always nervous about how she could then represent and talk about her risks and so on." Do you recognise that there was this risk of a gap if you weren't as fully committed to the governance aspects as Tracey Boyce says you ought to have been?

A -- So yes, I was uncomfortable and I felt extremely just unsupported in terms of -- you know, if you feel supported when you are in a swimming pool with rubber rings and everything and everybody takes that away, you feel a little bit adrift.

Are there any people in current senior leadership roles who are not carrying out their full brief?

'Q. The Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that'

Is this a trend that is still happening? If it is, how is it being addressed?

Q. And, in that role, what were the challenges? Was it a straightforward matter to implement these radical changes to how governance was to be done within the Trust?

A. No, it was really tricky. It was -- I mean, it was a bit like the performance era and that takes, it takes time, it takes consistency, it takes -- no, it was very difficult. Was everybody accepting of these processes? Did people want to add this on? I mean I have read in other evidence where in -- after my time in 2016/2017, they talked about giving additional PAs to consultants or 0.5 of a PA. We didn't do that at the start because we wanted to see: Can we buy you into actually this is part of your job role anyway? Now, there's a tossup between adding on a bit and paying you to do it, or you winning the hearts and minds and saying "This is part of my role anyway." I mean -- so, the whole thing just takes time to slot together, not just -- I mean, IT's not my thing, but, even that, but it was interesting reading people's statements about the use of IR1s and, you know, saying "Oh, well, I wrote the IR1" and it nearly felt like they came to an end-point there. No, the IR1 is to flag -- "I need to then talk with my line manager, they need to come back to me, we need to see what we're going to do about it." But they felt like they had discharged their duty just by doing it. So we hadn't got the culture there yet. It wasn't there yet**.** They hadn't the ownership.

It takes time for people to realise that governance is your business and somebody is not going to do it for you.

Is this understanding of governance widespread in the Trust today?

……..

Q. Another feature of some of the cases that we'll look at shortly is, I suppose, the delay from - let me not call it a delay - the passage of time between incident and final report. Obviously you have a lot of steps in the middle, you have to assemble the material, get the timeline, get the screening done and then research, interviews, analysis, drafting, maybe multiple drafts, lots of steps till you get to the final report. Some cases have taken three years to produce an outcome, again can you, in the generality,

not necessarily referring to any particular case, but what is the problem there in realising the prompt delivery of an SAI outcome?

A. I suppose that's one of my sort of greatest regrets, that many of the SAIs took such a long time. It was essentially resource, resource of the governance team, myself and a small team, the number of SAIs, the complexity of some of them, the timelines, then diary management, sometimes getting a Chair. So if you start from the initial, we screen, we have to decide there is an SAI, we have to decide who the panel is, who the Chair is. There were challenges in always getting chairs, particularly if there was an external Chair required. Then organising the meetings, getting the diaries aligned. If we had to interview individuals in relation to the SAI it was getting their diaries aligned as well. So steps, small steps all along the way all slipped over time and unfortunately and regrettably the SAIs took too long.

Q. Yes. I suppose more often than not you're looking to an experienced clinician to Chair an SAI?

A. That's correct.

Q. Perhaps a clinician with other clinical and governance commitments; was that part of the problem, getting clinicians, who are no doubt to be thanked for putting his or her hand up to do the SAI when it is undoubtedly something that they maybe wouldn't necessarily have wanted to do? Is there a solution to be found? Have you thought about whether there is a better way of doing it, rather than calling ad hoc on clinicians out of the blue, perhaps, to become involved?

A. So the clinicians all have very busy clinical schedules and they did the SAIs within that diary commitment that they had. So that is why one of the governance structures looked at having some time set aside for people to be -- for chairs to have that half PA a week to help facilitate governance and SAIs. The other element was to have professional chairs, for want of a better phrase. And the Trust now does have some people who Chair SAI meetings, that's their -- that's what they do, they have the time and the commitment to be able to do that.

Q. Because if we start with the principle that the SAI review is taking place in order to provide learning and an opportunity to do better in the future in respect of, for example, a clinical issue or a behavioural issue or a technical issue, whatever it might be, the learning obviously has to take place in a considered environment, you don't just rush out with the conclusions right away, it has to be considered and thought about. But three years down the line or two years down the line is, would you agree, not much benefit if there is a real problem there that needs addressed?

A. They do need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So two years is too long.

‘Conducting SAI’s need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So, two years is too long.’ With the learning from this Public Inquiry on this matter – how is the SLT responding?

Q. -- inefficiency, that there is also an aspect of individual working styles and differing case mix. So: "If a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters, then inevitably the waiting list will grow more quickly than that of a colleague who lists chronologically."

A. Yes.

Q. Was that a problem?

A. It's still a problem. Because, you know, if you look at our current waiting list, the patients who are waiting longest are waiting for bladder outlet obstruction surgery, there is the occasional Nesbit's that's waiting. So clearly other cases have been picked ahead of them. I didn't make the comment when you put up the data of the waiting lists, by the way, but if you look at that in great detail you'll see that there are differences across the team.

Q. Yes.

Is there clear guidance on surgeons choosing to take cases in a chronological order? How regularly is this audited?

……

Q. So Mr. Mackle appears to paint a picture of resistance and difficulty in trying to persuade the consultants of either the need for change or the recommended pathways for that change. He names Mr. O'Brien as holding out particular views that seemed to be contrary to the direction of travel the Trust wished to go down at that point. First of all, is that your recollection of the tone and content of those meetings?

A. Those meetings were certainly set-up to make the changes and when the changes happen in any Department, it was quite a major change which was going to completely change the practice and working of all of us. So there is going to be a certain degree of resistance, there is no doubt about it. But our point throughout the meetings and which I would still maintain was, if we are going to change we should change it with all the resources provided, with all the infrastructure provided. You can't just be saying that you start an MDT, one example, and just go and find out how you do that. No, you need all the other job plans of the so-many-other consultants. If you call it resistance or obstruction, look, it's a two-way traffic. Management, if management want a consultant to work in the new way of working, then they should be able to provide the proper infrastructure, proper resources, and if those resources are not available or scarce, then it is not a resistance, I will certainly feel that my patient will be -- the safety of my patients will be compromised. So if Mr. Mackle thinks that that was resistance, then I'm afraid I disagree with that. I certainly said that we are happy to make changes. You'll see from my email to Alison Porter, sorry, my letter to Alison Porter that we did start at MDT. We did ask for a red flag system to put up. And we did express that we are happy to send the pelvic surgery to Belfast, but this is not the way it has been done. It should be done with communication. So there was certainly a lack of communication from the review implementation on the start.

It did improve once we started the Steering Group meeting. I'm not aware that they were playing with us, if Eamon Mackle was challenging and Gillian was going around different, that is the way of management. But certainly we speak what we felt at the time is correct for the betterment of our patient. I'll not recognise that it was a resistance, I'll say that it was an insistence to provide us the resources for to setup all these new changes.

Q. If I could summarise your answer in the sense that you felt any objections that came from you were based on patient priority of their care and their needs, and you felt that your justifications for responding in those meetings in the way that you did, you were driven by patient –

A. Of course –

Q. -- putting your patient first, and that any interpretation of those objections by you as being obstruction, or any other resistance, is one person's interpretation rather than what your intention was. Would that be fair?

A. It would be fair. Can I give you an example to explain that, why it is felt. Suppose you are Mr. Mackle, I am Mr. Akhtar, you ask me 'Mehmood, from tomorrow you are going to see 12 patients in your clinic, five of them will be a cancer patient'. I will certainly say, I said 'Mr. Mackle, I'll be happy to see that, but I need this, this, this thing'. Will that be a resistance? Because I don't feel safe that five cancer patients should be seen in my clinic back-to-back with seven other patients. As Alison also accepted in the letter, there was delays in the clinics because cancer patients take a longer period of time. So will it be a resistance? No. It will be asking for the resources to run a better service. That's what my point is.

'Management, if management want a consultant to work in the new way of working, then they should be able to provide the proper infrastructure, proper resources, and if those resources are not available or scarce, then it is not a resistance, I will certainly feel that my patient will be -- the safety of my patients will be compromised.'

As the Trust presents a new vision and strategy that may have an impact on ways of working – it will be important to understand the range of impact it may have on the delivery of clinical practice and put in place good communication pathways and the resources necessary to support the adaption.

Q. We'll come to the specifics of that in a moment. I just want to ask you about the Serious Adverse Incident review process, which is prefaced by the incident reporting mechanism or Datix and look at those as tools of governance. To what extent over the past ten years have you directly used and encountered incident reporting into serious adverse incident reviews? I ask that question in separating it from your exposure to them through the Patient Safety meeting, and clearly, completed reviews come on to the Patient Safety meeting agenda and are discussed. So that's the question?

A. I certainly use them and I am certainly using them more, particularly if I find a stent that's been in too long, I certainly will do an IR1 so that we're aware of it. I have done perhaps not as many as I should do, well "should do", I have done several over the years. But perhaps I should have done a lot more but I can't give you details on them. They were not, obviously, serious. They were probably operational measures on a ward. I think I did one -- once a patient, I was concerned about fluid balance management on a ward and I did an IR1. That's one that comes to mind, but I don't know what came of it.

Q. Yes. Well I think that's, I suppose, one of the points that I wish to explore with you. The responsiveness of the system in terms of telling the informant, you being the informant in that context, what has happened, what is the outcome. Let me come to that in a moment. You said, maybe, over the years, "I could have used the instant reporting mechanism more than I did". Your caveat being that they weren't terribly serious incidents. What was the culture around that or the understanding of when you should be using it. Were you encouraged to report incidents when they arose, particularly where they affected Patient Safety?

A. I don't know if anybody -- remember anybody saying "you must do this". Perhaps as you go through your career you're aware that if you see something that's not right, it must be reported. But I don't think anybody said you must report -- not like now, you must do a Datix on this. It is just something instinctive. In other words if it is not right, you should report it.

Q. You're not suggesting this was A Trust where, if you like, the requirements for reporting were regularly emphasised or publicised. You know, there wasn't an effort to create a culture of, if you like, utilising that system to bring forward shortcomings in practice or in service?

A. It's difficult to say. I don't think we are constantly reminded about it. Perhaps the Trust assumed that we would do it because we knew the system was there. But, yes, I think nobody was concerned about policing us, I think.

Q. Is there a sense that it was cumbersome system or an awkward system, time-consuming system to use to put the complaint into the pro-forma that we've all seen that comes with the IR Datix arrangements?

A. I preface this by saying I'm not using it as an excuse: Certainly I thought it was cumbersome, it wasn't user friendlily. I suppose the other thing was, as you said, you didn't get feedback. It went into a black hole and that was it, you never heard of it again, unless it turned into an SAI or something. So that probably might have been an issue as well. If you knew that you were reporting something and you got something back and it said -- but when you just report something and never hear about it again, there probably isn't the impetus to keep doing it. But that's not a justification for not doing it. That's my thoughts as I'm sitting here.

Q. Yes. I suppose if you've gone to the trouble of opening your eyes to and realising that there's a concern or a problem there and you make the effort to put that in writing by engaging with the system, you're saying it would make sense to obtain a letter back or a quick email back periodically saying, yes, your concern is credible or correct, and this is the steps we're taking and, ultimately, that's are the steps we have finally taken and these are the conclusions we have reached?

A. I think the system would be better. Then you would -- I think people would sort of think, well, something is going to be done about this. So, yeah, I think the system would be better if there was an outcome sent back to the person who reported it.

Is a yearly audit being done to check how effective the system is in reporting the conclusion back to the person who raised the concern and/or completed an IR1?

Q. Mr. Glackin makes the point -- and this is at paragraph 31.1 of his statement, WIT-42307, 31.1. He says that in his opinion: "...senior managers did not work well with Urology. Engagement with the Department by Clinical Directors, Medical Directors, Assistant Directors and Directors For Acute Medical Services was very limited and infrequent, in my experience. I do not know how much job planned time they had allocated to management activity." So that may be a factor in the degree to which they engaged. But it does seem, if we just use Mr. Haynes' correspondence as a means of litmus testing this. He, presumably with the knowledge of the team, is clearly dissatisfied on behalf of patients, that not enough is being done to break this theatre capacity impasse. You say that more recently they have come up with initiatives, Daisy Hill, Lagan Valley, thinking a bit more imaginatively. Upon reflection, would you tend to agree with Mr. Glackin, indeed Mr. Haynes, that not enough energy came down from senior management to recognise the real risks for patients here?

A. Absolutely. I mean -- you know, if what we're doing now was done several years ago, you know it may have changed things somewhat. When I was referring to getting on with managers, I was probably talking to Head of Service, Martina Corrigan, higher up than that I certainly had no, or very little, if no engagement personally with any of those people.

Q. Yes. Have they any visibility in any meaningful sense for you as a consultant?

A. For me personally,

Q. Obviously you've referenced these initiatives, Lagan Valley, Daisy Hill, you have operating space there for patients that are fit to go there. Do you get a sense that over your ten years in-post, the

ability of the Service to deliver for patients within the catchment area has improved, has it got worse, or is it more or less the same?

A. It's still the same because our referrals are going up ten percent a year as well. So referrals haven't stayed static. I mean if that stayed static, you could probably would see a difference, but everything is increasing, so it's hard to say. We're doing more imaginative things. We're extending ourselves more. But there's more coming into the system as well.

'Q. Do you get a sense that over your ten years in-post, the ability of the Service to deliver for patients within the catchment area has improved, has it got worse, or is it more or less the same?

A. It's still the same because our referrals are going up ten percent a year as well'

Does the SLT agree with this assessment? Are there further options that are currently being explored to try and meet the demand for services?

Q. So you've had a lot of detailed questions about things that have happened. I'm quite interested in your observation of what you actually thought of the medical management and leadership structure at the time, if we talk to '16/'17 this was all a big issue. How well did that work? How well did it not work? Do you have any thoughts as to what the problems were there in terms of how it interacted with you as a practicing clinician or any other thoughts, because you haven't had a formal medical management role, and you've referred to that a few times? So what do you think about it all?

A. So, Mr. McNaboe approached me on the corridor one day, and he had recently been elevated to AMD, and he said to me "Do you want to be CD of Urology?" It was a short conversation.

Q. Yes.

A. No, thank you.

Q. Why?

A. Because I don't feel that the people who are taking up those roles are adequately supported and resourced to deliver them, and you'd be set up to fail.

Is there currently a fully developed resource in place to support and equip potential candidates for medical management and leadership roles? If not, what can be done to achieve this necessary standard.

A. I mean, the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated. So, I mean, the team in Daisy Hill, I was seeing them on a regular basis, I was meeting them in theatre, and so we were chatting about things in the tea room, but there were no tea-room conversations that I could have with the clinicians or the people in Craigavon. When I did meet with management, it was in an official meeting.

Q. And given your role also covered urology in Craigavon, was there any -- did you have anything set up to engage with those clinicians or staff that might have informed you in your role?

A. There were meetings in Craigavon, in urology team meetings, but I found it very difficult to attend those, because if I attended a meeting at Craigavon, I would have to either drive there and drive back again, which took up all my time, or attempt video conferencing, which really was not very successful.

'I mean, the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated.'

What steps are being taken to make sure current senior management staff in the Trust who are not based in Craigavon are fully integrated?

A. Yes, I got support. I remember being with Gillian Rankin, talking about these things in the Acute Directorate. The response of the Associate Medical Directors was yes, but again, that's very interesting but do you realise what we're asked to do.

Q. Just to be specific, what were they being asked to do?

A. When I told them that I was going to change the M&M system into a Patient Safety system, and that there would be eventually patients working with me in the oversight of it, but in the first instance we would invite a nonexecutive director to, you know, gently introduce the idea that that should be the case, my argument was, well, it's better to have that debate in the Trust and being, if you like, questioned by Trust Board, rather than, if you like, a more embarrassing intervention by the Coroner much later or an. So that was the argument, really that we should really focus on these things. I'm not sure if it was much different than any other Trust.

Has the intention of 'patients working with me in the oversight' of the Patient Safety system been delivered? If not, what is the SLT's view of implementing this idea?

Q. Clearly in the 2,000 or so pages that you've read and your conversation with a colleague, you formed an opinion of Mr. O'Brien. I just wonder if you would share some of these views; that he was someone who worked in isolation rather than as a team player?

A. Yes, I think he obviously did. To his detriment, I think, to the patient's detriment. He didn't seem to want to collaborate with his colleagues as well as he should have done, especially the radiotherapists in Belfast. That would have been -- a close relationship would have been ideal. And he had his own way of doing things and perhaps was reluctant to change. I think a lot of energy has been wasted in battles about who should do the triage and who should be the urologist on call and the urologist of the week, and how should we run the MDTs, instead of dealing with the issues. They were allowed to sort of spiral out of control. That does raise the issue, if you have a problem within a department within a hospital, it shouldn't be left just to deteriorate further and further and further and end up with an inquiry. A lot of these problems could have been addressed and dealt with at a much lower level than what's happened now.

Q. You may well be right and we'll certainly be reflecting on that when we come to write our report.

'I think a lot of energy has been wasted in battles ……instead of dealing with the issues. They were allowed to sort of spiral out of control.'

Is the SLT currently aware of any areas of practice in the Trust where this statement could still be found?

……

Q. Clearly, within your statement, your first statement, you reflect that over the years of your career the volume of administrative work has increased exponentially, you say without a corresponding increase in time allocated to address it. You give some examples, no doubt by way of example rather than comprehensively, of the type of administrative work that you had to undertake: Triage of referral letters, correspondence with GPs, discharge letters, results sign-off, attendance at and preparation

for audit, to name no doubt but a few. Administration work was a challenging feature of your role, is that the point that you are wishing to get across?

A. Yes, it seems to -- it doesn't get detracted, it always seems to get more in volume and in content and in time to have it done.

Has the time allocated for administrative work for clinicians been recently audited to see if it is adequate and if adjustments need to be made?

Q. One of the things you said today was around as clinical lead you can't know everything, which is clearly true. You only know what people tell you or what data you are provided with. What is difficult to see is what discussions did you have and did it lead to any data to help you with this in terms of complication rates for operations, blood loss, return to theatre, efficacy of pre-op assessment, these kinds of things. Did you sit down as a team to say we need to have some measures to know if our care is safe, we need to decide what those are and can someone collect that information for us. Did you do that?

A. We do have an audit department. It was –

Q. I know that but did you, as a group of clinicians, say this is what we think matters for urology?

A. Okay. I don't think so.

Q. And do you think that would be helpful?

A. Absolutely.

Q. Did you have any direction from what you might have called, I think you referred to it as the higher echelons, in terms of what kind of things you should be looking at in terms of quality?

A. Yes. We certainly have this through our Patient Safety Meeting now, that's –

Q. Has that changed in recent years?

A. Our Patient Safety Meeting is fabulous now. If I may say, it was a breath of fresh air to have all the young consultants coming when Mr. Glackin arrived, he took charge of that and did a marvellous job.

Q. But you still don't have these measures?

A. No. But it is our audit and our audit department has improved considerably. There's now an audit coordinator and we have -- where we would have had maybe one or two audits a year, we now have a specified list that we go through. Some can be maybe more complex. Some are short-term snap audits. It's very audit driven now at the moment. For the last two moments I have been at, our audit tracker has been at them and we have discussed all of that. And, in fact, our Patient Safety Meeting used to always start off with deaths, morbidity, then audits and any other comments. Now Mr. O'Donoghue has switched it round completely. The first things discussed on the meeting are the audits and the morbidity because our mortality patients are, well touch wood, are fairly predictable.

Q. We hadn't heard about that. It's good to hear that covered?

A. It's really good. I'm very impressed with what Mr. O'Donoghue is doing with the system.

Q. On the more mundane side, a basic patient safety issue is things like writing a letter to the GP, doing the triage, following your guidelines, looking at results, and I get the sense that it was too easy, in the past anyway, to do the wrong thing in some of this. Therefore there wasn't really a track on whether

everybody got a letter, whether everybody looked at results. Now, you showed us a little scorecard for results which is clearly an improvement and I would imagine some other metrics will come. But this business of the culture where it is too easy to do your own thing is key in patient safety, as I'm sure you're aware. Why do you think there was this tolerance of people just doing what they liked a bit?

A. It's the pressure of the volume of work to get through.

Q. Just that? Who should sort it out? We talked about the Trust, but where do you think the responsibility lies for ensuring these things are not tolerated. Because they are very basic patient safety things, really?

A. These are within the department yourselves. And if it's not being done then maybe a stern conversation is maybe required, or a specific sort of focus on these things at a departmental meeting saying here's what we want to –

Q. Do you think there was enough emphasis from the top of the tree on these things as opposed to targets, money, waiting lists, whatever?

A. There could have been more support from above, probably, yes

'Q. But this business of the culture where it is too easy to do your own thing is key in patient safety, as I'm sure you're aware. Why do you think there was this tolerance of people just doing what they liked a bit?

A. It's the pressure of the volume of work to get through.'

Does the SLT consider that the existing checks and balances in the system are sufficient to prevent a similar situation occurring when it comes to 'doing your own thing'?

Trust Improvements

Q. You've reflected already, I think, this morning, that standing back and looking at this there was a failure to follow the steps set out, whether you look at MHPS itself or the local guidelines and, in particular, giving you a role which really didn't belong to an operational manager both in terms of the screening report and contacting NCAS. They were roles, really, for a medical practitioner. Do you think, in terms of your experience of matters subsequently, that the Trust has learnt any lessons from this, the way in which this process was handled?

A. There has certainly been huge improvements. I think when Dr. O'Kane came in as Medical Director, I think she saw quite early, in terms of managing doctors in difficulty, that there needed to be a much more structured process and she put that in place in partnership with Vivienne Toal. I think that has been, in my experience, much better because of it. So, yes, now I think that Maria saw it almost in advance of this process of the Inquiry starting because I think that the Doctors in Difficulty Oversight Group commenced, I couldn't say when, but certainly not long after she came in to post. It was one of a number of things that she did to bolster. So, yes.

It would be helpful as an interim response before the Inquiry conclusions and recommendations are available (next year?) for the Trust to map out key learning points and how the system – processes and practice, have been addressed and altered. For internal and external audiences.

……

Q. Of course NCAS can always give you advice to cause you to change your mind. Is it not much more logical to seek their advice in advance of any decision so that you can weigh up that advice and take up the various factors they are suggesting you weigh up and then reach your decision. Have you not done it the wrong way round?

A. Possibly. All I can say is, as I have said before, this was a Christmas holiday, New Year's holiday, things were moving very quickly. You know, it would have been difficult to have choreographed all the moves. This would normally have been the way, in my experience, we would have operated, both in this Trust and in other Trusts, that an intended direction was taken, then you would have consulted NCAS in the light of that. I could see it probably better to speak to them first, but that was not the normal way it was done, in my experience.

Reinforce clarity on the optimal point of when to consult with NCAS.

Q. Again, taking into account that this Inquiry has to reflect and maybe make recommendations around this, have you any thoughts about that? Is there a need to streamline the process? Is there a need to -- I don't mean that you're not professional -- but a greater need to professionalize the process in the sense of making it somebody's specific responsibility?

A. Yes. I could share you a few thoughts on that. I mean, I mentioned before that for the individuals the Case Managers and case investigators have protected time in their jobs to do this, being expert enough to have received appropriate training to be appropriately resourced with administrative support, and HR support at the times they need it are all challenges within the health service at the minute. If that was improved, that would help a lot. From my own office, at that point the Medical Director's office was essentially composed of myself and, in relation to these matters, Mr. Gibson. It was very underresourced to provide this. I had highlighted this issue before I left the Trust with a paper to try and bring forward appointments of more staff to help with this, in particular, with Deputy Medical Director posts, one of whom would have a specific focus on this area. But it wasn't possible for that to be supported at the time for financial reasons. So, yes, absolutely. You were trying to do this on top of an incredibly busy and challenging job. At that time I seem to recall we had a -- I'm not making excuses for myself, I'm just painting the context in which this is being done -- we had a major issue with the Emergency Department in Daisy Hill Hospital which was having to be completely restructured and was at crisis level. There was a crisis in the breast care surgery system where we had to get a regional approach pulled together to try to ensure patients were not left wanting in the Southern Trust. There were so many issues going on. This was a relevantly small part of the Medical Director's job and, to be honest, did not have the manpower, the time, required to focus on this. But I think the main issue that would have made a difference would be protected time, training and admin support for the case managers and the case investigators, because they are the ones actually carrying out the investigation. It would have been helpful for me to have had a bit more support but, to be honest, I think the bit that would really make the difference would be the time and training for case managers and case investigators.

Is there adequate protected time, training and admin support for case managers and case investigators now within the Trust?

Q. That leads me to, you'll be glad to know, the final question that I want to put to you. As someone with the experience that you had of MHPS, and you described at the outset of your evidence to us that you were a founding member of the Faculty of Medical Leadership and Management, and that has been your career path, largely, if you had to sum up one thing, what do you think was the cause of things going awry here? Because it is quite clear to us that things did go awry.

A. Inappropriate deference based on status rather than ability

Has this equation shifted to a more balanced perspective?

Q. So there was to be an Inquiry into or an assessment of what was in these backlogs?

A. Yes. An "assessment" is probably the better word, as opposed to an "investigation". Because an investigation would have required the appointment of investigators and that certainly was not something that we talked about.

Q. If we could just very briefly go back to the record of the meeting on 13 September please at TRU-00026. These words "formal" and "informal" were bandied about in this context and I just want to take your view on this. There is reference to a formal letter being sent to Mr. O'Brien on 23 March, the letter we discussed earlier. Again, your reflections on that word. Let's see what we can establish here, there was no formal process commenced in March 2016.

A. No. No. But I think, again, I think where the "formal" word has come in, it was probably the first time. I think it was the first time that ever anything was documented to Mr. O'Brien. So that's probably why there is maybe some confusion over the formality. I think there was a level of formality there by putting the concerns on paper.

Q. Yes. So, by contrast to what we know had now taken place in previous years of ad hoc communication with Mr. O'Brien to ask him to improve or do certain things, this was putting a degree of formality around a request for the plan on the four issues that had been raised?

A. Yes.

Q. But you're not suggesting, and as far as you're aware, this Minute isn't to be taken as suggestion that you or the organisation with Mr. O'Brien was within, kind of, any formal structure or system or process?

A. That's right.

Have a clear understanding of the difference and application of an assessment, an informal investigation process and a formal investigation process.

Q. If we scroll up the page, we can then see that this Ping-Pong ball gets batted from you to Martina. Then from Martina, scrolling up the page, to Michael, and then Michael takes the view, going up the page, scroll down again, please. Michael Young eventually expressed a view, I'm not sure what the reference is. Go to TRU; I am just trying to find my note, Chair. Go to TRU-274729. That's it there. Right. Okay. So Martina is inviting Michael Young to speak with the clinical director, Colin Weir about the issue. Does the issue ever come back to you?

A. No.

Q. Should it have come back to you?

A. No. I think it should have been filled in. An IR1 Form should have been filled in. I think that's what should have happened.

Q. I realise that there's many hands on this?

A. Yes, I suppose are you asking me should I have gone back to close the loop?

Q. Well, did you ask anyone for an IR1 or did you not see that as your role?

A. No. I didn't. It would be within my role to ask for an IR1, but I didn't do it. I didn't close the loop.

How important is the principle of 'closing the loop'? What does this look like in practice?

Q. I asked the question from the angle of whether you, as the practitioner leading the investigation, or the Trust who owns the process, if there is impact on the practitioner as you describe, whether the delays that seem to punctuate the process -- perhaps inevitably because of complexity or whatever else -- can that be better managed by the investigator or is there a need for better support by the Trust for Trust for the investigation in order to move it along with greater efficiency?

A. I think Maintaining High Professional Standards is not fit for purpose. I suppose the reason I'm explaining this is that in terms of Maintaining High Professional Standards, it's my belief that the investigation is done to the best of your ability within time constraints that are available, and I'm not sure that that's the correct way to carry out an investigation if you want a more robust outcome. I'm not sure how much time this Inquiry has but I suspect that time has been set aside -- in fact, I know that time is set aside specifically for it. No time is set aside for Maintaining High Professional Standards investigations in terms of my job plan, or in anybody else's. I mean, I was assisted by Mrs. Hynds, and no additional time was set aside for her either.

Q. Mm-hmm. So, the picture emerging from your evidence so far is that you, a senior practitioner, with perhaps more experience than most in the role of an MHPS investigator -- you have gone through four investigations -- you are asked to do this; can you refuse, in real terms

A. Yes.

Q. -- or is it part of your nature perhaps to assist the employer where you can, despite the pressures?

A. You can refuse. This is done as a voluntary additional activity. It's not my nature to assist the employer. It is, however, my nature to ensure that patient service, patient care, quality of service to patients, is considered and regarded with seriousness.

Q. Don't apologise. A moment or two ago you used the word "robust", a robustness. This is what I took from your answer. I can't bring it up on front of me as I stand here, but what I took from your answer is that these pressures on your time often led to a lack of continuity in the investigation process, leading you to be concerned as to the robustness of this investigation; is that right? Is that what you were wishing to convey?

A. Yes. I think as doctors and lawyers, one of the things that's difficult is setting things down and then picking them up and then setting things down. None of us, for example, like to be involved in proceedings which, you know, go on for a week and then they disappear and then you come back and in the middle of that, maybe the next day, you are doing something else. That made it very difficult. There were some delays in this investigation which were of my own making because, I was, as I have explained earlier, very busy through this year. It was an unusual -- unusually busy year. Some of it was of my making. Some of it was of other people's making. But in the sum of it, you are looking at something, something comes to mind, you think oh, yes, I must look at that again but then you are not looking at it again for maybe another month. I think that isn't helpful, which is one of the reasons why I think if there was, for example, a day a week set aside, you would always be coming back to, right, how far have we got, what are we doing with that? It would help with time scales, it would help with prompts. Whereas, for example, when you are waiting for witness statements to come in and so you are sort of, well, I can't do anything further until those come in, I have got all these 101 other things to do so I will go and do those, you don't keep things to the forefront of your mind in the same way, which I think is unhelpful.

Q. In terms of your approach to this role, given your experience and your training, did you feel yourself well-equipped for it?

A. Yes.

Q. But that has to be set in the context of the strains, I suppose, of your everyday professional life in terms of fitting it in and doing it efficiently?

A. Yes. I mean, I think I had the appropriate training and the appropriate approach and appropriate seniority. If you are including in the appropriately equipped whether I had the appropriate time and resource, then no. I felt I was an appropriate person to do the investigation and, if I was doing it again, I suppose the issue would be of support.

'I think Maintaining High Professional Standards is not fit for purpose' Understanding that maintaining High Professional Standards is currently undergoing a review process – is the Trust taking all of the learning from this Inquiry and feeding it into the Review process?

Q. Would you agree with me that if there are administrative-type shortcomings in one area of a clinician's practice, it would be within the obligations of a Trust and its decision-makers to set the terms of reference wide enough to enable you, as the investigator, to explore whether those administrative shortcomings exist elsewhere?

A. I suppose it's the balance between earlier things in NCAS, which is about not making this so wide that, number 1, the investigation is unmanageable, and number 2, that you are just saying I am going to look at all practice and see if I can find something. I think it's about -- my view is that, yes, of course screening needs to be properly carried out, of course it does. But I think if there are specific areas of concern that have been raised by managers or by SAI reviews or by complaints or by patients, well then, those are the areas, and issues around those areas certainly. I don't think it's a well, let's look at everything. I suppose, Mr. Wolfe, and I have said earlier, you know, Mr. O'Brien's colleagues and managers, certainly who gave evidence to -- who I was involved in interviewing, were certainly very clearly saying that they had no concerns about his clinical practice, you know, other than, you know, the potential for patient negative outcomes because he wasn't doing things like triage which he didn't agree with. You know, as I say, people seem to think that other areas he was spending lots of time on and those seemed to be clinical areas.

Q. They were answering questions within a particular framework, the framework being your terms of reference.

'Would you agree with me that if there are administrative-type shortcomings in one area of a clinician's practice, it would be within the obligations of a Trust and its decision-makers to set the terms of reference wide enough to enable you, as the investigator, to explore whether those administrative shortcomings exist elsewhere?'

In the light of what has been revealed so far in the Inquiry, what would the SMT's response be to Mr Wolfe's question and Dr Chada's response?

A. As I explained, the process was Mrs. Hynds would type it up the statement, she would send it to me, I would compare it to my notes, I would make changes, I sent it back to her. All of that was being done without, for example, admin support. You know, Mrs. Hynds, I'm aware, was typing these herself, which I think I highlighted in my Section 21 notice, that here was a very senior person within the Trust who was spending evenings typing up things, which I felt wasn't a good use of either her time or my time. Perhaps what wasn't helped was Mrs. Hynds doing it, sending it to me, me adding bits to it

because that, of course, causes delays with every person that needs to sort of look at it, and then it went back to the person and then they had to check it and send it back with any amendments. So, it was a slow process. I absolutely accept that at least some of those delays were down to me and some of those delays were down to lack of administrative support.

Q, 'So, it was a slow process. I absolutely accept that at least some of those delays were down to me and some of those delays were down to lack of administrative support.'

Note the recurring theme of the need for more administrative support by the Trust when Investigations are being carried out.

Q. I think you probably were aware of that, or certainly some of your colleagues were. Patient 16, if you just want to glance at the cipher list. If we pull up TRU-01366, 23rd December. You can see the name in the attachment line. We're familiar with that SAI which started life as a complaint from the patient's daughter in December of that year, and there is consideration being given there to whether this falls within the SAI process. I raise that simply as another example in order to seek your reflections on maybe what are you doing now, perhaps, that's different when you sit down to compose Terms of Reference to ensure that they are sufficiently broad, without doing injury to fairness or doing injury to the notion that this cannot be so high, wide and handsome that it becomes meaningless.

A. Yes, I think the difference I see now, and probably Dr. O'Kane has brought this difference to it, is the questions around, so what else do we know? What are the complaints? What are the litigation cases? What are the SAIs? So you're on, you know, there's a range of data that you're trying to gather a picture around whether a job plan is in place, an appraisal is in place. It's trying to build a picture outside of just what you are kind of currently dealing with and I think that's helpful.

Q. When looking at this and listening to my raising of a potential criticism around how the TR were developed here, do you rely on the hindsight defence to say, 'we simply couldn't have imagined a need for a broader set of Terms of Reference'?

A. No, there were things we should have checked at the time. I don't look at it, oh, you know, now we know what we know. I think there were questions that we should have been asking. There were other problems we should have sensed at the time, and we should have checked those out. For me probably one of the biggest lessons for us as an organisation is around that problem sensing and how attuned we are to that.

Highlighting the role of problem sensing and asking 'other' questions to gain a broad picture.

Q. When do you say he was first alerted to the fact that the four-week timeframe both recognised in the guidelines and the MHPS framework was not going to be achieved?

A. I advised Mr. O'Brien of that at the first meeting we had with him on the 24th January.

Q. Did you ever follow that up in writing or in an email or send around to everyone else and say, look, I know we have these deadlines or these aspirational timeframes but given the issues that are arising, can we set something that's more realistic. Was there ever a discussion around managing time in a realistic way?

A. With the Oversight or with the Case Manager?

Q. Yes.

A. No, I suppose there wasn't. There was an acceptance that four weeks was never going to be achievable and that it was a matter of trying to progress as we could progress, given the capacity and

workload issues that we were facing into. So no, there wasn't that discussion in terms of what was a more realistic time scale.

Going forward, what mechanism is in place to ensure timescales involved in investigations are realistic? Unrealistic timescales will inevitably result in failure.

Q. As I say, the other meetings that were recorded you had with Mr. O'Brien, 9th February 2017, 30th August 2017, 6th November 2017 and 1st October. You said that you couldn't look at those initially. Have you had the opportunity to read through those subsequent to that?

A. Very recently, in fact. It has taken quite a while for me to get to the point of opening those. I just simply didn't want to open them. I felt that for me, you know, to share them this length down the road was entirely fruitless. I had absolutely no opportunity to determine whether or not it was accurate or otherwise. I suppose I struggled with that for quite a bit of time. I think the thing for me as well is that had the request been made, there were options to -- there were options that -- it would have been something that would not have been -- that would not have been dismissed. We agree this, we do this quite regularly. We don't do it all the time, again it's a capacity issue. If somebody feels they want a particular hearing or meeting recorded, we facilitate that, and that would have been facilitated that had that request had been made openly. I think it was the covertness and the underhandedness of this that was really impactful on me.

Are there a regular 'support check-in's' in place for all the witnesses in this Inquiry?

Q. Going forward, would you also be of the view that things could have been sooner?

A. Absolutely. I say absolutely and I caveat that again with they should have been done -- I would say rather they should have been done sooner. Could have been done sooner was the difficulty and that was the challenge, because of capacity and workloads and other priorities and all of those other competing priorities. Should that be Mr. O'Brien's issue? No, it shouldn't, that's for the organisation to deal with. So it should have been done more timely. I suppose if you're asking me could it have been done more timely, again I go back to all of the challenges that were being faced with at that point in time in terms of workload and other priorities.

So, whilst I -- you know, in terms of accepting carriage of this case and support to this case, knowing at the outset that capacity was going to be a huge issue, that's a really significant learning point for me. I believe, going forward we have to set the appropriate times aside and the resources to these things in order for them to be done in the way they need to be done. And to avoid the impact of lengthy investigations on the subject of investigations.

Resources and capacity did not meet the expectations of the MHPS Framework and the Trust Guidelines – what is the Trust's strategy to make adequate provision for future investigations?

Q. From an Employee Relations perspective, when you see other aspects being added along or considered like the private patients issue, did it trigger in you any curiosity that perhaps there needed to be a bit of a deeper dive into what the potential problems were, or the problems that were in existence were at that time? Did you think let's have a proper look at this, there's other issues coming up as we go along?

A. Is the question pointed at broader issues than what was in the terms of reference?

Q. And also whether it triggered any curiosity in you to think maybe we need to have a look at wider issues here. There's an opportunity perhaps to not focus just on this but to look at things that are arising, that have been suggested. You've heard that through Dr. Chada's evidence?

A. I have. It is something, you know, even outside of here that I have reflected on in terms of was there opportunities. Obviously now what we know in 2020 wasn't in front of us at the time of the MHPS investigation. I suppose it's that consideration of should we have known or could we have known? I suppose the only thing I can say on that - and it's probably very much mirroring Dr. Chada - it's really hard to describe. We were meeting with individuals as part of this where not only were they not telling us there was a clinical performance issue, they were telling us very much the contrary. I think I'm quoting Michael Young here as the clinical lead who was describing Mr. O'Brien as a very competent clinician, who was describing him as somebody he would want his family to be treated by. That was the flavour of the witness evidence as we went through, that, you know, the problems here were about not getting things done but if you were the patient who got in front of Mr. O'Brien, I suppose the message we were getting at that time was you're going to get a very, very good clinical service from Mr. O'Brien, and he's a very good clinician. I suppose again on reflection, I think that's where we have looked at this and said it's all this stuff around Mr. O'Brien's clinical practice, that's the problem, and haven't probably gone and said -- and that curiosity that you're describing, we didn't go fishing. I suppose I'm very conscious that we don't do that. We don't do that in any investigation. I mean, you look at what's in front of you, you look at what's coming up in terms of where your evidence is pointing you. Witness evidence was not pointing us in that direction, and that's the only explanation I can give for why we didn't go broader and look at the broader piece.

Is there scope to add in a clause to the Trust guidelines that can facilitate looking at a broader picture if a 'deeper dive' would be thought to be of assistance to the investigation?

A. I think we are learning, and that this is the one learning we should be taking forward, the clarity of roles and responsibilities; who escalates it; who should be acting when. At the centre of all that - I think we're talking about so many other elements - but the centre of all this is our patients; people, you know, our community. So we need to work around that and the process has to be right, the system has to be right, the support, the organisation -- and I'm not talking about, I think this is not about Southern Trust, it's about our whole system. We need to work to improve our system. We need to see an improvement going forward.

What plans are in place to assimilate the learning from this Inquiry and where appropriate, share with the wider system to influence improvement in the delivery of person-centred care?

Q. Thank you for that. If you could pick one or two learnings from your experience and from your observations of the experiences of others who were participants in this MHPS journey, what would those learnings be? Would they be resources, for example?

A. Well, as I alluded earlier, I think there are multiple factors. My experience was everybody was trying their best but not working as a team. I don't think we were working as a team; which should be. Again, team not necessarily means one team has roles and responsibilities, who is the leader, who is taking ownership, and where it goes next. There's a system, and processes weren't there to support us. When I say about the systems and processes, it's about the resources, it is about the environment; all of them were not there at that point of time.

How is the Trust 'role modelling' the principle of operating with a collaborative team approach to investigations?

……..

Q. Did you have any support and did you ask for any support? Was anybody identified for you? Bearing in mind this has been quite a difficult investigation, it will have taken its toll, and again was there a mentor or somebody you could be signposted to to bounce ideas off who was independent?

A. Psychiatrists are required to have a mentor. It's one of the things that our college recommended. We always did it informally anyway but it's a formal thing now with the college. I would always have had people that I would have informally sort of discussed things with or if I was having difficulty with. In terms of support, from that point of view, from sort of an emotional point of view –

Q. No, I am talking about practical support rather than the emotional side?

A. From practical support, no, not really. Mrs. Hynds was very helpful and, as I say, would have done a lot of the admin work in terms of tracking things down and sending e-mails. I would have talked and she would have typed, you know, in terms of putting things together but no, no practical support outside of that. I had a secretary who is absolutely wonderful, but my secretary was already assisting me in my Associate Medical Directorate role, and my clinical role which was a very busy role, and I didn't feel it was appropriate to expect her to add to that.

Q. I am thinking more of a senior critical friend of some sort. These investigations nearly always cause problems of some sort and one's own experience is always limited. In retrospect, would that have been helpful just to ask you some critical questions along the way?

A. I think in retrospect, that would have been helpful. I think one of the difficulties, and I've mentioned it already, is the lack of expertise in doing these. These are not something that we do in our everyday practice. I think I'm -- I mean I don't know and the Trust could probably comment on this, but I think I have done more than most, so I'm not entirely sure who I would have leaned on for that. Absolutely, I think in retrospect that would have been extremely helpful.

What is the Trust's view on providing a senior critical friend for investigators in formal investigations?

Q. Then you received another update from Mr. O'Brien to Dr. Khan. This is on the 21st October 2018 and Dr. Khan says that new concerns have emerged. Did that concern you from again a patient risk or a patient safety perspective?

A. Of course it did, I have no doubt about that. Again the issue in and around that was my perception - and this is just my perception - that there were at least two, if not three, processes that were going on at the same time. There was the Trust Board business that was happening; there was the MHPS process that was going on; there was my role in that. How they linked and meshed together, I found to be most difficult. I knew there was an obligation on the designated person to report to the board, I saw that, but I didn't see the opportunity to do that. There was no history of MHPS being reported to the board during my time, and my understanding is that in the history of the board, there was no reporting process into the board or into governance. Now, that has changed significantly over this last year, year-and-a-half.

Q. In what way has it changed?

A. Now there is a report that comes to governance, which looks at it in very general headline terms. It's looking at progress being made and, therefore, there is an opportunity for scrutiny and for challenge against each of the cases that are listed. Before that, there was no opportunity for that to happen.

This is a change that should be logged as an active improvement of process.

Q. Obviously with the budgetary constraints that Trusts have, and we know that the Health Service have at the moment, what would your view be on a regional resource perhaps provided by the Department of Health where you have a pool of people with requisite experience and expertise who could be drafted in externally to a Trust.

A. That would work, that would work. Interestingly we have a similar sort of model in HSC at The Beaches where they have a number of consultants. I'm actually on their list of consultants of people who are available to do things like SAI investigations, etcetera. So they could expand their repertoire to cover performance investigations, so that would work. But yes, that's a good idea; externally commissioned but available

Maybe the Southern Trust could facilitate a meeting with the other N Ireland Trusts to discuss the merits of developing a regional resource that can be called on when needed to assist in investigations.

Q. At this stage you're offering the Trust perhaps some information on how to set up that process. The first paragraph I'm particularly interested, about four lines down where you offer the suggestion or advice: "The investigation should not be an unfocused trawl of Dr. 18665's work...." What was your thinking in offering that advice?

A. I think it's very important to have terms of reference which reflect the allegations that have been raised. I know this was discussed in some detail this morning with my colleague, but the other thing that I did talk about was a lookback, and I think that's something that people don't think so much about. So, had the lookback been done, probably the information would have been found at that point which are supported adding to the terms of reference. When we do our training, this is something we talk about a lot, the investigation should be to a focused terms of reference. Patients coming to harm is obviously the main priority, so you don't want to have to investigate huge -- I mean, the investigation took them some 18 months. You don't want to make the job any more difficult than it already is. But the patient then lookback focuses on if there are any issues for Patient Safety. That might have flagged up that there were other issues that should come into an investigation and could properly have come into an investigation had there been a patient lookback.

Q. You do, quite rightly, point out that your advice doesn't stop at the words "unfocused trawl". If goes on to suggest that if there are concerns about adequate treatment or adequate records, this could be managed separately with an audit lookback to ensure that patients have the appropriate standard of care. Are you proposing, in fact, a separate process, a parallel process?

A. Parallel but separate, yes, absolutely. Because if you give that job to the case investigator, it would be far too broad. It's a priority, obviously, to identify any patients that have been inappropriately managed.

'Had the lookback been done, probably the information would have been found at that point which are supported adding to the terms of reference'

What would a parallel investigation involve? Is this an approach the Trust would like to use in future investigations?

The MHPS determination resolved that there should be an independent review of administrative processes. I want to ask you about that. If we could have up on the screen, please, AOB-01923. Just scrolling down the page, please. Under Final Conclusions/Recommendations, it said that: "The investigation highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services directorate. The report identifies that there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr. O'Brien. No

one formally assessed the extent of the issues or properly identified the potential risks to patients". Is that a conclusion with which you agree?

A. Yes. I don't think that's unfair.

Q. Arising out of that and what he says there at the bottom of the page, he says: "I recommended the Trust carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes". Now, we know that recommendation had not been addressed by 2020 and then there was, I suppose, a flurry of activity in the summer of that year to get the process moving. When did you first become aware of this recommendation?

A. It certainly was in 2020. Maybe early 2020.

Q. In terms of your contribution to it, can you help us understand what role you played in the review?

A. It was towards the latter end of probably 2021. This recommendation was picked up by Dr. O'Kane in terms of progressing it forward. Dr. Donnelly and Dr. McCullough were asked to take this forward and to draft a model or a proposal which would meet this recommendation. So, I have to say what was done by Dr. McCullough and Dr. Donnelly, and subsequently by everybody else, did not, in my view - I haven't listened to Dr. Khan - did not capture the essence of what Dr. Khan wanted to happen, even though despite many eyes and many fingers over it

What has happened to the draft model/proposal in response to Dr Khan's recommendation?

Does the SMT agree with Mr Carroll's summary that the draft model/proposal does not capture the essence of what Dr Khan wanted to happen?

Q. I want to come to that aspect of the narrative later. Could I ask you this just in terms of the impossibility, as you put it. There is always an opportunity, is there not, to work in a different way to bring different methods, different levels of intensity to the task at hand. Your colleagues, and you may look unfavourably at their approach to triage, but whatever standard they brought to it, they were getting it done, they were processing the cases. As the SAI suggests, they were in many cases organising investigations, moving the thing along. It wasn't just a traffic light system, as I referred to it yesterday, for some; perhaps all of your colleagues. Why could you not evaluate what you were doing in order to fit within the demands on your time and the resources available to you?

A. You know, I think that for years I had been doing that. I think you indicate that there's always a possibility. I think it had come to a stage that it was no longer sustainable. I think language is very, very important. I thought that Mr. Haynes, when he was writing to Esther Gishkori in October '18 when he was considering resigning from the post as AMD, he talked about the Trust's "institutional blindness to unmeetable expectation". There comes a time when you have to say this situation I have found, all I was dealing with was I have found it to be unsafe, I cannot do it to the extent that I believed it should have been done. That's what I stated.

The Trust's "institutional blindness to unmeetable expectation".

Is this a sentiment that could be experienced in the Trust today?

A.I think there's a role for external input, whether it's as an NED or whether it's in some other advisory role, in order to get two parties at a stage where they're considering - now I'm not talking about issues like criminal or other really serious issues, I'm talking about these kind of performance issues or whatever you label them, to get people around the table to try to address it

There are some considerable advantages to having external input to facilitate discussions, provide an analysis and assist with recommendations in informal and formal inquiries.

Q. Do you think that's something that might be helpful if the issue around documentation, confidentiality, patient data, was specifically addressed at induction for doctors so that they understood the way systems operate to allow them to engage with them?

A. Yes, I think it would be useful.

Does the SMT consider this to be a good idea? If so, what steps can be taken to implement it?

……..

Q. "If I or others, while working as a Cancer Tracker MDT coordinator Band 4 or as Cancer Services Coordinator Band 5, raised any concerns that were identified as a serious adverse incident, I do not recall being advised of the outcome of any investigation if it was logged onto the Datix". This, you say, was due to being a Band 4 or Band 5, and it was your understanding that you did not need to know. So that I can fully understand, hopefully I've got this right, you might have raised a Datix incident report, we've seen one example already and I think you cite other examples?

A. Yes.

Q. You've raised them because of a concern that clinicians providing a service to patients which impacts on your service were maybe - this was the reason for the investigation - were maybe not doing their job properly; there had been some issue or concern, perhaps a delay, leading to an impact or potential impact for the patient. Is it not important that you should know how such reports have been dealt with so that you can learn –

A. Yes, I would agree.

Q. -- for the future?

A. Yes, I would agree with that. I think it is very important for that information to be passed down so I was aware and I could also make my team aware, because if you don't know what's happened or what's went wrong, how do you fix it?

The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked?

Q. You have also said that the CNSes are now allocated to the consultants' result clinic. When did that process start?

A. That would have started when we came back from our period of redeployment in probably March '21. At the same time, the managerial duties were taken over by the manager of Outpatients. Basically, my managerial duties were taken over by Outpatients, and the manager of Outpatients was responsible for managing the other staff. That freed up the nurses to be able to be more proactive within that role. What happens now is night and day as compared to what would happened at the beginning of my tenure. So, we get the schedules through, we know when the clinics are happening. Usually because I can do the e-roster from my previous role, I have kept that on for just the CNS team. So, once we know what clinics are running, I can allocate a CNS to that clinic. What the CNS does in the morning or the afternoon of that clinic, she has the clinic list in front of her; she will screen through using ECR; she will know exactly how many patients require the key worker input; she will have all her information sitting, and indeed she will be proactively in the consultation with the patient, the consultant, and family.

Q. That's expected that the nurse is in that consultation for the results?

A. Yes.

Q. Is that a result of two things, the reduction in the admin duty appointment of someone to take over those duties –

A. Yes.

Q. -- and also greater resources for CNS?

A. Yes.

The success of a nurse-led intervention – a development in practice and a good news story. How can the SLT/communications department relay 'good news/constructive developments' to the Trust - boosting morale and narrative?

Q. You have reflected as well at paragraph 24.5 of your statement that when you raised matters through the escalation process, you didn't receive any response. Typically you were, if you like, out of the loop or kept out of the loop in what was being done or what had been done. Do you feel that more feedback to teams on the ground carrying out your kind of role would have been useful?

A. Yes. It would have been useful to know -- obviously we don't need to know everything that's going on and some of those things were confidential, but it would be -- even just to know that, you know, we are dealing with it and take our reassurance that we are dealing with it, because there was a feeling that we were continually escalating things; we were, if you like, adhering to our side of the process but we weren't really sure what was happening outside of that. So yes, it would have been nice to know that.

Note – another witness expressing the importance of 'closing the loop' when they have raised a matter through the escalation process.

Q. "I believe the previous governance arrangements relating to the Cancer MDTs were not sufficiently robust to identify the issues in Urology." "A cancer MDT administrator was appointed in January 2022. They are now leading on establishing robust governance arrangements around the cancer MDTs."

A. Yes.

Q. And that's in place. How effective are all of those posts, those additional posts, how effective are they in bolstering or reassuring you around governance?

A. Those are very effective, you know. They can run reports to give us an assurance that when decisions are made at MDT, that, you know, we can now monitor the outcomes and assure ourselves that those outcomes are actually happening.

Q. He does mention that the peer review process was stood down during Covid and, at the time of his statement, had not recommenced. Has that recommenced, do you know?

A. Not a formal commissioning of peer review or peer review visits; that isn't happening. However, in the absence of that, I think it's good practice to continue to monitor our MDTs against the measures that are there. So, you know, our service improvement will continue to monitor our quoracy, monitor key worker role. That work will continue to happen, even though it's not properly commissioned or we do not have formal site visits.

Are the plans for peer review and peer review visits to start again?

Q. Yes. The SAI made some recommendations about how things could be done better. I suppose if you didn't appreciate that things weren't entirely optimal, then you perhaps didn't appreciate the need for improvements but I'll ask the question anyway. Have you noticed any change in the MDM environment since these issues emerged in 2020/'21? Have you noticed things being done differently? For example, is the team -- is the membership of the meeting better supported in any way, is it better organised, is the discussion any different?

A. A lot of it's similar but there seems to be more emphasis on particularly making sure the patient has a key worker. That's one thing, or a nurse who's kind of looking after that patient. That's something that I have noticed, there's been more emphasis on that. Maybe some other things but I can't really put my finger on them particularly. But there just seems to be maybe more structure and...

Q. Yes. The Trust have carved out a new role for the person on the management side, if you like, who attends. So it's now an Angela Muldrew who is the MDT coordinator. It is said of her that her time, she's now better enabled to give more focus and more support to the needs of the MDT. Is that something you've observed from your role or do you think that's more recognisable in the hands of a urologist?

A. Yes. I think the urologists would know more.

The have been recent improvements in Urology in the Southern Trust - in meeting quoracy at MDT, the appointment of a second radiologist, the appointment of an MDT coordinator and the addition of more CNS's. These developments will have contributed to raising staff morale and improving the delivery of patient safety and care.

Q. Is there anything within the current system that allows you, the radiologist, or the tracker or any other responsible person to know that the clinician hasn't yet actioned the report?

A. Yes. So, this is what I mean by more recent changes. These are things that are being worked on. As we currently are, there is no way of knowing what's happened.

Q. So, there is a mechanism by which you can check to see administratively whether your report has gone out, you do the dictation and it's checked. Then does an administrator, a clerical person, issue that for you?

A. No. So, if the report goes automatically electronically, it just goes out, straight onto automatic, straight onto the electronic care record. There is a paper report sent as well at some point. It will be a little bit slower, obviously. That's done by the administration staff. If there's a flag put on, then that's when the administration staff would be involved as well. They would send the email to the referrer.

Q. So, as we stand in 2023, where do you think the gaps and the improvements are necessary?

A. Well, there's lots of improvements that -- I mean, there really is a lot of improvements that are possible, from using, you know, mobile devices to be able to alert consultants; you have to be sure who's covering and you have to make sure that the report goes back to someone who's actually available, not someone who's on leave; or there is a safe mechanism for someone else to check if someone else is away. There has to be an acknowledgment of reports; when you receive them that you have to acknowledge that you've received them. If there's recommendations, then someone has to check that those recommendations have been followed, or if they have not been followed, why they have not been followed. Lots of back-up, admin staff to do all these tasks of reporting and checking. So there's quite a lot of change.

What are the SLT's thoughts on these suggestions?

Is there anything else you would like to say or want to cover while you're here?

A. No. Other than, you know, I'm very sorry for the position that we're in and it's a source of deep regret for me for that. In terms of some of the work that's going on now to address maybe improvements, and particularly the governance link, I think some of that is going in the right direction. We described the governance report. One of the things I had started, and it's maybe just because as I'm talking now - I don't think it's in my witness statement - some things that I think is important in terms of relationships and stability within the Trust and the leadership and bringing together information, is, I had, as you know in my witness statement there, some responsibility around the quality improvement sort of agenda. In particular, in 2016 I had established a quality improvement steering group, which was intended at that time to do what the systems don't do yet, which is a bit more triangulation of information and insights from a number of sources. That group had been established, but it never really got full traction because of the changes in personnel, et cetera. It continued to meet. But I think there is something there in terms of learning around, aside from just data driven - which is important - data driven indicators and change and bringing information together. But the relationships particularly across the professional disciplines, that steering group we had established had the Head of Social Work, Head of Nursing, Head of Medicine, with a key indicator around enabling our workforce. One of the thing that was described, I suppose now that you have asked the question, I did hear some evidence from Marc Williams. One of the comments he made is that the organisation didn't encourage people to improve services. I would disagree with that quite strongly. I think the point of establishing the quality improvement function within the organisation was to do just that. We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted. In the first year of establishing the improvement team, Dr. Wright and I had established from the governance agendas, and in particular the complaints data, around issues around communication and, at that time, infection prevention control. We did a campaign with staff on a broad spectrum of encouraging people to do improvement projects, and we committed in support of 15 projects in that year, taking information that was coming from governance. I think that's something that could still be done more, that there could be a bit more done in that space.

'We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted'

Has the SLT updated its approach to quality improvement projects?

……

Q. Does that apply for the MHPS process as well?

A. So, we would never have known about an MHPS, definitely not. It wouldn't be something that would be shared at my level. It would be kept with a tight cohort of people.

Q. Does that apply even if the learning or some of the issues that arise through the MHPS have a direct impact on your role and governance and perhaps patient care? Are you not informed of anything about the outcome of an MHPS?

A. Unless there is a staff member that has been -- their contract has been terminated, I wouldn't know.

Q. Did you ever share that or mention that to anyone and say is there any way we can get beneath some of the more formal procedures that actually can highlight aspects of governance that need improved? Were they conversations that were had at any level?

A. No, because I didn't know what I didn't know at that stage, if you understand what I mean. So, it wouldn't have been on my radar to ask that question.

Q. By the time you had left the Trust, was there any movement in thinking that that sort of issue needs to be looked at, that there perhaps is a wider benefit from a governance perspective in bringing other people inside the tent, as it were, so that learning in an anonymous context can be rolled out?

A. Not in that context. Having said that, I was aware of a Medical Director's office contacting me and saying, you know, has so-and-so -- is there any complaints or any SAIs involving this staff member? But they weren't -- you were just asked to check out if there was any incidences with that. There was no information coming back, if you know what I mean, to say look, this is what's happening in that case. It might have prompted you - that's only just before I left this started happening - that would have prompted you, oh, is there something going on? But you wouldn't have had any detail on that and you wouldn't have had any context where that's concerned, because very often the information was purely from they are revalidating, or it's for their appraisal; not necessarily that there's an investigation going on.

'Q. Do you think that there's a way of sharing information with you at your level as the coordinator, Governance Coordinator across Acute Services, that would allow you to carry out your role more effectively, assist in the protection of patients with a reduction of risk, and also anonymise sufficiently to maintain the confidentiality of the individuals involved?

A. I think so. I can see the benefits of it if you were aware there were other issues because then you are kind of joining all the dots, aren't you? You don't have all the dots to join otherwise.'

What is the current policy on sharing anonymised information and learning from MHPS/SAI's with the Governance Coordinator across Acute Services?

A. You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well because, very often, instead of looking at, well, that's a human factors issue, people still have that kind of blame 'oh, you never guess what so-and-so has just done. That needs to stop. For you to have openness and transparency and good learning coming through, you need to accept we are human, human factors, people make mistakes; this is the mitigation we put in place; this is the learning that we put in place so that the whole stigma of being involved in a serious adverse incident is removed. Because there is a stigma for staff that are involved in it, they are quite stressed about it and they think that people are pointing the finger at them. Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well.

'You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well'

'Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well'.

How can this narrative be reinforced throughout the Trust?

Q. "I also believe there were too many individual processes, MHPS and/or insufficient joined-up thinking. For example the details of the MHPS process were kept confidential".

We raised that point before. The first point, there are too many individual processes?

A. It's not just MHPS; there's obviously nursing and midwifery processes as well. Any health professional, allied health professional, have their own professional bodies that they would have investigations through. Also, HR have another process for other staff as well. You know, you have got your conduct or your capability processes or your disciplinary processes and things like that. They don't necessarily all marry up and feed into each other. That's what I meant by that.

Q. Have you any suggestion as to what the answer may be or are you just identifying that those individual processes perhaps be joined-up thinking, and anything that would unblock that would probably be helpful?

A. Yes.

Q. Then you say at 22.6: "We should be an organisation with an effective corporate memory so that when an adverse incident happens, that learning is not only shared through the division or area of practice but extended to all areas within the Trust. Lessons must be learned by all teams, and action plans from recommendations should be kept live and revisited at least annually to prevent reoccurrence. Too often learning from adverse incidents is shared and there is some learning for a few years, then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems reoccurring." The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate.

A. Mm-hmm.

Q. But your suggestion is that when you lose people who remember things, everyone thinks they are starting again?

A. Yes. Yeah.

'The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate'

Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?

Q. You have said this previously but just to give you an opportunity to say anything else about it: "A deficit in one area of practice should provoke curiosity and require sampling of other areas of practice". We can see in the timeline there's a possibility of that thinking pre-MHPS, post-MHPS September 2019, 2016, 2017; there were signposts perhaps along the way. Do you acknowledge that that should have been the lens through which things were looked at various parts of this journey?

A. I am a great believer in always lift a stone, don't take it on face value, and I don't think we took that opportunity as an organisation early enough

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern. Also patient information and patient involvement. We have a statutory obligation, actually, to involve patients right from design,

implementation and evaluation of all of our services. I think the Task and Finish work showed even when patients and relatives had been through a difficult time, they engaged with us, they trusted us to try and improve our services. I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public.

'But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work'

'We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services'

'I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public'

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go though to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'

What are the next steps to move towards this goal of inclusion, partnership, and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'

Q. Absolutely. Another thorny thing that's come through from a number of people, and it's on your Risk Registers at the Trust, is about standards and guidelines. Clearly a lot of bureaucratic things are involved when you try and make sure they have been read and the Department has looked at them. It would appear that there has been no systemic way of ensuring that when a standard and guideline is adopted, there's any kind of measures of whether people are actually using it. Is that correct?

A. I wouldn't say it's entirely correct. Caroline Beatty, who let the standards and guidelines work in Acute Services for many years, has now moved to corporate. She has moved to corporate because there was an acknowledgement that she had a best practice model - that was also acknowledged in June Champion's report - but that it needs to be corporate. A lot of standards and guidelines don't relate to Acute, but there's a lot that relate outside of Acute and there wasn't the same focus.

Q. But how would you know if a consultant wasn't following it?

A. The audit and the checking and the role of the change leads is critical here, for them to be able to evidence for us. I am back to the issue of clinical effectiveness and clinical audit and we need more of it.

Q. I think you would agree that we don't actually have any measures of the clinical outcomes in specialties, for many specialties. There are in some but certainly not in many surgical specialties.

A. Yeah.

Q. Has the Trust fully embraced that now, do you think? It's not very easy just to put it in if you recognise the deficit, but is there a full recognition of that?

A. I think they are on that journey. I think they are starting to think even MDM outcomes for different specialties is part of that.

Q. But MDM, it's still the same thing in that you are following a guideline?

A. Yes, but I still think there's a piece of work to get us to a watertight place.

'Clinical effectiveness and clinical audit and we need more of it. We don't actually have any measures of the clinical outcomes in specialties, for many specialties'

This is key information that is needed for quality and patient safety – can this audit process be embedded across all specialities with a timeline for action?

Q. You understand that one of the focuses for the Panel is the governance system and processes that allow decision-making, I suppose, to be tracked back to origin. This seems to have been a fairly relatively important discussion that was going to slightly change the route by which triage was going to be approached, and certainly there's some contested evidence now around what was expected to be done. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely, because I know from the meeting with Mrs. Burns, I did put it in writing with regards to the plan with Mr. O'Brien not triaging. But I have looked back and I have never actually shared information with regards to the GP, the default of the GP prioritisation, which is now, you know, a regret. But then again, I don't think it was, you know, for me to do it because it wasn't my decision. It was a decision made by two assistant directors in discussion with a director, so I absolutely agree, we should have had minutes from that meeting, albeit even if it was an e-mail note.

'Q. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely'

Is the messaging clear throughout the Trust on the importance of documenting all decisions taken and circulating them to the relevant people?

……..

Q. Ultimately it seems to come to this, you use this word which we're hearing a lot about, triangulation, "triangulation of risks was therefore challenging". You seem to put a lot of store by the need for good data access and good data analysis; why was that? Why is that?

A. Very simply, it's really challenging to identify risk when you can't see it from the different systems all aligned. So you may have a large amount of information but to identify from one system to another to another and pull that all together is really, really challenging and without being able to pull the information together you don't get the overall picture and, therefore, you can't see the overall risk. So some of the issues that had been identified, you know, with good data systems may have been easier to identify. But again it's as good as the information we put in so, therefore, making sure that your staff have the appropriate training to make sure that they know how to identify risk, how to fill in an information form so that you have got a clinician name to identify if it's a clinician or identify if it's a specific issue in relation to a medication or the sort of recording of the deteriorating patient, all of that is really, really vital to be able to really identify the risks that we have.

Q. Do you know whether - obviously long out of the job you were doing in Acute Directorate - do you know whether the picture has changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?

A. It is still a significant challenge. The systems haven't changed that much. If you look at the demonstrations of the new Datix system that's available, you can put everything from your incidents,

complaints, litigation, safeguarding, audit, recommendations, everything can go on it and be potentially triangulated and have reports coming out of that. So we don't have the most modern version of that. In relation to audit, again we need to continue to develop a system to put our audit recommendations on. And data analysts are really challenging to employ and we have a very limited team of probably one person. And again even having IT specialists who can put applications across data to, such as one of the click applications that will pull information from one or two systems into a report that is pictorial, for example, again there is a challenge with being able to resource those people within the organisation.

'Has the picture changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?'

What needs to change in the immediate, mid, and long term to confidently triangulate risk issues within the Trust?

Q. It's been suggested to the Inquiry that perhaps the most significant impediment to moving SAI cases forward is the availability of the lead responsible officer on the review, who is inevitably a clinician?

A. Yes.

Q. And usually a busy, committed clinician; is that something that is just inevitable or are there ways of driving momentum and encouraging expedition that you have now recognised that perhaps weren't a feature of some of the cases we have seen?

A. Yes. Well, I think when you're using a working clinician, that will increase the length of time, because if they have not got protected time to carry forward this SAI review, we are really depending on their clinical commitments and trying to fit this in around that. What we have been doing since 2019 is doing a lot of the preparatory work, in that we are writing the timelines, we're making the packs. So we're doing some of the groundwork for the Chairperson in advance of the first meeting. Obviously they'll still need time to prepare for the first meeting and review the information that they have available. But I find that that can quicken the process.

Is there now in place the provision of protected time for the Chairperson of an SAI panel?

Q. So, you are reflecting back out of your own experiences of Chairing or leading three SAIs, and more widely, is that fair?

A. Yes. So, my own experience is that they do take too long. And for the reasons I've outlined, I think that is not helpful. Because if there's quick learning needed then you're not getting that out there as it should be, you know, across the organisation. Secondly, when an SAI report comes down through the governance structure to the M&M patient safety meeting, for instance, what you get is basically a set of recommendations. It's often very difficult to contextualise those recommendations, to put them in a scenario where the people in the room understand, you know, this is what has happened and this is why we're making these recommendations. And another problem that I think with the recommendations is that I may Chair an SAI, Mr. Haynes may Chair an SAI, Mr. O'Donoghue may Chair an SAI - and this has happened in our department - and we all make slightly different recommendations on the same kind of core issues. I think it would be better if the SAIs are conducted by a team of people who have knowledge of what other recommendations are being made, so that there is a consistency in the recommendations. So, it is not infrequent when you are drafting the agenda for the patient safety meeting to have several SAIs coming down through the governance team, and really we don't have time to fully consider all of the recommendations and all of the nuances arising from those SAIs. So, there are other ways of sharing that information. You know, you can do

case review type presentations at M&M meetings or similar learning events, and I know that that's used in other specialties. And it's probably more effective than just providing us with a summary of recommendations.

Has there been a recent review of how effective and efficient the structure is in running an SAI Review, its recommendations and cascading the learning? Have the suggestions in the witness's response in the above paragraph been considered?

Q. I'm sure the Inquiry is interested in, I suppose, the nature of the governance relationship between these two centres. In essence it's one patient, and while they're going to different facilities, they probably think, right, globally this is my care package, so they will want, I suspect, to be assured that if things go wrong on either side of those centres that it's being well managed so that you are alerted in Craigavon if Belfast thinks things are not as they should be and vice versa. Is that a relationship - is the relationship one that works in that way?

A. I don't think that there is enough sharing of information across the cancer network here. I think that -- I can't recall what's been provided on a unit basis from the centre data demonstrating timelines and pathways. I can't recall that for either bladder cancer or prostate cancer. We've had a recent exercise whereby all of those units providing kidney surgery have participated in a project. So I have participated in that at Craigavon on behalf of our Trust, and my colleagues in Belfast and Altnagelvin have participated as well, and I think the Ulster. So that's the kind of work that we need to do. So, I think it's somewhat frustrating to hear things being thrown back at the units when, indeed, the communication coming the other way from the centre could be better.

Are there current plans in place to continue to develop collaborative relationships and roll out continuity of care pathways across different centres?

……..

Q. The subject matter of the email is "Stent Registry", that you have just mentioned. Do you recall if that was developed, if that was something that came into place as a result of you having identified that there were stents that hadn't been removed, but also that they hadn't been referenced in the discharge letter?

A. I don't recall the invitation of a stent registry, no. I mean this was brought up in a meeting, and everyone agreed, yes, there should be. But I don't recall a stent register was, you know, started at that time.

Q. Do you recall if there was any clarity at that meeting about who would take that forward? Who was to take that idea and make it a reality?

A. No, I don't recall particularly, yes.

Q. But your recollection is that it didn't happen or you don't remember it?

A. No, if it happened I would remember it, but probably it didn't happen, yes.

Q. Do you remember if any of those two cases progressed to an SAI? Do you remember any of that information?

A. No, I don't know the outcome of that, actually. I filed the incidents and I didn't get any feedback -- it is not just to I think going back, I think filed about five or six incidents, and I did not get any feedback of those - the outcome of this review.

Q. And in relation to you having identified it and reporting it as an incident in the first place, is it your understanding that then others would look at that and take a view as to whether it met the criteria for an SAI?

A. That's right, yes.

Q. And if that were to happen then perhaps someone would speak to you about it to get more facts?

A. That's right, yes. Exactly.

Q. And did anyone ever come to you to get more facts about that?

A. No.

Has a stent registry been introduced? If so, is there evidence that the system is running smoothly?

Q. So when you came, for example, did you have a whole session as part of your induction on how to deal with serious incidents, or how the incident process worked at Craigavon? Was that explained to you?

A. No. No, there was no proper induction, but I picked it up as work along.

Q. Was there a regular learning from serious incidents throughout the hospital? Did you have any part in those events?

A. That was my main emphasise. Like I myself reported a few incidents.

Q. Yeah.

A. I didn't get any feedback on those. So the wider circulation I feel that any lessons learnt from anything should be circulated to all, those 11 team, not just only to the particular consultant or clinician or staff.

Q. So you didn't get personal learning, but also you weren't aware of general learning activities made available to you?

A. That's right, yes.

More evidence to support the need to overhaul the SAI system in the Trust.

Q. So different settings, different cases, different clinical issues. Common denominator was a failure to provide for or to conduct preoperative assessment. The Inquiry is interested in this issue generally from a governance perspective. In terms of your own practice first of all, I mean where you're encountering a case for theatre, whether with or without significant co-morbidities, is it the practice of you and your colleagues, to the best of your knowledge, to use a preoperative assessment format?

A. Yes.

Q. To the best of your knowledge has the situation improved in governance terms since any of the cases that I've touched on here?

A. So the capacity of the preoperative assessment service has improved over time. Certainly back in 2015 they wouldn't have had the same capacity that they have now. But my recent experience is that the capacity is still some way short of what it needs to be. Even if lists are provided in a timely manner, the pre-op team are still struggling to get people through the pre-op process ahead of surgery. So that

still leads to problems because it may mean patients being cancelled because they haven't completed that process, and that's what would happen, they would be cancelled.

Q. Yes. Well, I was going to ask to what extent are you aware of a culture where risk taking is tolerated? Clearly it might be suggested that the cases that I've, the examples I've referred to shouldn't have proceeded?

A. So I think, you know, particularly with - and I'll just refer to the number. The learning from Patient 91.

Q. 91, yeah?

A. Right. That obviously had a profound effect on how we operate in the Southern Trust. So every patient who is having an endourological procedure, that means a telescope into the urinary tract, is having an MSU beforehand, and the results acted upon. So there are still patients where that is not happening ahead of time quickly enough, and those patients are getting cancelled as a consequence.

A. We deal with a very comorbid population of patients. So not all of them have their preoperative assessment with a nurse, some of them have a consultant led preoperative assessment by an anaesthetist, and the purpose of that for those patients is to get a very clear handle on their comorbidity and what the expected complication rates would be, mortality, predicated mortality rates. So that's all documented very thoroughly in a clinical letter by the consultant anaesthetist, and that would then be a two-way conversation between the consultant anaesthetist from the pre-op clinic and the operating surgeon. So that happens a lot. And as you can imagine, there are times when between you, the anaesthetist and the patient, you have to come to an agreement as to what you're going to do, because not every patient is optimally fit.

'My recent experience is that the capacity is still some way short of what it needs to be'

What plans are in place to support and deliver a robust preoperative assessment service?

Q. We have heard quite a lot about waiting-list management and how it's done differently, perhaps, in Southern Trust. I mean, what was your view of the -- being sent Excel spreadsheets of all the patients under your name every week or every period to try and sort out -- I mean, did you think that you needed more help in that respect, or what was your personal view on that?

A. My personal view is that there now is a urology booker –

Q. Yes.

A. -- and you need administrative help to fulfil that role because the waiting lists are so large that they can be a little bit overwhelming; you are thinking, right, who do you pick and how do you operate? The obvious thing everyone says is, right, well, it's the person who is last on the list. The reality of that is, it isn't the case, and the reality is you need a three-pronged approach and then it is very time consuming. So I give an example of PCNLs, is, I can't just take the exact last person, but I'm very aware of them and I plan to then do them, but I have to update their imaging, have to see them in clinic, because time has changed that person, their comorbidities in the situation. So you have to be very mindful of taking the next person who is due on the list, and, at the same point, you have to say, right, who on this list is going to come to harm? Who is hiding in that list that needs to actually be next on that list? And then the third thing is, you have to be aware of, well, what happens if you have cancellations? You need to maximise the resources you have. So I have been very clear on having a shortlist of people I can bring in very last minute who I know are really well and aren't going to cause the anaesthetic department -- and I know their urines will be negative when they get tested, so the

list is used. So you have to do it in three different approaches to try and maximise, one, your resource and also try and tackle the problem.

Q. So when did that schedule come in?

A. So the schedule had started in the past few weeks.

Q. Right. So, up until then, it was purely down to the Urologist to sort it out?

A. Yeah.

This new post of a Urology booker dealing with long waiting lists is a positive development and will help consultants address some of the large administrative challenges they face.

Q. If we could start with your statement again at WIT-51697, at paragraph 7.2 you're reflecting again on governance. You set out, I suppose, what might be regarded as a pretty traditional view in terms of governance in urology. "As a clinician, it means following GMC guidance of safeguarding high standards of care by maintaining competency and revalidation, monitoring of risk and, if a concern is identified, to respond promptly and manage." You say: "Mechanisms need to be in place to provide quality assurance for accurate, timely and reliable data that can derive constructive information for continuous improvement or identifying concerns." In your experience, whether as a consultant or as the clinician lead, were there sufficiently robust processes in place to provide reliable data in this context of improvement and risk?

A. I think the introduction of the Datix system in principle is a good mechanism of identifying problems. An issue with the Datix system, I find, is that it can be a bit on the cumbersome side to fill in, but that's a process thing. But as part of identifying issues, I think it has an important part to play, whereas before we had the Datix, it was hard to amalgamate enough sort of information to identify a trend.

Q. Yes?

A. It's how the Datixes are then put together to get the trend -- I'm afraid, I don't know, I'm not part of the screening mechanism or knowing how a Datix works further down the line. I'm afraid I don't know enough about that.

Q. Have you ever seen fit, whether as a group of people looking at any particular issue or as an individual wearing your clinical lead hat, perhaps, ever seen fit to ask for the generation of a report using Datix data?

A. I'm glad you asked that question because I haven't seen a report. It seems to be information going in and the only thing that you see coming out are individual sort of cases, as opposed to a trend being seen. So I haven't -- I've wanted to ask that question, actually, of, you know, can there be an annual appraisal or an annual sort of statement of what comes out of Datix. Now, unless that is coming, I don't think I have seen it. I may be wrong.

'I haven't seen a report. It seems to be information going in and the only thing that you see coming out are individual sort of cases, as opposed to a trend being seen. Can there be an annual appraisal or an annual sort of statement of what comes out of Datix?'

Can the SLT update clinicians on this issue? If it is the case that there is now an annual appraisal of Datix data - is the learning from this process reaching the relevant staff?

"Safe cancer patient care and pathway tracking is usually delivered by a three-pronged approach of MDT tracking, consultants and their secretaries, and urology specialist nurses." So, it is portraying, at

least in public sector NHS medicine, the use of the nurses as part of a three-pronged approach to Patient Safety, ensuring that the appropriate steps along the care pathway are being taken. The last sentence of the paragraph there is the important one. If we go over to DOH-00126 and if you go to page 105, Prof. Kirby. It's saying that the use of a CNS is common for all other urologists in the Trust. I'm struggling to find it. The sentence I want is in my note so I'll just read. It is on that page: "The absence of a specialist nurse from care presented a clinical risk". What is meant by that is the absence of the nurse meant that there wasn't that -- absent from the equation was that additional level of security to ensure that things got done. We've looked at an example with Patient 1 or Service User

A. You've agreed with me that that was a case that should have made its way back to the MDM for two reasons. It didn't make its way back to the MDM. If a nurse had been present in that patient's care, he or she would have seen that deficit, potentially, and ensured that the patient's case was discussed in that way, perhaps with Mr. O'Brien, and then arranged for the case to go back. Is that a fair understanding of how a nurse might assist in the avoidance of patient risk?

Are there clear guidelines on when a case should be brought back to the MDT for discussion and guidance?

Q. If you are prescribing off licence, you have an obligation to explain to your patient and record why you are doing so?

A. Yes.

Q. The efficacy of the approach must also come into question in terms of its optimalisation. A patient receiving 50mg as a monotherapy may be receiving some benefit but it's not the optimal benefit, and that's why 150mg is realised as the appropriate approach?

A. Yes. I would agree with that, yes.

Q. You have suggested that perhaps one thought around this -- we'll have to ask Mr. O'Brien -- a patient struggling with 150 or he suspects he might struggle with 150, there are side-effects so we'll use 50, that view is not uncontroversial, is it? The dosage may not be terribly relevant to the question of side-effects?

A. Well, a good question, really. I don't think anybody has actually studied the incidence of side-effects of 50 verses 150. There are no trials so we don't know for certain. But I suppose empirically you could argue that giving three times the dose is likely to produce more side-effects. The dominant side-effect is gastrointestinal side effects, which I think one of them, Patient A, got, and gynaecomastic breast enlargement that is quite troublesome with patients with Casodex. I don't know if anybody knows whether that's more likely to occur with 150 than 50. The effects on PSA is stronger with 150.

Q. I think we are all familiar with that, perhaps. My question was in terms of the guidance, the licensing?

A. Yes.

Q. I know they are two different things. Is there an indication, whether in guidance or as per the licensing, for, if you like, a prescription, a lifetime prescription of 50mg of Bicalutamide?

A. No, that's not a licence indication. But, as I say, doctors do treat patients off licence. You can treat patients on what they call a named patient basis. Before we had a licence for Sildenafil, Viagra, I prescribed it for thousands of patients off licence with a named patient basis, because while we were waiting for the licence to come through, they were desperate to get hold of it. That's what we did. Mr.

O'Brien, he could be criticised but I think it's not a -- what's the word? -- not negligence to prescribe that dosage. We need more information about why he choose to do that but you could ask him about that yourself.

Has a current audit been done of off-licence medications that have been prescribed in the Trust? Also, an audit done into whether the patient has been fully informed.

……

Q. That is my question to you, really. Who do you feel is leading that? You've described the consultants coming together, the Trusts coming together, do you feel there is a political mandate for this now to happen and do you have a clear sense of how that is being supported by, say, the Chief Medical Officer's Office and Public Health, and the Commissioners? Is that clear to you?

A. I think that everybody, both in urology and in general, know the direction of travel. We've had the Donaldson report, the Compton report, Bengoa report -- numerous reports that have said what needs to happen. I don't know that Stormont in itself will actually make that happen because they've had 15 years before it collapsed to make it happen, and it did.

Q. What do you think would make it happen? I`m just interested as a clinician in the service.

A. I would like Chris Heaton-Harris to close down numerous A&Es. That`s what I think would help. You know, because the political parties will not do that because of the outcome that would be in their own constituencies. Whereas someone who wouldn't have the same political back -- what's the word? -- blow-back from it then could make that decision. We've seen it happen in terms of other things, that the politicians can't agree to do it and therefore you need someone from Westminster to make that decision for them. Personally, I believe that what needs to happen with the Northern Ireland Health Service is that there are far too many acute units, far too many A&Es, that some of those need closed. And I don't believe, even if you have a health minister and Stormont up and running, that that decision will be made. In my view, the only way that will happen is if Westminster say, Right, you are spending far too much on health, you need to make your system more efficient, and the way to do this is to close down this, this, this, this and this.

Q. I think that`s an interesting perspective. I think, looking at this from the point of view of the Urology Inquiry, touches on all of these issues: what happened to the Donaldson report, the Bengoa report, what is going to happen next. However, I think what you've said to me is, partly as a result of pressures, partly as a result of learning to work differently during COVID, and certainly assisted by the GIRFT report, there is the backbones of a plan which, if properly implemented and taken forward in what I would call a delivery plan as opposed to an aspiration, would assist greatly, in your view, in taking urology and, by implication, other specialties at the same approach further? Is that what you`re saying?

A. It certainly will improve things. At the minute there are pressures in every urology unit and we have to work together in order to improve that. The progress that has been made in Craigavon with the complex stone service, it shows that if you have the right people involved and the right resource behind it, that you can actually create an exceptional service. I honestly believe that's what it will be. There's no reason why the other aspects of urology and other specialities could not do the same thing if they had the same support and the same resource put into it.

'The progress that has been made in Craigavon with the complex stone service, it shows that if you have the right people involved and the right resource behind it, that you can actually create an exceptional service'

What are the SLT's thoughts on taking this example of service improvement and using it as a stimulus and encouragement for other aspects of urology and other specialities to move in a similar direction?

Q. Could I ask you just a practical question. Do you think that enhanced or advanced triage could be effectively undertaken by personnel other than consultants?

A. It could be undertaken by a Clinical Nurse Specialist, certainly, with wide experience, I would have thought.

What is the current guidance in the Trust on Clinical Nurse Specialists carrying out advanced triage?

Q. Yes. Is there anything about the current working practices of the MDM that you would change or improve if it was within your gift to do that? Particularly in the area of Patient Safety and the governance of the actions that are part of the everyday life of the MDT?

A. Well, it certainly runs much better now. I certainly welcome people looking on, making sure that -- the cancer tracker is ensuring that the patients are going through the system effectively. I think our Clinical Nurse Specialists also are actively involved with the patients and they're also another failsafe mechanism, and they are ensuring that patients are going through the pathway effectively. So there's lots of people that take part. I think, certainly, the nurse specialists, because they are the key worker for the patient and they make sure the patient goes through the system as well.

The recent development and appointments to two new roles in the Trust - the cancer tracker and the Clinical Nurse Specialist, has had a marked effect on the efficiency of service delivery and the quality of continuity of care for patients.

Q. The Inquiry must have put an enormous strain on everybody in the department, I imagine. What benefits have you seen, if any, so far, and how do you think you personally could use the learning from this Inquiry for the benefit of the department going forward?

A. Well, I suppose results -- whether it is because of the Inquiry or just has evolved over time, I mean they are now coming electronically. We have a little tally of how we're doing. So that has improved. You know, it's -- we're not dependent on bits of paper. Even the bits of paper we used to get come as PDFs to us now and we sign them on line. That's become more secure rather than having bits of paper floating around. I think, certainly, we've got more Clinical Nurse Specialists. We had eight or nine. So those numbers have gone way up. So I think things are certainly improving.

Q. Those are some specific things. What about, you know, your feeling that you maybe slightly more empowered to raise things for long-term strategic planning of services. That has been a huge problem for a long time in terms of demand and capacity. This has really come to the forefront. What opportunities does that bring for you as a group of urologists?

A. Well, we have a meeting once a month. We can certainly talk about that or if we have any ideas, put it on the agenda for discussion.

Q. Do you recognise it is your role to do that? I think what I've seen a little bit of, people thinking somebody else is going to do something?

A. Some people are better at big ideas than others.

Q. Of course.

A. And some people are grafters. But I think –

Q. Because actually you have a lot of good things going on, is my observation.

A. Absolutely.

Q. What I am trying to say is how you can use this and have you thought of it in this way?

'A. There's no inhibition. It's a very encouraging department. I mean, it has all these issues but as a department itself, it encourages new ideas and it is quite receptive to new ideas. It functions very well. MDT functions well. It's not an unhappy place to work'

Can this constructive personal account from the Inquiry be reflected in the SLT's response to the Inquiry and relayed back to the department?

2. Quality and patient safety

None of the 9 SAI's had a clinical nurse specialist

Is the provision of Clinical Nurse Specialists regularly monitored now?

Patients and families want to know the depth and breadth of the problem – the why and the how as well as the what has happened. How is this being addressed and communicated?

A. Patients are partners in care. The culture aimed for is such that a patient and/or a member of staff can raise any concern at any time.

Is this currently the case?

A. Patient related outcome measures were not presented at Board level or in governance reports

How are they tracked now?

A. Consent in cancer is critical for good care. Patients fully understanding the options that are open to them – these discussions need to be supported.

Currently – do the clinicians in the Southern Trust have a clear understanding of the

consent process?

How is this being monitored and audited?

A. Best practice and good practice – letters sent to GP and preferably copied to the patient – explaining the options available to the patient and reasons for selecting a particular course of action. The patient should have the opportunity to correct or qualify whatever is written. Doctors making notes about consent is essential.

What is the Trust's current policy on this?

Are patients receiving letters and results now as standard practice in the Southern Trust?

Q. What is the standard of care?

How is it communicated now to patients, families and throughout the Trust?

Patients in SAI's did not know nurse specialists being available to them was standard care.

What should a patient expect?

A. An MDT process that's fully quorate and fully functional, appropriate support and CNS's who will have their name and number. Patients need to know that they will be supported through their cancer journey.

The patient experience and the patient pathway into medical practice – how is this audited now?

A. I think the amount of energy and time and effort that went into performance left less time and capacity for a deeper focus on patient quality outcomes. Probably 80% of your energy went into doing performance

What would you say are the percentages now?

Q. As you look back now, can you see that right from the beginning there was a very clear Patient Safety issue here?

A. Yes. I can.

There was a marked lack of awareness and sensitivity to the key thread of Patient Safety throughout the period being investigated by the Public Inquiry. Also, a lack of focus and regular audit of patient experience, their journey, and outcomes. How is this different now?

Timeliness is a patient quality issue and a patient safety issue.

……..

Q. Just from a perspective of how things operated, I know you said that Mrs. Gishkori indicated that there was a line of communication and there was someone between you and her. Is it the case that you wouldn't have felt comfortable just going to her door and rapping the door and saying, 'this situation has arisen. I can't get my hands on an AD, and I need to discuss that'. Was there, in effect, a barrier to you for doing that?

A. Yes, I felt that. Not with the other Directors. I suppose that was the difference because we said I was there from 2009 to '21.

Q. How was that barrier presented to you? Was it said to you that you shouldn't do this or that you did do it and the response was not welcoming? What was it that happened that made you reluctant or to know that you couldn't do that?

A. Not long after Mrs. Gishkori started in the role, and I was used to just popping in to the office to her personal assistant, Ms. Stinson, I would have said to Emma, 'are they free?', because you obviously wouldn't just knock the door and then go in, which is what I have done, you know, right from the start. This particular day I just said I just need to give Esther the heads up on something. I knocked the door went in to Mrs. Gishkori. She said, 'I'd prefer this didn't come from you, it came from an Assistant Director. I'm clear that the lines of communication is Heads of Service, Assistant Director to myself'. That was near enough at the start of it. I was a bit taken aback because I had such a good relationship with the other Directors, so I was a wee bit taken aback.

At what point does the need to keep to the strict escalating line of communicating concern become a block to a patient care and safety issue?

Q. I just wonder if I could ask you, generally, on those issues, given the length of time over which you had an awareness -- you and others had an awareness of varying degrees of concerns around those issues. Was there ever a point from 2010 when it was realised that these had the potential to impact on patient care and safety?

A. I've had quite a bit of reflection on this. I suppose pre -- the notes at home, the un-triaged, un-dictated, was always classed as being admin issues, wrongly for me now. On reflection, I didn't associate that with Patient Safety up until probably 2016, and it really hit home with me personally whenever, in 2017, I recovered the 783 letters and one of the patients, I think Patient 13 maybe, one of the patients actually was just a couple of weeks younger than my own husband, and the first line of the letter just rang alarm bells with me. Even though I'm not clinical, the fact I worked for 35 years in the Health Service I have sort of picked up some clinical terms. It was that realisation that because of what had been classed as admin was really Patient Safety and, you know, that patient became part of the 2016 -- sorry '17 SAIs. Up until that I would have said they were admin issues. When you read the report it says "admin issues" but it was obviously a Patient Safety, on reflection.

'It was that realisation that because of what had been classed as admin was really Patient Safety and, you know, that patient became part of the 2016 -- sorry '17 SAIs. Up until that I would have said they were admin issues. When you read the report it says "admin issues" but it was obviously a Patient Safety, on reflection'.

An important realisation and principle for admin staff to take from this Inquiry.

Q. Was there ever a suggestion that the plan could have been updated to reflect those findings that there were gaps in, potential deficiencies in oversight?

A. No.

Q. Did you feel that you could have brought that to anyone's attention, to say, 'well, we may ostensibly be covering this potential lacuna, but the work I have done or the work that's been undertaken shows a vulnerability for emergency and day case patients'?

A. To be honest, I didn't actually look at the ins and the days at that stage. I was concentrating in the midst of a very operationally challenged busy job and trying to make sure that the four areas that I had been tasked with, that I monitored them. In hindsight, yes, I should have thought of that, but I didn't.

Heightened awareness of the quality and patient safety lens is fundamental in every operational and clinical areas in Healthcare Trusts – what measures are you putting in place to achieve this?

Q. At that time, what was the sense of Patient Safety issues and was the Oversight Group as sensitive to those risks as it needed to have been?

A. No. We weren't as sensitive as we should have been. I think, actually Esther's paragraph there, around, you know, this lifelong commitment, built-up single-handedly, this narrative around him being an excellent surgeon, an excellent clinician, that was the prevailing sort of form at that stage. It probably desensitised us to the risks from an administrative point of view. It was as if they were two separate things and they shouldn't have been.

Q. I know that, you know, we will maybe come on to your reflections later, but I think we can have a snapshot of that now, I think there's a sense in your reflections that this prevailing narrative about his excellence as a surgeon created a form of a blind spot to more urgent and more effective action. Is that fair?

A. Very fair.

Are there other types of narratives that can potentially hide the sensitivity to the importance of Patient Safety issues?

Q. Upon reflection, you could have gone back to NCAS and said, 'listen, we have this grievance. You had previously written to us on 21th September to advise us on how a new action plan could be developed. We now have this grievance. Can we do the action plan in this context or is there another way around it?' That kind of advice wasn't sought?

A. No. No, it doesn't appear to have been. I think there's -- part of, probably, the issue as well and some of the challenges around this, Dr. Khan was both the Case Manager and the Medical Director at that point in time. There wasn't that other set of eyes on this too. It was one and the same person, which certainly didn't help because you didn't have another set of eyes from a Patient Safety perspective, I don't think, on it.

When a Case Manager has another significant role in the Trust at the time of the investigation is there provision now for another 'set of eyes' to input on a patient safety perspective?

Q. "There was also, I believe, a view by many that Mr. O'Brien was an otherwise excellent clinician which resulted in a failure to grasp the real significance of the link between poor administrative practices and patient safety. I was not experienced enough to challenge this thinking at the time and both of these points have provided significant learning for me as a result of this case." Maybe that says it all, but feel free to add to that, if you wish.

A. Yes, I mean, if you just scroll back up, please. Yes, that bit around the complexity in most part linked to the fact that his administrative practices had not been addressed over a number of years. I think back to what I was trying to say around the informally and how we need to really, really focus robust processes around that informal stage. In this case I think views were probably entrenched. Trust seemed to have disappeared. There were tensions between, probably, Mr. O'Brien and a number of others. I think that, in itself, just inevitably maybe made an informal process in 2016 almost kind of doomed to failure, maybe right at the outset. There needs to be a willingness, I think, on both sides, for both parties to be able to make the best use of that informal process. Back to the psychological safety of the practitioner, I mean it is absolutely critical in all of that. I suppose that's what I was thinking about that. If we move down a wee bit, please, if that's okay. Yes, I think I've said this on a number of occasions just around the poor administrative practices linked with Patient Safety. I mean, that's really, really important.

How and where is this message being flagged up currently in the Trust?

Q. So just to finish for today. You're saying as a Senior Manager, you have a Clinician who you know is placing patients at risk if he's not doing triage. You've seen Patient 93's case come through the system. At this stage do you know that Patient 10's SAI is coming through the system?

A. No.

Q. You don't know at this stage. But nevertheless, you and those around you must have known that failure to grapple with this was placing patients at risk?

A. Again, not wanting to repeat myself, but that level of analysis was never done. I think it was always that this was Mr. O'Brien and his admin issues, and this was a plan that Dr. McAllister felt he could bring over the line.

The patient safety lens was not applied.

Q. In terms of setting terms of reference, can I broaden this out as I think it's probably an important issue. The Trust has told the Inquiry through its witnesses that, in 2020, a range of issues relevant to Mr. O'Brien's practice were discovered; the Trust considers those matters to be shortcomings of

practice. This was investigated through a number of processes, including nine SAIs. Now, the MHPS investigation set off in 2017 and didn't identify the kinds of issues that were discovered in 2020. The question, I suppose, that arises is should other aspects of Mr. O'Brien's practice have been the subject of MHPS investigation when you took up the reins? In light of your experience across a number of MHPS processes, can you help us at all in terms of the development of terms of reference; how is that done; could it be done better? The public will want to know why an investigation that took so long under your watch didn't get to find what was there perhaps to be found, and was only found two or three years later?

A. First of all, Mr. Wolfe, I didn't know about the additional issues raised in 2020, I'd already left the Trust by that point. I suppose what I would say is that terms of reference -- so, how this process works is that there is an initial screening process, and then terms of reference are drawn up and then a Case Manager is appointed and then a Case Investigator is appointed. I have used the phrase earlier but I think it is relevant, this is not a fishing exercise. You know, terms of reference are clearly and specifically and very often precisely written. Really, the Maintaining High Professional Standards document indicates that actually - and I think the NCAS document actually takes that even further, makes it more clear - that you are not there to start looking at every aspect of a doctor's work, you are there to look at areas which have been specifically raised as an issue. However, during the process, if somebody comes along and says something to you which rings bells, well then, of course it's your responsibility as an investigator to raise that with the Case Manager. I have identified, I have highlighted already that on one occasion that occurred and we raised it. But I was quite shocked by the findings that came out in 2020 because we had no inkling through the investigation - and I understand you will get evidence, you will receive evidence from Mrs. Hynds as well, I expect she will say the same - but I had absolutely no inkling. In fact, quite the opposite. The information that I was being given by almost everybody was that this was a good clinician who, in fact, was overinvolved; spent too much time with patients; wanted to do advanced triage, you know, look up blood results, look up imaging, send people off for other investigations, you know, before, you know, progressing to seeing the people, the patients. The information I was receiving was that there were no clinical concerns.

‘But I was quite shocked by the findings that came out in 2020 because we had no inkling through the investigation - and I understand you will get evidence, you will receive evidence from Mrs. Hynds as well, I expect she will say the same - but I had absolutely no inkling. In fact, quite the opposite’

It is very important in terms of patient safety, to spend the appropriate time to get the Terms of Reference for an investigation right.

…….

Q. Thank you. Last question. This whole Inquiry and everything that we have heard about in your investigation is overshadowed by the huge problem with waiting lists in Northern Ireland. The waiting times are so long that there's a sense that that overshadows everything. That doesn't mean that people shouldn't do their job responsibly, as you have alluded to. But are there any very senior level discussions as to how people should minimise the harm to people on waiting lists generally? I can't see any evidence of that in any of the Trust documentation. Did you have discussions about that as Associate Medical Directors, for example, because when times are this long - Mr. O'Brien has a point - patients will come to harm?

A. I know at meetings there would have been discussion about trying to verify waiting lists, for example, by writing out to people, you know, 'do you still require this appointment and things like

that'? I think a letter would have gone back to GPs to say this person has been added to the waiting list, it's a waiting list, if the situation changes please contact us again. In terms of whether the waiting lists were being scrutinised to look to see whether something -- people needed to be pulled out and moved or whatever, I'm not aware of that. Mental health, where I work, is a bit different, urgent things are very urgent. It's a little bit different because of the type of morbidity and the risk of mortality that we deal with. I'm afraid I probably haven't fully answered that question. I'm not sure that I am able to.

'But are there any very senior level discussions as to how people should minimise the harm to people on waiting lists generally?'

Has the SMT had the opportunity to discuss this?

Q. Even though there's potentially, as you say, no history of things like this coming to the board, it could be said that ultimately, as a board member, you still have the responsibility to keep patients of the Southern Health and Social Care Trust safe. Whenever these concerns -- I don't know if you think this was at the time when you started to have concerns about patient safety or if it would have been earlier, but whenever that came to your mind did you not think to yourself the board needs to be informed in some way, whether that be in a way that keeps the other aspects of the investigation separate from the board so that the board would be made aware that there was a potential risk to patient safety?

A. There is no doubt in what you are saying. Whenever these other aspects were being uncovered, then I understood that the investigation was going to expand even more, and that did concern me. The avenue for how I was going to inform the board and governance, I didn't see that avenue because I had no history of that happening and whenever - I think I mentioned this earlier - whenever I asked at a general level, look, I am concerned about job plans, I am concerned about appraisals, I am concerned about safety, in terms of the specifics of this case, then there was almost 'we don't do that, we have to wait, it might contaminate, if you want to call it, the investigation'. So there was a misunderstanding both in terms of myself and in terms of -- well, I can't speak for my colleagues. In terms of myself, there was a misunderstanding in terms of how I could feed into the board and the opportunities to feed into the board. Again, I will come to this is a learning for me. I come back to guidance for the nonexecutive director. I think that needs to be clearly stated that this should be the case. It wouldn't take too long to draft up a booklet for prospective designated persons to make the role more explicit and to give them the structures whereby they can operate within, and what the expectations are.

'It wouldn't take too long to draft up a booklet for prospective designated persons to make the role more explicit and to give them the structures whereby they can operate within, and what the expectations are.'

If the SMT agrees, how soon can this be done? There are to be new appointments soon to the Board and a booklet (as described) would be a useful part of the induction process.

Q. I think as a NED, your first MHPS investigation was particularly challenging, if it's any consolation. Mostly the involvement isn't of this degree and I am sure people have told you that already. You quite clearly made a big point about the clarification of roles and responsibilities, and everyone involved in this process has made similar points. There is clearly a need to define that. That's pretty consistent down all levels of the Trust, actually, in terms of who was doing what in regard to this issue. Another feature which has come through quite clearly from our witnesses is that there's a huge emphasis at the Southern Trust on performance targets. I think one of your Acute Medical Directors put it as I would not say that quality was overtly discarded. But many people have said the focus was on performance, performance, performance. I think this is because of the waiting lists and it's understandable. Equally,

as a board member your prime responsibility is also for patient safety, and the fact that the board was unaware of all of this for such a long time seems to me to be quite a significant issue. You weren't the only board member who knew about this, the Medical Director knew about it, and yet it wasn't raised with board members for a discussion. You feel you didn't have a route. This says something about the culture of the board. What was your experience as a board member of the relevant priority of performance quality and finance and so on? Would you accept that perhaps there's some learning in this in terms of patient safety being more of a priority issue?

A. Yeah. It's an interesting question simply because the board within maybe this last year, year-and-a-half, have created another subcommittee which is a performance subcommittee.

Q. Mm-hmm.

A. Probably in direct response to the waiting lists, I would suggest. However, I Chair the Patient Client Experience Committee, and coming through there there is a marked interest in quality and in the patient experience. I haven't really been asked about this but there was an occasion where ironically I had to attend the Urology Department within the Trust, and I used the opportunity to ask some questions. As a result of those -- and I did declare that I was a nonexecutive director, by the way, it wasn't a subversive thing - and I used that opportunity to ask questions. As a result of that, I brought I think it's the lead nurse back down to the Patient Client Experience to describe what the patient experience was in terms of the quality of experience that they were actually getting out of Urology. My query wasn't as a direct result of being involved as the designated NED. In answer direct to your question, I think there's a balance within the Trust in terms of performance and quality. We try to address both of those. There is a direct input or interest in performance because there's a Performance Committee and they do a lot of drilling down. The quality bit of it is done through the Patient Client Experience where we look at SAIs; I would look at concerns and complaints; we have the HCAT; we have Care Opinion which is looking at the quality of the experience. So, that's part and parcel of what we do. So there's a balance; I would argue there's a balance to that.

How often is the narrative and focus at Trust Boards monitored to make sure there is a balance between the quality of patient experience and performance?

Q. Is it not the case when you think about it or reflect back on it, the fact that triage wasn't being done, except for red flag referrals, that was known for some time; that's what you were being told in September. To the extent that a failure to triage raises the potential for patient jeopardy, is that an issue that ought to have been recognised and grappled with earlier, even if it didn't lead to a formal investigation?

A. On reflection, yes. On reflection when I think about it now, failure to triage must involve some risk to patients, and the fact of the subsequent SAIs and things proved that. Perhaps I should have probed that a little bit more with Simon when I spoke to him. Whether that would have changed the advice is a different question.

'Failure to triage raises the potential for patient jeopardy'

The application of the quality of patient care and safety lens is central to all the work of the Trust and should be kept on the front page.

Q. Another thing I think it would be helpful for your observation on this, the administrative issues, as they were called in this, are really very extensive, yet there was a blindness because people felt it was totally unrelated to clinician capability. In your experience is there quite often a link between very

severe administrative issues, conduct and capability, or do you think it's possible to separate them like this, like they have done?

A. No. Actually, I suppose I have to confess, reading through this bundle I was getting increasingly irritated by referring to these issues as administrative because not writing notes, not triaging patients on time, not writing letters to GPS are not just administrative issues in sort of the way that -- you know, it's not the same as not having, you know, put your parking sticker up on the car. It is a different type. This goes to the core of clinical care. Because when you're a surgeon, only a little bit of your work is cutting, the rest is it is what has been referred to as administrative in this. There is an overlap. People who are bad at one area of their practice are often not terribly good in other areas as well. So, yes, there is a connection and an overlap. I suppose if I was to criticise myself, probably in that discussion about Simon Gibson I should have majored a little bit more on that.

'This goes to the core of clinical care'

A clear understanding of the relationship between the consistent delivery of clinical care and administrative efficiency is an important principle to underline throughout the Trust.

Q. While there was various, perhaps, attempts in the Trust to start some type of informal process or engage with Mr. O'Brien, for one reason or another Mr. O'Brien was spoken to in March 2016 and then wasn't actually spoken to again by senior management in the Trust about these concerns until the day after this letter. What are your reflections on that with regard to the advice you offered to the Trust here? Would you have offered the same advice that a formal process was now to follow had you known no one had spoken to Mr. O'Brien for some nine months at this stage?

A. That's a difficult question. I think it was very regrettable that nothing substantial had been done but I must say that the matter -- you know, he should have had the opportunity to address these issues. And I think had he been given the opportunity, things might have been different but I still felt that the allegations were quite serious on a first off. There was the real potential for harm here. And if you scroll down the letter further you'll see about a chart appearing, that troubled me greatly. You know, I was -- I thought, you know, that the allegation there is that, you know, the unspoken allegation, I suppose, is that that chart was brought back by him and I thought there was something, you know -- well, something unprofessional about that if, indeed, it had been him that left the chart back.

Q. Again, the complicating factor here is whether you were or were not aware of Dr. Fizpatrick's advice. But definitely in September 2016, Dr. Fitzpatrick, on looking at a very similar set of concerns, advises that the Trust, at least in part, should engage in some sort of informal process - he doesn't use these words, I'm paraphrasing - or a supportive process with Mr. O'Brien. Your advice here, at the end of December, is that a more formal process is now warranted. What exactly had changed?

A. Well, even with the benefit of hindsight the SAI is worrying the Medical Director enough that he wants to formally exclude him, you know. So, presumably his situation has changed between September and December and he's the one that's medically qualified and possibly better qualified to make that judgment than I am, in those circumstances, with the SAI.

Q. I might just ask you to expand on that. Is there any suggestion there that there was a bit of a power imbalance between you and Dr. Wright here?

A. I think we have different skills. I don't have any difficulty challenging people where I think it's inappropriate, but if they are worried about a clinical issue, a specific event - and I haven't seen this SAI myself, you know - I think that does make you reflect in the world in which we live. You know, if he's so worried that he wants to formally exclude him. You know, it would be easy for me to say now

maybe you should have done an informal process, but I think if patients are being harmed, well then, you do have to bear that in mind as well

'But I think if patients are being harmed, well then, you do have to bear that in mind as well'

If patients are being harmed should never be a secondary thought in the work of the Trust – the application of the quality and safety lens is central to the work of the Trust.

Q. I suppose in light of what we have just talked about when you mentioned risk there in particular, was the issue of patient risk and lack of awareness about the location of notes something that was ever discussed at those meetings?

A. It would have been raised but because of one of Heads of Service was over security and catering, the other was sterile services, Katherine and the secretaries and the booking, we were a very diverse group. Some of my issues might not have really been relevant to them, such as the catering issues wouldn't been relevant to me. It would have been more generic terms that we would have made discussions about.

Q. What about on your one-to-ones with Anita Carroll, would that have been the opportunity, I suppose for you and Ms. Carroll to discuss risk? I am conscious that we are framing it in that way now but were those words actually used? Did anyone say this is a patient risk, there is a risk of harm, this is not just a notes issue? Or was it we need to get these notes, we need to find them, we need to get them in?

A. I think our big drive at the time would have been we need to get the chart.

How is the SMT checking the implementation of the message throughout the Trust – that clinical and administrative work must include continual awareness and accountability for patient safety and risk?

Q. You, as the head of this, we talked this morning about -- looking now at staffing and the impact of you getting an insight into your day-to-day, the Panel can see what you were juggling. Also, then when there were issues and you had senior management telling you to not progress those issues, how did that impact on you?

A. It was difficult because you wanted to keep your managers and ultimately your staff motivated. You wanted to keep yourself motivated as well. You just had to get on with it, but I always had a stance of you never ask your staff to do something that you wouldn't do yourself, so I would -- I've covered minor injuries, I've done a nightshifts in ED, I have filed charts because when you were at your very crux, you just couldn't sit in your office and see your staff suffer. So, my managers and I would have actually went onto the shop floor.

Q. So, people were shown goodwill; could it be described as that?

A. Yes.

Q. That was to try and keep the system going?

A. Yes.

Q. Heather Trouton says: "The culture of Acute Services was a culture that was focused on performance and financial efficiency". Do you agree with that?

A. Yes.

What is this balance now in Acute Services between patient quality and safety, performance and financial efficiency?

Q. You have also said that "the processes need to be seen as systematic ways to prevent harm". I had touched upon it earlier that it could be seen maybe by the consultants that the systems were a way of monitoring what they did, but you are saying that they actually are trying to provide a fail-safe so that issues of harm don't arise?

A. Absolutely.

Q. So it's a perception issue as well, it's a bit of a change of mindset; would that be right?

A. Yeah. Very possibly.

……

Q. What was the impact of delays in returning triage for you and your staff, first of all?

A. It was a lot of chasing up for the red flag appointment team because they were constantly checking what was coming back in, updating their spreadsheet. If they're still outstanding and they still maybe would have escalating again that these are still outstanding. The trackers then would have been updating the CaPPS System, linking in with the red flag appointment team. It probably would have caused a lot of emails back and forwards trying to track the progress for each patients. And still being mindful that their clock was ticking and you were trying to get the patients in to be seen.

Q. So, against the background where there are all sorts of pressures, as you have described –

A. Yep.

Q. -- this was an added difficulty that you could have done without?

A. An additional pressure, yes.

Q. Was there a concern that delay risked harm to patients?

A. I don't think at that point, no, there wouldn't have been. It would more just to get the referral back just to get the patient seen in clinic. As I say, at time investigations could have been questioned by the time the referral had been returned.

An example of how an incomplete task in one part of the system can have knock-on effects on other people in delivering their roles and most importantly on the care of patients.

Q. And you agree that there should have been a key worker allocated?

A. Absolutely and I struggled with trying to determine why that wouldn't be the case. I did note, on looking back at the evidence, that some of the patients were admitted through the Emergency Department and that progressed, you know their diagnosis. We did not have the resource to check who was on the in-patient ward at any given time. If patients were admitted through ED and were diagnosed with a cancer of whatever nature in relation to Urology, we depended on the consultant or registrar to let the CNS team know that, so that we could go up and meet them with their family and bring information to them. And we have done that on occasions, we would hope with additional resources and the way we are planning things now that we can do, you know, there is more improvements to be made in relation to that.

Has the loop-hole of patients who come through ED onto a cancer ward been addressed in relation to having access to a key worker?

Q. You reflect on those cases in your witness statement at 7.28. You say: "I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done. From my perspective, I feel I could have been better informed regarding what had or had not been done about my concerns". In this regard, those were concerns that hadn't actually been raised with anyone beyond Mr. Haynes?

A. Correct.

Q. You didn't raise them with Martina Corrigan –

A. No.

Q. -- or with anyone within your own line management in nursing?

A. Yes. And with hindsight, I think if I had to do that again, that's what would have happened.

"I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done''

Important recognition of the anxiety that patients can endure on waiting lists.

Q. We have seen that letters weren't automatically copied to patients from the doctors, but we get the impressions that the nurses usually did do that; is that your experience?

A. Yeah. I know within my nurse-led clinics, I would always copy the letter to the patient. A number of the consultants do this also.

Q. Is that happening more now, do you think? Not universally, possibly.

A. I think it's the same as what it had been, yeah.

What is the SLT's line on the policy of patients automatically being copied in to letters from doctors?

Q. You mentioned a range of KPIs. Do you ever see those KPIs for the cancer nurse specialists or does that go as well as?

A. For the nurses in my area of responsibility, yes.

Q. What are the recurring themes from that, if you had to summarise it for us? You know, they are doing a lot of very important work; are there some recurrent issues coming up from their KPIs that you have had to take on board in terms of making improvements, for example?

A. I think one of the KPIs is regularly doing a holistic needs assessment with patients. You know, yes, when patients have a diagnosis, they want to know what's happening to me, what's my treatment planned, how long can I expect this to last, and then obviously, you know, when patients get to the end of their treatment, we, at that point, try to do another holistic needs to see, do an end of treatment summary to see what the key issues are moving forward and how we can support those patients living with and beyond their cancer diagnosis.

Q. Does that go to a Trust committee on patient experience, or how do you –

A. Yes.

Q. -- report upwards on that?

A. So, that would go to our PPI Panel within the Trust.

Note – the important value to the patient and the clinician of conducting a holistic needs assessment with the patient

Q. You've reflected in your statement - I needn't bring it up on the screen but it's WIT-60286 - that you received support from urologists in relation to your expressions of concern around the standard of the independent sector work.

A. Yes, I think that's true. My memory is not very clear on that but I do remember some of the urologists not being too happy about the reports, yes.

Is the SLT happy with how the Trust monitors the quality standards of any services provided by the independent sector in the Trust?

Q. You got into this helping governance out roll particularly because of your background, I think, in the patient safety research, and governance alongside that. What was the biggest thing you learned from that research? Then, if you had been able to do something really that would have made a big difference in the Trust, what would that have been based on that, because it's bound to have changed your outlook considerably.

A. Hmm, that's a good question. Probably for me, the thing I learned the most was the value of near miss reporting or no harm incident. I think for me that was one of the biggest things because the number of times when you look at something serious, for example if you take the case of the -- the thing that really got me interesting was the case of Wayne Jowett, if you know it?

Q. Yes, I know it well.

A. So, that piqued my interest way back in 2000 in terms of how that could have happened. When you read into his case, he was the tenth child or adult to die as a result of that incident. The fact when you start to look into that and you get into the background to that, the number of times there have been near misses with heterocycle chemotherapy like that, where luckily someone had spotted it. To me, that was a big driver for me in all the work I did, to try and encourage staff to tell you when it nearly happened. For the staff, particularly telling you about something that nearly happened is a lot less scary than having to come forward and say someone has been harmed, so it was win-win. It was win for the staff; they felt more comfortable telling you about it. Then for the Trust, the organisation, you had that opportunity to fix it.

Q. What would you done with that, if you had been able to? Do you see that as something that could have made a difference to the culture at the Southern Health Care Trust, and what were the barriers for doing something like that?

A. I think the barriers were resource. As I say, the vast majority of incident reports we got, harm had occurred, or a level of harm. You would have needed a big resource in terms of training, encouragement and facilitation of staff. I think it would have rolled as it did, we found in pharmacy. Once staff understood what you were trying to do with near miss reporting, it wasn't scary, they could see the benefits, it then took on its own role, because certainly you'll have seen in some of my papers, we started a newsletter –

Q. Yes, I have seen that.

A. -- in the medicine safety. They used to be called cheese news, which was very -- we had a wee cheese thing on it but we changed that. Staff looked forward to getting that. Again, we were trying to

be proactive, what nearly happened, and share with them, make it interesting news articles, fun, to try and pique their interest and get them to look forward to reading it every week

How can the SLT impact a shift in culture in some areas of the Trust where staff are encouraged and supported to move from a reactive approach to a learning and proactive approach to patient safety and quality care?

A.The other area, and again under Mr. Devlin's Chief Executive accountability meetings, I think, yes, you will have had that in your witness statements as well. There was, again albeit you could say it is siloed in the sense that it is looking at specific directorates, but it was certainly aimed at, we created those dashboards to try to say well what the safety indicators, what are the quality indicators. So my team were very much around trying to enable that. As I said it is a corporate role to try to enable the optics on some of that and governance was a part of that as well, as well as other indicators that come from finance and HR. So it was to get a broader look at the challenges in the organisation. But, given the scale and size of it, I think there are certainly opportunities. And why I mention, perhaps, in my last comments there around the likes of, whatever it is called, quality improvement, steering group. Certainly I know when Dr. Khan was acting in the medical role, he says we could build this to become some sort of safety quality oversight group. And it didn't need to be producing just reports, it needed to be relationships, insights, putting things on the table and trying to make connections. So I think there is something more that could be done in that space. Whether that could actually be replicated at other levels given the scope and span of the organisation into particular service areas, something like that I think would be useful.

What is the view of the SLT on this comment?

What further realistic plans regarding safety and quality improvement can be moved forward into action?

……

Q. Just a couple of clinical things. I was interested with your experience in the obstetrics and gynaecology life before the last job, and the comments you made on trigger lists and near-misses and things. Looking back with all your experience, how do you think we could use that, especially in urology but perhaps surgical disciplines?

A. Certainly I would feel in a specialty like surgery, you could have a trigger list as such that you can -- I mean, our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again. Then, from that then there's rolled out learning in theme of the week and things like that, you know, that is ongoing and is live and it keeps going. I can see how transferrable that is for Urology, looking at your near-misses. Your near-misses are a sure sign that your system is weak, and putting measures in place to see how you can prevent that happening because a near-miss one day is an actual event the next.

‘Our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again.’

Can this idea of a trigger list being used as an audit tool be applied to other areas of clinical practice in the Trust?

Q. Just before I move on, Patricia Kingsnorth had indicated that the staff turnover and the transient nature of staff in a Trust can cause concerns and challenges for good governance. Would that be a view that you would agree with?

A. Well, it's a view that I agree with but it's also evidence-based, so we know that where you have high turnover of people into an area, they may not be familiar with policy, with procedures; they may not be familiar with the working environment or the operating procedures; there isn't the same continuity of care for the patient. A lot of that translates into service delivery issues. There were issues with, for example, how we measure quality in the nursing care that we delivered, and there were a range of issues in poor performance that were directly linked to that high flexible agency and bank staffing. We were able to compare that with other wards where there were stable core staff and they weren't such an issue. The management styles, capability issues, there were a range of issues ongoing but very definitely linked to high turnover and workforce concerns in that ward.

How regularly is patient safety and the quality of care monitored and audited on wards that are experiencing a high turnover of staff?

Q. In the absence of any report or product that you can point to, and I have to say the Inquiry is unsighted on that, can I suggest to you that you did not, nor did the Oversight Committee, engage in any assessment of the risk to patients in terms of what had been uncovered?

A. I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly. A risk assessment at this point, sometimes you write a risk assessment to make sure you understand what risks are going to be, but at this point in time we knew exactly what the risks were.

Q. Did you? Because it wasn't until 2017, when the other clinicians in Urology sat down and began to look through the untriaged referrals, that a picture began to emerge that in excess of 20 cases, the referral into the system was wrong and triage would have led to an escalation of the referral from routine or urgent into red flag. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?

A. Until the consultants, which you say is January 2017. I wasn't, to be honest with you, sure of thatdate but that's when they started to do the waiting list initiatives and look at the triaging. The patients were then seen by them. Yes, you would be quite correct in saying that.

'A. 'I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly'

Q. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?'

What learning can be taken from this (and actions if needed) to ensure that the principle of assessment of the risk to patients is always paramount in clinical practice?

Q. Do you have any observations as to the reluctance around that because it is a quite a good safety net?

A. It's a really good safety net and it's really interesting that you raise that because in my field now, we're in specialist palliative care - I'm the Director of Specialist Palliative Care - specialist palliative care is very much about the patient and family understanding where they're at.

Q. It is.

A. That there is, you know, active treatment to undertake and how are we going to see this through? So, we have regular debates in our governance forum about giving the patient and family the letter. My clinicians today are extremely reluctant about that.

Q. Why do you think that is?

A. Well, they tell me that it is because of some sort of protection for the patient and the family and from the clinical -- and I regularly tell them, 'If I am your patient I want to know every single detail for myself please.' So, they come from at it from, like, you know, we're protecting our patient but really, I think it's just the thought of getting used to actually saying out in black and white where you're out. They haven't just reached that point yet. And they are very good, my clinicians are very good at breaking bad news, they're very good at having those conversations but they still can't write it down.

Q. That's different from writing it, isn't it?

A. Yes, very.

This is an issue that has come up several times in the Inquiry – can the SLT clarify the guidance across the Trust on patients receiving letters after appointments recording their treatment discussions and plans?

Q. But at least from that time, you had on paper an identification that clinical risk was in your mind, would that that be fair?

A. That would be fair, yes.

Q. Given that, and your knowledge of that and your awareness of that and your operational head on, if can put it like that, was there ever a sense that you needed to speak to your medical counterparts and say, "This isn't just our problem operationally, it isn't a notes and records or a record-keeping problem, this actually has the potential for significant impact." Did anyone cross the potential divide and say, "We need your help sorting this out"?

A. From my perspective, I would have escalated and I would have had quite a number of conversations with regards to them issues with Mr. Mackle mostly so, and Mr. Young would have helped me out with sort of clinical issues that I would have felt that I wasn't able to address. To cross that, I didn't -- I don't believe I ever said -- it was quoted to me so many times by managers -- this is always an admin issue -- clinically, Mr. O'Brien is brilliant and we have no issues with it. Like, for example, Mr. O'Brien was his Clinical Director and one of his quotes is "If I had to come in, I would have had no issues coming in under Mr. O'Brien." So I think that clouded, wrongly, my judgement -- I have reflected on this -- in that I felt there may be an issue because nobody else did and that's my fault, I should have escalated it further. But it's one of those things that when I was escalating it or and thinking it and saying it in a letter and then it was removed, that it was me was thinking it was, where it really wasn't, if that makes sense? I'm probably not saying that very well.

Q. I think Vivienne Toal said something similar. She said "His excellence as a surgeon blinded us to the issues" -- I paraphrase her, but would that be a view you share?

A. Yes, yes. And I think it was everybody else sort of, you know, in and around and sort of up/out would have said that, that there was no issues clinically and it was all admin.

Post Inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

Q. Do you think that this particular example is something -- I don't mean the case, I mean the process -- the failure, and you might be right that it's relatively isolated, but is that something of such significance that it just has to be got right and, therefore, it has to be monitored?

A. It could be that, in hindsight, you could say that. But if you have -- if the vast majority are coming back and saying "Yeah, we do this" and there's peer pressure and we're saying "Tell your people you really must do it" and "Your CD and your AMD says you must do it" and "It's good patient care" -- "I don't know" is the answer. There's a line somewhere and in hindsight is a wonderful thing, isn't it.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

How operationally robust is the role of peer review and peer pressure in maintaining patient safety and quality standards throughout the Trust? How regularly is this audited?

……..

Q. I was just going to ask that. Was audit not viewed or how did things become so skewed that audit wasn't viewed as an integral part of quality improvement?

A. It should be. But the resource went to focus on quality improvement training, supporting the quality improvement as opposed to supporting the audit element of that.

Are all elements of quality improvement being addressed in the Trust now?

Q. Yes. When you talk about risk in this context, I suppose the risk that follows from being unable to proactively pursue governance issues, spell that out for us, what does proactivity mean in this context? Can you give us an example or two and what risk flows from the inability to pursue it?

A. So if we take some of the elements of governance. If we are looking at SAI reports, having them be able to be addressed and identify learning at an early stage and the recommendations be implemented and audited just to ensure that they were appropriately implemented is one risk. So delay in learning; delay in implementing recommendations; the inability to audit to provide assurance; to ability to provide frequent and robust training to teams in how to complete a Datix appropriately; how to identify risk; how to mitigate that risk again was another challenge and would have been a risk.

Q. Was it the case that, although you're talking the language of risk to Mrs. Gishkori, that while sympathetic, she didn't appear to be able to provide complete solutions, she talked about some initiatives that were tried, but did she appear to get it, that there was real risk here?

A. It would have been really challenging for her not to have got it because when you bring the number of outstanding SAIs, when you highlight the inability to audit to the level that we would have wanted to, it would have been really difficult for her not to have understood that risk. The challenge of providing the staff would have been a challenge from a financial perspective. But, again, how that was escalated outside and up to SLT I'm not fully aware of.

It is a key message in ensuring patient safety to listen well and pick up messages.

Q. Do you think the Trust continues to remain vulnerable to an inability to bring together different strands of information, some might call it intelligence, around the practitioners who may be putting patients at risk?

A. I think, because of the systems that we have in place at the minute, the Datix system, while it has improved, the ability to triangulate all the information is still a challenge. And again without good data analytics to help pull all the reports together, to evidence the trends, it could remain a challenge and does remain a challenge.

What immediate steps are being taken to provide good data analytics to mitigate the risk to patients?

Q. A couple of things, well first of all if I can just ask you about Datix. It has been updated but you're not on the newest system, why is that? Is that a resource issue?

A. I would imagine so. I can't say for definite but I would imagine that is, and there would be a cost associated with that as well.

Q. The new Datix that is currently in operation, is it any less cumbersome to input the information than the previous one?

A. Not really, no.

Q. So would you accept then that in some ways it is perhaps not fit for purpose?

A. Yes, you could say that it is not fit for purpose.

Q. I mean, obviously the easier it is for people to make a report –

A. Yes.

Q. -- the more likely they are going to do it and if they are put off by a cumbersome system that requires a lot of training and that isn't particularly user friendly then it's not really going to be the most effective system, is that fair?

A. That's a fair point. But on reflection you still need to capture the key essence of what the incident is in a factual and concise manner.

Q. I accept that entirely. But if you're having to tick a box, if you're logged out after a certain period of time, then those are things that surely with the IT skills that people have nowadays could be improved?

A. Could be rectified, yes, I agree.

Is the current Datix system user friendly? If not, what can be done to rectify this?

A. So, I think the key to managing patient safety concerns is appropriate escalation. So, I think if a trainee was raising a concern with a clinical supervisor or educational supervisor about a patient safety concern, I would expect the CS or AES to raise that with the Clinical Director of the service and then escalation as appropriate. So, to me, it comes back to the heart of how you manage clinical performance concerns and about early -- you know, if there is escalation, that it's dealt with appropriately, people in senior positions respond to that appropriately and investigate it appropriately.

Q. And in these particular examples, rather than generically, what would be best practice to happen, given the information that I've read out, the information you've provided to the Inquiry? If this were the case and you had spoken to Mr. Young, do you consider that these are cases that should trigger an approach by him to act accordingly to perhaps explore your concerns to speak to Mr. O'Brien, to speak to a colleague? Do you think these pass the threshold for necessitating some governance action?

A. So, I would have expected him to have a conversation with his Clinical Director. And, you know, these were patients who were on the ward, these were patients that he would have been aware of, you know, on the joint ward rounds. So, irrespective of whether or not he remembers me talking to him about it, he would have had sight and visibility of these patients.

Q. And also would it be right to say irrespective of whether you're right or not in your concerns, there's an obligation?

A. Absolutely.

'So, I think the key to managing patient safety concerns is appropriate escalation'

Do all the staff in the Trust have a clear understanding of the appropriate escalation process? This is an important strand of practice that keeps patient safety to the forefront.

Q. But in terms of what should be done around reviewing that case for learning –

A. Yeah. I mean I think what they saw demonstrates is that the number of people involved in this discussion didn't adhere to process. The process was to report this as an IR1 and allow that process to run its course. In parallel, the patient could be seen clinically and treated.

Q. Yes. One of the things that's probably overarching a lot of what we'll discuss in the course of today is the, I suppose, the appetite for challenge and the - how that feeds in to the safety culture. I pick that example. I suppose you would agree with me that it doesn't reflect well on –

A. I think there's an initial misstep of not doing the IR1. If you had done the IR1 at the very beginning you wouldn't have this issue of the round-robin discussion going on, it would have gone through the correct process.

How can the importance of reporting an incident, where appropriate, as an IR1 be understood, re-enforced and engaged with as a positive step in maintaining a safety culture throughout the Trust?

Q. Yes. I think you referred yesterday, or I referred you to the point you make that patient outcomes and the data around that is now perhaps more very recently beginning to be used, is that the kind of stuff that's –

A. Yeah. So I think there are other specialties that we can learn from. Orthopedics have had patient related outcomes for a long time, and I think that that's something that we could definitely, as a specialty, adopt and adapt to our needs. You know, the Trust could invest in very simple things like

surveys of patients to ask them what has happened every time somebody comes into the hospital, you know. How was your experience? Did you have a complication? Well, the patient is going to tell you if they had a complication. So there's a very easy way of picking up morbidity, you know. There are other safety systems that other Trusts that I have worked in have used such that you cannot get to theatre if your VTE assessment is not completed. You cannot prescribe medication on the system unless you have put in the patient's weight and their VTE status. So, these are safeguards that are built into the system to allow safe practice.

Are comprehensive patient surveys been routinely used in all the specialities in the Trust? If not, are there plans to introduce them, audit them, and share the learning?

Q. I mean, do you have a sense, as the lead of the MDM, that while systems are always vulnerable to human error, that safety nets, if I can describe them as that, are as robust as they need be, or do you have any lingering concerns that keep you awake at night in this context?

A. At this period of time in 2018, we didn't have resource to properly audit and quality assure what was happening, and we had flagged that up as a concern. We now do have that resource. So as I spoke about earlier today, we run a check on random cases every month to ensure that outcomes are actioned.

Is there regular monitoring and awareness across the Trust on how effectively its 'safety nets' are functioning? How quickly is there a response when vulnerability is flagged up? Has this been recently audited?

…….

Q. He reflects here, there's just a number of points but one which you can perhaps help us with. He says: "It has increasingly become a common occurrence for no ward rounds to be undertaken by the urologist of the week over a weekend. It has been reported that one whole week went by in recent months without one ward round being conducted by the urologist of the week." He says, and this is perhaps a point that you can help us with directly: "As often as not, I have begun my urologist of the week without hand-over from the previous urologist of week and ended it without the next urologist of the week being present." So I suppose that latter bit might be you?

A. I would disagree with that totally, because I always met him and we discussed the patients. So I would disagree with that.

Q. Yes. So I think you've said, just to be clear, for the first year and a half after the introduction of the UOW model –

A. Or in until he retired, because he would always follow me, so I would always have met him and discussed the patients.

Q. So I think urologist of the week model came into place in late 2014, early '15?

A. Yes, within a few months of me starting there.

Q. Yes, and he retired in July 2020?

A. Yes.

Q. Is that about five years?

A. Yes, so it's probably longer, yes. Yes.

Q. So you succeeded him on urologist of the week rota?

A. Yes.

Q. For five years?

A. And if there was some reason that I couldn't get to it on a Thursday, we would certainly have a phone call and discuss the patients.

Q. Did you consider whether it was a phone call or participating in the, if you like, a joint ward round, the incoming and the outgoing, that was an important patient continuity of care and/or safety mechanism?

A. But a phone call you can equally talk about the patient equally as well, than spending four hours walking around a ward. If it's commoner to do the ward round, but if for some reason one couldn't, it was a phone call.

Q. Has it now moved to a phone call completely or comprehensively?

A. Certainly, I think that it is, that it's a phone call, yes, and it's equally as effective.

Is there a regular check taking place on the quality of hand over at all levels on the wards throughout the Trust? This is an important patient safety and quality issue.

Q. Yes. What I'm sort of poking at a little here is, I'm asking you a question I suppose about the effectiveness of the patient safety meeting. It is an ideal forum or opportunity to corral the problems and identify the learning. But I'm anxious to, I suppose, take your view on whether that is sufficient if there is a disconnect between that and the implementation of the solution?

A. I suppose the patient safety meeting can make recommendations and inform the appropriate people, but it can't police it. In other words, you know, if something is sorted, it can come back to the Patient Safety meeting. But I don't think the Patient Safety meeting is well enough resourced so that -- you know, I'm doing it now, so I can't go and chase up all the time that something is being done. You know, I depend on people to contact me and say "we have now done this". But I don't have either the time or the resources.

Q. In terms of -- I mean, one can imagine that those clinicians attending the Patient Safety meeting are in a good position to articulate, I suppose, their concern, their alarm, their worry about any issue of practice that comes there. Are there listening ears in terms of those on the governance and/or management side? Are they present at the meeting so that they can hear this alarm, worry, if that's how it is to be characterised in terms of any particular clinical issue?

A. Yeah, and very often a Head of Service comes to the Patient Safety meeting. We now have audit people at it as well. You know, we have a good turnout of medical professionals, nurses, doctors, at the meeting. So it is a good forum for discussion, discussing concerns. I think it is effective, albeit slowly effective. But it is, things do change ultimately. Maybe not as fast as we would like, but they do change.

Is the SLT happy now with the efficiency and effectiveness of the Patient Safety Meeting? Are there any further steps that could be taken to enhance its effectiveness?

A. Well, I remember discussing this patient. So it wasn't just the stenting, it was having the MSUs before the procedure as well which we felt was important in this particular case. The fact there was no MSU, I think that was the one that we really concentrated on.

Q. Okay, so the absence of MSU is a cardinal sin in that context. But, equally, I think it's a point Mr. Haynes makes in correspondence with management in 2018, the delay in managing this patient back into the system for delivery of extent removal or replacement or whatever it was, was not helpful. So has your Patient Safety meeting, in the context of this case, and you were particularly told to look at Recommendations 5 and 6, did it grapple with that delay issue?

A. We were all made aware that we should submit data if the stent has been dwelling more than one month. So all the recommendations were discussed. They weren't written there, but they were discussed.

Q. So back to the top of where we started: In terms of solutions to the stent delay issue, clinicians are being taught to look more imaginatively at whether a stent is required and, if it is required, to assess whether a stent with a string can be used?

A. So if it's appropriate, yes.

Q. But there will be cases where it is not, and I suppose what the Inquiry wishes to understand, because we've seen quite a number of stent cases, and that is why I am spending so much time on it, what can you say about today, October 2023, that could re-assure the public that they're not going to get into difficulty with indwelling stents staying in too long and being forgotten about by clinicians who don't have it on a management plan?

A. Well, as I said, we're probably putting in less stents because if we're putting in stents with strings, the cohort of patients that are waiting for stent removal is less. We are doing, as I said, primary ureteroscopy. So if it's feasible we're treating the stone when the patient comes in acutely, rather than putting a stent in and bringing them back at a later date for treatment of that ureteric stone. Three is, a recording is better in that we now have two codes, a code whether there's a stent in or whether there's a stent not. So we are aware on the database that a patient has a stent in situ. We have a Scheduler appointed in the last few weeks who now takes pools lists and so -- or pools the patients. So the next person with availability will get that patient Our correspondence; so I do and my colleagues, so when we do our letter from theatre, we document that there is a stent in place, and that's always documented. I'm sure that the registrars do that as well. Our Waiting List Form is done at the time of theatre. It's an online form now, or the "green form" that we keep talking about, it is now online and it is done and sent to the secretary at the time, after the operation, and it's marked clearly that there's a stent in place and the date it was put in. And we're acutely aware of it as well. We do Datixs if the stent has been in more than a month. So we have lots and lots of ways to try to prevent it happening.

‘What can you say about today, October 2023, that could re-assure the public that they're not going to get into difficulty with indwelling stents staying in too long and being forgotten about by clinicians who don't have it on a management plan?’

Does the SLT have up-to -date information on how many stents remained in situation for over a month in 2023?

Now, that brings me to another point that I've made I think in my witness statement. There is a quantum of work that it is safe to deliver, and if you are funded for a team of seven consultants, and you've had various locums coming in filling posts and then they leave, and you're then back down to a team of less than that, perhaps four and a bit as we are at present, the Trust is expecting four and a bit to deliver the workload that was previously delivered by more people. That's not safe.

‘There is a quantum of work that it is safe to deliver’

Can the SLT assure the public that all its consultants are operating within safe levels of practice?

Q. Would you have expected, as Clinical Director, to have been made aware of governance issues that arose that may impact on patient care and patient safety and patient risk?

A. Yes, I think I was.

Q. You were or you would have expected to have been?

A. I would have expected to have been, yes.

Q. You've said that you have listened to the Inquiry, and you are obviously more knowledgeable, perhaps, now about the issues than you were at the time, I think that's probably self-evident from your statement?

A. Yes.

Q. Just on the back of your last answer, where you said you would have expected to have been told, the issues that you've heard brought to the Inquiry's attention, are they issues that you would have expected to have been made aware of during your tenure as Clinical Director?

A. Could you specify some of them?

Q. Well, some of the issues around triage, for example; I know you had some basic knowledge of that, but the extent of that issue, would you have expected to have been made aware of that?

A. I think so, yes. I was made aware of it and I did address it. But I'm trying to think of some of the other things that were -- like, the retained swab, I wasn't told about that, or the Bicalutamide, I wasn't told about that, and I am not sure that it was widely known outside of his clinical practice, I don't know, but...

Q. Were you aware of any MDM recommendation divergence?

A. I was aware that the radiologist wasn't there and that they were trying to recruit a second radiologist, but I didn't really notice the missing pathologist, to be honest, because I was on the other side of the screen.

Q. Well, that's a slightly different question now, that's about quoracy and capacity.

A. Yeah.

Q. And specifically in relation to MDM recommendations that may have been diverged from post-MDM, was anything like that ever brought to your attention?

A. No, it was never brought to my attention.

Q. Now, when you say that they might have been brought to your attention, or in fact I think you said they should have been brought to your attention as Clinical Director, any issue that raised a potential patient risk?

A.. Other issues might have been drawn directly to the attention of Mr. Mackle, for instance, and I might not have been involved because of my remoteness, so it's possible that I missed out on things. There were other things that were presented at M&M and I would have picked those up if I was there.

Q. Now, you've mentioned Mr. Mackle. Would you have expected him to have told you some of the issues that he became aware of?

A. I think so, but I would -- because we didn't meet all that frequently, it is possible that some things didn't get mentioned, but I would have thought, yes.

Q. Was there a sense that the person on site - for example, Mr. Mackle based in Craigavon - was there a sense that he was better placed to deal with those issues and, therefore, you just expected him to do so or he expected you to do the same in Daisy Hill?

A. I think there's a little bit of that, yes. I mean, I sort of dealt with everything in Daisy Hill and there's very little that we didn't sort out on site because just the practical issue of being there, and I expect the same thing happened on the Craigavon site. If I wasn't there, the information sort of got to Mr. Mackle before it was going to get to me.

'There were various pathways for governance to go through. For instance, some things were raised as IR1s, that was a pathway I was not involved in at all, so I wasn't made aware of any IR1s, even the ones from my own site. They went through a different pathway, through the AMD and the CD, assisted by, I think, someone from ENT, which someone -- kept changing, but I wasn't involved in IR1s so I never knew about those'

'Various pathways for governance to go through' – unless governance pathways are streamlined, and communication is clear there will be an increased risk for patient safety. How confident is the SLT that streamlined pathways and clear messaging are being delivered throughout the Trust?

Q. You've said that you weren't a core member of the MDM and there was some discussion about what would happen if a recommendation was made by the MDM and then, after discussion with the patient, there was a change of plan and you said that it should be referred back to the MDM. In any case, should that be recorded somewhere, even if it is not referred back to the MDM?

A. Well, if you change -- let's say, for example, as an extreme example, the patient was in palliative care and it was totally impossible to prescribe what you had been asked to prescribe. I think you would record it in the notes. You would certainly record you made a change of plan. If it is a regular just change of plan because of patient choice, that should come back.

Q. That should come back to the MDM? Just in terms of -- would you accept that the one case that you had to deal with in terms of Mr. O'Brien relating to the charts in the bin, that was a formal disciplinary process which proved to be effective. You had then to deal with him on an informal basis in terms of the charts at home and the triage, and we now know that those -- while you may have thought had borne fruit, in fact hadn't. Is there a lesson there to be learned about how to approach these matters?

A. I'll accept that.

How recently has the role and the protocol of MDM's been reviewed? Is the SLT confident that the guidelines are operating smoothly throughout the Trust?

Q. Yes. I suppose we've received evidence -- and this is 2011, so the Inquiry is looking at, obviously, a broader period than that -- but we received evidence that might suggest on one view that the measurement of quality, a sense of inquisitiveness around quality wasn't necessarily there; wasn't party of the operations and culture of the Trust maybe as the years go on. Did you get support for what you were trying to push? If you did get support, how was that manifested in activity terms?

Is there currently a greater 'sense of inquisitiveness around quality' throughout the Trust?

Q. We've heard from, I can't remember now which witness, but basically with the drive to meet targets, that was where the focus was, and you've sort of confirmed that today. Is it fair to say that Quality got lost and the Quality metrics and the need for Quality got lost in the need to meet targets?

A. In general, I would say to me it felt it was submerged. It was meant to be there, everyone agreed it was the right thing to do but it was always 'but we've got this other thing to do first'. I mean, the reform of M&M into a Patient Safety system, I would consider that a big achievement. That was exhausting. No one told me to do it, no one particularly helped me with it except, you know, Anne Brennan, Stephen Wallace and a few others.

Q. I'm thinking more now at Board level. Because the focus was so constantly on performance, do you think that the whole issue of quality of service was lost? The consideration of it was lost at Board level?

A. It was put on the long finger, I suppose, is the better term. That's good when we get round to it. I mean the simple things were infection control, because that was the one area where I had a lot of control over. So, you know, introducing bare below the elbows, the proper isolation of patients, changing behaviours, doctors not have dangly things hanging over patients and so on, proper insertion and checking of IV lines, we did get good engagement with that. We had a team of infection control nurses, they had the imprimatur of the Medical Director behind them and we also had the ability to audit compliance. In small ways in very obvious things like that, because if you don't do that, you're going to get a C. diff outbreak or a Norovirus outbreak, or you're going to get wound infections -- sorry, not wound infections but IV line infections. So, there were certain wins. We were, and I say we, we had infection control nurses doing audits. At one stage we actually brought in PPI, Personal and Public Involvement. I don't know if we got round to it but we had two people from the community offering to help us with the audits. To me, that was a good success, where you can actually make changes but it takes quite a bit of an effort.

Q. It took effort but perhaps not money?

A. You do need resource. As I said earlier on, there was an awful lot of arguments about money. You can get into the trenches over this. The arguments should be about capacity and demand. As I say, capacity should be never running at 100 percent and then you can do things. So, the argument augers back from central government is we're putting money in, but you have to measure demand which was increasing. Our capacity was being squeezed in terms of efficiency saving, so the mismatch. You had great sympathy for frontline staff on a ward, a ward sister, and the pressures they were under. Even small things like, you know, cutting back on the hours of a ward clerk who should be taking, you know, administrative tasks off the ward sister was a false economy. There were pressures coming from everywhere. I was very aware of that more in infection control than anywhere, more than any other things, because it is a very direct, obvious thing that you can measure and look at. People did work with us. In fact, at one point we were the highest performing Trust in the UK both with regards to C. diff infections regarding peripheral lines. So, I can't be too hard about them, they did work with us when they could.

‘Q. Because the focus was so constantly on performance, do you think that the whole issue of quality of service was lost? The consideration of it was lost at Board level?

A. It was put on the long finger, I suppose, is the better term’

Can the SLT and the Trust Board currently provide the relevant evidence to show that there is now a good balance in the quality of the service and performance delivery in the Trust?

A. You would have to ask Mr. O'Brien himself why he was so beloved of the 50mg dosage. That seems to be his preference. There is some effect at 50mg, it is not a treatment that has no value and no impact. Just 150mg would work better and has a licence for it, but doctors often use medications outside their licence; it is not at all unusual for doctors to do that. The 150mg dosage does have more side-effects than the 50mg, particularly breast enlargement, hot flushes; those two things. The use of Casodex, as I mentioned before, is potency preserving and doesn't give some of the other quite dramatic side-effects of castration therapy using LHRH analogue. So I think Mr. O'Brien certainly could be criticised for the use of that drug. I can't explain why that's -- why that was his choice, but I don't think you could say he was negligent in using that. It's not the wrong treatment, it's a less than ideal treatment. Remember, the background of prostate cancer is highly controversial because you can go from active surveillance to radical prostatectomy with robots and so on. Open prostatectomy, radiotherapy with hormones and now high intensity focused ultrasound and all sorts of new treatments coming in, many of which don't have licences for that either but patients are getting them. Prostate cancer is one of the most controversial treatment areas out there clinically, and Mr. O'Brien had his own idiosyncratic way of dealing with it. But I can see that would bring him into conflict -- well, into disagreement, not conflict maybe -- with radiation therapists in Belfast, which probably explains why Mr. O'Brien seemed quite reluctant to refer his patients into Belfast for radiotherapy. That reflects his desire to keep his own patients under his own care, even if it is a bit idiosyncratic. Again, reading from what I have, it seems to me the patients seem to buy into this with Mr. O'Brien. They trusted him. He must have been a good communicator with them. I'm not sure he would have explained absolutely the pros and cons of all the things he did, but he seems to care for his patients to a great extent. But he was using idiosyncratic ways of treating them that he may or may not have explained to them.

'That reflects his desire to keep his own patients under his own care, even if it is a bit idiosyncratic'

At what point does allowances for a consultant's idiosyncrasies become a safety and care risk for the patient?

Q. Would you accept from me, perhaps, that having excellent knife skills does not an excellent surgeon necessarily make?

A. No. You do need the administration, the communication and the surgical dexterity. So, there is an issue there with Mr. O'Brien.

'Would you accept from me, perhaps, that having excellent knife skills does not an excellent surgeon necessarily make?'

The Chair of the Inquiry gets to the heart of the matter with one strike!

……..

Q. A few questions which were really around safety culture, safety culture, governance culture, whatever you like. It is quite a complex area and it comes from both ends, it comes from the department, it also comes from the Board, it is the government to some extent. It is all about how things work rather than what processes you have. Just as a starter on that, there's a lot of evidence that the way you work together as a team, the way you support colleagues, the conversations you have, the openness with which those conversations take place is the softer part of safety culture, which is critical. Without that you can have lots of systems, but people don't necessarily give of their best. In terms of the safety culture of your department, I'm struck by the fact that there were quite a lot of serious patient issues in terms of just letters, triage, results, pre-op, even I might say the efficacy

of the WHO checklists in terms of I would say these pre-op issues should come in the first phase of that. What is your view as to why some of these issues weren't really discussed openly in the first place and, also why, when there was a significant issue when you were sat down in 2017, in the January, why didn't you all individually speak to Mr. O'Brien and why didn't you talk to each other about the atmosphere in the department and how what needed to change to improve this. What is your feeling about the cause of that?

A. There wasn't a negative attitude in the department. I think we all got on well.

Q. If you got on well, why didn't these things come up?

A. Apart from Mr. O'Brien, perhaps. The rest of us got on well. I think it was probably a difficulty -- I think to use a phrase, and it wasn't something I experienced, but a phrase Mr. Haynes had used, a challenge to challenge.

Q. Do you think it was just that?

A. It is probably not as simple as that, I suspect. I think it is probably a complex situation that has arisen over a long period of time.

Q. These are really critical issues and it is never just one person. One person may be a catalyst for things not being totally open, but it's clear that these things didn't regularly get discussed in the way that I would expect. I mean, I can't envisage a department where you have somebody excluded, coming back to work, all these serious issues, and no frank conversations. I can't envisage that. So it does indicate there are some barriers there. You say the rest of you get on. Do you recognise the fact that building trust among everybody is critical for patient safety?

A. Absolutely. If you get on, you can speak to people. You can -- and you are not afraid to bring -- if you're having problems, bring it up. So, no, I think it is very important.

Q. And you have said a few times you can't just do what you like, you can't just do your own thing and yet this was tolerated. Now that, I suppose, you would say is the challenge to challenge issue. Who, in your view, should be dealing with that? Were you clear, for example, on the respective roles of the clinical lead and the Clinical Director and people going up the hierarchy? Did you have a clear view in your own mind about who should be picking up some of these issues, which were evident to various people, even if they weren't totally joined up?

A. Well, I assumed, more than assumed because I can see in the evidence that lots of people had been trying for the last 20 something years to get somewhere, not successfully in the slightest. Whether people should have been more forceful in getting things agreed –

Q. Do you have a view as to where that responsibility should sit?

A. I suppose ultimately these things sit with the Medical Director and come down. I mean, he's obviously not -- he or she is the last person in the chain. But...

Q. Is that right or should there be more interaction? How much interaction did you have with people, say, like the Medical Director?

A. I have had no interaction with the Medical Director. I think, serious issues going on like this, you know, would certainly, and the Medical Director would have been aware of it. But no, there are several people in the chain before the Medical Director who, from what I have read –

Q. But were you yourself clear on it, I know you have read some things now but at the time did you have a clear picture in your own mind of who did what?

A. Well if I had an issue I would probably have gone to Mr. Young first. I would also involve Martina Corrigan. That would have been my direct contact

Q. Okay. There's been a lot of favourable comment about the change in the Patient Safety Meeting and the improvements that have happened, which is clearly good. But you said a couple of things today. One of them was it only gets to the Patient Safety Meeting if something goes wrong. And you've also said you weren't sure how something should get to the Patient Safety Meeting. So I just want to ask you about whether any efforts had been made to support the department to look at data and information in a way that would actually give you a bit of a heads up. So, for example, you have a nice little scorecard about results. That is helpful if consultants are provided with that. My own experience is that is usually done on a comparative basis and consultants are quite competitive so they don't want to be in the red, whatever it is, you know. You can do it with triage, for example, you could do it with pre-op assessment compliance, you could have done it with the glycine issue. Have you had any support as a department in terms of developing those sorts of metrics to be automatically collected for you? Time to stent insertion would be another one?

A. Yeah, the clinical governance department, the manager of the clinical -- comes to all our Patient Safety Meetings, she has been coming for the past year, has been guiding us in audit and has been –

Q. This wouldn't necessarily be audit. This would be automatic data. Has anybody had that conversation is the question?

A. No. But it is something I may visit and add it into the Patient Safety Meeting. I think it would be useful. I will speak to clinical governance about it.

Q. It just helps to build trust?

A. No, I think it is certainly something I will add in.

Has this conversation with clinical governance taken place and what has been the outcome?

Q. The other aspect of patient safety which has increasingly come to the fore is the patient's role in understanding about their own treatment and in asking questions. Now, you mentioned that you copied letters in England and not here because it wasn't done and I know it is not mandated in Northern Ireland. What's the barrier? Why are people not keen on it? You yourself didn't seem to be that keen.

A. There's no barrier, really. There's nobody said you shouldn't do it. It just wasn't done, but there's no barrier.

Q. Would you agree, it is another check. If you are supposed to have a scan and you haven't had it, you'll be on the phone, won't you?

A. Saying that, I copy results to the patient. But yeah, but I do say to patients, you know, I do summarise at the end of the consultation, you are having this, this, this and this –

Q. I know?

A. -- but it is not written in a letter and I think certainly perhaps I'll change my practice.

Q. I can remember when it was introduced many years ago now and lots of people were resistant. But actually, it seems to have brought benefits generally?

A. I think it is not something that would bother me, it is just something I will do.

This issue of writing letters to patients has been raised several times during the Inquiry – going forward, can the SLT develop guidelines/policy and recommendations for clinicians in the Trust?

3. Culture and behaviour

'You can create policies and procedures and evidence-based practice, but unless you get the culture right, the rest just falls away' Adrian James (President of the Royal College of Psychiatrists)

A. The culture not such that you can raise difficult matters in MDT meetings. Not the openness required.

Is this currently the case?

A. People had concerns but didn't have a meaningful way of escalating them

Developing a culture of challenge and escalating appropriately – how is this being shaped now?

A trend of there being knowledge of a problem but not the appropriate escalation steps were taken

How is this process being tested now?

Consultant practice – independent practitioners with a lot of autonomy are difficult to challenge in the management line and in the medical line

Medical management line – do clinicians feel comfortable to challenge now?

Q. You are – the Inquiry might consider, pertinently explaining that there was a culture within which you had to work, which involved, as you suggest here, trying to work around deficiencies rather than go to the root cause, sort out that root cause and provide a lasting solution

Does any of this culture remain in the Southern Trust?

Mr O'Brien had a long history of 'an intermittent nature of compliance' – do you have in place an effective screening mechanism to pick up this behaviour now and requiring it to be addressed?

Patients are partners in care.

How is this principle being integrated into the culture and strategy of the Trust?

Where and how often are your Trust values highlighted and measured?

- Working together
- Excellence
- Compassion
- Openness and honesty

……

Q. As a general point, you mentioned that there were several meetings with Mr. O'Brien that had been recorded without your knowledge.

A. That's correct.

Q. I just asked you what your views were on that?

A. That's right. Yes. Sorry about that. I suppose the three with the colleagues, I was angry about, but there was other people in the room with me. The one that annoyed me was on the 9th January when I agreed to meet Mr. O'Brien outside of the hospital. I facilitated a meeting in his car when he was handing over the outcome sheets and advised me of the letters in his drawer. So I actually feel quite violated about that, that a colleague would, on a one-to-one basis record me because I don't know what he expected me to say or do. The other three meetings, it's very obvious from listening to them that there was an agenda of Mr. O'Brien's because the meeting is steered to the areas that he wanted to talk to us about.

How 'visible' are the values and required behaviours and consequences circulated within the Trust?

Q. I just want to probe that relationship a little bit more, if you don't mind, both in relation to the communication aspects and also any impact her style of management or your style of engagement with her may have had on the culture of dealing with issues as they arose. When you say that her approach was different so that it perhaps wasn't open door that you had been used to, as Head of Service, what impact, if any, did that have on your day-to-day operation or ability to seek help or to make decisions?

A. Working with the previous Directors it probably did hinder because if you had something -- like you needed to give a heads up on something, for example, the Emergency Department was really, really busy and you needed to know was it okay to open -- you know, bring in extra staff to open a bay, you couldn't go in to her to ask her that. She had always said if you needed to highlight anything to me you just needed to go to one of the other ADs. If Mr. Carroll was not about I would go find one of the other ADs I wasn't directly reporting to, for example Mrs. McVeigh, and sort of speak to them. I suppose I sort of got used to it because she had been there for a while but didn't have the same relationship and, you know, didn't feel that I could go to her if I had to escalate something.

'The culture of dealing with issues as they arose'

How is the Trust currently promoting and monitoring this principle?

Q. Is there any way that your work on the Just Culture and so on is intended to flatten that hierarchy a bit and not keep everything in services?

A. Absolutely. And I think in terms of from a collective leadership perspective we have much more work to do on that, but I think, you know, recently in the past number of years there's much more a sense of needing to work together and we are each other's safety net, really, and seeking out help, seeking out support from a corporate perspective, as opposed to trying to keep it from within because they don't really want anyone to look at that.

'We are each other's safety net' – what does this look like in practical terms?

Q. Is there any work, do you think, to be done around the culture that creates that kind of, I suppose, fear that you are describing, or sense of foreboding?

A. I have been involved in governance work in the Trust beyond this where we did governance teaching in a multidisciplinary way. It was very interesting, as doctors, watching how difficult it was for secretarial staff and admin staff and even nurses to some extent to feel that they had a role in raising concerns. You know, it was very interesting to go along to some of those meetings where we were

encouraging people from every level to raise concerns and to be aware of their responsibilities in doing so.

How frequently is the importance of raising concerns addressed in the Trust? How robust and secure is the whistle blowing route to the Chief Executive?

A. I suppose the point I make in terms of the support and accompaniment from, you know, an individual who is legally qualified, I think that only serves, again, to further legalise and put an adversarial process into play as opposed to an open, transparent, candid process about what has happened. So, I think there's challenges with all of those things as part of the MHPS. If we are trying to move in the direction of that restorative just and learning that we are in Northern Ireland, I think that's going to be a challenge alongside MHPS, but work that needs to be done.

Is work being done now in the Trust to address what a restorative, just and learning process looks like in practice? How is this being communicated?

…….

Q. Around these issues, and it's a bit of a theme through aspects of Mr. O'Brien's shortcoming, there's an appreciation from management that there's something of a problem, but I suppose the refrain that you pick up on and is punctuated through your report is a limited appreciation of the extent of the issue. It's almost we knew there was an issue but, shock, horror, was it really that bad? While we talk about missed opportunities in your report, what were you thinking - even if it's not in your report - what were you thinking about the state of management in terms of the regulation of Mr. O'Brien's practice? Be in a position to know the extent of it?

A. I thought that the management struggled to manage Mr. O'Brien. I thought a lot of that had to do with the type of person that Mr. O'Brien was, his seniority; there were a number of factors. But I thought managers struggle to manage him and I formed the impression that they were afraid of him.

Q. That is perhaps an odd thing to say for us looking into this. Did you get any sense of why they were afraid of him?

A. Well, I think some of this information, I'm sure, is in the report but the impression that I got was that they had attempted to -- they had attempted to manage Mr. O'Brien in the past, had not been successful in doing so. Rightly or wrongly or whether it's urban myth, I'm not sure, but the information that I was being given was that they felt that Mr. O'Brien would complain or would go down a legal route or wouldn't pay a blind bit of attention anyway. So, I got the impression that -- that was my impression, and certainly I appreciate you are going to speak to these witnesses, but my impression was that they felt unable to manage him and they felt restricted in their attempts to manage him because of how he might react to that.

Is there provision/requirement for all the staff in the Trust to access training on the Trust's values and how they apply in the workplace?

Q. In this case, and I'm sure you found it in other places, there clearly are multiple issues with the whole investigation, with the whole interaction with NCAS but it seems to me that they basically ignored lots of things in terms of the NCAS advice. That's what it appears to me. I don't know if it was entirely deliberate or if part of it was accidental but it indicates as a cultural problem, I think. In your experience over the time you've been doing this, what are the cultural issues at play that cause this sort of attitude? Or do you not think there are any?

A. Oh, there are. First of all, I think you pointed this, there's this fear of -- you know, they treat doctors differently when they shouldn't. They're just employees. And doctors, many of them often think they should be treated differently, which doesn't help matters. Doctors are senior people, they're well-paid. Many of them, particularly surgeons, are fairly dominant. So those are all issues that make it difficult to manage doctors. You're absolutely right, there are a number of cultures around. I mean, there's a terror of MHPS. If you look, for example, there's the formal and informal processes in MHPS. Everybody is terrified to go to the formal processes, whereas actually there's not that much difference.

Q. Would you agree all of that needs to be more clearly defined, because people seem to have got their knickers in a twist about it?

A. Yes, yes. They do. That's a reasonable suggestion. Yes, they have. They've got really messed up with it. They get terrified of going "formal", whatever that means. As I say, I'm not entirely sure that there is that much difference because you are still applying common sense; you're defining the concerns, investigate concerns, you're deciding what to do about it.

What initiatives can the Trust introduce to help to address the historical culture where medical employees are viewed and treated differently?

Q. The opposite was true in this case. Everybody was saying he is a great clinician, he's a great surgeon, there's no problem there. That seems to have blinded people to perhaps doing a more focused trawl. Is that one of the problems that there are in terms of carrying out these investigations? I think Dr. Wright summed it up by saying it was -- I'm paraphrasing what he said but basically it was an overreliance on deference?

A. Yes, I think that's fair. I mean, this is somebody who was very senior. He had obviously done great things in the past and he had set up the service and run it and there was significant deference to him. Certainty from my experience, having spoken to Mr. O'Brien, he's an awfully affable, pleasant fella. All of those things would make it more difficult for people to suggest that there was an issue with his practice, yes.

Q. Is that all the more reason then, where you do have someone of that seniority and that reputation, that it is important to bring in someone external to lead this investigation?

A. Yes. Again, an external person won't be blinded by the fact he's the most senior surgeon and he has been there forever and everybody likes him. They will stick to -- they will actually do the investigating. I'm a great fan of external investigators because they don't have the baggage that comes with being part of the organisation. Also, if they are externally commissioned, they are on a commission, they are going to do it on time, they are going to do it in whatever timeframe you agreed with them.

The Trust values, principles, and standards apply equally to every member of the Trust.

Q. But the other side of the coin, Mr. O'Brien, is that with Patients 11, 12, 13, 14, and 15, you put those referrals in a drawer and didn't take any steps by way of triage, any variety of triage, and they went on, each of them, to develop cancer in circumstances where the information on the referral, had it been looked at, would have led to an escalation from routine in one case, urgent in four of the cases, to red-flag. Do you accept that?

A. I do accept that, yes.

Q. Do you accept that failing to triage routine and urgent referrals creates a risk of harm and in some cases may lead to actual harm?

A. Of course.

Note - having this understanding did not result in a change of behaviour and approach by Mr O'Brien

Q. It might be akin to navel-gazing to ask you to comment on something like that, but there is a theme in the evidence received by the Inquiry to date, sometimes colourfully reflected in the evidence, that you were beyond challenge because of your status. And we saw yesterday, perhaps, over a period of years, an informality to the challenges directed at you to put your house in order. And here, some might suggest, is another example of this, putting it on a longer finger and a more informal approach than the Oversight Committee has. I suppose, reducing this to a question: Did you have a sense or did you make it your business to create a sense of untouchability?

A. I've been -- no. I've heard people answer you with a short answer. The short answer is no. And I've been bemused and amused by this deference thing and that I'm unchallengeable, and I hope I haven't come across as being unchallengeable. And irrespective of whether or not people were of that view, these were serious concerns that they did have and they needed to be addressed, and that can only be done by challenge. But challenge can take place in the kind of collaborative manner that we have already discussed. And I think, actually, that she -- I think her sentiments are perfect because, you know, I did build up the service from scratch, single handedly, and it does -- in that context, and for good, let's address this. Now, whether it took two months or four months or six months was immaterial. Frankly, 189 charts remained forever undictated. But that's, you know -- the process that ultimately did take place didn't address all of the issues. So, there was a better way of doing it and I agree with her sentiments. But it doesn't infer for one moment that I was not challengeable.

There seems to be a lack of insight into the evidence on the part of Mr O'Brien just what a challenge he presented to others in the Trust.

Q. Thereafter, what was the reason for recording conversations and meetings? Because, for example, you had Mr. Michael O'Brien in attendance with you at many of these meetings. So, in terms of an ability to report back to Mrs. O'Brien what was going on, you didn't need to covertly record conversations for that reason? A. That's true. So what was the reason? So we got on, think on 18th January, the note of the meeting of 30th December with Ms. Hainey and Dr. Wright. And, you know, even though Dr. Wright described her as a professional notetaker, we saw that there were inaccuracies and on first hearing me say that anyone might consider is it not just a little bit of nitpicking, but the one thing that really offended us both was this note that on 30th December my wife had said, in quotes, that "at the end of a long career, that this is how you are repaid". And that was not said. So, I came to appreciate that no matter who's there, it is the convenor who produces the note. And the note cannot be depended upon. Now, I do appreciate the sense of intrusion and violation that can be felt by anybody at the receiving end and I wish it proved not to be necessary to do so. However, when it comes to my meeting with Martina Corrigan, I have read the transcript of that meeting many times where I have gone over again and again and again how it is recorded that the majority of the 668 have been processed, the outcomes have been done. In fact, very often not only has the outcome been registered, but the operation that was the outcome may already have been done. All of that. So, I found, actually, that I had very, very good reason, ultimately, to have a reliable record. In fact, when I look back I very, very much wish that I had a record or a recording of the meeting of March '16.

Q. At no stage did you seek permission from –

A. No.

Have the people who were recorded by Mr O'Brien, unbeknown to them, received a personal apology from Mr O'Brien?

Q. Now, you've support in your view around the difficulty of getting things done when there are different chains of command. If we could go to WIT-12157. This is from Heather Trouton. I may have the page wrong but I have the extract here which I'll read out for you: "Both the Head of Service and I as non-medics found it very difficult to challenge Mr. O'Brien's clinical practice. We were reliant on his clinical colleagues to provide that clinical challenge, and this I believe did come but only at a later stage when a number of new consultants came into post who had experience outside the Trust and outside Northern Ireland who knew what was acceptable practice and what was not and who were not afraid to speak up". The actual detail of that extract is about clinical practice but I think the point reflects what you're saying, non-medics dealing with medics. Was it your experience that that was something that didn't happen?

A. Yes.

Q. Do you think that that was a culture thing as well, that there was a culture -- not perhaps just in this Trust but there was a culture that only medics could deal with medics?

A. I think, yes. Short answer, yes.

Is there still a culture where only medics deal with medics?

Q. No. Okay, thank you. In a similar vein, do you think the people in senior management of the Trust actually understood the issues of Records on the ground? How much contact did you have in terms of being able to explain the reality in where you work, as we have indeed heard today?

A. I just don't think it would have been held -- it wouldn't have had the profile that meeting the targets, meeting the financial stability, having beds for patients. I think Records fell a lot lower down in the pecking order.

Q. You have described about, I think you called it silos - other people have used the same term - where you felt that the reporting lines were separated from each other, different levels of staff. Quite a lot of people have described an inability to challenge medical staff. Did you feel that medical staff were treated differently from other staff with respect to discipline; disciplinary procedures, for example?

A. Well, they definitely would have been treated much different to my staff.

Q. How did you feel about that?

A. Well, I think it's unfair. We are all members the Trust and we are all on the payroll.

Q. What do you think the disadvantage is of that atmosphere in terms of patient care?

A. There is a lack of control then at the top if the consultants have one way of working but it doesn't match or marry with how the Trust wants to take forward.

Q. Where does that impact, do you think? Where do you think the impact is felt in the end?

A. Well, I suppose ultimately it would be with the patient.

Is this tension still there in the Trust - with a 'lack of control at the top' where some consultants have one way of working but it does not match or marry with how the Trust wants to move forward?

Q. Now, we don't need to go to it but you had sent an email to various staff, and the Panel will find that at WIT-60590, and it was on that issue of secretaries doing private work during working hours and to remind people that that wasn't permitted. What was the extent of that problem? Was that a significant issue or was it something that rumbled on and you had to, every now and again, remind people of their roles?

A. I think it was an issue that came up every now and again, and perhaps - I can't remember now obviously - but perhaps Medical Records Manager may have said to me, look, some of your secretaries are getting these charts and we know they are for private patients. This is not necessarily O'Brien, I am talking about other people as well. It wasn't a huge, huge issue but every now and again people needed reminded, you know, you're not supposed to be in here, rocking up doing private work, do it in yourown time; we've enough to be doing. Do you know what I mean?

Q. Would it only be made known to you if somebody came along and said, look, I know X is doing that, or was there another way in which you might know private work is being done on NHS time?

A. No. The main way is actually by people telling us or Medical Records informing us, or whatever. That was really the main way. We didn't have -- like, there is a report that can be run for private patients but it wasn't something we would have had time to do; let's see who is doing private work and let's catch them out. It wouldn't have been on your radar.

Is the SMT confident that no private work is being undertaken now in Trust time?

Q. It's about the secretarial, Consultant, line manager dynamics. Sometimes there appears to be a tension between the secretarial role and who she should be listening to, if I can put it like that, or who she should take direction from?

A. Yes. It's actually a very difficult group of staff to manage because obviously the vast majority of secretaries want to keep in with their consultant, if you like, and their consultants would be very supportive of their secretary, et cetera, et cetera. They do have a close working relationship. Then we are this crowd that comes along, actually, you are actually supposed to be listening to us. A lot of the time nobody is interested in us, do you understand me? The consultant is the big guy here, we are not.

How can the SMT challenge and address the power dynamic in the delivery of person-centred care in the Trust?

Q. Now, we have talked about the DARO from 2010 and the e-triage 2017, and the problems persisted before then. Did you get a sense that Mr. O'Brien was struggling to adapt to new systems of work?

A. No.

Q. Because, as you have explained, the DARO system was a secretarial function and the triage was done by the other consultants. Did you feel there was any systems disconnect for him that perhaps might have been a training need? Anything like that ever discussed?

A. No.

Q. Do you think there was too much tolerance or deference shown to Mr. O'Brien's work practices?

A. Way too much tolerance.

Q. Yes. The other thing I wrote down was bypassing systems. Now, why does this happen, do you think? What is the root cause of that? Is it frustration, is it people have fear of speaking up and tackling it?

A. I think it's purely out of frustration and trying to get the job done.

Q. Do you think that has improved at all recently? Has there been any positive impact of this dreadful pressure you must feel as a result of the Inquiry? Have you seen anything that –

A. I think there's definitely a willingness to change things and there's more of a willingness to probably listen a bit more to people like me. I hope that's carried through when the Inquiry finishes and it doesn't all fall. I mean, my experience of our Trust is very much - and I know I am not going to be popular saying this - but if there is a problem, sure we'll recruit somebody at a very high level. That's not what solves the problem. Quite often it's down at the foot soldiers.

Underlining the importance of operating a listening, inclusive and partnership approach at all levels and strands in the Trust

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Q. Obviously the mischief which the monitoring plan served to address was the question of can exclusion be avoided, can Mr. O'Brien be brought back to work and enabled to work his job plan in a way which the Trust considers to be safe. From that perspective, did the monitoring arrangements allow yourself and Mrs. Corrigan to have confidence that things were going in a relatively safe direction?

A. Yes, I think that would be fair to say. I think in the length of time -- and I would say we monitored him far too long, but in the length of time we did monitor him Mr. O'Brien, for those aspects that we were monitoring, largely they were kept in check. So yes, I would say -- and where there was deviations, bar the one in October, on October 18th, they were picked up relevantly quickly and dealt with and escalated to the case manager.

Q. You say he was monitored far too long. What do you mean by that?

A. Well, I suppose to have anybody on a monitoring plan from 2017 until you retire in June 2020 - although we stopped monitoring him when COVID hit in around March of 2020 - it has never been my experience that you monitor them essentially for three years, you know, and you are monitoring the same thing all the time. Again, with hindsight and 20/20 vision, I think we should have brought the Oversight Committee meeting back, we should have met more regularly. There should have been greater oversight from the Oversight Committee in terms of, you know, what position we were at six months in, 12 months in. I know the parallel process was going on in terms of Dr. Chada and Dr. Khan, but I can't help but think, sitting here now, it may have been helpful and we could have brought about another way of monitoring Mr. O'Brien. I don't know what that was but I think to monitor someone, just simply monitoring someone for three years can't be seen as a success.

Q. What were the aspects of it? You say we didn't meet to review the arrangements at any point. Thinking about how it did work in practice, what are your thoughts on it? If you had been given the tools to change it or revise it in any way, what would you have introduced?

A. Well, I suppose the first thing - and you've made reference consistently today to it - we didn't communicate with Mr. O'Brien. That's the first thing. This was consistently poor. We should have. I think there should have been, particularly after the 26th meeting, again there should have been oversight as to have all those actions been completed; and that wasn't done. Then I suppose just in terms of meeting with Mr. O'Brien, see how he was getting on. Then continue to monitor those aspects

that we felt still remained clinically important. Also asking him, you know, his concerns, his stresses, his worries and what we could do as an employer to help along that. We didn't do any of that.

'We didn't communicate with Mr. O'Brien. That's the first thing. This was consistently poor.'

Have the guidelines on regular communication between parties and consistent monitoring been reviewed and reinforced in the light of this experience?

Q. In light of what we know was the Trust's purported concern to get these charts back, and you have a situation where one of your managerial colleagues is seemingly, and for reasons we can explore with her, endorsing a continuation of the status quo ante, how does that sit with you?

A. Well again, it undermines the principle or the purpose of the March 2016 letter, in that the Trust felt it appropriate to formally write to Mr. O'Brien asking them to action the four elements of what was documented in the letter and for him to come back with a plan. In fact, Martina was a part author of that letter to Mr. O'Brien. I suppose what I would say to the Inquiry is that it undermined that letter and the purpose of that letter.

Q. The fact that the letter had been issued... Just to focus on this issue of the notes - nobody had rapped his door again to say, 'March letter. You were told in clear terms, get these notes back'. The fact that that doesn't happen and then we have this, Mrs. Corrigan endorsing retention of the notes for the purposes of allowing him to dictate, it reflects an inconsistent practice at best?

A. I wouldn't disagree with you on that. It doesn't read very well.

The importance of clear and consistent messaging.

Q. If I might tease that out little bit with you. Most doctors would prefer to be managed by their peers, by people who understand the job you have to do. So you would have a different view?

A. It depends, actually, what the management team is. You know, we had -- we had a small team. I was a lead clinician of the Urology MDT. So I played a management role. Our department had a lead clinician in Michael Young. I appointed, when I was lead clinician of the cancer MDT, Tony Glackin to be our governance lead in that role. So, yes, we can manage one another, but with regard to –

Q. The line management.

A. Yeah. You can take that so far. I think that when you get up to Associate Medical Director - and I have seen it too many times over the years - there may come a time for any individual in that role, where they have to toe the party line rather than the role that they used to do. And some people stepped down from that management role because they couldn't do so and others have toed the party line. So, I think I'm speaking a truth and I'm speaking it in moderate terms. I preferred the situation where you went along with your shopping list and even though I got frustrated after a few years as to the productivity of it, I preferred there was an honest separation, go along, this is what we need, and whoever it was would say, well you're not getting it and we can't facilitate that and so forth. Now, whether there's some bridges across the water that's another matter and how they should be is another matter. But –

Q. That's your view?

A. -- that's my view.

'John Templeton being the Chief Executive, because he always said he was just a clerk whose job it was to facilitate doctors and nurses and other professionals looking after as many people as possible who

were in need of it. And I think that, you know -- it's been alleged I wasn't a team player. When I read that I wanted to ask well I wonder which team they're talking about, because I felt that I was a team player very much with my colleagues, both medical and nursing. But was I a member of the Trust? Was I part of that team? I was to varying degrees. Was I part of management? No'

It would be helpful to provide, post Inquiry, some clarity on what it is to be a member of the Trust.

Q. Around these issues, and it's a bit of a theme through aspects of Mr. O'Brien's shortcoming, there's an appreciation from management that there's something of a problem, but I suppose the refrain that you pick up on and is punctuated through your report is a limited appreciation of the extent of the issue. It's almost we knew there was an issue but, shock, horror, was it really that bad? While we talk about missed opportunities in your report, what were you thinking - even if it's not in your report - what were you thinking about the state of management in terms of the regulation of Mr. O'Brien's practice? Be in a position to know the extent of it?

A. I thought that the management struggled to manage Mr. O'Brien. I thought a lot of that had to do with the type of person that Mr. O'Brien was, his seniority; there were a number of factors. But I thought managers struggle to manage him and I formed the impression that they were afraid of him.

Q. That is perhaps an odd thing to say for us looking into this. Did you get any sense of why they were afraid of him?

A. Well, I think some of this information, I'm sure, is in the report but the impression that I got was that they had attempted to -- they had attempted to manage Mr. O'Brien in the past, had not been successful in doing so. Rightly or wrongly or whether it's urban myth, I'm not sure, but the information that I was being given was that they felt that Mr. O'Brien would complain or would go down a legal route or wouldn't pay a blind bit of attention anyway. So, I got the impression that -- that was my impression, and certainly I appreciate you are going to speak to these witnesses, but my impression was that they felt unable to manage him and they felt restricted in their attempts to manage him because of how he might react to that.

How is the SMT going to respond to this narrative when questioned by patients and the public?

Q. Do you find your line manager very accessible to you if you have any issues?

A. Absolutely. We are lucky in that we have a very supportive line manager. We don't always agree and we argue and we debate whatever but yes, very supportive.

Q. So there's always an opportunity for you to bring things up?

A. Yes.

Q. Do you find that that works both ways. If you need to be told anything - and we will look at an example you have given later around biopsies, I think that's a current issue - generally is communication that might impact on any of your operating systems normally very good?

A. No. Communication is extremely poor but not from my line manager. The fact is communication is very poor, I think, from all the Heads of Service in Acute, which I would have a lot of dealings with. My work very much involves a lot of them. If you think of Martina Corrigan is the Head of Service for Urology, ENT, she wouldn't have been -- she would have been actually okay in keeping you informed. But say there are other people in charge of surgery, maternity, medicine, whatever, they don't always keep you informed in a timely way. Sometimes they do, sometimes they forgot, sometimes it's the OSL

people forget actually we need to be told certain things. But that doesn't necessarily go to Anita for Anita to tell me, that actually should be from them to tell me directly.

Q. Is that is that sometimes because people don't know they need to tell you, or can that be personality driven - some people are poor communicators?

A. I think it's a mixture of everything. And people are extremely busy and they just don't think, but then we would be kind of saying to them, look, you didn't tell us about this, you really need to.

Has the SMT sought current evidence on the quality of the lines of communication with all the Heads of Service in Acute?

Just to follow up on that last question. We have heard about particularly Mr. O'Brien's reluctance to change his working practices. Would you be of the view that unless people know the reason why they are being asked to change, you are not really going to tackle that reluctance?

A. That's a fair point.

Q. So, it again comes back to the communication issue, and if people don't know why they are being asked to do something, they are not really going to understand that it's a good thing. As you say, this was something that was - the DARO system, for example - helpful to consultants but unless that's explained to them, they might not actually see it as something beneficial?

A. Fair point, yeah.

Clear communication is necessary to ensure everyone is on the same page and has the same understanding of operational processes and the request for compliance.

……..

Q. Just last question. There was some discussion about letters being copied to patients. What's your view of that, because I was interested to see that you frequently copied your letters to patients –

A. Yes.

Q. But that wasn't commonly done?

A. Yes. It wasn't a practice that everyone done, in the same way when you were sitting in with various consultants at uro-oncology clinics, people work differently. Some people wrote down the majority of the consultation; others would have dictated that immediately after the consultation. So, people practised differently, but you had to be in the room to know what the practice was.

Q. I guess that's my point. Do you think it is important that patients do get a copy of their letter, is a more direct way of –

A. They are one of the main members of the team that's making the decision, they have to be engaged in it. Any virtual clinics that I am doing, they will get a copy of that letter.

How readily are patients in the Trust perceived by staff as being one of the main members of the care team?

Q. Do you feel that when you do raise concerns around that or any aspect, do you feel it should be the case that it’s fed back down, if I can put it that way; that you are told, even in broad terms, of any learning from that?

A. Yes. I think it's part of the process; the process is cyclical. If it doesn't come back round and you don't know what happened, it's sort of -- it defeats the purpose, I think, because learning -- it's all about learning and being transparent and knowing what happened.

Q. Just on that point, there has been talk about the SAIs obviously yesterday. Was there any formal learning identified for the CNSes as a result of those, for example, nine SAIs?

A. I think, as I said, comparing the CNS role in terms of key worker then to now, absolutely. It's a more robust system, it's a more proactive system. There is now a person within Cancer Services that is in charge of audit, and they would send us a retrospective list at the end of every month of all the new diagnoses from that month. We appoint a CNS each month to cross-check that with the key worker activity so we can identify if indeed any patient doesn't have a key worker and rectify that.

An example of learning and action from SAIs being effective – such examples could be shared regularly throughout the Trust to evidence the value of a learning culture.

'we want to create a more restorative learning culture moving forward. I think for me the importance of establishing and addressing risk to prevent any harm, and how that has to be done robustly, cannot be understated how important that is. If that's managed well and robustly, then you can potentially then come to an agreement as to how to address issues and manage issues in a structured formal way but maybe not necessarily through, you know, formal sanctions'

Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT?

Q. Another issue which has come through really in most of the MHPS witnesses was around a certain lack of transparency at the time that that happened. What I am talking about is nobody really knew much about the Oversight Committee; they weren't really sure what happened when matters were escalated up and senior people were talking about it. I think in your statement, you've emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing. I think the training that we have just rolled out has very much covered that in terms of making people aware of what the Oversight is, what the purpose of it is and what it's all about. But yeah, I think it's a journey about embedding some of that culture and some of those messages right across the organisation.

'Q. You have emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing.'

What measures are in place to test the current position in relation to transparency, fairness, and openness? How frequently is this audited?

Q. "What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?" And you say: "I do not think that management take concerns seriously within the Trust and often fail to act or do not communicate that they have done so. I have previously raised, for example, in regard to the duplicity" - is that duplication –

A. Yeah.

Q. - "of investigations and that hasn't been acted upon. When one raises an issue, usually a response is not received. "35.2. Many issues I raised in regard to radiological practice through the Radiology Clinical Director and the Radiology Service Manager which are not specifically neurological are not addressed by managers and opportunities for the improvement of patient care and efficiency are lost." You give examples of SPA entitlement for service improvements, and teaching. "Such issues are raised infrequently as I do not think time raising them is not well spent." Then at 35.3 you say: "There is scope for improvement in radiological practice. Managers need to acknowledge each and every issue raised with them and state how best the issue could be dealt with, rather than appearing not to engage at all." You finish by saying, "Areas of improvement should be discussed with clinical and nonclinical managers and a plan made to make improvements to the service." Does that reflect your experience over 15 or so years, doctor, that you are articulate in raising concerns from time to time about issues affecting your own practice, your service and its impact potentially on patients, but you seem a little despondent that the culture generally doesn't seem to direct responses by to you?

A. I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to. I tend to find that, in the Southern Trust, I think there are so many big issues, major issues, that managers are probably dealing with many of these in their limited time, particular clinical managers, the limited time for managers are dealing with these things. So, things that I raise that are comparatively minor are probably just ignored, because there's no time to deal with them. I think that's probably what happens.

Q. Apart from giving you responses, can you think of any ways, any vehicles, any structures that aren't currently in place that might, with little effort and little resources, be put in place to improve things?

A. I think the problem is that we have -- the supporting professional activities, which as you probably know, is part of the job plan or things other than clinical work, of which it's kind of recognised that 1.5 is the minimum, and that's really for personal revalidation and, more recently, is supposed to include some teaching, but it doesn't include service improvement. I think the Trust is very unwilling to give individual consultants additional SPA time for managing a service. So, any improvements that you wanted to do a service you would do in our own time. I don't think there's been -- there hasn't been much encouragement to give consultants additional time, certainly in radiology anyway.

‘I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to’

What plans are in place to address lack of engagement and to boost staff morale by underlining the importance of listening and communicating clearly?

Q. Even so, you said a few things that indicate that the relationship with management, as you call it, wasn't fantastic. Who do you regard as management? Who is management? Do you mean the service administrators and people down that end? Do you mean the senior management of the hospital?

A. Well, the service administrators and then up to Katherine Robinson. Yes, that is who I see as my management.

Q. And that is where you feel that it wasn't very helpful. Do you think the Trust as a whole creates an atmosphere where all the staff feel valued?

A. Not particularly, no.

Q. Why do you feel that? What do you think the source of that is? I am sure they wouldn't set out to be like that.

A. I don't know how to describe or why it has went that way. I think everybody is just running about chasing their tail and nobody has time for anybody.

'Q. Do you think the Trust creates an atmosphere where all the staff feel valued?

A. Not particularly, no. I think everybody is just running about chasing their tail and nobody has time for anybody.'

Think about the importance of and how to 'be present and available' in interactions with staff amidst a busy workload.

……

A. The issues of changing the behaviour of the consultant team to meet the required new-to-review ration of patients, and new clinic templates in Outpatient clinics to increase the day case rate and lower the inpatient elective workload and to meet the BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the the requirements for change tailored to each individual's practice.

A. You expect people working in the Health Service to automatically understand about safety and to learn whenever there are processes going on which are not in the best interests of patients as seen by most of the world. So, it is difficult managing somebody who has a view that whatever they are doing is the safest thing, despite the rest of the world disagreeing with that.

Are there any current areas in the Trust where there are difficulties in bringing about behaviour change?

A. I think the journey that we were on in terms of embedding the culture of if an incident occurs, recognise it as an incident, discuss it, report, let's learn from it.

Q. Yes.

A. That learning process, and making sure that the culture was around learning from an incident as opposed to let's hide it, we don't want to know about it or own up to it, that journey of opening the culture was a journey in progress. That's a really, really important organisational journey. That's what

the core thrust of the corporate review of clinical and social care governance was about. I am sure you have heard about that and seen the documents around that. That was absolutely the core of what we were seeking to do. As you well know, it takes a long time to change a system. That required all of the staff working day in, day out in the wards and Outpatients in every which part of the hospital to embrace that culture, to recognise. I mean, there were still times when a senior leader, a senior clinician would come to me and say, 'by the way, I quietly want to tell you this has been happening for a long time, nobody has been prepared to own up to it but did you know', and you go gulp, deep breath time, 'right, what do we need to do'? So that's –

'The journey of opening the culture was a journey in progress' – post Inquiry, what does 'opening the culture' require at this stage?

- 'There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame.

- Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed?

A. An impression I formed, and information that other people gave me as well.

Q. Yes.

A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, it was very, very plain. I was bullied to within an inch...

- At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands.

- I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place

- Eamon Mackle told me they were drawing bets of how long I would last'

This narrative is now in the public domain and can be interpreted in several ways. The SLT may need to address the themes that are raised on two fronts – for the staff in the Trust and for patients, carers, and the public interface?

Q. Can I ask you this: Was it your sense that by the end of your time in the Acute Directorate, governance, in terms of its capacity and resourcing, was in a better place than what you found at the beginning, or was it treading water?

A. Ever so slightly. Every so -- well, we treaded water for a long time. It was ever so slightly better but, to be honest, whenever I left, anything was the last thing from my mind so I didn't even think about governance when I was going away. I was looking forward very much to working with Patricia Kingsnorth because she, to me, had exactly the same idea and I knew I could -- we could have -- and she was very proactive in Maternity. So, it was slightly better. Certainly the language that I used in my meetings about governance being important, and trying to bring on board. But, as I said to you before, you know, the culture was performance, performance, performance, and I don't know that I did very much to change that as an individual.

'The culture of the Southern Trust when I joined was performance, very much performance driven'

How would the SLT describe the current culture?

'There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so'

How can team working be enhanced in the Trust?

The biggest thing that was maybe just pie in the sky for me was changing the culture in relation to governance. Culture eats strategy for breakfast. If you are going to ask me what I learnt, that's the biggest thing.

'Culture eats strategy for breakfast'

Has the SLT adopted the priority of establishing a constructive and empowering cultural lens before delivering the detail of forthcoming strategy?

A. I believe in terms of communication, there were silos. In terms of management that would have been above me, people didn't necessarily follow their roles and responsibilities. That was actually a trend right across, and I would say that to you. Roles and responsibilities, for me, is every bit as important as following up a procedure. I need to know what my role is but I also need to know what your role is so that we don't overlap or I don't do your job, causing conflict and concern. There was an awful lot of dissatisfaction in that. I believe it's because people didn't know what their roles and responsibilities were and they just did whatever they thought on the day.

Q. Where do you see the responsibility for fixing that as lying?

A. Well, whenever it's a culture, it's very, very, very difficult to fix. It would needed to have come corporately from the top on down. It would needed to have been -- you see, you can't make somebody do something unless they believe it's right to do. You know, me making people believe, from my very, very small part I discussed it, discussed the importance of -- and it's not even hierarchy, it is just communication lines. I didn't mind talking to whoever in the canteen or whatever, but as long as the information that needed to be passed up and down went through the proper lines.

Recognising the key role of good communication flow throughout the Trust as a tool in changing the culture.

Q. -- the understanding of what is to be done. I mean, does that -- I mean, looking back on it, do you think these what might be described as teething problems or difficulties were just inevitable, or was there training shortcomings in how the Trust went about it?

A. I don't think -- I don't recall the detail, to be honest, of the training and the rollouts. What my -- what I recall was, we were at a time when, you know, for example, 2014, Francis was -- they were accepting the Duty of Candour and it was so broad -- we still haven't got it in Northern Ireland! So, like, we were at a zero or minus starting point, so we were, like, building our culture. And it was very similar to the challenges that you faced at the start of the performance culture. And while people said the, you know, the written IR1s, you know, went into a black hole, that was great when they could say that. When it was popping up on their e-mail that they had an IR1 notification and needed to do something with it, clearly history tells us, for example, in 2014 there was a backlog of unopened IR1s! So it didn't change the -- it takes time to change their actions and their responses. You can put in all the systems you want, but you have to build a culture where -- and I think it was just very early in those days and it was very early in Northern Ireland as well -- across the UK because Francis was only just coming out and, if you look back now -- if you look at it with a 2023 lens, it's

completely different. But that was a different time and we were learning different things, so I think -- I don't think that -- I honestly can't tell you the detail that went into the rollout. I mean, certainly we were writing -- "writing" is the wrong word. We were producing 450 IR1s a month across Acute in 2014 when I look at the reports, so I don't think we had any -- we didn't have -- obviously, the quality of those and what they were reporting, you could dive into that. But I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?". And you can put in the system, but it doesn't necessarily mean that people are going to change their role and responsibility and how they view it.

'I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?".

'A. It demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities.'

Is the current messaging in the Trust consistent, empowering and across the board when it comes to the requirement of a clinician's individual responsibility, accountability, and action?

Q. And recommendation 4 related to the use of timely discharge letters?

A. Yeah.

Q. And she makes the point in 3 and 4 -- this is page 10: "We are relying on people to do the right thing, which is the weakest safety net..." -- and she asks the question: "Did the team consider anything stronger in terms of making sure this didn't happen again?" So, for example, alerts for unread Radiology reports/ monitoring of discharge letter performance. So at least one of those aspects, the Radiology is something, as I say, you were familiar with and the Inquiry is by now familiar with the history of that through a number of incidents and with a number of patients. Are you able to assist us at all -- I know the final report was signed off in August, you weren't there, but was there any attempt in your time to correct those two issues in the context of this case?

A. No, because, as far as I was concerned, we hadn't got the right conclusions yet, and you have to get the clinicians to own the conclusions. So I can't implement things like -- I can't -- you could -- you could try and tell them to do something about unread Radiology reports, but they would have to accept that and then go and do it. Monitoring of discharge letter performance is interesting and I think the concept of how much -- these are senior people, these are senior clinicians. Telling a patient -- telling a GP how their patient is doing and what's happening with them is probably, in my book, quite basic. Do you need me to check that you are doing that? At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"? And I guess these are senior people, they're senior clinicians, this is in the best interest of that patient in front of them and -- yeah.

Q. I suppose, what you're putting your finger on is the extent to which the organisation can afford to place certain issues on trust by reference to professional obligations?

A. Yeah.

'At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"?'

How is the SLT building this narrative into current culture?

Q. You also mention that there needs to be a clear management structure as there's no line of accountability for clinicians?

A. Yes.

Q. Would it be more that there is a line of accountability but that it wasn't actioned properly?

A. There was -- yeah, that's a fair point and I suppose listening to Mrs. Burns yesterday too, it was interested to hear that at that stage they were only all new and they weren't used to the challenge part of it. But I suppose it's something to ask the clinicians but I don't ever think they considered the clinical end as their managers. It was more to do with, you know -- like they nearly seen me not as their manager as such but as part of the team. I was the go-to person as opposed to, you know -- now, their job plans and their appraisals, etc., etc., I couldn't have become involved in and they would have pulled other people. I just think there's that disconnect for the clinicians, albeit the people who are in post, they don't seem to go to them.

How is the SLT addressing the ongoing need to facilitate a culture within the Trust based on respect for the different roles and responsibilities of all employees in the Trust in the delivery of quality care and patient safety?

.....

Q. And a lot of the things you mention are the outworking of clinical governance, the end product, coroners and medical negligence, civil claims, learning from perhaps the wrong end of the telescope. Do you consider that there is -- well, what part do you think that culture in a place has to play in both the triggering of governance and the effectiveness of any action taken?

A. I'm going to answer the -- in answering the question it's quite complicated, but in 2018/19 in Belfast, I brought in a system based around the measurement and monitoring of safety, and it was based on a document written by the Health Foundation in 2013 by Charles Vincent. And basically, it turns your organisation into a problem sensing organisation, where you ask really profound questions, like: Are you safe today? Are your systems reliable? Are you learning from past harm? Are you looking forward to see where there's going to be issues? And we've adopted that in Belfast as a way of thinking and about how we problem sense, and I think that you're right, you have to learn it from harm, but it is - it tends to be reactive. What we try to do is shift that thinking into how can we make sure we're safe today? So the out-workings of that are daily safety huddles, right the way up to executive team, ehm, weekly huddles where divisional teams come together and they review all their safety data from the previous week and look to, you know, is there any immediate learning? Is there anything that needs to be raised as a concern?

Because I think I said earlier on, at the heart of any safe system is staff feeling safe to raise concerns and be open, and be open when things go wrong, and when things do go wrong, that they will feel safe and that they won't feel that they're going to be blamed. Because we're all human, we all make mistakes, and it's important that we accept and acknowledge that we will make mistakes. But it's how we learn from it. And I think how we make our clinical governance even better is how we focus on how we learn, because that can be difficult sometimes to make sure that you put systems in place that engineer a change.

On a scale of 1 to 10 what is the SLT's estimate of where the Southern Trust is at in terms of it being 'a problem sensing organisation'? How can this approach be fully interpreted and applied across the Trust?

Q. Now, you spoke to Mr. O'Brien and he mentioned that he had discussed this case with a urologist in the United States of America. I don't suppose you remember the name of the urologist?

A. No, but his response stuck in my mind. Because, you know, I remember asking him and I remember him saying somebody else had raised this as an issue and he had spoken to somebody in the United States of America who said in the circumstances it was a reasonable course of action.

Q. And he didn't say who the other person was who had also perhaps shared your views, who had expressed the same view?

A. No. I mean, I think that, I suppose I felt brave challenging him and I got an explanation back which was, it was difficult to argue with.

Q. And you don't recall - you can't say whether you spoke to Mr. Young about this issue or not? You just don't recall?

A. So, undoubtedly, you know, because of the joint ward rounds, I would have expected that Mr. Young would have been aware of some of these patients. And when I did raise concerns with Mr. Young, as I've said in my statement, his response was "That's just Aidan".

Q. And what did you take that to mean when he said that?

A. It's hard to know how to interpret it. But I felt I was speaking to another consultant and raising an issue and that was the response. And, again, you look back and you think 'I'm a second year trainee, I don't know everything about urology, I'm working with senior consultants, maybe they think this is acceptable'.

The importance of addressing the cultural power imprint/imbalance in clinical teams, particularly in terms of delivering safe patient care.

Q. And do you think that the culture within an organisation and within departments, and even within clinics, has a part to play on whether people feel comfortable raising governance issues?

A. I do. Yeah, I do. And I think looking back, you know, when I think when I arrived here from London I didn't know anybody here, I was very, you know, not quite isolated, but certainly didn't know how things worked. So that takes a while to get - not just to understand the governance structures, but also to understand exactly, as you say, the culture. Just coming in from it cold, it takes a while to understand the culture.

Q. And the two parts of that maybe are the confidence of the person who needs to speak about something and also a listening ear or a willing recipient of that information?

A. Yes, both of those things, exactly, yeah.

Q. What would make it easier, in your view, for junior colleagues, or indeed any colleagues, to raise concerns such as this?

A. Yeah, I think first of all, it is a culture where everything gets discussed in a friendly, non-confrontational manner, and essentially just leading from the front as a more senior consultant now, I certainly would encourage open discussion in our peer chats when we're discussing patients, and we

try not to have a hierarchical approach to that, but we do bring -- I have a lot of experience now, so I bring that to the table. But we really try and create a culture where junior members of staff feel empowered, and that's really just by having a friendly attitude to how we operate.

Q. And have you had to talk to colleagues over the years informally about issues maybe just that you needed clarity on or were concerned about? Have you had experience of that?

A. Sure. Certainly as Clinical Director that would be a weekly occurrence, yeah.

Q. And as Clinical Director, is that something that, in your experience, has brought about the necessary change, or have you had to then instigate formal governance processes?

A. There have been occasions where formal governance processes were required. But as I say, for the most part a more informal discussion solved a lot of things.

The importance of senior consultants 'leading from the front' in developing a friendly, non-confrontational tone in open and transparent discussions. Establishing a culture of listening and empowerment of junior staff.

Q. Do you think it should be mandatory that patients are copied in to all letters?

A. I think that's becoming the culture now. I have some issues regarding certain circumstances, especially where the patient has got very short survival who don't want to know about that.

Q. Yes.

A. So there are some challenges. But overall, yes, I think patients, and patients, with the new IT systems coming, will have full access to their health records. So I strongly support that.

Q. What do you think the barriers to that have been?

A. I think cultural and paternalistic approach to medicine over the years. "Doctor knows right".

One practical way of moving the provision of medical care on from a paternalistic approach will be to provide patients access through IT, to their medical notes and copying them in to the letters relating to their care.

……

Q. Moving on from that point and looking at your experience as a total, in all of your experience as a Consultant Urologist, is it your view that the culture within an organisation and the way in which people communicate within that culture can have an impact on Clinical Governance, either positively or negatively?

A. It can have, as a person from outside, a negative effect on the Clinical Governance. There is no doubt about it that if you don't take all the people onboard before deciding or making decisions or providing resources effectively, certainly it will have some effect.

Is the SLT aware of any current areas within the Trust where staff feel they are not onboard with the decision-making process in their area of practice?

Q. So when you met at the beginning of January 2017 as a team, and you were told about the exclusion of Aidan O'Brien, and you describe the shock you had at that meeting, and I can well understand that. What were you told as a team about who you could talk to about it and where you could get support with the Department and so on? Who dealt with that with you?

A. Nobody.

Q. Who do you think should have, apart from you wanted a senior medical presence there, which I understand, but you know, who did you regard as your first medical manager go-to person for something like this? Because this is a huge deal for a department.

A. Yes, I agree. I think the first port of call should have been the CD.

Q. So did you feel you could go to your CD?

A. No, the CD was in the middle of the issue, and that wasn't offered? It wasn't. Neither were any other support services within the Trust offered. I've had a subsequent experience, not a pleasant experience, where I was sign posted by Dr. O'Kane, as it happened, to psychology. It was an unrelated thing to what's going on in this Inquiry. And that was useful, probably would have been useful back in 2017. But there wasn't any support put in place for us as a team.

Q. Did you feel you could talk to the other members of the team about it or did you feel it was all totally secret?

A. We would have had chats informally amongst ourselves as to how we were going to organise things and get on with sorting things out. There wasn't really any safe space created for us to vent, because I think some of us

Q. As it went through, I mean this unfolded and, as you know, it all took a very long time to sort out. Did anybody update you as a team? Did they bring you back together and say "This is what's happening now", or did they bring you together with Aidan O'Brien in any way?

A. No.

Q. No. Did you feel you could go and talk to him about it?

A. No, I felt that was very difficult. The period of 2017 was extremely difficult, and perhaps a few years later he would have come to me to talk about clinical matters and he would have sought my opinion about cases. But, again, I felt there was a really big barrier to us discussing other things.

'There wasn't really any safe space created for us to vent'

Is there easy access to support for staff members who are experiencing a stressful situation and needing a safe space to explore the issues?

Q. I get the impression from the totality of your evidence that, well, you did actually say that there wasn't a collegiate way of working. Has that improved?

A. Yes, I think it has, and I think in particular at the MDT it has improved, but I think it's also improved within the consultant body, the junior doctor body, and the nurse specialists that we work with. I think the atmosphere in the Department is better than it was before. So, I think we're in a better place as a team now than we were two years ago.

Q. And if you had to say why that was, I mean obviously this Inquiry being set up, all of the attendant SAIs and everything, I'm sure, as Dr. Swart has said, was very traumatic for the team. Is that sort of out of adversity comes improvement, or what would you say?

A. I think, you know, many of the things that have been identified correctly by others, to give them their credit, Dr. Hughes, others, we've taken that on board and we've implemented the changes and we realise, as a team, that we're in a safer, better environment than we were before. So that gives us

all a sense of achievement in terms of we've turned things around. But also we realise that we're all in it together, we're all pulling in the same direction. And I think that's what has allowed us to move on.

How can the SLT share this positive narrative now in the Trust?

Q. In that respect. As we observed this morning, Dr. Simpson, towards the start of your tenure as Medical Director, you were, I suppose in the context of Dr. Aminu's case that we looked at, you're furrowing your brow and saying, looks like there's a professional clinical governance issuing within urology, and, as you explained this morning, you were seeing that in other places as well. That was an issue in 2011. Fast forward to 2015 and issues that you think you should have known about, should have been brought to your attention because they were unresolved, weren't making it to you. Does that suggest perhaps that, at least within urology, the culture of not disseminating, not communicating, not escalating hadn't really changed that much?

A. That's quite possible. It's difficult to change culture. I would have seen that, I think, in the context of Craigavon Hospital generally going right back to 1992, when Craigavon was its own Trust of the 17 Trusts, which was never a good idea, separate from the community, separate from Daisy Hill. My instinct, both as a consultant starting in 1992 and then Medical Director 2011, was there was that sense of elitism that really might have been partially justified but is not best -- it's not well disposed to, you know, proper clinical governance. For by MHPS, GMC and so forth, the way to deal with these things at the coal face. Healthy teams keep each other right and they set the right culture. It's not reasonable, you know, to expect any clinician of any stripe to be at their best for 30 years. You know, performance will wax and wane, the team should compensate for that. Where they can't compensate, that's the time to escalate. Teams can't compensate whenever the clinician is not working with them. If that keeps going up the chain, then it is clear that by the time it reaches any medical director, then you know there's a much larger problem.

‘Healthy teams keep each other right and they set the right culture. It's not reasonable, you know, to expect any clinician of any stripe to be at their best for 30 years. You know, performance will wax and wane, the team should compensate for that. Where they can't compensate, that's the time to escalate’

Is this a reasonable statement? It reinforces the importance of maintaining a healthy team environment.

Q. As I proceed through today, I'm not going to bring you to every case where there's perhaps an argument that the case could go back. I think the issues may be important on a general level. It reflects, perhaps, an approach to medicine that, I think as you indicated at the start, is not ideal and perhaps now frowned upon in terms of particularly urology; that's our focus, but perhaps more generally. Clinicians, in order to offer their patient the best quality of treatment, need to relinquish ownership of the cases and follow, if you like, the rules of the MDT?

A. Yes. I'm not sure "rules" is quite -- I think "advice" is a better word for MDTs. But yes, collaborative working clearly is preferable to working in isolation, especially these days where the complexity of the treatments that we can offer patients is increasing. But, on the other hand, you know, a sort of counter view is that the patients, especially in urology that we look after, are getting older and more frail. It is not unusual now to look after patients over the age of 100 years. You will often find that what the MDT, in the absence of the patient or the patient's family, will offer standard therapy when, in reality, you need to tailor that treatment to what this patient, individual patient, needs, and the individual clinician who takes overall responsibility for that patient, the urologist who is going to be sued when

the patient puts in a claim of negligence, it wouldn't be the nurse and it wouldn't usually be or the radiotherapist, the radiologist or the pathologist, it is the consultant surgeon, urologist. So you have to have flexibility between MDT advice, which is often regarded as best practice, and then you need clinical freedom to make the right decision for the right patient and then take medicolegal responsibility for that. So, you have to defend what you've done. If what you've done is counter to what the MDTs has advised, then you are taking an individual risk for yourself if you do that. There are plenty of situations where the sensible thing to do is not do what the MDT says but to do what the patient would like.

'Collaborative working clearly is preferable to working in isolation, especially these days where the complexity of the treatments that we can offer patients is increasing'

Is the SLT aware of any consultant currently of whom it could be said 'works in isolation'? How is this being addressed?

Q. One other thing just in relation to -- we were talking about actioning scans. Would you accept that if the waiting lists are long and a review appointment cannot be held as soon as the clinician would like them to be, it is more incumbent upon the clinician to check scans as soon as they come back, or results as soon as they come back?

A. Yes, I mean, ideally what we need is a joined-up electronic system. The technology is there now to do remote consultations, order scans online, look at the results online and, you know, action urgent cases, you know, literally within a few days. It could be done but the problem is that we're dealing with such an overloaded system. It is quite hard to change things within the system because doctors are brought up to do things in a certain way. We were all brought up in the sort of paper era where we had to have the notes and the patient in front of us, but now suddenly all these things can be done online. You can see that there are all sorts of issues. Dealing with the very senior surgeons in the department can be the trickiest issue, really. It is hard to get them to change.

'It is quite hard to change things within the system because doctors are brought up to do things in a certain way.

Dealing with the very senior surgeons in the department can be the trickiest issue, really. It is hard to get them to change.'

Given that evidence-based change can be a challenge – how is the SLT addressing this challenge and is progress being monitored with regard to this 'trickiest issue' amongst senior clinicians?

……..

Q. I suppose when the Inquiry is reflecting about issues such as this, it sees the potential for patient harm and it sees that colleagues in the team are aware of the problem. And on your account it is put into the "too difficult to challenge" box and the problem goes on. And you have expressed it, perhaps, on understandable human terms, I'm the junior consultant, he's the senior, it's difficult. But reflecting on that, and we can look at other issues where that seems to be the explanation for the behaviours, it's not good enough, would you agree, and, secondly, is that -- is these kinds of behaviours, can they be cured, can the culture be changed?

A. Certainly it's not good enough. On reflection I probably would -- if I was in the same situation now I probably would and with another colleague I probably wouldn't let it continue, I would certainly act on it. Can it be changed? You are probably trying to change a personality to some extent. I don't know what Mr. O'Brien did earlier on in his career. I don't know whether he dictated letters in those days, I

don't know. But, certainly, it shouldn't have been left to go on. It shouldn't have been left to fester, as you said.

Q. Your options, you are on, I suppose, the receiving end of these behaviours and your patient is. You are facing into the frustration of not knowing what's going on with this patient and having to dig a bit around the edges to come up with a viable plan. Your option, having faced into this issue, maybe across a number of patients, is to speak to Mr. Young, the clinical lead, or perhaps the Clinical Director, Mr. Brown and/or to complete an incident report. It would merit an incident report, do you think?

A. Absolutely, it would have. I certainly should have taken more action -- I should have taken any action, I should have taken action on the matter because it is a risk and I hold my hands up, I should have acted on it.

Q. For fear that you may think I'm beating up on you, I asked Mr. Haynes -- Mr. Haynes was aware of the example I drew to your attention, Patient 103, he didn't raise an incident report on that. He dealt with it by way of airing his frustrations with Mrs. Corrigan, so that the issue was known about but it wasn't put on that formal footing of an incident report?

A. And I think I probably would have aired it as well and I would have talked about it but didn't do anything formally about it.

'Are these kinds of behaviours, can they be cured, can the culture be changed?'

How can the SLT present this Inquiry discussion to the Trust's workforce in such a way so as to empower individual staff to address this challenge when they come across it and to emphasis the risk to patient safety and care when it is not addressed?

4. Communication

Mr O'Brien's case has been referred to the GMC.

When the GMC give their conclusion, think through the comms that will be required for the Trust, patients and their families and the public.

Q. Going forward, you know, if you have to do all of this again, apart from the things we have already talked about, what do you think the key learning for you personally from this is, from that whole dynamic?

A. In terms of my learning, is around the importance of communication with all the stakeholders from the very get-go. And that, if you do use and apply the policy properly from the get-go, it has the potential to work.

Highlighting the key role of clear communication with all stakeholders from the start and continuing through processes and clinical practice to delivery. How is this being evaluated currently and how recently were any adjustments made?

As a SMT, think through how to support regular messaging to all the Trust stakeholders – making sure that it provides an accurate, constructive and empowering narrative.

With the comms you have currently in place – is it keeping your staff engaged, supported and valued?

How does the Trust capture the morale of its staff?

……

Q. I want to ask this. Are you clear that, notwithstanding the conclusion of the investigation and the issuing of the determination in the autumn of 2018, that Mr. O'Brien was clear and there was clear communication to him that he remained subject of a monitoring arrangement?

A. Okay. There was no clear communication to him that it was to continue. I accept that. Nor was there communication with him to say that it had stopped either.

Q. In circumstances, and we'll come on to look at this now, where the organisation wasn't able, or felt itself unable to proceed with the outworkings of the determination, would you agree that, upon reflection, clear communication around these issues was important given the particular patient-related context that you were dealing with?

A. Yes. When you go back over it all I would not dispute that at all. I would completely agree with that.

Note the importance of clear communication and understanding – when this is poor, the standards for patient safety can be significantly affected.

……..

Q. You have mentioned about a concern that red flag referrals are prioritised and there is a danger that because of that, routine referrals are getting longer and longer with a concern that people are becoming more unwell, having originally been maybe allocated as routine?

A. Yeah.

Q. What's the situation with that now? Do you have any knowledge about how those people are moving along?

A. I think there's still an issue.

Q. Still a backlog?

A. Yes.

Q. But it's your evidence to the Inquiry that if there was that capacity in the CNS, that there would be greater movement along the journey for those patients?

A. Yes. It could only be a positive thing

What interim communication steps for engagement are operating with the lengthy waiting lists in the Trust?

Q. The note of the SAI indicates that the problem was with the clinical nurse specialist, that Mr. O'Brien had expressed concern about that, and the note reflects that he didn't understand the role of a nurse specialist. Just in relation to that SAI meeting note, does that properly in your view capture what you meant?

A. No. I have been misquoted. I've been -- I have been misrepresented.

Q. Well, what did you say and what message were you trying to impart to Dr. Hughes?

A. So, I would have said very similar to what I said in my Section 21. Aidan would have been very particular in his use of language and words, and I think it was just the "key worker" word that he didn't like. It's not -- I don't for one minute think he didn't understand what a key worker was, or indeed

what a CNS was and what my role was, he absolutely did. I believe he did value that role. It's just he could have been very specific about his use of words and language and phrases.

Clarity around language and terminology used throughout the Trust will bring better cohesiveness and messaging.

Q. You have also been on this Task and Finish group. What have you personally learned from being on that?

A. There's a lot of wheels in motion.

Q. Yeah.

A. And sometimes the people on the ground don't get fed back to us as to where we are with things and what is happening.

Q. Because you mentioned a few things. Were the changes made quite quickly to start with? What was the pace? What was the feeling of that meeting; was there a sense of urgency? Or...

A. I feel people wanted stuff to happen more quickly but perhaps the resources weren't there to enable that. But there definitely was willing, whether there were resources as timely as there should have been.

Q. Whose job did you see it to unblock those resources; where did you see that?

A. I saw that happening at a higher level than me.

Q. Did they explain to you how that actually all worked –

A. No.

Q. -- or was that a mystery?

A. Mystery. It was not explained.

Q. Do you think that's right, do you think it should be a mystery?

A. I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions. Yes, I think that could be important, yeah.

Q. Did you and are you taking all of that learning back to these consultant meetings and trying to tell people what's happening? Because the nine SAI Task and Finish group, I mean it's a big deal, isn't it, and it ultimately was a big part of matters of this public inquiry. Did you see it as your role to come back and tell everyone what was going on and were people interested, or did it fizzle a bit? I just get a sense from you that it's fizzled slightly.

A. Yes, I think that would be a fair comment to make. I know I would have mentioned it within our small team in passing but certainly not formally. But some of the consultants are on that Task and Finish group as well.

'I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions'

Taking time to explain clearly a process will reap the benefits of better engagement with it.

Q. If I could summarise. Where the SAI was bemoaning this disconnect between one service and another where it was saying there was a lack of support for the MDT, the response to that has been to carve out a specific role focused on those issues, and that's what Mrs. Muldrew is addressing?

A. Yes.

Q. Where the SAI complained, or concluded, that there was virtually no audit, no monitoring of how this MDT was performing across a range of issues, the appointment of Mr. Quinn is dedicated to that concern?

A. Yes.

Q. Are there any early indications of how all of these changes are bedding down and whether you are yet in a position to say whether noticeable positive changes have arisen?

A. Well, there has been some positive change in that even from the NCAT audit that was carried out on all of the tumour sites with the Clinical Leads, the information that was clearly coming out was that there was no -- for MDT principles around how an MDT should be carried out. We are now developing an MDT principles document, which clearly sets out what's required of an MDT; things like an MDT pro forma that's to be completed to bring your patient for discussion, which brings a much better, you know, information awareness around the kind of things that were going to be discussed at MDT. It's a minimum data set to bring your patient forward for MDT. That's been developed also in partnership with the MDT leads and chairs. A communication policy as well, where there was a felt need that we needed a communication policy. So, responsibilities for each member involved in an MDT process for what they should be doing pre, during and post-MDT in terms of communication out to patients.

What stage is the development of the MDT principles document and the communication policy at?

Going forward post Inquiry, it would be very helpful to oversee the streamlining of language and terminology, values and principles of all the Trust documents.

Q. Do you think that the poor communication allowed problems to exist and persist, such as the ones that the Inquiry are looking at? Do you think the poor communication from Urology towards Cancer Services assisted in creating an environment where problems were not dealt with?

A. I suppose I have used a couple of examples here that I was aware of.

Q. Well, you were aware of the issues around Mr. O'Brien and triage from 2015, I think? Do you recall that?

A. Yes. In regard to red flag triage, yes.

Q. I know that's not one of the examples that you've referred to but if I go back to my initial question. When you saw those emails -- and I'll give the Panel the note for the emails. 2015-2016, referring to Mr. O'Brien, referring to triage, referring to referral, referring to the build-up of patients who were not coming through the system and representing a blockage to get through the care pathway. Did you think that the failure for that information to be properly communicated to you allowed problems to persist in Urology?

A. Probably, in hindsight, if it had have been more joined up communication, that everything was together, it probably would have dealt with things at a much earlier time.

Lack of clear communication adds to a confused picture, delay in understanding issues and taking the appropriate action to ensure patient safety and care.

A. I think there seems to be a bit of a disconnect in what governance inspired to do and what is actually happening. It is just not achievable to have that gold standard.

Q. One of your reflections as well is that management needs to engage more with the workload. Was that a disconnect as well?

A. Very much so, yes.

Q. What could they have done about it, do you think? What should they have done about it?

A. Well, I think they just started to strip away any support we had.

Q. This is on the administrative side?

A. Yes. So we started off with four, I think four audiotypists; we ended up with one, and we were just expected to work harder and harder.

Q. You have reflected in your statement at WIT-76358 that the move to the Breast Service, I suppose, has led to an improvement in your working environment and you find it to be a more effective service. What are the differences that you are observing from a position as a medical secretary in that service by contrast with the Urology Service?

A. It is basically the difference in day and night.

Q. Could you give us one example of how things work better and are better for patients because you're able to do your job as a secretary in a better way to work?

A. Because you had more time to do it, more time to check on things. We attend the MDT meetings so you are very much aware of the cases that are discussed at MDT and you follow it up. It is just a pleasure to work in compared to urology.

It would be helpful for the SLT to continually shape an appropriate and empowering narrative around the realistic expectations of the workforce as it deals with a demanding workload and stretched resources.

…….

The benefit of having the open door policy, having the senior clinicians dropping in and out, the benefit of walking the corridors, walking the wards and spending time with staff to listen. Now, not every member of staff would have opened up about things but many did. When you are walking around the hospital with a cup of tea in your hand, as I always did - it's one thing I haven't got here, is a cup of tea - a cup of tea in hand, it makes a deliberate statement, 'I want to have a chat'. I know people are busy and if you find there's something very serious to talk about, you come back and find a time to have that conversation.

Q. So visibility was a benefit in relationship building and confidence-building?

A. Very much so.

What steps can the SLT suggest to encourage all members of the senior team to become more ‘visible’ and for the SLT to lead by example?

Q. You have said that this was one of the best serious incident investigations you have been involved in. What was about it that made you say that?

A. From a family engagement. I suppose that was my big thing with SAIs, was the whole family engagement bit. The early learning being shared as well as we were going along, because that information was being drip-fed. I can see the restrictions with this SAI very clearly with the benefit of hindsight, but at the same time, I mean, we did look at a systems approach, this wasn't about finger-pointing. This was looking at our structures in place and that's why I feel that was a really good SAI. I think the intention of the staff involved in the Review Team and the commitment that was there, I mean everybody worked so hard. At the same time, that feedback to families, keeping them in the loop, keeping them informed, to me that was an example of good practice of how to do it from a family engagement point of view.

Can this approach be applied to all future SAI's in the Trust?

'Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you'

One of the main ways of bringing people with you is to ensure there is quality and frequency of communication. Some thought needs to be given to this.

Q. Another thing that you talked about, I think, was the admin review. Now, having read the MHPS determination and the substance of it, it's quite clear that people have interpreted that external admin review as different things.

A. Yeah.

Q. If you'd interpreted it at the time and you'd read the statement that there were managerial failings and there needed to be external review, what kind of review would you have envisaged that to be? I know you weren't in charge of it.

A. I think we would have looked broader at roles, remits, responsibility, governance, actions, escalations, evidence of a concern materialising into some process.

Q. Yes.

A. It would have been bigger than is there triage happening or whatever. It would have been literally a root-and-branch review of how our systems working, and have we got the right balance between operational busyness and governing our systems and ensuring the patient is safe in our care.

Q. That's I think how many people would have interpreted that. Why didn't that happen, do you think? What was responsible for that inaction?

A. I think a ball was dropped. There was a recommendation that appeared to look like it was belonging to Acute but, in actual fact, it never said it belonged to Acute. It said independent but it had Acute in the middle of it, so I think somebody thought an Acute will deal with that and it wasn't dealt with. I think also the sharing with the operational team, I know Mrs. Gishkori had it, but Ronan had no idea that there was implications for him as Assistant Director, even for, you know, some of the oversight. I think it's back to the sharing appropriately, even of what had started as confidential type processes.

Post Inquiry – it will be important to establish clear lines of communication for information flow and learning throughout the Trust. Also, to check that everyone has clearly defined roles and understands their responsibilities and accountability. Underpinning this will be the outlining of Trust values and principles and the strategic aims for the next five years.

……..

Q. We had a patient come to the Inquiry to give evidence, his name is Patient 84. You can see, if we just bring it up on the screen, PAT-000225, he directed a complaint to the Trust on 19th September 2016. Without going into all of the fine detail, this was a case where there were -- a complaint where there was a number of issues but primarily and at the heart of it it was a patient who had a stenting procedure. The stents had to be removed. The patient had been given the understanding that they would be removed by a certain date and that date moved and moved and moved until he got into some considerable medical difficulty, had to be admitted to hospital with infection, had to be re-admitted and was not, as you might expect, terribly happy with his treatment, leading to this complaint. And you were at that time responsible for managing or coordinating complaints and we can see, for example, PAT - well it's three pages further on at 228 - we can see that your first step, I suppose, is to send out what I take to be a pro forma kind of response which might be politely described as a holding response or an acknowledgment?

A. An acknowledgment of complaint, yes.

Q. Yes. This was one of these cases where you were unable to comply with the 20-day aspiration. A number of holding letters were issued over the following months, leading to a substantive response on 1st December. If we could have that up on the screen please, PAT-000231. That would have been signed off by Mrs. Gishkori. Now, if we scroll down through it. Just further on down, on to the next page perhaps. When this patient came to give evidence, and indeed in subsequent correspondence in response to this output, he took exception or he explained that he took exception to how his complaint had been dealt with and what was particularly sore with him was that his perception was of being made to feel guilty about complaining because - and he drew this or he was caused to feel this - because he was told that, in essence, the service is struggling to meet demands and cancer patients have to come first, if you like, and that's perhaps contained within that paragraph, commencing: "Mr. O'Brien confirms that ideally patients who have a stent inserted should have this removed and have this performed within four to six weeks later. However, the demand on the urology service is unrelenting, with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway." Just to show you how it was expressed by the patient when he came along to see us, if we go to TRA-00094. He came along at the opening week of the Inquiry and he says that, just scrolling down, he says: "Obviously, when they brought in the cancer patient stuff and, you know, while obviously I have sympathy with them life threatening conditions and things but that wasn't I suppose - you shouldn't be made to feel guilty." In other words, he took it as why are you complaining, there are people worse off than you. Did you draft the letter?

A. The information contained in the letter would have been a direct lift from the information provided by the service area. Having read that now again, I accept that the patient would be annoyed by the content of the letter and I am sorry for that. I can understand where the patient is coming from. I think the attempts to explain the pressures on the urology service have not been communicated as well as they maybe could have been.

Q. I suppose linguistically it's a difficult balancing act, you perhaps want to communicate something of an explanation as to why the treatment has been delayed?

A. Yes. Yes. And that explanation had been given to various other patients who were waiting as well.

Q. Yes. I think what you are acknowledging this morning is that, from his subjective perspective, it's understandable that he would feel annoyed?

A. Yes.

Q. And maybe there is a learning here in terms of how you convey the message?

A. Yes, exactly.

Treating each patient with dignity and respect includes attention to the quality of communication - a key component in delivering person-centred care.

……

Q. I'm sure it's just we all have different ways of speaking and it may be just your own particular verbal tick, but I was struck by the fact that you kept refer to "ideally" things would happen. You used it in connection when you were explaining the risk and benefit to document discussions with patients in the notes. You used the word "ideally" in that sense. But I`m sure that you would accept, would you not, that that is actually something basic rather than ideal?

A. Yes. I think the more that is written down now, the more important it is. You know, for example, the issue of consent. We just used to originally ask the patient to sign the form consent for a TURP, sign it, and go. Now you need a long explanation of what you've said to the patient and what they're committing themselves to. So, things are changing. The better the documentation, the better for the patient.

Q. The better for the patient and, arguably, for the surgeon also?

A. Yes.

Q. Because you have speculated about whether or not some of Mr. O'Brien's patients would not have wanted to travel to Belfast to get radiotherapy. We'll never know because it is not documented in some cases. Whether they would have wanted to retain their sexual function rather than have the particular androgen therapy; we again won't know because it is not documented. So while protecting the patient, it also protects the surgeon?

A. Yes, absolutely right. That's more and more important in an increasingly litigious society.

The importance of accurate documentation – not just driven what by ‘an increasingly litigious society’ but more importantly a record of the quality of communication, the accessible and full discussions and decision making that has taken place between the doctor and the patient.

Q. Then just a final question. This will be obvious to you but could you just make some comments on the value of cancer guidelines, cancer networks and so on in terms of standardising therapy to some degree and so thereby reducing inequality, you know, between the wealthiest, the poorest, the best informed, the worst informed. What have you seen in terms of answers to that. Do you have any comments?

A. I do. They're very helpful. I think that guidelines are guidelines, they're not rules, they're not mandatory. They help us make decisions because, in the end, as I've said several times today, that the patient's choice has to be preeminent, guided by the clinician who understands the patient and patient's family and takes into account guidelines as well as the view of the MDT. So all of these things need to be put into the mix to end up with a patient who is happy with what's being recommended and what treatment is being given to him. Guidelines are very important. I think we're lucky to live in a country where such good guidelines are produced and constantly updated in such an admirable way.

‘The patient's choice has to be preeminent, guided by the clinician who understands the patient and patient's family and takes into account guidelines as well as the view of the MDT. So all of these things

need to be put into the mix to end up with a patient who is happy with what's being recommended and what treatment is being given to him'

How strongly is this message reinforced in the Trust today? Could this quote from Professor Kirby be included on the Trust website?

…….

Q. Now, in terms of your management role, and you helpfully tried to describe it for us on the last occasion, and, indeed, when we were asking Dr. Simpson about the role of clinical lead, he had it might be described as a degree of sympathy for the role. It wasn't particularly well defined, there being no job description, et cetera. When it came to March of 2016, Mr. O'Brien is handed a letter in a meeting which he was asked to attend with Mrs. Corrigan and Mr. Mackle. You knew nothing about that meeting, is that right?

A. Correct. I didn't know about that meeting or a letter or anything had been undertaken. I wasn't part of that process and didn't hear about that until afterwards.

Q. Perhaps that is a reflection of how others perceived the role of clinical lead, that you were kept out of that loop. Would it have been helpful, given what was being asked of you in terms of trying to manage the triage issue, for you to have been appraised of the fact that this process was starting?

A. It may have been advantageous. I had been involved before, helped out, it hadn't worked, it was needing a higher level of input to make it get sorted out. Whether I should have been appraised of it or not or at least know about it is a question, but I wasn't.

Q. Clearly you weren't. But the Inquiry will have to reflect upon how management works, how it did work in this situation, or how it failed to work and whether any lessons are to be drawn from it. So you're cast in the role of clinical lead. We can see not infrequently people are rapping your door to ask you to help out to try to resolve, to take this example, triage. They meet with Mr. O'Brien to discuss triage, amongst other issues, and you are not advised that this process is happening. How can the management of that kind of scenario be improved for the future?

A. It would be improved by involving the full team in the situation, yes. I think I probably should have been at least informed of what was going on.

The importance of clear communication and collaboration across the management and clinical lines of the service when dealing with an issue that straddles both.

Veryan Richards

19/01/2024

Themes and considerations for the Southern Trust Senior Leadership Team

This document:

- is a streamlined version of several papers presented at the Southern Trust External Reference Group meetings 2023/2024 covering the court transcripts of the Northern Ireland Urology Public Inquiry

- provides context to the 'USI learning – 19th January' document

- can be used as a reference tool and contribute to the development of a new vision and strategy

Note – The Inquiry has raised points of learning, observation, and challenge during the Public Inquiry Court hearings. These points are grouped into themes, accompanied by the relevant court transcript text giving rise to some questions and comments for consideration (some points were raised several times and are included to demonstrate some of the common themes)

Structure

1. Leadership and Governance - Tracking, clinical decision-making, and audit; Quorate; Job description, appraisal, and handover; Trust Board; Silo mentality – segregation operationally as opposed to integrated working; Priorities; Training; MHPS; Oversight Group; Management; Trust Improvements.

2. Quality and patient safety

3. Culture and behaviour

4. Communication

1. Leadership and Governance

Tracking, clinical decision-making and audit

A. Trust lacks an effective system to manage and track the administrative working of clinical decision making. Nobody could be assured that the service was being delivered safely in the absence of tracking and audit.

This also applies to monitoring the delivery of quality care. There are weaknesses in both the governance of the organisation and in elements of clinical care

There is a need for better tracking – the role of co-ordinators.

Trusts failure to carry out some of the recommendations from the March 2017 investigation

Is this still the case?

A. Clinical audit was not a strong feature in the Southern Trust. The line of sight from the Boardroom to the bedside should be clear in a high functioning system – this was not the case in Urology

A. We did not have consistency in the team – one reason for missing things

Is there a robust system now for the learning from SAI's to be monitored and actioned?

A. Dr Hughes findings/recommendations – some were being addressed before Covid.

Are they continuing to be addressed now?

What is the current monitoring system to check that private patients are not being bumped up the NHS list?

Are pre-op assessments being audited now?

What is the Trust policy on minuting meetings – which meetings?

…….

Q. Might it have been something that the medics involved in both the work to prepare for the Return-to-Work Plan and looking at the work that had completed in June 2017, might it have been something that they noticed and could have adapted the plan to reflect?

A. Yes. I think because the people that would have been seeing -- as in medics -- would have been seeing patients without that information on them, if they had escalated then we would have known, but nobody every said there was -- at that stage, in between the '17 and, sort of, '19, that there's letters missing. An in-patient discharge wouldn't be so bad because obviously there is electronic discharge from the ward so the juniors would have done that, it would be signed off. It was more to do with the day cases. They weren't dictated on, but nobody every said they were missing. It's one of those things, unless you're told, you don't really –

Q. Does it go back to your point that this was an opportunity at this point to perhaps delve a little bit more deeply into what was happening as regards Mr. O'Brien's practice and also procedures in place? Do you see that as a missed opportunity now?

A. I do, yes.

Q, Does that also reflect the tradition, if I can call it that, that you spoke about earlier of when people raise issues, nobody generally comes back to tell them how they was resolved?

A. That's correct, yes.

Note the importance of regular monitoring of process being carried out efficiently and where possible build in a practice of 'closing the loop' on raised issues.

Q. Was the barrier to that not having a specific Deputy Medical Director who could devote themselves to that? Was the barrier cultural? Your mechanics seemed to be working fine but meaningful discussion was not necessarily available for us to look at.

A. That's a very good question. The mechanics at the time I was there did work very well. Actually we knew when people were being appraised. We had almost 100% compliance. We did have a fairly advanced quality assurance check on appraisals, that the right questions were being asked. What we didn't have was a matching up of agreed specific clinical data that was agreed within teams that were relevant to them. It was too much left to the individuals to bring data themselves. So for peer comparison within urology, for instance, that was not robust enough. Part of that would have been simply the culture within Northern Ireland medicine. There has been a lot of resistance to introducing that type of data on a systemic basis. But I have no doubt that having someone assigned with a dedicated role as a Deputy Medical Director, for instance, with that as their role would have been very helpful. That's what I was trying to achieve. I don't think that by itself would have changed the culture but it would have been very helpful.

'What we didn't have was a matching up of agreed specific clinical data that was agreed within teams that were relevant to them. It was too much left to the individuals to bring data themselves. So for peer comparison within urology, for instance, that was not robust enough.'

Has this now been tightened up?

……

Q. These are general questions really based on your experience as a manager in the Trust. Just to start with, in your role as Assistant Director did you get any regular reports that provided any kind of range of metrics about the performance of outpatients generally? So I'm thinking about time to first appointment, time to follow-up, dictation times, workload by consultant, complaints, patient feedback. Was that ever pulled together so that you could look at it by speciality and see what was going on?

A. I suppose the short answer is no. That level of detail we didn't -- was not provided.

Q. Would that have been helpful?

A. Absolutely, yes.

Are the measures now in place that capture this range of metrics?

Q. I know the Inquiry has heard evidence around specific charts and tracking in relation to Mr. O'Brien, but from a departmental position would you agree that the validation and the tracking of charts was something that was ongoing over the years during your tenure?

A. Yes. We tried -- we tried to keep our housekeeping up-to-date but unfortunately, due to staffing levels, if anything was to fall, it would be that where the core business would be to get the chart for the patient. But these things would have been put onto the work plan because you didn't want them to fall off the radar and they could be reviewed and what can we do. And if you couldn't do everything, at least can we try and do a few things every year.

Q. Was it because of the vulnerabilities of human nature that the chart issue - and we'll see it when you're raising it with your managers later on - just didn't go away?

A. Oh yeah. It was ongoing.

Q. Right up to 2019?

A. Yes.

Q. By the time you left, the situation would have been -- was it the same; was it enhanced?

A. No, there were always issues with tracking. The system, the patient administration system, it's an old system and there is no flexibility within it and it is very reliant on human input. Before I had left, I put in a business case for iFIT and that actually is where you have a label with a chip in it and that's attached to a chart and it's all wifi driven. If you are taking the chart from one area to the other, the wifi picks it up and actually updates the code. So, you don't need that manual input and you would know then when a chart has moved from one location to the other. The business case was passed and it was waiting for money and then Covid hit. But iFIT is actually being implemented very shortly within the Southern Trust, which will be fabulous and will resolve the tracking issues.

Q. Who will be able to provide us with more up-to-date information on that? Would that be Anita Carroll?

A. Yes.

How is the implementation of iFIT going? Has adequate training been given to all staff involved in using this system?

Q. Tracking of patients charts on PAS. "Would you please remind all your staff that it is absolutely crucial that every chart is tracked when moved from one location to another. Recently, due to a chart not having its tracking codes updated, a patient's operation was cancelled. The chart was later found in a different service and in a different building. The consultants have stated that from now on if the chart is not available, they will not operate on the patient. "If you take a chart, you must track it to the new tracking code. If you don't have access to pass to do this, then you must leave a message for a member of staff from the area that you have taken the chart from giving them details of where the chart is going and asking them to track this for you. This is not just a request to help staff when looking for charts, but this has a direct impact on the care we are providing to our patients. No chart, no surgery, no appointment. Would you please circulate to all your staff". You sign that off. I don't think you could have been much clearer in that email in setting out the repercussions of -- and you have provided evidence there that someone actually missed an operation, a booked operation, that was cancelled because of that?

A. Yeah.

Q. Was that the first time that you were aware that an operation was cancelled or was there something about that that triggered this email?

A. No, that would have been a specific event where the operation was cancelled. I had explained before there if there was a chart missing, about the Records member of staff would have looked for it, the supervisor, the manager, they really did do everything that they could to get the chart. For this to happen, you know, they would have taken it very badly. It would not only have upset them but also they would have wasted so much time. It just had to be spelt out. You know, look, it's not -- sometimes when you talked about tracking a chart, that it was just that's Records having a bit of a moan.

Q. Is that what you felt?

A. Sometimes, yes. It was a bit of a moan, that's them moaning again. So this was, look, it's not just us moaning, this actually happened, a patient was prepared for their surgery; they came in today and it was cancelled because somebody hadn't tracked the chart properly.

Q. So, this is the real life consequence for that?

A. Yes.

Q. If I understand what you are saying correctly, your experience was that at times people were a little lax or a little indifferent to attempts to track charts?

A. Yes.

Q. Was that because it was such a common problem?

A. I just don't think sometimes people saw the importance of it. "Sure I'll take that chart and I'll leave it back", and then you forget to leave it back and then something else happens. Sometimes the admin processes just weren't taken -- weren't followed as well as other processes might have been.

Q. Do you think there was - and disagree with me if you do disagree - do you think there was a lack of respect for aspects of your work or the admin process, that people just didn't give it the due diligence it deserved?

A. Yeah. I think it was that it wasn't given the due diligence.

Q. Do you think there was any impact on the culture towards charts and admin, because there didn't seem to be any sanctions for people who were perhaps a bit - I want to say lackadaisical because I can't think of the word that is not lackadaisical - but who were a little bit casual in their use of charts? There was nothing done if you didn't bring your chart back home or put it in the library or code it properly, so perhaps a failure to sanction was a bit of an acquiescence?

A. Yes, and sometimes I think we could have been a victim of our own success. We would have done KPIs out, and like I've said, Craigavon library alone would have been pulling 19,000 a month but our percentage rate of charts would have been 99.5% availability. That would have been an average. So, we did get an awful lot of charts but the staff really worked hard to make sure that they did that. Maybe if we just hadn't searched and searched and searched and that percentage had went down, maybe then people would have taken notice because there could have been more noise in the system.

Q. And more impact?

A. Yes.

Q. So your diligence was your downfall in some respects?

A. Yes.

Post Inquiry – consider fresh and innovate ways to encourage everyone in the Trust to value and respect all the roles and functions needed to deliver safe care and quality care for patients.

Q. Now, you have also said in your statement that more auditing is a must, and there's a lot of focus in the Trust on targets, performance and bed management, and that those issues - I presume you are speaking historically - those issues distract you from governance?

A. Yes.

Q. And therefore governance was not always the primary focus?

A. Yes.

Q. Is that still your view of the way things are run at the moment?

A. Yes, but I think there's a real willingness to change. And I think that's come out because of the Inquiry.

…….

Q. Could I just bring you then to the overarching SAI report. If we go to the section on governance and leadership, WIT-84302. It says in the third bullet point, it largely repeats the sentiment we've already seen, that: "There was no system to track if recommendations were appropriately completed". Can you see the sense, from a tracking perspective and from a patient's safety perspective, of having a tool, whether it is a live tracking device or whether it's some form of audit to be in place, to bring the monitoring of the treatment further along the line?

A. I can definitely see the benefits of it. If it was properly resourced and the functionally within CaPPS expanded to allow you to track a patient through -- say, they had a bladder cancer through maybe multiple occurrences or stuff like that, there definitely would be a benefit for the patient.

Q. In light of what we heard from you in evidence earlier this morning, would I be correct to form the impression that given the resources that you had at that time within tracking, it wouldn't have been feasible to do much more given the resources you had?

A. I would agree, that's totally right. The tracker were under immense pressure with increased workload. They were struggling to track what they were commissioned to track, you know, 31-day and 62-day to first definitive, let alone a whole patient's pathway for years.

How are the realistic expectations of staff working in the Trust set, monitored, reviewed, and adjusted?

Q. The incident report which I showed you there, the essence of it was that it appeared that a direct referral had been generated in your place in the Southern Trust but hadn't been received or dealt with in Belfast, and it took a GP to write in a year later and raise the alarm. Can you help us to understand what might have gone wrong there?

A. I suppose because -- I don't know the case exactly but I suppose one thing that could have went wrong is they had hormones commenced, their first definitive, then oncology referral was generated from the Southern Trust. Therefore, because they have been closed in CaPPS, they wouldn't have been tracking that to see that they had got the referral. It's the only explanation that I can give.

Q. But again, not knowing the case –

A. Yes.

Q. -- and I know we're in a sense speculating, but in terms of any case going that route, you've outlined the kind of correspondence that must be generated –

A. Yep.

Q. -- at your end, at the Southern end?

A. Yep.

Q. If that is not responded to for whatever reason, Belfast Trust have a computer problem or somebody is not doing their job properly or whatever it might be, what is the alarm bell in that situation; what is the safety net?

A. In my time I don't believe there was a safety net there, but looking back now, there needs to be one, you know, to follow up those patients that aren't being actively tracked. But once we have done our -- to me it is with the consultant, the patient is the consultant's responsibility. Because oncology referrals would also have been generated, it just wouldn't have been say a CaPPS oncology referral, most consultants would have followed that up with an actual written letter to oncology that maybe contained more information on that referral than the CaPPS referral.

Is there a safety net in place now for patients who are not being actively tracked?

Q. At WIT-80977, you are referring to the lookback exercise in relation to the role of the Cancer Tracker and the benefits of tracking patients past their first appointment. Is that improved, in your experience? I know the Panel heard the Cancer Tracker evidence this morning, but from your experience is that system in any way better for you?

A. I think there is still improvements to be made on it. I'm not sure if they are still funded to only go to that point of first definitive treatment. But there certainly is more engagement in relation to the audit processes.

Q. Now, you've said, looking back in your statement, that you didn't think governance arrangements were fit for purpose, and. Is that something that you still feel –

A. I felt from the outset when the Mandeville Unit opened, you know, where people went for cancer treatment, there was no footprint at all for Urology within that setting. I found that strange. It removed the opportunity of meeting on the corridor or seeing the door open in an office where you could put your head in and say 'any progress with, you know for example, the advertisement for the CNSs, or any new equipment requirements. We didn't have that. They were in their corridor and we were in ours and the two never passed, except there you would have seen these people at the AGM or MDT. There wasn't engagement all the time. We would have worked closely with the cancer trackers and red flag team. They would have been in and out of the unit so we would have significant engagement with them.

Q. Is that the situation now; is it still that disconnect?

A. There is more to do. I thought about these just recently. We are as a team improving and striving to continue to improve. I have no doubt the cancer team is doing that and others,

'The findings indicate a disconnect between Urology MDT and Cancer Services management'

'We just haven't had the opportunity yet to come together and say what all has been achieved thus far, and collectively how much further can we go.'

Has the SLT checked recently on the connecting progress between Urology MDT and Cancer Services?

Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently?

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of pathway tracking that was alluded to in the testimonies yesterday but, to the best of my knowledge, that isn't currently in position at present.

Q. And do you think that would be a good idea?

A. Absolutely.

Note the improvement in the provision of a key worker for patients with a new diagnosis.

Has the SLT knowledge of how ready is the system to address 'whole pathway tracking'?

Q. Thank you. In terms of the key challenges that remain to be addressed arising out of the recommendations, you have highlighted already the difficulty that might affect more Trusts than the Southern Trust in dealing with the tracking issue. Is that the key challenge or the most difficult recommendation to comply with?

A. I think actually the whole thing around the audit of MDT, I'm not sure that any Trust is resourced to provide the level of audit that we would like to do. In regards of assurance around processes and systems of the MDT, and we have talked about it as a group of cancer operational managers, that it is

definitely something that we would all like to do; we just haven't been resourced to do it. I know Southern Trust has gone at risk to appoint our two posts in, and we will see the benefit of all those posts in time. But it's at starting point, and we certainly would like to do much more audit than what we currently do. In particular around the key worker side of things, we also would like to audit and ensure that the key worker, in relation to those recommendations, they are actually doing what we say they are, you know, in that they are allocated, they have provided the information and those kind of things. We are not just resourced yet to do that.

Are there any interim audit measurements in place on the placement and effectiveness of the key worker role?

……

Q. In that vein, a lot of people, mainly I think after your time, had said that there was a very big emphasis on performance and that data for performance was looked at very carefully, but that there wasn't much robust data to cover quality issues other than when things went wrong, and that, therefore, one didn't necessarily know, for example, if cancer peer review standards were not being met, or if people weren't following policy, or if people weren't using best Royal College guidance. Was that something you recognised in your time and did you have any views on that?

A. All that data was there. All the cancer review documents were there, again with clear action plans. All the RQIA inspections, announced and unannounced, were clear, they were always in Trust Board papers, they were in my directorate governance papers, the action plans against them were in directorate governance papers.

Q. I am talking more if you were asked what's the quality of clinical outcomes in Urology, would you have data to look at?

A. No, I wouldn't have at all. Whilst we as a Trust joined CHKS and we engaged in the process of contributing our data to CHKS, I think in my time it only got to maybe a divisional level, it didn't get to specialty level. There was a process of cascading, cleaning and assuring the data. Certainly I think there was a basket of 23 metrics that we were measured against, and we rated highly in the UK against that, but those were largely around performance and that's maybe where the perception has come from.

Q. I think that is what they said.

A. Yes.

Q. They said this is performance.

A. Yes. The audit of clinical practice and having an audit against that either locally or nationally, no, I felt that was a gap.

Is the SLT happy that there is now a high standard of robust data to cover quality standards across all the specialities? If not, as a priority, what immediate steps can be taken to address this?

Q. If we go to the Directorate Risk Register of July 2019 at WIT-94611. If I can read the extract from that rather than we all strain our eyes trying to find that. It says: "As of April 2018, there are 1,609 standards and guidelines identified on the Trust register. 74%, which is 1,193 of these, are applicable to Acute Services Directorate. Of these, 34%, 405, remain at a partial or non-determined level of compliance, with many identifying significant external barriers impeding the Trust's ability to comply." I think you have mentioned some of those external barriers are buy-in from GPs, and you have also mentioned, I think, the Board as well?

A. Yes.

Q. HSCB?

A. Yes, about implementing certain processes. You know, you were tried to waiting on those processes being fully implemented.

Q. From the figures provided in April 2018 to Dr. Khan's report eight months later, the figures have risen from 34% to 47%?

A. Mm-hmm.

Q. Did you ever undertake a similar sort of analysis to find out what the standards and guidelines situation was while you were the coordinator?

A. I hadn't, no, but my standards and guidelines manager did do, and she would have produced reports for me and then for my senior colleagues as well every two weeks. These would have been discussed then.

Q. Would they have been discussed in percentage terms of the total not yet implemented, or partially complied or needing reviewed?

A. Yes.

Q. The figures that I am bringing you to from 34 to 47, do these sound about right in your recollection of the amount outstanding?

A. Yes.

What are the current figures?

Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly?

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback through the system. It was more difficult to do that for me with such a broad remit, so that's why the guidelines team were particularly good and particularly active at following through on that.

Is the system for guidelines monitoring fit for purpose and regularly audited?

Q. There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.

Q. The Panel has heard evidence about the fairly recent realisation of cancer tracking to maximise being able to follow. I think, the evidence is that there's still room for improvement; that that process is not a fail-safe either. Given that, the cancer tracking issue and the CNS issue, might the findings and

recommendations from the nine SAIs more helpfully have provided systemic suggestions around care pathways generally that might have included CNS and less emphasis on the CNS providing the answer for all of those nine patients?

A. Yes.

'Q There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.'

Is it still the case that various parts of the system are struggling to deliver successful care pathway oversight?

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern

Does the SLT consider 'the missing clinical audit' an area of concern? If so, what are the steps to address this?

Q. Okay. Thank you. You had a comment about deep-dives, and made a comment about not all are brave enough to do it. That's an interesting choice of words. What did you mean by it?

A. Again I am back to that expression I used there about lifting the stone and seeing what else. I think you should never -- especially when you have recurrent issues, say for example like triage and delays and patients who are not being seen in as timely a way as we could offer. I think hold on a minute, we need to have a deeper look here; we need to actually sample; we need to audit some of the work. You can't just accept, and we did in many ways accept he is a really good clinician and take that as read. We should be able to evidence that in this day and age. We audit our own performance and our peers. I think we should be able to do that and I think that takes bravery.

When there are recurrent issues taking a deep-dive approach to them is important, sampling and auditing some of the work. 'Lift the stone and see what else is under it.'

Can the SLT identify any current recurring issues in the Trust where this approach needs to be applied?

.....

Q. Under the key duties, the first key duty, perhaps, importantly, is, you were to "Take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and they are providing timely assurance and alerts to both the service director and the organisation." We get a sense of how you found the ground, so to speak, within your Section 21 statement. I suspect you are going to tell us today that your ability to provide the kind of assurance that things were operating at a sufficiently high standard of compliance was not, despite your best efforts, was not available to you because of resource issues?

A. Yes. I couldn't have provided an assurance in the organisation that all aspects of clinical and social care governance were robust within the Acute Directorate. There was a very small and limited team available, at times it was me and one other part-time person, so things in relation to audit for

assurance wouldn't have been robust at the time. And there was an internal audit report that highlighted that the Audit Committee hadn't met for some time within the Acute Directorate and then that was one of the actions that I put in place to try and make the system more robust and try to provide a form of assurance to the Acute Director and, therefore, SLT.

What is the current standard of auditing across all aspects of clinical and social care governance? Where standards are low or the auditing process not taking place - what actions are planned to address this? Is this a standing item on the SLT agenda?

Q. -- to implement actions around standards and guidelines. You talk, at paragraph 3.126 of your statement, about establishing a forum encompassing lead nurses, midwives, allied health professionals, radiography to ensure that the actions needed to implement standards and guidelines was shared and embedded with frontline staff?

A. Yes.

Q. Were those initiatives that you took forward?

A. Yes. So whenever I went into the acute governance role the worry was that the recommendations stopped at a certain level and sometimes what you find within governance is it doesn't filter down to the wards and departments. So this was our attempt to make sure that the lead nurses and midwives and AHPs were fully appraised and involved in developing the actions from the recommendations.

Q. One of the things I suppose you had a concern about, as reflected in your statement at paragraph 3.96, was that it wasn't always possible to provide assurance audit that guidelines that I suppose had been adopted by the Trust were actually being adequately implemented by frontline staff?

A. So to provide assurance you need to try and develop an audit and make sure that the audits are completed to identify that all of the actions are taking place and within the Acute Directorate there wasn't the resource to be able to sufficiently do that. For some standards and guidelines there were very robust audits but for others there weren't.

Is this forum still operating? Are resources being identified to support the auditing process to ensure that there is implementation of all the actions at ward level?

Q. Is there anything in the system, either for you or for the consultants, that flag up when results have been sitting a while or waiting or if there is any delay in look at them?

A. I know the secretaries, they would, if a patient has been seen in an out-patients clinic and they are having an investigation, they are put on to the patients administration systems as what they call DARO which is discharged awaiting results. This is placed on the PAS. The secretaries would run reports then monthly and this will show if there is any outstanding results that needs to be actioned. So the secretaries could contact the consultants or even myself, if I have requested anything or if there is results available they could contact me.

Q. Now you speak about DARO at 14.3 and you say that the CNSs don't have access to the DARO functions?

A. No, that's for the secretaries would have access to that.

Q. Do you think that it would improve follow-ups if you did have access? Give us a bit of background to that, why you have said that?

A. I think it would improve my follow-up. You know, if nurses had, maybe, or Nurse Specialist had access to it we could be notified if there is results outstanding or if the result has become available. It would probably be around the same as what NIECR or Sectra would be and it could notify us if we have put in a request and results are available.

Is this a suggestion that could be implemented?

Q. Was it your experience at the time, or has it been your experience since, that perhaps consultants who are more senior, who are more used to their own way of doing things, find it difficult either to be challenged or to adjust their practice to reflect advances?

A. So, I think that at the heart of safe consultant practice is good team working, and that working in a functioning team where there's a built-in peer review, essentially. I think when you work in isolation, there's a risk that you develop practice that maybe doesn't follow best practice or best guidance or, you know, keep up to date with current best thinking.

The importance of clinicians seeing themselves as an active team member where there is a built-in peer review approach operating.

A. So, my reading of that was that we knew that the tracking only went to first diagnosis. We understood, we discussed that that was a problem. It would have been much better if tracking was extended beyond that and resourced beyond that. But it wasn't, because we'd already explored that. Dr. Hughes was coming from a perspective, as I understand it, that he had been a medical director in another Trust and he had also been, I think, a NICaN lead at one point in time. And he should have been very well aware that tracking in the Trusts here was only resourced to first definitive treatment. Now, he may have made different decisions in the Western Trust as to how to resource their tracking, and he may well have done that, I'm not aware, but I think that's where he was coming from. I've maybe lost the second point. Oh, yeah, the quality assurance about whether MDT outcomes would have been adhered to. So, at the time, as a group we would agree the MDT outcome for each individual patient. That would be spoken out loud in the room, the tracker would record that, and then the tracker would type that information into CaPPS, usually at a later time, and that would be provided to the person who Chaired the meeting to review the outcomes as they had been recorded for factual accuracy. And once that had been agreed, that would go back to the tracker to be circulated out to the whole MDT and that would then allow the CaPPS letters to be generated to the GPs and they would be posted out to the GPs. So, that's how that happened. So that was that bit of quality assurance to make sure that the outcomes were correct as discussed at the meeting. Now, it comes then to whether or not individual clinicians adhered to the outcomes when they met the patient. We now have in place, in very recent times, less than the last 12 months, support available within cancer services whereby we run a random audit of whether or not outcomes have been adhered to. That information is brought back to the MDT and shared with the MDT. I also receive that report as the lead clinician, and if there are cases that don't appear to match what the outcome was, then those cases are addressed on an individual basis.

Has the effectiveness of the tracking system recently been audited in all specialities in the Trust? Do steps need to be taken to improve the system?

……

Q. So the -- just so I'll be clear on your answer. You carried out the triage at the point of vetting the referral letter, you also took a clinical view whether tests were required, and dependant on the results of those tests the categorisation may have changed?

A. That's right, yes. Yeah. Like you know especially for those with like, if we mark it as a routine one, then I don't want this patient waiting for the CT results, which could be something different, marked as routine, 1 but I want to see the CT report, and then, if needed, to upgrade, yes.

Q. And was that the way triage was done when you arrived at Craigavon, or was that a system that was introduced while you were there?

A. As I told, initially we were just doing normal triaging, like marking as routine or urgent. We would not be investigating. But I think the advanced triaging started a bit later.

Q. And was that something that all the consultants -- was there a view taken that all the consultants would approach it that way, or was it really up to each individual clinician as to what approach they took?

A. I think this was the policy we agreed within the Department. So I presume every consultant was doing it .

Q. And do you know when that policy came in?

A. I'm sorry not exactly when.

Q. But your recollection is that there was a view taken that that is the way in which triage should be carried out?

A. I felt that it's the better way like, you know patients, rather than waiting for months and months to have a clinic visit, and then to ask for an investigation. So I think this advanced triaging speeded up the process of investigations.

Q. I suppose I am trying to get to -- there's two issues really. The first is what you did as a clinician, and you have explained that. And the second issue is trying to establish if advanced triage, as it's referred to, was a policy, or a conscious decision made by the Trust at some point. So I think I understand your position at the moment to be that you considered advanced triage to be the most appropriate way for you to assess patients for prioritisation, but the second element of that I just want to make sure your evidence is clear, was there a decision collectively made that advanced triage was to take place in the way you have described?

A. Yes.

Is the advanced triage approach to assessing patients for prioritisation an agreed and recommended approach? Are there Trust guidelines on triaging red flag, urgent and routine referral cases?

Q. If a patient wants to remain on the Bicalutamide 50 monotherapy, and I know this patient did and you referred him on to Mr. O'Brien to discuss that, as he was his patient, the patient said to you "I want to stay on this", and you know that it's outside the licence conditions, and the risks we discussed earlier, what would be your response to that?

A. As I told, nobody should be on this monotherapy because there's no -- absolute no indication at all for this treatment. So I would explain to the patient that it's not the conventional treatment, it's not indicated, so the appropriate actions will be, there are other choices, like patient could be on active surveillance, depending on the stage and, you know, Gleason score, whether these categories. So other treatment options are either active surveillance, or curative treatment, or watch/waiting, depending on the staging and grading of the prostate cancer.

Q. So you would provide the patient with information to explain to them why it wasn't appropriate?

A. Yes, absolutely.

Q. Would you continue to prescribe it to them because of their belief that it was helping them when clinically that isn't an evidenced based belief?

A. No, I wouldn't personally recommend to continue. Yes.

Q. Now, you obviously felt that there was, the issue was dealt with at the MDM. You raised it as an issue. Mr. O'Brien said he would go and review the patient. And you formed a view that you didn't need to take the matter any further?

A. That's right, because I thought this is the first case I came across then. So I thought it was properly addressed at that point, like this.

Post Inquiry, would it be a reasonable outcome for the SLT to underline the message that all prescribing in the Trust should remain, where possible, within the licenced requirements?

Q. I think it's Recommendation 5, if we scroll back up. So it's talking about -- yeah, it's talking: "This will be achieved by appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance." Is that what's not in place?

A. I think we're still only funded to first treatment.

Q. And is there agitation or advocacy around this?

A. Yep.

Q. As far as you know?

A. This has been spoken about for a long time. It is known to the people who lead our cancer services that this is appropriate.

Q. What would be the utility of it from your perspective? Can you paint for us some examples of where you see the potential for patient safety or patient risk if this isn't in place?

A. It's hard to think of examples straight off the top of my head, but there are some cancers that we survey or monitor for very long periods of time, bladder cancer would be one example. Some of the prostate cancers, fall into that category. So those would be the patients I think who would benefit from that process. It would be very resource intensive. You know, the trackers are currently tracking perhaps 700 live cases. So that's a lot of people to keep an eye on. If we went to the whole of pathway tracking, that number would invariably increase, and if we had some form of tracking mechanism for all those patients who were on forms of monitoring and surveillance, my own personal workload of cancer patients probably comes into the range of three or 400, minimum. So you multiply that out across the team, you can have an idea of how many patients we're talking about.

Q. In terms of -- you mentioned a moment ago that there's now I suppose better accessibility to the cancer side of management, whereas it was painted in fairly bleak terms within the SAI reports. There was talk of a disconnect between the MDT and cancer side, and I think you've echoed that in your Section 21 statement. In what ways has that connection been "enhanced" probably isn't the right word if there was not much there to start with?

A. I think the key appointments have been those of Angela Muldrew and Mark Quinn, because they are then able to work with the MDTs across all the different specialities to provide the kind of audit

support and back office support, if you like, for the activities that we undertake. Secondarily, we have a new cancer service's CD. He's a medical oncologist. He happens to attend our MDT, which from my perspective is great because I have a direct line of communication, and that has given a new impetus to improving the governance and oversight of all of the MDTs. So you'll be aware that there was a piece of work following this report from Dr. Hughes that was undertaken by Dr. Tarek, who was the AMD for this service, and out of that then there has been lots of new changes, and I would say certainly in my experience with the Urology MDT, improved support for us.

'Recommendation 5 "This will be achieved by appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance."

To what degree has this recommendation been implemented and embedded into practice? What are the next steps to take to achieve this recommendation?

Q. Do you see a role as well for the CNS nurses in terms of, if you like, superintending the process to ensure that the care that perhaps was suggested or recommended by the MDT isn't forgotten about or isn't taken off in a different direction?

A. So I don't think they have a specific role in being the watchman, but they have definitely a role, as all the members of the MDT have, in ensuring that appropriate care is delivered to the patient, and they have clearly a role in advocating for the best interests for their patients as well.

Q. Just finally in terms of Mr. Young, were the comments that were being made to you in the context of his stone clinics or was it cancer care?

A. I've no knowledge of his stone clinics.

Q. I'm talking in terms of what the nurses were saying about his use of them?

A. So Mr. Young, when I first arrived, would have had a cancer practice alongside other aspects of his practice. In later years he has withdrawn from the cancer practice. So, I think what I am reflecting is when he was doing an Outpatient clinic in the Thorndale Unit he may not have had the CNS in the room for all of the consultations. He may have, and I am presuming this, he may have used them at other times, he may have asked the CNS to see the patient, I just don't know, you will have to ask Mr. Young how he practised that. But it is my understanding that the nurses would not have been in the room for the whole clinic in the way that they would have been for mine.

Q. In terms of what has come after these revelations, has work been done to reinforce amongst your colleagues the primacy or the importance of the key worker role in both cancer and benign care, where the patient wishes to have them?

A. I think as consultants we all accept the importance of the CNS role, and we try to involve the CNSs in - I think they're in nearly every aspect of what we do in an Outpatient setting, both benign and malignant, or cancer.

'Has work been done to reinforce amongst your colleagues the primacy or the importance of the key worker role in both cancer and benign care, where the patient wishes to have them?'

When was the last audit done on the availability of CNS nurses to meet the request of patients to have one accompany them on their treatment pathway? What did the audit show and have there been any subsequent actions?

Q. Just stopping there for a moment, in relation to triage as it currently is -- I know we've have confined it to 2019 -- currently, what's the position regarding triage? Is that something that is manageable and managed by the consultants at the moment?

A. Well, we did advance triage in 2019. It's no longer completely advance triage now. But, yes, I still fulfil all the triage would be in the on-call week.

Q. And when you say it's not advanced triage now, has the system changed again somewhat since 2019?

A. It has, yes. So we used to do advance triage for a lot of the patients, especially the red flags and the urgents, and even just for some routines to try and prevent them from having an appointment if they're not required. Given, however, there is very much a lack of consultants and the backlog, in doing advance triage at current, what that then does is if you have a hundred patients to triage and say you do a hundred scans, when are you physically going to follow those up? It's not physically possible, at present, to do advance triage in the way we used to do it.

Q. And that's because of the numbers, the staffing numbers?

A. That's due to staffing, yes.

Hopefully, with the three new consultants arriving in spring 2024, it will be possible to increase advance triage again.

Q. "what appears to have gone wrong is failings in a process, a process of ensuring that concerns of staff shortages from a doctor and nursing perspective are addressed to provide suitable care, a process of ensuring that regular audit of processes is undertaken and disseminating to the department. Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided." Now, your experience has focused on the staffing issue that you consider were the contributor during that period of time. The Inquiry has heard evidence more broadly. But the mention of the audit, the regular audit of processes, what's your understanding now of what the audit of processes are that are undertaken that would provide some reassurance about the non-reoccurrence of the issues that we have been discussing?

A. Well, it's probably best to split that between benign and then cancer because I can speak of my experience of being with the MDM, the audit processes that are now in place are very reassuring -- they are reassuring to many parties, to patients, but also to as yourself, as a clinician, you want to know that what you are doing is right, and what you're doing happens, and so there is an audit process in place to make sure the decisions that are made are undertaken. There are audit processes to show that are the right number of people at meetings and, if not, why not? So audit is massively important.

'Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided'

Moving towards a high standard of auditing throughout the Trust should enhance safe and quality care for patients, and give assurance to staff and the public.

Q. "The urology MDM was under-resourced for appropriate patient pathway tracking. The review team found that patient tracking related only to diagnosis and first treatment. That is the statutory targets of 31 and 62 days. It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care." The point that's being made there is that this MDT, in terms of its governance, did not have a facility that scrutinised the progress of the patient along the care pathways. So if delays in referral happened, for example, it wasn't spotted. If referral didn't happen, it wasn't spotted. Can you help us with your own experience, particularly in the public

sector in the NHS. Was there good governance, and was that governance around ensuring that patients got what they were expected to get in terms of treatment?

A. Well, in general they did but I think you have to recognise that the system is overburdened, it's swamped. I think I read that Mr. O'Brien's hospital was getting 160 referrals a week, urology referrals a week, and we'll come on to talk about triage, I'm sure. Of those 160 patients referred in urology, at least half would have cancer. That's 80 patients that need to be discussed every week, and you have a waiting list that's getting longer and longer and longer. Inevitably, delays will come because patients are not coming in to be treated, and you have emergencies pouring in through the Accident & Emergency Department. Inevitably in such an overloaded system, you are going to get delays. It is really hard for individual clinicians to look after their individual patients, or build in systems in a hospital whereby these sort of errors that we're seeing in these cases are bound to occur. I'm afraid COVID had compounded that enormously. It is a system right across the NHS, not just in Northern Ireland, where we're seeing the system is overloaded. Clinical Nurse Specialists will help; a really active MDT with a full complement of different specialists will help, but inevitably some cases are going to get delayed and lost in the system because there's too many patients.

Q. Yes. In your experience would an active, job-specific tracker assist in the process of ensuring that care was delivered appropriately and on time?

A. Yes. You could call a tracker an MDT coordinator, because it's so difficult for the individual clinicians when they have to operate and do Outpatients and dictate on their clinics, and so on and so forth. To try and to keep track of all your own patients is almost impossible. I think one or two of the cases illustrate maybe Mr. O'Brien didn't prioritise some of the really urgent cases as well as he could have done. The patient with the penile cancer, for example, was rather slow; methodical but too slow in the way it was dealt with. An MDT coordinator with a specialist nurse badgering and liaising directly with the patient would definitely have improved the situation.

Is the role of a job-specific tracker/coordinator in MDTs clearly defined? How realistic is the provision of a tracker in MDT's?

……..

Q. Do you accept that this was a period of time where the information was there, people knew what was going on and there was a failure to grapple with the patient risk issue that was at the heart of this?

A. 2016 was very important. I agree fully with what you're saying. There was a missed opportunity there. I don't think we realised the volume of what we were talking about but, certainly, here's a further example that should have been escalated. It's only been picked up whenever the patient is coming through the system again. So it's knowing -- it's getting ahold of those untriaged letters was the crux of the point.

Q. But it was perfectly obvious to some, wasn't it?

A. Yes.

Q. You might say it wasn't perfectly obvious to you, but if the letter has not come back, there's a way of tracking that isn't there?

A. Yes, it is via the booking office, not knowing it's coming back

Q. As clinical lead, you didn't take this forward?

A. Well, these are the minutes of the meeting and I had thought that they had gone higher. It wasn't me taking the minutes. I had thought that they had moved on but I have been told that they weren't.

Q. I suppose if you, as clinical lead, are not going to bring this issue forward, whose responsibility should it be?

A. I thought these sorts of minutes go to -- if we're taking a minute from the departmental meeting, it goes to Martina Corrigan and I would have thought that, you know, it would go up the chain from there. I didn't take it to the AMD or any level like that. These were discussions that we had on that day and taking them further, I'm not aware. Apologies.

Q. Just to reconcile that from a position where a failure to triage had caused considerable difficulty, of which you were aware, for a large number of patients and here you have a meeting which is getting close to looking at those kinds of issues through the lens of you clinicians, some of you are struggling with the whole concept. Surely, recognising the problem, there was an onus on the clinical lead to take these matters forward and make sure they were addressed?

A. I accept that.

Is the SLT confident that clinical leads in the Trust are following through on their reasonability of checking that issues discussed and that are to be escalated higher at departmental meetings have actually done so?

Q. Now, you observe in your statement -- maybe just bring it up, WIT-103617, paragraph 6. So you personally discontinued the use of glycine when the new resective scope system was on site. And you understood, next paragraph, the other urologists had also changed to the saline system. Why did you change? Did you feel it was an obligation to change given the direction signaled by the Chief Medical Officer's office and the adoption of a policy by the Trust?

A. Yes. It was a directive. But, in saying that, having used the use of glycine for 25 years and well used to it, I observed that this was coming through as a safer option. It was easy to learn and, as a comment, that the use of the cut and the diathermy were not quite as good as the glycine, but was a fair swap because of the safety issue.

Q. You go on to reflect there, paragraph 6.9, that you were aware, and we've seen the emails, that Mr. O'Brien did not like the saline system, he regarded it as an inferior system. You personally thought he needed a further period of time to get used to the saline system. It has only come to your knowledge recently that he never did convert to using saline and continued to use glycine. How was it not obvious that he had failed to make the transition?

A. We all operate independently. I don't go to Mr. O'Brien's theatre list. I don't think any of the rest of us go. We all have our theatre days, and there's very little overlap. I had thought that, and again hadn't heard until I directly asked the question from theatre, had he actually moved over. So I thought that we were –

Q. When did you ask that question?

A. Very, very recently.

Q. Yes. Of course, upon the purchase of the equipment it might be suggested that clinical lead or perhaps the clinical director would assemble the team and say, right, we have the equipment, you know the policy, you know our expectation, I expect each member of the team to enter into a

commitment to use it, because it is safer, it has been directed upon us by the CMO. Was there no such conversation or communication with Mr. O'Brien?

A. I think there was the expectation that he would move like the rest of us too. I don't remember him informing us that he had not moved over. I agree, it's a question maybe I should have asked. This is a theatre directive as well. It's not just me in the department –

Q. Of course?

A. -- it's not just me in the department asking the question. There's CDs and AMDs. I'm not entirely sure if they knew Mr. O'Brien hadn't moved over either.

Q. We can see, if we bring it up briefly, it's the policy or the directive coming down from the CMO at WIT-54052. Under the heading of "monitoring", it is said that the Trust's audit department will need to monitor that the recommendations are implemented. An audit would have revealed outliers in terms of the expected practice, enquiries aware of no contemporaneous audit. Was this matter audited?

A. Not to my knowledge.

Is the SLT confident that the system that is now in place to monitor the directives from the CMO that come with recommendations of being audited, is functioning well?

Quorate

Quite a few MTD meetings were not quorate.

Do the services that are currently provided meet the professional assurance and standards and regional guidelines? Good audit and data collection are necessary.

The importance of MDT meetings being quorate – with the right expert representation.

How is this system monitored?

Western Trust 98% quoracy at MDT meetings – not the same in the Southern Trust.

How is this measured now and what is the figure?

……..

Q. You do mention as well in your statement about the MDMs and the quoracy issue. We have heard something about that yesterday and have and will do from other witnesses. Your experience that was if there wasn't quoracy, then at times patients discussed at regional meetings. Can you just explain that, how that came about?

A. If there wasn't a radiologist on hand and a decision was pressing or was time-sensitive and needed to be made, that patient could have been added on to the regional meeting. It's not that they -- if we'd had a radiologist, that wouldn't have needed to have happened, but that's on occasion what did happen in order for the patient to proceed down their pathway.

Q. You have said that can lead to a delay in decision-making. Was that because of the infrequency of the regional meeting or because of some other reason?

A. Because the regional meeting is for specific cases that need to be discussed there. Had we had quoracy within our MDM, some of those cases that were discussed there perhaps wouldn't need to have happened there, so it's maybe putting stress on another MDM when it was really our responsibility to have a quorate MDM to have them discussed there.

Q. In practical terms, if a radiologist was absent locally and there was one available regionally, they could use their expertise?

A. Yeah, on occasion.

What percentage of patients currently are discussed at regional meetings due to lack of MDT quoracy in the Trust?

Q. The second point is the quoracy is low due to low clinical oncology and radiology attendance. It had been, in October 2017, 25% attendance and it was now 11% by May 2018. You say that only five meetings were quorate throughout 2017 and it is perceived that this has decreased even further. "Therefore, more patients are not benefiting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision-making process and treatment. 3. Long waits for routine referrals. Due to increasing number of referrals, services concentrating resource on meeting red flags and urgent demand. Routine referral waiting times have increased from 52 weeks to 128 weeks, present day. Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded." The Inquiry has heard evidence that routine referrals, sitting back, not getting priority because of the red flag in urgent referrals, posed a risk to patient safety. I presume that's something that you would agree with?

A. Yes.

Q. In relation to the quoracy, you have identified there delays in decision-making processes in treatment. So, the level of oversight that perhaps is anticipated by full attendance at MDT for Cancer Services is absent if quoracy is not met and the right people aren't round the table?

A. That's right.

What are the 2022/2023 quoracy figures for MDT meetings in Urology and cancer?

……

A. Yes. So, there is an issue about how quoracy is counted, okay? And I'll explain that in a moment. But we now have the situation where we have two radiologists, and that has helped a lot. We are also in the position where we have a single clinical oncologist linking in from Belfast, and her attendance is probably in the order of high 70s to 80%. We have two medical oncologists, one who usually physically attends the meeting and the second person links in by video. So, those aspects have improved. However, when you count quoracy, you have to count all the core members. And if one of those core members is absent, you're not quorate that week. So, as you can see from the top line there, on that particular week there was no clinical oncologist. So, technically we are not quorate. Quoracy has never really been an issue for pathology, urology, clinical nurse specialists, and the tracker, the coordinator. So really the quoracy issues lie in radiology and oncology.

Q. And, of course, one always will anticipate that there will be a meeting here and there where one of those disciplines can't attend.

A. Yeah.

Q. And you've explained the setback that that causes in terms of some cases. Because, as you say, you don't necessarily need an oncology discussion around every case, or for that matter a radiology discussion around every case?

A. That's correct.

Q. But I'm just trying to assist the panel to gauge where we're at now in 2023.

A. We're in a stronger position, but we are reliant on a single clinical oncologist. And if that person is sick, or that person takes leave, then we don't have their valuable input

Quoracy is an issue that has come to the fore several times in the Inquiry. Is there any further guidance that the SLT can give on the challenges of meeting the quoracy standard?

Job description, appraisal, and handover

It was noted, more than once, that there is an issue with having proper job handovers.

Q. Can you recall receiving a hand-over from the outgoing Clinical Director?

A. No, I did not receive a hand-over.

Q. Just so we are perfectly clear, there was no orientation, say, from the Associate Medical Director, the Medical Director, the Assistant Director?

A. No.

How is the Trust monitoring the importance and delivery of the hand-over process?

Has guidance now been implemented throughout the organisation?

Has the job planning and appraisal system been over hauled?

Is it correct throughout the Trust – you are assigned an appraiser, an independent person who is not within the speciality?

Quality of care and patient experience is key in appraisals

…….

Q. Could I put it into these words and you can tell me whether you agree? You were seeing a situation where operational and clinical managers were alleging shortcomings on Mr. O'Brien's part. You were also seeing or hearing about successful appraisal, if I can put it in those terms, and revalidation. Your questions, presumably, were in circumstances where this clinician is said to have significant shortcomings in his practice, is our system of appraisal working appropriately or effectively. Is that what you wanted to look at?

A. I suppose it's even before that. The link of appraisal into the job planning and also beyond that, of linking appraisal into performance, management, clinical governance, all of that needed to be looked at. There was kind of joined-up working between the so many elements of professional governance and clinical governance which we are aware now were not as robust as they should be. I was trying to indicate that although it's not an immediate issue which is obvious now, but in my experience -- I was heavily involved in appraisal and revalidation and job planning in my directorate, and I found it a very

useful tool to be able to identify, to support, to make sure that the safety element is there. That was the thinking in my mind at that point in time.

Is the system of appraisal working effectively now?

……..

Q. When Mr. O'Brien took those two months out to do his appraisal during the investigation, did you ask to see the appraisal, as a matter of interest, which was happening in the middle of the investigation? It might have been quite enlightening.

A. No, I didn't ask for appraisal to be seen. I was interested in the appraisal and revalidation purely because when it come to me -- this information came to me essentially at the beginning of the investigation, that Mr. O'Brien was successfully revalidated and had appraisals. I was interested to know what was the process behind it and how was that not linked, why it wasn't linking to his job plan and other elements. I was interested in the bigger picture of the appraisal feeding into the professional governance, the revalidation, and also the job planning going into the whole process of not necessarily identifying just the identification of concerns but also supporting the doctor, making sure these are professional governance arrangements, and why they have not been coming together.

Q. Then there was a delay in the job plan as well. That never came through, I think; is that correct?

A. Unfortunately, I understand it never came through. It was progressed to the level to Mr. O'Brien for agreement but I don't think it was completely agreed and signed off from both parties.

Has the Trust recently reviewed its policy on appraisals, job plans and revalidations?

……

Q. We will bear that reflection in mind and explore it for what it means shortly. But can you tell me from an organisational as well as an individual practitioner's perspective, what is the importance of job planning, in your view?

A. I think it's really very important. It's the key contractual document that should be a partnership approach between the consultant and the Trust to identify the supporting mechanisms that are needed to allow consultants to deliver the work. It's an opportunity for them to discuss with their clinical manager what is expected of them and what they will need to enable them to deliver that for the year ahead. So, it's very much a performance management type of tool in the sense of having those meaningful discussions to decide how is it possible to deliver the work that has been assigned, and it should also then feed into demand and capacity information so that that's driving the job planning discussions.

Q. You mentioned demand and capacity. Is job planning a tool which can address that issue?

A. I believe it has the potential to. I think that's the original intention of it in relation to it should commence with a review of what the service needs to deliver for the year ahead, with the service. That should be considered and then designed into individual or team job plans with job plan objectives to align, taking on board what supportive resources or supporting mechanisms a consultant may highlight at those meetings that are needed to deliver the service. It allows then the service to ensure that objectives are aligned and job plans are aligned with the direction of travel that the service has to deliver and commission to.

Currently - how streamlined is the flow from individual job planning to the objectives and direction of travel that the service has to deliver?

Q. I suppose, used properly, job planning, if it's actually done, will leave the employee, the clinician, with an understanding, and the manager would have an understanding, as to what's expected, and failure to deliver on what is expected will lead to questions or challenges being posed; is that fair?

A. That's fair, yes.

Q. It provides a basis upon which inquiries can be made?

A. Absolutely.

Q. Those inquiries could potentially lead to a disciplinary route; is that fair?

A. Yeah, potentially, yes. I mean it's a contractual document so it's a contractual requirement on both parties to participate in it.

Q. Equally, in some cases the failure to deliver on objectives within a job plan might raise a wide range of other issues, the need for help or assistance?

A. Absolutely, yes.

Q. It may lead to conclusions in relation to how well the service, how well the employer is assisting the employee, supporting the employee to deliver on the plan. But it's important to have that baseline, isn't it?

A. Very important, yes

Taking time to establish a clear baseline for the contractual document between the employee and the employer is key to understanding and delivery.

Q. Okay. You described very eloquently potential uses of job planning?

A. Mm-hmm.

Q. The challenges, which I think many Trusts face; you would not be alone in that?

A. Yes.

Q. Again, have you an agreed strategic approach to this for the future led by a senior doctor who is saying this is what we are doing?

A. I think that's what we are moving towards. We have had early discussions with our local negotiating committee that this is the area we want to focus on, and our Medical Director is fully behind that and that's the direction we are going.

Q. Have you ever used job planning as the tool you described it could be used as the basis for disciplinary action, if somebody is not fulfilling their job plan? Has that ever been done actually?

A. Not to date, no

Q. Has it ever been done the other way around, to say this consultant can't fulfil their job plan and they need support?

A. Yes. No, I think that does happen, you know, in terms of some of those areas which are very good at job planning. I think our focus is we want to get back to the importance of a job plan meeting and actually having a face-to-face meeting.

Q. Have you actually taken a consultant to say you are not fulfilling your job plan, this is a problem, you have to do something, we have to do something together?

A. Yes. No, we haven't got to that stage, no.

The importance of having a face-to-face job planning meeting

…….

Q. Now, did Mr. Carroll give you a briefing as to what had occurred in the years prior to your taking up post that had raised governance issues?

A. Not with regard to Mr. O'Brien. He did give me a brief of the issues that were current, which were around the three sites, which was the Urology ward. There were a lot of risk issues in that ward at that time, and workforce issues, and a lot of quality indicators in terms of care. We put together a response to that with the corporate nursing team as well to try and stabilise 3 South. But that was the real emphasis for Urology in 9 June '19.

Q. So, the emphasis was on the immediate –

A. Yeah.

Q. -- issues that you were facing. Did Mrs. Corrigan ever raise the issues with you about what had preceded your tenure as regards governance?

A. No. Again, I believe that those were felt to be in hand at that point in time.

Q. Are you saying that with hindsight?

A. I am saying that with hindsight. I didn't know about them at the time, I wasn't sure of that. But as things emerged, that was my perspective, that they probably felt they were being managed.

Q. Knowing what you know now, do you think that you should have been told?

A. Absolutely.

Q. If you had have known then, what would you have done to reassure yourself about what was in place to prevent any reoccurrences or to ensure good governance?

A. I would have wanted to understand what range of intelligence there had been, not just that led to the MHPS but before that. So, I would have wanted a chronological list of all of the issues that had been raised over years or all the concerns that had been raised over years, but in particular the MHPS and the recommendations from it, and the monitoring processes and the impact of those.

As one of the learning points from this Inquiry - what measures are in place to ensure a full handover process is seen as a priority for people taking up a new post?

Q. We know that Mr. Weir, by September 2018, had produced a job plan and left it with Mr. O'Brien

A. Yeah.

Q. -- to agree or disagree?

A. Yeah.

Q. It was never, ever finalised, it was never, ever signed off. Did you take any interest as Director of Acute Services in trying to drive that towards a conclusion?

A. With the job plan, no, I didn't, to tell you the truth. The job plans were very much the medical side of the house, the professional side. For some reason, though, I always had to sign them off at the end. I always felt uncomfortable because I didn't know what I was signing but the Director had to do it. But these were very much led by the Medical Directorate and not me.

Is it appropriate for the Director of Acute Services to sign off 'medical professional' job plans?

……..

Q. You say in your statement that you didn't receive a handover as such?

A. No.

Q. Is it right?

A. That's correct. Dr. Boyce would have been supporting the Director at the time but there was no formal handover from a previous sort of full-time coordinator.

Q. Just in terms of the importance of a handover, Patricia Kingsnorth, when she gave evidence she said from a handover point of view, you handing over to her as you were exiting you were able to give her 45 minutes of a handover. First of all, are handovers important in your view? And the handover that you provided for Patricia Kingsnorth, was that adequate?

A. Handovers are important. And I think in retrospect 45 minutes probably wasn't enough. Although I was there on the end of the phone or if she needed any other guidance or support at the time.

The importance of setting time aside to complete a full handover.

Q. So, you make the point that you're the subject of appraisal for the purposes of validation, and it's said on a number of occasions, so I get the impression that you think it important to say it repeatedly that this is not a performance related review, and in answer to other questions you make the point that consultants are outside of the performance management loop. Tell me about your thinking on that. Are you suggesting in those answers that you think it would be a good idea, in light of experiences within urology services at the Southern Trust, and perhaps elsewhere, for you and your colleagues to be subject to some form of performance management?

A. Yeah, I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.

Q. You refer to it as, I don't think I need to bring that up on the screen, it's paragraph 47.2. You seem to value the opportunity, if it had stayed like this, for a confidential reflective exercise in professional development; you see advantages or benefits in that. But what you say is that the process has now morphed into something akin to bean counting - my words - it's a formulaic capture of documents - your words?

A. Yes. I think bean counting is equally good as a descriptor.

Q. So, moving from the positive side of that spectrum to the negative, why was this opportunity for reflective discussion around professional development, why was that useful and what has it now become?

A. So, when I first became a consultant, the appraisal process was between two peers and was largely a discussion, and you felt that you could have a confidential discussion about the challenges that you faced, the difficulties that there were, perhaps share the successes that you'd had, all of that kind of thing. Now nobody's really interested in that. They just want to make sure that you meet all the domains that the GMC have set out, that all of those -- in our Trust they use an electronic method for capturing all of that, I think it's common across Northern Ireland, and, you know, as long as you've got a tick in every domain, that's really what it's about. You know, you can see from the spread of specialties that have been my appraiser, many of them don't have that much insight into my specialty. Maybe I don't have that much insight into theirs. So, you know, there's something of questioning the value of that conversation. They don't have the performance data, they can't possibly meaningfully interpret the performance data in the different specialty, you know. How would, for instance, an emergency medicine consultant interpret the data of a surgeon? It's difficult for them, I would think. It would be difficult for me to interpret the outcomes of their work. I don't do their job.

Q. So, if, as you imply, it is, to use another metaphor, a box ticking exercise, are there implications of that if, for example, the practitioner has some frailties or –

A. So, a point that was made to me by Robin Brown, who was at one time CD for urology quite some years ago, and more laterally has been one of the senior members of the revalidation team, he said to me "I'm not looking for all the good points in your appraisals. What I'm looking for are the little indicators that there are problems", and I think that's largely what it has become, and it may be very difficult through this appraisal process for the Trust to actually pick up where there are problems. Not too many people present warts and all in their appraisal, I would suggest.

Q. And your seeming endorsement of some form of performance management, whether integrated within the appraisal process or standing separately from that –

A. I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.

Q. Knowing what we know, and there may be a bit of a debate about what precisely we know has emerged out of urology services in the last few years, particularly arising out of the processes relating to Mr. O'Brien, do you see in that particular context a specific merit around performance management or –

A. Yes, I do. Because I think if you identify these things at an early point and they're out in the open, then it allows the team to, first of all, identify and name the issue and, secondly, then to think of ways that the team can address the issue together. It means a more consensual collegiate way of working, you know. So I think there are merits to that.

‘I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.’

‘I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team,

what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.'

What is the view of the SLT on this approach and suggestion?

……

Q. Could I bring you to a reflection from Mr. Glackin around the appraisal mechanism. If we go to WIT-42316. If we go to the top of the page. He expresses the view that the appraisal process has morphed from a confidential reflective exercise in professional development between two professionals which, elsewhere in the statement he welcomes and, like you, found extremely useful, but it has, as he says, morphed into a formulaic capture of documents, such as reflection on complaints, records of continuous professional development, through evidence a recommendation for revalidation by the Trust's responsible officer. In other words, I think he agreed with my re-characterisation that that is either bean counting on box ticking. I forget the metaphor I used. But I think the point he's making is quite clear. Has that become your experience, that there has been a change in the character of the process, or do you still remain relatively content that it is a positive experience?

A. Well, I can probably only speak from my experience. I mean there certainly is where you're collecting all the documents, but they're essential because they're evidence of engaging in various activities to support your practice. I mean, I have had confidential discussions, I've reflected with my appraisers, and so it hasn't been my experience. Perhaps I had a good experience, but it -- and I found it -- and I put a lot of work in and, as a result of that, I try and achieve everything that I've set out to do for the following year. It does set -- it does give you a focus of where you want to go. So I found it useful.

Q. Have your appraisers been external to Urology?

A. One of them was internal, it was Mr. Young, but the other three them were external. One in Radiology, A&E, and aesthetics, so I've had four.

Q. Is there something, if you like, to be preferred from using a person from another discipline to conduct the other?

A. I think it is probably a good idea in that they can be, certainly, more objective. You know, if I'm a colleague of yours, I mean you mightn't be as hard on me as perhaps somebody else might. I'm only surmising.

What is the current guidance on using an external appraiser for appraisals? How practical would it be to make this a desirable requirement?

Q. In terms of the handover, we've obviously got a picture of turnover amongst the consultant staff, particularly during those years until perhaps relatively recently when things may have settled down to a degree. To what extent is the handover problem well addressed at this time?

A. There is still no policy in place, to the best of my knowledge in the Trust, describing how this process should be managed. Within our own department what we have been doing, we've had a number of locums in the last few years and we've had other members of staff retire. So, for instance, from the cancer perspective, those patients who are coming to MDT where it is clear that that person has retired or left the Department, those cases are shared out formally and they're handed over to a new

named consultant. From a results perspective, when somebody has left employment of the Trust, we have agreed to share out the results of those people and divide the workload between the existing consultants.

'Q. In terms of the handover, we've obviously got a picture of turnover amongst the consultant staff, particularly during those years until perhaps relatively recently when things may have settled down to a degree. To what extent is the handover problem well addressed at this time?

A. There is still no policy in place, to the best of my knowledge in the Trust, describing how this process should be managed'

Is this still the case?

Q. ''custom and practice went unchallenged with respect to the timeliness of correspondence, triage, monitoring of volumes of activity and chronological listing of cases for theatre." So is part of your concern here in terms of what we learn from all of this is that, as I think we discussed on the last day, performance management, more focused performance management is key to getting at the problems at the earliest possible stage?

A. I think we need performance management. I think we also need openness and transparency in terms of job planning and what people are delivering and what they're expected to deliver. You know, practice. Even amongst a small team like ours, we all have sub-specialist interests and, you know, it may not be possible for us all to see equal numbers of patients, but we should be expected to deliver a reasonable volume of work, and that should be agreed, and we should be monitored to ensure that that's happening, you know. I think, you know, timeliness of correspondence and completing triage in a timely manner, all of that stuff should be formally agreed, it should be, you know, recorded in a job plan, and it should be recorded in a policy for the Trust.

A clinician recognising the constructive role of performance management and the need for openness and transparency in job planning, what people are delivering and what they are expected to deliver – suggesting that this should be a Trust policy. What is the SLT's view of this suggestion?

Q. Yes. I wonder is your slight awkwardness or discomfort around this reflected in something Mrs. Corrigan has said, if I can ask your comments on this -- if we go to WIT-26304 and at I think it's paragraph E, she's reflecting some learning arising out of, if you like, all of this. She says: "In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. For clinical staff, they need to know who this is and what authority they have as their accountable..." -- and I think that should say "manager". "It is my observation that there wasn't a clear line of accountability of management while I was in post. So whilst the consultants were directly accountable to their responsible officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a clinical lead, Mr. Young, and whilst I believe it was understood that he should be managing the rest of the urological consultants, Mr. Young never had an actual job description outlining what this should entail and, from my recollection, only got 0.5 of a PA to be the clinical lead, so I don't believe that he ever felt that this was his role, although this would be a matter best addressed by him." And here we are! It's set up for your comment, I think. She's speaking in tolerably clear terms, but, to paraphrase, is she echoing something of what you've just recently said, that, really, you didn't accept that you were the manager of these collection of Consultant Urologists in the kind of sense that she's describing -- that is with authority, telling them to pull their socks up if they needed to pull their socks up, and...

A. That's spot on. It's a small group. It's a small team. It's very important to get on to make the thing -- to make the work gel, to make the whole as a unit gel. So it's hard if it's -- if you're put on the spot. If someone needs to be put on the spot, that's fairly obvious, but, you know, I felt a bit pressurised on that front and I thought it was an unfair ask, if you want to put it that way.

Q. Yes. Plainly, you took the role on in or about 2000, give or take?

A. Yes.

Q. It's in much different-looking shape than it was in 2014 when you have five or six consultants, albeit for a short time, as we discussed earlier.

A. Yeah.

Q. Do you feel that the expectations that came with the job changed throughout that time?

A. Well, like most things, they change as they move on. I mean, I saw the role as a service-driven, sort of organisational job. I would have represented the unit at such things as our THUGS Committee -- that's our theatre users group! So I would have represented our unit for that to report to the Committee on what we wanted from Urology, and maybe backwards from that Committee to the rest of the team. I saw my role as leading on if there was any sort of major sort of project to get through, that would have been -- for instance, actually setting up the ICATS service on the 2009 process of how we're going to get this into the unit; I sought -- there was the saline resectoscope issue -- I sort of took charge in trying to process that, to make it happen, and maybe facilitated the departmental meetings. But, again, that was trying to get people to get round the table. And, again, I might have sort of managed the staff grades in a little bit more detail, albeit that the staff grades contract, their next in charge was actually the CD, I believe; it wasn't me.

Q. Yes.

A. Although I took control of it.

Q. Yes. And, in many ways, your pre-empting -- I'm not criticising you, by any means -- some of the bigger ticket items we'll explore through your evidence to see how they managed and to see how they both reflected on your role and how what they say about, I suppose, governance in general. Just before I leave what Ms. Corrigan has said, and it's up on the screen, she adds the sentence that she felt or she feels it was unfair, in any event, to have peers attempting to manage peers, as these were their colleagues and it was hard to hold them to account when they were of the same grade. So I think that's echoing at the very heart of your discomfiture –

A. Yeah.

The importance of post holders having a full description and understanding of their role with a clear line of management accountability. How is this monitored?

Q. Let me pick up on some of that. This was in part about changing culture, it was getting the system of appraisal in the mainstream. As you say, 40 to 60 percent, you got it up to close to 100 percent. At that level it was a success. I suppose if this Inquiry is looking at, I suppose, methodologies or instruments by which a Trust can pick up on doctors in difficulty, doctors not performing as they are expected to, if that's one of the Inquiry's interests, the Inquiry, at least going back to the early days of appraisal, the Inquiry would be wrong to think that appraisal was focusing robustly or rigorously down on that kind of issue. It wasn't about that, really?

A. No, and there's been criticism from the BMA and others since then where appraisals have been in some Trusts used more for performance. That, I think, isn't the right way forward. There has to be, if you like, a back-up to say, well, we're also going to look at your performance and adherence to guidelines and, you know, what we want you to do as an employee. This is about you telling us how you want to get better and can we help you.

Q. Right.

A. So it couldn't really -- I think there's a gap there in terms of performance management.

Q. Yes.

A. I tried to introduce it at the AMD level. What I said to all the AMDs was I want you guys to come up with your own performance targets for every year.

Q. We'll come to the AMD. Let's just step into this training document as a source to help us understand aspects of the appraisal process. If we go to WIT-25882. I think you've said in your evidence earlier the doctor's role includes identifying an appraiser for him or herself so they, in a sense, at that time got to select. It's for the doctor, at least in part, to identify factors that may inhibit performance. Of course, you say it was intended as informative as opposed to performance management. We see in Mr. O'Brien's case that he was appraised by his peer, Mr. Young, who was also clinical lead for five continuous years. Whether the purpose of the scheme is formative as opposed to management performance, that's not good governance, is it?

A. No, but it's a start because previously there would have been no requirement, really, to engage in appraisals. It was a start. There was a debate at the time as to whether or not a doctor should be appraised by someone from the same specialty. But what we tried to do as we moved on was to train professional, if you like, appraisers who could do that. I was in favour of that because my appraiser as an Associate Medical Director was Paddy Loughran, who was an anaesthetist, so I had to explain to him what I was doing in psychiatry, which is no bad thing. I believe the Trust now allocates appraisers, and I think it is changed every so often to keep things fresh. So, that wasn't ideal.

Q. As it says there, they have to identify factors that may inhibit performance.

Does the SLT think that the current appraisal system is fit for purpose? When was it last audited?

……

Q. Maybe it comes back to something you said on the last occasion, about, I suppose, a sense of awkwardness or reluctance to be able to challenge a peer about an obvious shortcoming in his practice. We've seen how in the past you've helped out, I suppose, rather than have a confrontation.

A. Yes.

Q. This was clearly a time for a confrontation, was it not, whether you to him or by escalating it to a clinical director, so that this could be finally resolved?

A. Yes, that's a fair comment, as a peer-to-peer that I could have, I should have. On reflection that's a very valid comment. But, having done this before and offered help and received, you know, it may have been more appropriate that somebody much higher than myself was actually doing that. And, potentially as a friend and a colleague, yes, I potentially could have

Could this point be a topic covered in all yearly appraisals for consultants in the Trust?

Q. So he is setting out in this form -- you'll recognise the format -- he's giving, in these boxes, details of his work. In terms of details of any other clinical work at 2.5 he tells you how triage red flag referrals when urologist of the week. It doesn't appear that that's interrogated in any way. Indeed it's a feature of the appraisals, and we'll look at these this afternoon, that his problems with triage are not addressed through this process. It is perhaps not obvious now, maybe with some hindsight, that he is telling you that he doesn't triage anything else apart from red flags?

A. I have gone over these appraisals and what's written in this first section is often a copy from the year before and it's only in recent times, when I have reviewed the whole document, that I saw that one line.

Q. It stood out for you as well?

A. Well, I have had to read the document several times. It's only in recent times that I've -- I saw that one sentence. Having done appraisals before, I accept that.

Could this text be used as an appraisal training example and learning point from the Inquiry?

Trust Board

Mr O'Brien's case was not discussed at Trust Board level until 2020. There is a space at the end of the Board meeting for AOB to raise concerns. Clinical risk was raised by Mr Haynes in 2019 but it did not come to the Board. Chair of the Board only had knowledge of SAI's via Dr O'Kane's report in September 2020. Governance connectivity and debrief were not rigorous in 2018/2019.

Are the processes and use of procedures operating effectively now with operational, clinical, and social care governance?

Q. An early alert was sent to the Department of Health in July 2020. The Trust Board was not notified until 27th August - there was a delay – why?

Was this the Trust trying to manage bad news?

What is your response to this?

A. It is a fair reflection to note that it was not a regular occurrence for information that was discussed at committee level to have any detailed conversation at the Trust Board.

…….

Q. "The document is not clear and at times we got completely muddled as to what their role actually is and how far they can go when contacted by a doctor through a process." I think you've just said, is that related to the O'Brien/Wilkinson experience?

A. Yes. Absolutely. I think Mr. O'Brien's expectation of the role of the designated Board member was not maybe something that was the same as our expectation.

Q. Unmoored from the O'Brien case, and based on your general experience in this area, and knowing perhaps the limitations of NEDs, no matter how enthusiastic or experienced they might be, what would you be telling the Department if they were listening to you? Is the appropriate role for a NED in terms of the relationship with the practitioner on one level, and in terms of their relationship with their fellow Board members going in the other direction?

A. Personally, I'm not sure there is a need for it. We certainly don't have it in any other, you know, non-medical staff group. However, I think the issue around maintaining the momentum is important, but I'm not sure that that necessarily has to be the role of a non-Executive. I think there are other ways to ensure that there is momentum maintained and maybe part of that is through the arrangements we have and the reporting through to a Governance Committee or onwards to Trust Board. But I just think that this is something that muddies an actual process. I'm not sure that it is terribly helpful. I think in fairness to a practitioner they might have an expectation, that is that they will step in and actually do something different.

Is there currently a clear understanding of the role of NED's within the Trust? Also, the role and expectation of a designated Board member?

……

Q. "I received broad general training on the MHPS Framework. The role of the designated Non-Executive Director was unclear and was highlighted as such by the trainer who, on several occasions, stated that the role was indistinct and that the Department of Health had been asked on several occasions for clarification but none had been provided." So, what did you take in respect of MHPS specifically and the training around that? Did you feel that it was beneficial, did you feel it gave you an understanding of your responsibilities?

A. I took away a general understanding of the role of the Non-Executive Director as the designated person, but in terms of the detail as to how they would actually carry out that role, I was still unsure of that role. With regards to the way in which it was actually delivered, there was an overriding comment made that, look, the role of the NED, if I can use that phrase, the role of the NED is indistinct; you have to search for it and you have bring it together, and this is what we have done for this level of training. At that stage I had no knowledge that I was going to be asked to undertake this role, so I was content that it was okay at that high level of understanding. On reflection now, I know that it wasn't sufficient.

Q. Do you feel it was part of your role to provide support to Mr. O'Brien? For example, sort of from an employer relations perspective or from a comforting perspective or beyond the role that you have described there, did you feel that formed part of your role as the Non-Executive Director?

A. I think this is one of the issues with the role of a nonexecutive director, is finding the word that best describes what the nonexecutive director will actually do as a designated person. I don't want to be pedantic about it but support can mean different things to different people. That's why I think there needs to be some sort of guidance material which describes the activity of the nonexecutive director. It could be supporter, it could be inquirer, investigator, it could be so many other things. But that wasn't clear within the guidance material, nor was that intimated to me. Whether or not Mr. O'Brien interpreted it in a wider degree, I can't stand over how he interprets that. I can give him what the guidelines say. But as unpacking that statement, that's most important.

More clarification and guidelines are needed on the roles of the non-executive director and the designated non-executive director.

Q. I suppose what I'm asking is were you accepting at face value that the Trust was telling you it's going to take longer than the four weeks and whenever that kept getting extended, did you just accept that?

A. Yes, because what else -- this is a -- what else was I to do? Was I to investigate that? Was I to bring people in and investigate that? Is the investigative part of the nonexecutive director a key aspect of it? If it is, then I doubt whether or not a layperson is the person to carry out this role.

Q. Who do you think then would have been more appropriate?

A. Someone placed within the health system, who is well trained. Because it is a well -- I believe now it's someone that needs to be well-trained, and needs to know the structures and processes within the nonexecutive director role. That person needs to know what he or she can or cannot do and what is expected of them.

What is the SMT's view on this?

Q. I think just to wrap up this bit about the board. Again I can be corrected if I am wrong, but it seems like the Trust had received a confidential update on 27th January regarding Mr. O'Brien's exclusion. Then it appears that the board isn't told anything until the Early Alerts in and around September 2020; is that right?

A. That's correct.

Q. So they hadn't been informed of anything in the interim?

A. No.

Q. Do you think that there's a governance failing in that?

A. Yes. Put simply, yes. But I think that the Trust was operating on what had been previous practice, and I can't verify that because I was only fresh into the Trust at that stage but that seems to me the way it was done. There's no doubt about it, that the board needed to be kept more informed, even at a general level, as to the progress of this investigation.

Is there more clarity now about the Trust Board being kept in touch with progress in an investigation?

……

Q. Mr. Devlin refers to reports that are sent up to the Board from the committees in his witness statement. He says that it is a fair reflection -- sorry, in evidence he said that it was a fair reflection that reports from committees aren't generally the subject of great debate or input at Board level?

A. Yes.

Q. Would that have been your experiences also?

A. It would. I think what the non-executive director members and the Chair of those committees would have brought for noting, you know, there would have been an update, maybe a verbal update on just what the last meeting had been about, et cetera. But I suppose the assumption was that's why you had the committee, the committee to do the work and to do the challenge, the discussion on behalf of the wider Trust Board. So, I would have said there wouldn't have been a lot of time spent on those at Trust Board.

Q. It seems that there was a slight shift, you have said, about the assumption in that assumption. Mr. Devlin states in his evidence: "It was not a regular occurrence for information that was discussed at committees to have any detailed conversation at the Trust Board." Then he goes on to say: "We did in probably October and November 2021 then begin to have a conversation about risk appetite and about what the process should be for escalating from committees to the Board."

A. We did.

Q. Given that was only in 2021 and given the historic nature of the issues before the Inquiry, do you think that conversation should have been happening sooner?

A. I think that's a fair comment.

Is the SLT confident that the Trust Board is now receiving and reviewing all the relevant reports and papers in accordance with the Trust's brief?

……

Q. So if you could wave a magic wand and resources weren't an issue what would you like to see happen in terms, first of all, generally in governance and more specifically what do you think is the one thing that would help prevent something like this inquiry happening again?

A. I think resourcing the teams appropriately, having sufficient resource to, both - at all levels, so making sure we had the right resource to make sure that the clinical workload was doable, having the resource within the operational teams to make sure that there was managerial time to make sure that actions were taken. From a clinical governance team it's making sure that the right number of people with the right skill set, the right training, the right time were available to review the incidents, take forward the proactive work, the education, the training, the audit, the triangulation of information, having data analysts that can actually really delve into information and show it in a meaningful way and having IT systems that mean that information isn't a challenge of going to lots of different systems to try and pull it together.

This reply could be a useful comment to feed into the discussions on outlining the vision for the next chapter in the Southern Trust.

Silo mentality – segregation operationally as opposed to integrated working

Q. SAI's seem to have been dealt with in silos – in different directives – not shared or given oversight by the Medical Director.

Is it possible to evidence that this is now different so that confidence can be developed?

A. There was not a corporate approach to Clinical and Social Care governance – there was a Directorate approach.

Has this changed?

A. There were also cross-site governance issues

What, if any, are the current cross-site governance issues – what plan is in place to address them?

A. There was a disconnect between the Cancer Service and Urology, they were not communicating with each other.

There is a need for more integrated working and joint ownership – how is this principle being filtered through the organisation?

……..

Q. You say in your conclusions towards the bottom of 912 for you, 01923 for us, that these are what you regarded as systemic failures by managers at all levels, both clinical and operational, to deal with those matters. What did you mean by "systemic" in that context?

A. I suppose the operational team and clinical teams -- the operational and clinical management teams provide the governance, the professional governance assurances. So, what I meant was that there must be failings at many levels in order to reach to this stage, both operationally and professional governance point of view. I was aware that these issues were raised at multiple times and they were not addressed by professional, clinical, medical and operational teams. So there must be -- I was trying to explore there must be other reasons and I wasn't finding that in the report. Therefore, I requested that there needs to be a further in-depth analysis investigation by the team which is independent, and they can do independent assessment and they should provide for learning for the organisation to go forward. That was my thinking, I suppose.

Q. Can I trouble you for an example of what you might have been thinking about, perhaps, for example, triage. You would have observed from your reading of Dr. Chada's report over a period of time, going back several years, triage was an issue being raised both clinically and operationally by management, but the issue was never resolved to the satisfaction of management so that a default arrangement was put in place whereby if triage wasn't performed, then the patient was placed on a waiting list in accordance with the general practitioner's designation. If that's a useful example, or pick another example of what you would seek to communicate in identifying this concern.

A. I suppose there were many examples, but more troublesome for me at that point in time was I could not find a valid reason that these issues were raised on multiple occasions and they were not addressed, so there might be a system-wide failure to get to that point. I was really troubled by thinking what's going wrong? Why is the system not working? There is a professional governance structure, there's a clinical governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.

‘I was aware that these issues were raised at multiple times and they were not addressed by professional, clinical, medical and operational teams’

‘There is a professional governance structure, there is a clinical governance structure, there are operational managers. There are so many levels of safety netting, so why we are not able to protect patients. That was troubling me quite a lot at that time, and still is.’

Have new lenses been applied by the Trust to monitor the safety netting so that there is concrete evidence that the safety of patients can be guaranteed?

Q. It's been quite clear from the people we have spoken to that although all the managers, medical and operational, were trying to do their best, there was a little bit of confusion at times as to who was doing what. So, the doctors tend to leave most things to the operational managers because they are so busy but when there's an issue with a doctor, it has to be managed by a doctor. It's my impression that this isn't as functional as it might be. Would you agree with that in terms of what you have seen for this Inquiry, and is it a more general problem in the Trust, or what do you think?

A. I do think that there was confusion about lines of management and who was to manage that area. I think that is an issue when it comes to senior clinicians and consultants in particular. There does seem to be this lack of clarity about what areas should be addressed by non-clinical managers and what areas need to be addressed by managers. I would completely agree with that, and I think

improvements in that have been made. I'm aware that -- I mean we did this investigation under Maintaining High Professional Standards, and we wrote out to people and said to them this is what we are doing. I'm not entirely convinced that people always knew what that meant, and particularly non-medical managers. However, it was explained to them. I think non-medical managers are anxious about managing doctors.

Q. And what's the solution to that?

A. I think there has to be a closer working with non-medical and medical managers. I think the problem, looking back from my time as a medical manager, the problem is you are not actually given enough time to do the medical management role because you are trying to manage performance but you are also trying to manage other governance issues, you are trying to manage SAIs, you are trying to go to 101 meetings, you are looking at service development, you are looking at quality improvement. You have two sessions a week perhaps and you are trying to do too many things in that short space of time. You try to do those to the best of your ability, usually outside of work time. So I think more time, more protected time to properly engage in management is, I think, required.

What consideration is being given to provide adequate time for more aligned working between non-medical managers and medical managers?

Q. You talk, helpfully I think, that categorisation of the initial concern can make a significant difference to how a case progresses with the distinction between capacity with options for assessment and remediation and conduct which can lead to disciplinary. If Simon Gibson, you say, did not know about any capability, clinician capability concerns in September 2016, that avenue under the MHPS Framework effectively disappeared. As I say, we're going to go on just in a moment to look at the issue of screening and the availability of, if you like, soft intelligence or soft information. What you may not know is that Simon Gibson is asked to perform this screening exercise effectively off the back of the March 2016 letter which identified the four issues that were rehearsed to you.

A. Yes.

Q. Is there a problem, or can you help us in trying to assess whether there's a problem, in that he gathered the information for that screening report –

A. Yes.

Q. -- by speaking to operational management. He was feedings back to this group that I've called the Oversight Committee, and there was no intervention, no contribution from clinical colleagues of Mr. O'Brien, I think it's fair to say. So, the Associate Medical Director was not brought into that loop; the Clinical Director wasn't brought into that loop; the Clinical Lead was not brought into that loop; none of his colleagues who don't hold managerial roles but are on the medical side and are senior clinicians were spoken to. Is that the kind of information that needs to enter into the system at the earliest possible stage in order to get the categorisation correct?

A. I think that's reasonable. Yes. Simon went to the operational managers because that's Simon's world. Simon is an operational manager, do he went along and he would have got the feedback around delayed triage, the things causing bother to the operational managers. You're absolutely right, if he had gone along to the medical colleagues, he would have probably got a different bit of feedback. He might have got some of the same stuff but he would also have got a more nuanced feedback on capability. I suspect if a medical person had been asked to do the screening report, it would have probably looked a little bit different because they would have gone to the medics. So, you're absolutely

right, and I think that's a reasonable observation, that, you know, somebody should have asked his medical colleagues.

Note the importance of gathering screening information from both the medical and operational strands of the organisation.

Q. We looked through the email, the two emails that you have indicated the patient risks specifically. Anita Carroll, Heather Trouton, Martina Corrigan are all sighted on those, and thereafter Debbie Burns told you to stop filling in Datixes. Would it be unfair for me to characterise it as being slightly disingenuous for Anita Carroll to say acquiesce to that direction, nothing is being done, when actually she is one of the people that could have done something?

A. But she did escalate.

Q. Did she ever speak to Mr. O'Brien?

A. No, but that wouldn't be how we worked. We worked probably in silos. It wouldn't have been for her to speak to the consultant, it would have been the AD for that area to speak to the consultant. Just as if there was an issue with one of my ward clerks on the ward, I wouldn't have expected another Head of Service to speak to them, I would have wanted to have been informed of that issue and then I, as the Head of Service for that area, would have spoken to that person.

Q. The Inquiry has heard evidence and likely will hear more evidence about those twin tracks of governance and accountability, clinical and operational, if I can use those shorthands. Is this a real-life example of one of the disadvantages of there being twin tracks when trying to deal with problems that actually cut across both?

What current advice is the SMT giving to the organisation when problems arise that cut across the twin tracks of governance and accountability, clinical and operational?

Q. In relation to that, you may have heard Mrs. Forde saying on Tuesday about the silo of line management, operational and clinical; very rarely they seemed to communicate across the barricades, as it were. Was that your experience, that there was a silo in the way things were managed or communicated up and down admin lines or clinical lines?

A. Very much so, yeah.

Q. Do you think that contributed to issues either not being identified, not being addressed and/or getting worse?

A. Yes.

More evidence of silo perception and working – presenting higher safety risk for patients

……

Q. And why is it that escalation is regarded as a substitute for action. Now I don't expect you have to have the total solution to that, but do you have any reflections as to why that's the case, other than the extreme work pressure, which we have heard about and which is acknowledged and the complexity of the organisation, is there anything else, do you think, that's fundamentally responsible for the fact that a number of things don't seem to have filtered up to the right people?

A. Yes. There's probably something in the space and it's very much in the governance space, I guess, people being very clear on what their roles and responsibilities are and it's not necessarily somebody

else's responsibility. So whether there is a diminution of people's understanding of what each person is responsible for and what you are certainly responsible for as a leader, I don't really have the answer to that. I do think, as you have articulated quite well, I suppose probably my own assessment and my own experience. Like I said, I would reiterate the fact that I do think it's not just as simple as saying culture, I think there is more to it than that. And I do believe there to be subcultures, but clearly it's a leadership challenge at all levels.

Q. So, in that vein, there is my impression, and I think we have heard evidence that people have concentrated very well in their areas –

A. Silos.

Q. -- of the different committees and in their professionals areas, so you can call it silos, you can call it all sorts of things, but it doesn't seem to be integrated governance in action as far as the evidence we have heard. So what discussions have been had at Board level about how to make a more integrated approach to performance, et cetera, a reality, because it's another thing that's easy to say and difficult to do. My question is around does the Board regularly discuss this, has it discussed it, did you have any contribution to that discussion and, in that regard, what did you regard your role as a Board member in terms of facilitating the difficult discussions underneath some of these issues?

A. Okay.

Q. So that's quite a broad area.

A. There's quite a lot there, yes.

Q. It's about integrated governance and how you as a Board member can execute your responsibility for everything, it's not just within your portfolio?

A. Sure.

Q. And whether the Board in a wider sense really grasps the need for that given the breadth of the issues you are facing?

A. So if I start with thinking about the intent of the Performance Committee, for example.

Q. Yes.

A. The intent behind the Performance Committee was to consider performance in a broader optic, and not just about –

Q. The numbers?

A. -- the targets et cetera. So when we would have had a session on cancer or whatever, I mean the Board determined whatever area to drill down into in a deep dive type thing, it was an opportunity then as Board members to really get under the surface of some of those things.

Q. Did you, do you think?

A. No, I think we made a start. I think we did make a start. What I can say as a member of the senior -- here's how I measure that: As a member of the senior management team those meetings started in October 2019 and at every meeting I learned something. I think that is a measure of what I wasn't otherwise finding out some way else. So there was an opportunity for people to talk people into the other issues they were facing within their services et cetera. So I think that could be part of the solution certainly going forward.

'But it doesn't seem to be integrated governance in action as far as the evidence we have heard'

On a scale of 0 – 10(being fully integrated) where does the SLT rate the current level of integrated governance?

……

A. Performance and governance are completely tied together. They are two sides of the one coin. They have to work together. When the pressures are higher, the governance has to be better, you have to consider it more. Who gets the last bed in the ED has to be around clinical priority and has to be based on good governance.

Q. "Better inclusion of non-clinical managers with clinical managers." You say that's been improved and we can ask Mrs. O'Kane about that?

A. Yes.

Is there now a good connecting structure in operation with non-clinical managers and clinical managers in all departments? Is this being monitored and where there are issues are they being addressed?

…….

Q. Do you think that's the main problem, that they don't have the time, the expertise, the training, the support to do it, or is there something else behind this? I mean you talk about back channel communication. We've heard it from other people about various things: hierarchy, silos, secrecy, fear, mistrust. These are not good words, and nobody in these roles would set out to be like that, I'm quite sure. So what do you think the problem was? And while you're answering that, have there been attempts to improve on it, do you think, or how does it feel from a practising clinician point of view?

A. I don't think the people who are asked to take on those roles are provided with adequate training and support. I don't think they have enough time in their week to deliver that workload. It's not really something that I have ever aspired to be.

'Hierarchy, silos, secrecy, fear, mistrust' – these are words that have been noted from witness statements in the Inquiry – does the SLT have a feel for how relevant are they today in the experience of staff in the Trust?

Priorities

Mr Devlin looked at organisational priorities – not MHPS.

A. It was not on my list of major issues; I was focussing on the areas that I saw on building the organisation

How would you describe the balance now in addressing the organisational priorities and the MHPS?

A. SAI's in 2019 were not drawn to my attention – I would have expected issues of patient safety to have been raised with me

If this is correct – why didn't this happen? Is there some learning here?

……

Q. Does it surprise you that more information didn't come into the whistle blowing framework about the concerns that we are now beginning to hear about?

A.I think it shows we have a lot of work to actually do. Does it surprise me? Possibly. I think we were in a situation where so many people knew for so long and, for some reason, those concerns weren't resolved at the earliest possible stage. I think what we have now to do is significantly more work around enabling people to be more comfortable about actually raising concerns. This is a long-term piece of work and it is a journey that we're on to try and ensure that individuals are raising those concerns in the best interests of patient care. It is absolutely an actual journey that we're on around raising that openness, and when there are concerns being raised that people take action. I mean, that is something more down the organisational development side of my role that we absolutely need to pay a significant degree of focus to moving forward.

'This is a long-term piece of work and it is a journey that we're on to try and ensure that individuals are raising those concerns in the best interests of patient care. It is absolutely an actual journey that we're on around raising that openness, and when there are concerns being raised that people take action.' How is this message being kept on the front page of the Trusts delivery priorities?

…….

Q. And one question the Inquiry would have to consider is why those concerns weren't uncovered earlier as part of the MHPS investigation, which took place over 18 months. An angle which could be taken might be that the parameters of that investigation, the terms of reference were set too narrow from the start. That in effect the Trust were only looking at what they knew, as opposed to establishing or satisfying themselves that there's no patient safety concerns or any further patient safety concerns and NCAS advice may have played into that. What do you say in response?

A. Well, I wouldn't really agree with that because I'm still back to the point of, you know, they did come to a conclusion that the matter should go to a conduct hearing which would have given them an opportunity to draw a line under it and presumably monitor Dr. O'Brien's performance to ensure it didn't happen again. I mean, if patients were still being harmed, that's a completely separate issue and we need to look at why the restrictions that were in place weren't sufficient to prevent that. If you're saying to me that patients continued to be harmed whilst this investigation was going on and after it concluded, obviously that's a huge problem. The biggest problem is why were the restrictions removed? The problem had never been addressed. They never got to a conduct hearing. They never really got to an acknowledgment that there was anything -- I mean I don't think Dr. O'Brien acknowledged that he accepted the findings. You know, in those circumstances, how was he continuing to work without some sort of supervision in place? That, for me, is the biggest issue.

With the knowledge that some patients had come or could potentially come to harm - was there supervision in place from 2017 onwards monitoring Mr O'Brien's practice?

Q. You've more experience than most of dealing with the MHPS Framework given your unique enough position. You obviously heard some of Dr. Fitzpatrick's reflections earlier. Does the process or does the framework work? Can it work? What might need to change in order to make it more effective?

A. I think there's a number of problems with MHPS. I think there's great difficulties in Trusts in managing concerns. I mean, we've seen this a few times now. You know, you pointed out earlier -- and it is something that we address in case investigative training but it's not getting any better. They don't have people freed up really, they add it on to their day job. I think they're completely -- I think the

situation in which the Health Service in isn't going to make it any easier any time in the near future. As you can see, this was taking up an enormous amount of time.

Q. Those issues you describe, I don't personally have a view on it and I'm not expressing the Inquiry's view by any stretch, are they issues with the framework itself, are they issues with almost the structures, the funding or the infrastructure around the framework in how it's implemented?

A. I think there are problems within MHPS but I think there are problems within organisations as well. I think there are difficulties -- there's a lot of tick boxing goes on in the Health Care system at the moment. I think there's a real nervousness around managing performance concerns. You're dammed if you do and dammed if you don't. There's real concern. I see it as people doing things just so that though can say they did them. It has become increasingly bureaucratic, and that has an influence on patients as well in that the time taken to do everything is hugely extended because of the need you are making sure that you're adequately covered, that you're not exposing yourself to risk. I think there's a lot of -- there's a huge amount -- I don't even know how you begin to fix it.

Q. That's probably not welcome news to the Inquiry at this stage.

A. I know but it's true

While considering the bigger picture, are there any quick win ways that can help the Trust manage this tension so that the wellbeing of staff and of patients can be upheld?

Q. I've just have got two short questions, hopefully. I'm still struggling slightly with the classifications of shortcomings and just two things with respect to, firstly, the dictation and, secondly, the triage. We know Mr. O'Brien could do it but he on occasion didn't do it. How do you classify that as capability or performance or something different and how do you work that out?

A. Well, I think if you have the ability to do something and you don't do it, that's a conduct issue. So, as I understand it, Mr. O'Brien didn't really agree with the triage that was a put in place but he was instructed that that was to happen but he didn't want to do it like that, so that led to the backlog. So it was as a direct result of decisions he was making about how he behaved. So I viewed that very much as conduct.

Q. What's the place of mitigation there, pressure of work, and things, would that change?

A. Yeah, I agree entirely with that. I think that was -- you know, there were mistakes made there about not freeing him up to do it. But I think even -- when it was drawn to his attention, you know, and it had become a big issue, that was the time that he could really have, even for himself he could have stopped -- I imagine if he had told the Trust I'll stop doing X, Y and Z, to do that. There would have been very little they could do about that. But he didn't. So I think that had he -- you know, I realise he did a huge amount of work and a huge amount of hours but he wasn't following specific instructions and he didn't make any -- well, he used to get the better for a while and then slide back which sort of as well implies conduct. He could do it when he had to but he couldn't consistently do it, probably because he didn't believe in it.

The importance of identifying and immediately dealing with a conduct issue

.....

Q. Now, I asked you before the break about learning, and I think it was my word to say there was ad hoc learning from the SAIs. I just want to indicate from your witness statement that you are a member

of the Task and Finish group. You refer to this at WIT-85936 at paragraph 20.5. This was a group established in 2021 to action the outcomes of the Urology SAI recommendations by the Trust?

A. Yes.

Q. Is this a way in which learning comes back out through the formal system to the CNS, or does the learning sit within the group?

A. So, in a way it's turning the learning into an action that results hopefully in an improvement. Myself and Kate - I think it's myself and - no, myself and Patricia - are within that Task and Finish group. But as for updating the CNSes per se, no, that isn't part of the remit of that group.

Q. So when it's tasked to action the outcomes of the recommendations, how do they do that?

A. So, I have been involved with the service user group. There's going to be a survey as to what information and role they expect within their journey, and we are looking at the information that's given. Out of also this Task and Finish group, I think that is where the additional audit resource has come from in terms of us now having a list each month of the new diagnoses and being able to cross-reference those. So there has been good that has come out of it, but there's more to be done.

How robust are the plans to cascade and embed the learning from the Urology Public Inquiry throughout the Trust so that a similar statement 'there was ad hoc learning from the SAIs' will not hold true?

Q. Yes. To try to summarise your experience over the last 10 or 15 years in performance –

A. Mm-hmm.

Q. -- in measuring performance and trying to assess what flows from it and what can be done about the difficulties and pressures faced, is it the reality that demand has outstripped, and continues to outstrip, the capacity to address the needs of patients in your local population across SEC as well as Cancer Services?

A. Yes, that's a fair enough reflection. It's not unique to Urology, it's actually the case for a number of the specialty areas.

Q. The Trust recognises that this places patients at risk and has communicated that to the Commissioner?

A. Yes.

When the Trust last communicated to the Commissioner that demand continues to outstrip capacity

In Urology - what was the response?

.....

Q. The review, what was the outworking of that in terms of how you were able to carry out your job effectively? You have mentioned the 2019 review. What improvements or did you see any improvements after that?

A. Well, there was improvements from the viewpoint that we started getting moving through those current SAIs, and then getting those finished, completed and sent to the Board and to the families. It never really sat comfortably with me getting those reports out to families because I would have built up a rapport -- in my last job, I would have built up a rapport with families, they would have known

him, they would have phoned me, I would have been able to contact them and say this is where we are at with the review. With these people, I was coming cold to them, do you know what I mean. The first thing they were hearing from me was a phone call, which was really difficult for them to take in, you know. We did a review of an incident that happened maybe two/three years ago and we were only completing it in 2019.

Good 'customer care' standards towards patients – should always be seen as a part of a deliverable care package and not an optional extra in healthcare. When was the last audit of this done in the Trust? What did the results show and what actions are planned as a result?

A. Oh, absolutely. On reflection, there's a lot of things that if I had have stepped back, took the time to step back and look at, you know, for example, one of the things, and I know we're talking about governance that always sort of was like a bugbear for a couple of the Heads of Service was the SAIs were done in isolation, which is fine. The recommendations came up and the next thing you got a list of 'These are the recommendations that you need to implement.' We never got a copy of the SAI. It's a wee bit like back to the MHPS. If you're given recommendations in isolation, but the biggest problem thing for me is, and it's come from this Inquiry, when I actually sit down look and all the SAIs and read them, the recommendations could be actually mapped across. And if we'd have done that at the beginning.

Mapping the Inquiry recommendations with the recommendations of other recent reviews and SAI's will be one of the first steps post Inquiry. This will contribute to assisting the Trust in shaping a firmer foundation, develop streamlined action points as well as the important task of building confidence with the public in the delivery of good and safe patient care.

…….

Q. Last one. I mean if a member of the Trust Board came to you when you are in your governance role and said 'How can you assure me that your consultants are following up to date standards and guidelines? What assurance can you give me?', what would you have said to them?

A. I would have highlighted the challenge of the resource that we had to do it. I can't remember the exact numbers back then, but now there are over 3,000 guidance. 2,800, all of them are applicable to the acute service. They don't come with funding.

Q. But will you be able to assure him is what I am really saying?

A. No.

How is the SLT addressing the miss-match between no available funding and assuring your consultants are following up to date standards and guidelines?

……

Q. Did you make those suggestions in any formal or informal way to those who were making decisions?

A. I did, actually. I think I must have said that and that's why I still remember it, but not in a formal way because we were never asked about any formal. It's only in the meetings I might have discussed that, that this is the way it should be.

Q. Do I take it from your answer that you didn't feel that you had been engaged with properly in relation to the review, the regional review?

A. The majority of the review happened without us present. We were only present on a meeting with Mr. Mark Fordham, which you might have some notes of the minutes of the meeting. That's the first time I recall. It was quite a feeling for me, in a way, that, yes, we are meeting and we thought, my understanding is when you meet you discuss the things. But the way it came across on to us, I was the junior most fellow so I kept quiet for the majority of the time, but the way it comes to us was entirely a one-way traffic, this is the things that has to be done.

'One-way traffic' – is it possible to currently identify areas in the Trust where staff feel their voices are not being heard and that the imprint is still one of 'one-way traffic' as opposed to collaborative discussion and decision-making?

Q. What I want to ask you about is your sense that you were reassured that safe systems were in place. As a practitioner, did you have any sense of being supervised, scrutinised, in terms of the work that you delivered, the actions that you took in relation to patients?

A. Well, in that if I caused a problem to a patient, I was aware that that would be discussed, either at a mortality or morbidity, so that would be investigated, so I was aware that that would be policed. I was aware that, you know, that I was policed that I was seeing -- although it was pre-booked for me, that I was seeing a certain number of patients in clinic. That I was -- I think probably, I'm not sure, probably in those days, I think it's -- I don't think paperwork results were policed that closely, as far as I remember, I can't remember. But I think they -- I think the word there is "seemed". It seemed, rather than me actually knowing.

Q. I quite take the point that if your actions, or actions of a colleague led to disaster, or led to injury, you would expect to be held to account, because that's a very visible evidence of something that has perhaps gone wrong. But you make the point that at that time I was aware that there wasn't any great scrutiny of results sign-off. You probably, if you had thought about it, would you have recognised that while systems were in place to spot that, triage wasn't being done, it wasn't always being done in a timely fashion. Ultimately enforcement action around that was less than optimal. You would, as we'll see when we look at some of the other incidents that arose, you would have seen that a failure to dictate, following a clinical encounter, wasn't particularly well-monitored and due, and Mr. Haynes, for example, I suppose stumbled upon it isn't the right word, but you became aware of it as opposed to some system of superintendence or governance becoming aware of it. Just some examples to set against your view that you felt reassured**.** Do you now, upon reflection, see holes in either the system of governance and/or the appetite for enforcing good governance when problems were identifiable?

A. Absolutely. I mean sitting here now, I can't say I was happy with -- I could be happy with how things were done then. I suppose, with regard to results, because in those days I wasn't signing results in NICER, I depended on my secretary who has been with me a long time and is very diligent, and she made sure I had all the paper copies and ensured that they were all signed-off. So I was dependent upon a good secretary.

'Q. But you make the point that at that time I was aware that there wasn't any great scrutiny of results sign-off. Do you now, upon reflection, see holes in either the system of governance and/or the appetite for enforcing good governance when problems were identifiable?

A. Absolutely'

When problems are identified now in the delivery of safe clinical care, how quickly is good governance applied? Where does accountability sit in finding a solution/resolution?

Q. If we could have up on the screen, please. WIT-50524. At paragraph 8.1, Mr. O'Donoghue, you explain that you strived to provide, along with Mr. Young, and no doubt other of your colleagues, to provide an excellent and efficient service for patients. How was that possible in terms of the excellence and efficiency of delivery. How was that possible when you see the state of the waiting lists and what lay behind the waiting lists?

A. I think on reflection, "efficient" is probably a bad choice of word. Excellent, in my eyes, I provide the best service I could, so I think it was excellent in that sense, but "efficient" perhaps shouldn't be in there.

Q. I suppose there's two ways of reading that. As you suggest, you did your level best to provide an efficient and excellent service but the Service itself, in terms of its efficiency and excellence was okay for those who got in the door, but it wasn't by any other definition an efficient or excellent service if you're waiting for more than a reasonable period?

A. Absolutely. I did my best with what I had, but I think if you were looking at it objectively, it certainly wasn't efficient. But I worked hard or I do work hard.

Q. Yes. You have explained to us that there were these recruitment issues and the Trust worked, as best it could, to try and fill the void with locums on the consultant end. Ultimately, you know, there are insoluble problems or at least problems that are difficult to get around on the recruitment side. You have reflected to us the efforts on the part of The Trust to innovate to some extent with the modernisation programme, and you gave examples of that, and the expansion of nursing services and the scope of nursing practice. Still and all, we're left with waiting lists the size of which we've just explored and no doubt the impact of COVID has been far from helpful.

How can the SLT actively support the Trust's clinicians as they aim to deliver safe care for their patients while at the same time psychologically experiencing the pressure of long waiting lists for consultation and treatment?

A. So I think, you know, for Mrs. Burns to give evidence and in the email statements to say that we were passing the buck, is clearly wrong, it's not in keeping with the activity that went on after this, and I think I was making the point to her, because the SAIs are not just about what happens in Urology, they're about what happens in the wider organisation, and that's why we structured the recommendation in that manner. The second point in her evidence then, if you have -- and if we perhaps go back to her evidence where she quotes the number of outstanding reviews, if you wouldn't mind showing that?

Q. Yes, it's in the transcript of her evidence. It's at TRA-07064, towards the bottom of this page. If we go down just there. Yep.

A. Okay. So I would ask the question: If you are receiving a performance report with 20,000 people on it overdue their review, would you not be digging into that a little bit further to understand who those patients are? What their clinical priority is? Would you not be asking your ADs and your heads of service to give you a clear understanding of the clinical risk involved in this situation? It's not good enough to say that you've got 20,000 people waiting, you need to know what's happening. We knew what was happening in Urology, that's why we did the uro-oncology review list, that's why we created various categories for the Outpatient reviews, so that we could in some way try to manage and mitigate the risk.

'I was making the point to her, because the SAIs are not just about what happens in Urology, they're about what happens in the wider organisation'

Post Inquiry – this is an important point to underline when the Report comes out so that learning can be maximised across the Trust.

Q. And in your experience of MDM attendance both during that particular period -- I know it's late on in our time, in our timeline, but what was the process or what did you understand to be the process or proper procedure, if there was to be a deviation from a previously agreed MDM proposed plan?

A. Well, it's paramount that if anyone deviates from a plan that's been discussed amongst a large group of experts, that that should be represented. You can't single-mindedly go off on a deviation from it. And so I would expect anyone who had then subsequently seen a patient who then the plan could potentially change, to represent that patient.

Q. So, for example, if an agreed plan was a certain form of treatment and the clinician then subsequently performed some tests and they came back that may have changed his view as to the appropriateness of that treatment, rather than just then make that decision, is it the expectation currently, or has it always been in your mind, that that should come back to the MDM for discussion?

A. It should have come back to the MDM for discussion and that's the way I would view it from an obvious standpoint of you've gone to a meeting to make a plan, you've gone away, something's changed -- well, you bring it back.

Q. And within that context, is it your view that the MDM plan is a proposed one, based on what is presented at the meeting at that point, but that it should always come back for collective endorsement?

A. If the plan is going to change beyond the proposed treatment or plan to something completely different, then it has to be re-presented.

Q. Is there any -- is there another perspective on that, that the MDM is a recommendation that the clinician then discusses with the patient and, together, they then decide what the best outcome is, given the patient's views?

A. Completely. So it's patient-centred care and we can only do recommendations to patients. But if a patient or a clinician then decide to go along a completely different path, it needs to be brought back because the reason being is if the patient decides on a different route, is there an alternative option which may even be better or enhanced, even if they don't want to go a recommendation. So it's not about just accepting "Okay, that's fine, go that way" -- it's about bringing back and going "Well, they want to do this -- what does everyone think? They want to do it, fine, but can we recommend anything else as well?". So it's the ability to bring back to discuss for the benefit of that patient. But, fundamentally, it's the patient's decision.

Q. So it's drawing on the expertise of the other members of the MDM. So, for example, if a patient doesn't want a proposed form of treatment because of side effects and that's brought back, an oncologist may say "Well, actually, here's another option -- if that's the worry for the patient, this may negate that worry" -- is that an example of what you're saying would be the benefit?

A. Completely.

‘So it's the ability to bring back to discuss for the benefit of that patient. But, fundamentally, it's the patient's decision’.

What plans are in place to audit whether the policy/principle of 'shared decision-making' is being implemented and embedded into clinical practice across the Trust? Where it is found to not be taking place, what are the next steps to address this?

Q. Another thing which has been of interest is in relation to the way things operated at the Southern Trust, and to some extent more broadly in terms of governance, but also whose role it is to spot things that are going wrong. Could you give me your view of the importance of the collegiate atmosphere amongst the consultant body in a department with respect to keeping patients safe? What has been your experience of (A), the importance and (B), the results when that becomes dysfunctional?

A. Well, it is crucial, really. I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet because it is so difficult. Some people are very difficult to deal with, especially senior surgeons perhaps. In quite a few units we've seen around the UK, interpersonal rivalries develop, and one surgeon will say to the nurse on the ward, "I would never have done that operation and my colleague can't operate for toffee", something like that. Then that can get out control and sort of vendettas develop. You are dealing with human nature. But when problems arise, they need to be addressed. Most hospitals now have -- it used to be three wise men but now I'm not sure, that system is out of date now. But the equivalent of that, sort of troubleshooters. In this case I think the troubleshooters should have gone in there, shaken the system up and devised better ways of doing things.

'I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet because it is so difficult. Some people are very difficult to deal with'

Are there any red flag warning signs and issues that are currently being swept under the carpet in the Trust today? What are the SLT's plans to address them?

Training

There are considerable issues in having AMD's who are full clinicians with a fulltime clinical role – resulting in lack of time to fulfil demands of ADM role. Are the current AMD's in a balanced role?

A. I was unaware of the MHPS process until the Public Inquiry

Q. Were you conscious, in 2017, when you gave your statement, that you were contributing to an MHPS investigation?

A. No, I wasn't

This is quite alarming – are you sure that your current senior staff in the medical and operational management teams are up to speed on all the relevant documents and training?

A. People had a very superficial understanding of how the MHPS process operated and what help could be obtained from it

Is there good training across the board in place now so that this statement is no longer true?

Are all the doctors practicing within the Trust up to speed on the training programme about good practice when dealing with private patients?

Q. Did you feel confident that you had a sufficient knowledge of the guidance and sufficient training to be able to discharge that role? (being appointed to be the Case Investigator into Mr O'Brien)

A. No. I don't think that -- it's okay doing courses, but you know, you do a course and three years later you've never put it into practice.

We'll all sign up for courses and do this, and do that, and management training and whatever, but it has to be close to the time. It has to be -- and then you do it and then you probably need somebody to be alongside you to direct you and help you do it. You cannot go into these things with one course or one lecture or a half-day, and then away you go. It's just not the way to do it.

There is some learning here about accessing timely training when being asked to carry out specific roles – how is this currently being prioritised and monitored?

The Chair raised the issue about leadership roles e.g., Assistant Medical Director – a specialist job which most professionals are not adequately trained for.

Is adequate training in place for leadership roles now?

A. I think that for something as fundamental as MHPS and the Trust Guidelines, just to fire out guidelines and maybe to train one or two people misses the whole point. It is important that every permanent medical employee is aware of the guidelines, aware of the process, and gets training in it so they understand what they are facing into if they are subject to either informal or formal, what their rights are and what the correct process should be.

Q. In terms of how that could be achieved?

A. Well, there's mandatory training. Every year we had fire training, every year. And the fires didn't change from year to year. Every year we had infection control training and, again, that didn't change from year to year. But something as fundamental as this I think it should be provided to all new starts within their first year and then it should be renewed at least every three year. I think it should be mandatory. This is their employment. It is expected of them. How they should behave. I think it's important.

What is the Trust's view on mandatory training and it being renewed every three years?

……

Q. Would you have appreciated when making these appointments that Dr. Khan and Mr. Weir were without training, at least at the point of appointment?

A. Yes. This was a widespread issue within the Trust. There were very few people who had appropriate training.

How is this being addressed and monitored.

On appointment does the Trust know an accurate summary of the training already completed by the appointee?

Q. Is there a need for Trusts to build capacity, familiarity, and a degree of, I suppose, comfort with these processes among medical leadership so that those charged with these key responsibilities are able to do them, I suppose, more efficiently and with less stress?

A. Yes. Absolutely. It's a major issue, I think, in processing these investigations. I have to say I struggle to think of anyone who would have been comfortable with this particular one because it was quite

complex and difficult. But, as a general theme, there are very few people who would have extensive training who are doing these investigations frequently enough. It is not just about training, it is then about updating your experience and keeping abreast of developing issues. You may be fully trained, carry out one investigation, then not be asked to do another one for a couple of years. So that's a major issue. My own personal belief is there needs to be extensive training of a bank of People within the province.

'It is not just about training, it is then about updating your experience and keeping abreast of developing issues' Can this comment be fed into the current training policy of the Trust?

A. From an Employee Relations point of view, we have reflected on, not specifically Mr. O'Brien's case but including Mr. O'Brien's case, on a range of feedback we've had over many cases where individuals feel that those supports are really a tick box, they're not really supports that are helpful. You know, that has been a theme of feedback that we have heard in a number of cases. As a result - and, as I say, not specifically related to Mr. O'Brien - but as a result of a number of cases, we have moved to the position of developing an Employee Relations guidance note for, primarily Employee Relations staff and Medical HR staff and, I suppose, investigators and service managers, that sets out a range of supports that need to be offered to individuals, which is much broader than here's Occupational Health or here's Inspire and Carecall.

Q. When was that guidance note issued?

A. That was last year. So that was 2022 that that guidance document has eventually gone through SMT and is now part of our processes.

We've tried to address that within this document to say that there needs to be an identified point of contact, probably from somebody in a line management role, to provide that support on an ongoing basis to ensure there are regular updates and that there are contacts made just as a check-in in terms of how are you feeling, how are things going for you, how are you feeling, and we built that into this new guidance note.

What is the plan to monitor the effectiveness in practice of this new guidance document?

A. I mean, ideally where you want to be with this is you would like to have these people who undertake these roles trained at a very close time to the point at which they undertake the role. In practice again, that's very, very challenging because you don't know when cases are going to land. You don't know, you know -- so from 2017, and we had a fairly substantive cohort of individuals who attended that training, probably very many of them had never undertaken the role of Case Manager or Case Investigator since, so it becomes almost a bit defunct. Then it's about, right, okay, we need to identify somebody for these roles and you're going back to either people who have been trained but trained quite a period of time before that, or you're trying to get formal training in place. So it is challenging, there's no doubt about that. I fully accept what you're saying in terms of you are doing that internally and that refresher piece, there is that danger. Absolutely.

Q. The other side of that coin is the individuals who are being asked to take on the role of Case Investigator and Case Manager are full-time employees with very busy practices –

A. Absolutely.

Q. -- who don't have time, one would assume, to look at the fine detail of the MHPS framework or the Trust guidelines, so a refresher at the point of need might be something that the Trust considers to be entirely appropriate. My question was merely aimed at if the person doing that in future –

A. Doing that. Yes I accept that.

'I mean, ideally where you want to be with this is you would like to have these people who undertake these roles trained at a very close time to the point at which they undertake the role'

'a refresher at the point of need might be something that the Trust considers to be entirely appropriate'

Is the Trust considering the principle and practicalities of doing this?

Q. You talked about medical managers not being properly trained to deal with MHPS, for example. I just wondered what your view would be to a regional team of people and bringing people externally in whenever one of these issues arrive so it would take pressure off the Trust internally in terms of its resources. If you had, if I can use the term, a flying squad to come in.

A. Parachuted in. Yes, and I suppose we have chatted about that even in relation to the training of the Case Manager and the Case Investigator, training, and if that was regional training and if that was run more often. I think if you take investigators in who are unknown to the practitioner, it makes life a whole lot easier because you are asking people who are working alongside, in some instances, to investigate colleagues or investigate people that they know and have to work with. So, that's challenging within itself. They don't build up an expertise, they do it so infrequently. So there is absolute benefit, I think, in terms of having a pool of people who build that expertise and go around and do those types of investigations. I can't see how else you would do it efficiently because internally within the Trust, the challenge is there's not enough of these cases for anybody to build expertise, and the capacity issues and the relationship issues and all of those things impact on that. So, taking somebody completely independently in, I think is -- yes.

What is the SMT's current view on this? If in agreement – how realistic is this approach in today's climate?

Q. How useful do you think training is; how important is it for people taking on roles such as the role you took on? And have you any reflections to offer the Inquiry about how medical managers - because it is typically medical managers who take on these roles - how should they be prepared by way of training or familiarity with the processes? How should that be done if the Inquiry were thinking about making recommendations around that?

A. Training, in a way, is also very important but I think that developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training. Training is one part of the expertise but there should be further elements to this whole, I say, a suite of tools available to people who are going to do the MHPS role. No doubt training is very important, and the right training for the right time.

'Developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training' Is there provision now to extend the scope of the training to include these elements?

……..

Q. Okay. Just in terms of your training, as you say you probably had done more of these cases than many in the Trust. In terms of training, it seems to be that there is a lack of expertise and a lack of continued knowledge and continued training, even aside from when you are being asked to do one of these things. We are looking at how the whole system could be improved. I wondered what your view

would be of having a regional pool of medics who come in to do these investigations? I mean, I was struck by your comment that no consultants will do these any more. So, how can that be addressed?

A. I completely agree that I think there needs to be a pool of expertise so that you are repeatedly exposed to this and repeatedly doing this, because you learn every time you do it.

Is the Trust planning to develop 'a pool of expertise'?

Q. Okay. That's interesting and helpful, thank you. Just one other thing. You talked about the impression that you formed. Impressions are formed on a cumulative basis. I take it was just an overall impression as a result of all you heard from everyone you spoke to?

A. Yes, and I suppose that's exactly what I was trying to say. It was information from witness statements; it was information from e-mails; it was information from the documentation I was provided with before; it was information from the meetings with Mr. O'Brien himself and trying to plan and trying to organise those meetings. You just form -- you stand back and you form an overall impression, you know. You walk away and you think this is my impression of something. It's never something that's formed in a single contact or a single moment in time. It's always something that's much, much wider than that.

An interesting scale – views, impressions, facts – can value be applied to all three components?

Q. In broad terms can you help us with this: In terms of MHPS, how well do you think the Trusts in Northern Ireland are served by the training provision that's available? Is there room for improvement around that, or can training be over-emphasised in terms of its importance to the safe conduct and the safe operation of the MHPS arrangements?

A. I think training is critical. Training is very important, and it needs to be the right training. A lot of it is even just around allowing medical managers and others to discuss how they would implement MHPS and what would they do. We use a lot of case studies to say, well, what would you do in this situation? That was always very interesting and people learned a lot from that. So yes, training is critical. Another thing is just because you went through a training in whatever it was, March '17, doesn't mean that in March 2023 you are still up-to-date and sorted in terms of conducting an investigation. There needs to be -- and that's probably an area where we don't do enough of, is coming back and reviewing it. It's okay if you have been doing investigations constantly since 2017, you probably reasonably up to speed, but quite frequently people do this course and three years later someone asks them to do something and they have forgotten everything they learned.

The importance of checking in with up-to-date training when participating in an investigative role in informal and formal investigations.

Q. I suppose that's the point. We've observed in earlier stages of evidence, operational managers seeking informally to orchestrate change or remedial action in terms of Mr. O'Brien's practice going back some years, triage being the most prominent example. But nobody actually, until 2016 in all of that, nobody actually sitting down with him, meeting and I suppose making him understand why these rules of practice are important and requiring him to comply.

A. I take your point, yes.

Q. Nothing had changed by reference to this particular example by the time you came into the role?

A. No.

Q. Why is that? What is the culture that is existent at the time? I suppose you may say this is a relevantly small issue, and I'm sure the Inquiry might accept that, but what is the difficulty that causes you to fail to sit down with the clinician and say listen, you have to do something different?

A. I suppose it's complex. If it was easy, we would fix it. In terms of the life of anybody working in hospitals, there are many, many, many challenges that you face on a daily basis. I suppose everybody is guilty. If the issue isn't sorted there and then, it tends not to be completed, the loop tends not to be completed because there's something else very quickly falls in behind it. If Mr. O'Brien was the only thing that occupied my life, that would be one thing, but it wasn't. There were many other challenges, not least, you know, Dr. McAllister's state of the nation was only a small part of the challenges which we faced on a daily basis in the health service. Two months of my working life each year was taken up on the role of the Assistant Director of the Week, where I stopped doing my AD of the week role and I was occupied looking after flow. That was one full week every six weeks. So, if you didn't sort out the problem at source there and then, unfortunately to get back to it, sometimes it never happened because there was just so much more to be done with the resources that we had. Every morning we came in and we were faced with overwhelming patients in ED, trying to find the beds for them. Part of my role in finding the beds was, well, what surgery can we proceed today with. That is endless and draining. So, plenty of challenges.

'So, if you didn't sort out the problem at source there and then, unfortunately to get back to it, sometimes it never happened because there was just so much more to be done with the resources that we had.'

It is difficult with major time pressures and lack of resources to think clearly, pick up on important issues and prioritise – is there training that staff can easily access that will build skills to assist them in these situations?

Q. I just want to highlight some of the issues or some of the provisions that the Trust required throughout the years. On the first page - just move down slightly - you will see the headline. The title of this is the Policy For the Safeguarding, Movement and Transportation of Patient, Client, Staff Trust Records, Files and Other Media Between Facilities. You will see the publication date there is August 2006. This is really one policy captures all. The introduction states 1.1: "The aim of this policy is to ensure that staff safeguard all confidential information whilst travelling from one facility location to another during the course of their working day". Then we see at "It is the responsibility of all staff to familiarise themselves with the contents of this policy". If I can just stop there and ask you about that issue. Were you aware of these policies being made available to staff, any staff or medical staff?

A. No.

Q. No. Do you remember if there was any training given to staff around the requirements of these policies?

A. Not that I am aware of.

Q. Would it be the case that if there was training around records and charts and movement and transport and storage, that it would likely have to come from your department?

A. Because that encompasses all of the health, not just health records but all records, I would have imagined that would have come from information governance.

Q. And did you ever know them to provide any training on these issues?

A. Not that I can remember.

Q. Did you ever attend any?

A. No.

Q. Now, you'll see the guiding principles then at 2.1. It states: "Everyone working for or with the HPSS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to patients and clients and to his/her employer. This applies equally to those, such as students, or trainees, on temporary placements". 2.2: "Staff must notify their line managers immediately on suspicious of loss of any confidential information". If we go over the page. 2.3. "Managers must ensure staff are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information". Were you ever aware during your time in charge of records of anyone being disciplined for breach of confidence, or for the way they have handled or stored charts or records specifically for that purpose?

A. Not disciplinary action. We may have spoken to some of our staff. Like, say you have been going along a corridor and you might have seen a trolley of charts left unattended, so you would have spoken to that individual. But in my area, nothing that led to disciplinary

Policy For the Safeguarding, Movement and Transportation of Patient, Client, Staff Trust Records, Files and Other Media Between Facilities 2006

Has this policy been reviewed and updated? Is training now being given to all the staff that this policy applies too?

Q. Do you think it would be a good idea if there were specific training programs or continuing professional development points, or some way in which the Trust could bring home their policy aspirations to people who actually operate - I don't use that word medically - who actually work in the Trust so that they better understand their obligations and their responsibilities?

A. Yes. I think we could improve the training aspect. We do have e-learning for some of the things but maybe more specific training on this. Or, you know,

Q. By the time you left in 2020, did you have any knowledge of any training that was in place at that point such as that?

A. No. No.

Q. Just the main point from that, I suppose, from your perspective as a manager was that you instigated the request rather than it being something that was available

A. Yes.

Q. And there may be changes now, you just don't know, I suppose, having left?

A. No. make sure it is included in the junior doctors' induction.

Is training regularly provided so that staff fully understand their obligations and their responsibilities?

Q. Just in relation to learning. Again for the Panel's note, that's dealt with at your witness statement WIT-60390, and over the page 60391. You have sentences of self-reflection, I think, in your statement where you have said you need to be more proactive and less reactive; you need more staff to audit so errors can be picked up. One of the things you have said and I wonder if you could just explain why

you think this might be helpful, that there's "no governance forum where admin managers can engage with clinicians about administrative issues, and this should be encouraged".

A. Yes.

Q. I know there was a meeting with the consultants at one point when they called to discuss the systems, but that wouldn't be something that the admin would be able to call a meeting with the consultants to attend?

A. We can call all we want but nobody would turn up, so...

Q. So what you are advocating for in that sentence is the possibility of everybody getting together to iron out issues or to identify how systems might be better improved?

A. I think admin on the whole has no centralised forum to air concerns, thrash out different things or whatever, that there are medics also at. I remember back, and I am talking early '90s, there used to be an old, what was called then the Medical Records Committee. It didn't deal with medical records as physical charts, it dealt with the wide-ranging issue of admin. We hadn't had that so I believe that is very much needed. There's probably a perception in the Trust that the Heads of Service for each area deal with all of those sorts of things, but I think their roles are too wide. I think admin needs a section on its own for governance, and for the right people to be added and for us all to thrash things out. That's my opinion.

Q. I suppose that's more focused when you look at the number of people that are under your remit. You have 200 people who do such vital work at that level of the Trust. Then that sort of forum, you think, might prevent either issues arising, or short-circuit what needs to be done to fix things?

A. Yes.

Q. Do you think there's a good enough understanding among clinicians about how your systems operate?

A. I think each clinician will have a very good understanding of how each of their secretaries work. How other things operate, no, I wouldn't be so sure.

Q. Would they be aware that the secretaries really answer to you rather than them?

A. I am not so sure about that.

Q. Helen Forde, when she gave evidence, I had asked her whether she was involved in training doctors around charts and tracking and the issues around that. Do you have any involvement in dealing with medics or training with them?

A. No, but when Helen drew up that document, she did speak to me. A couple of things then that I had wanted to say were on that document, if you like. So I didn't do the work, she done the work, but it was a joint kind of thing, if you know what I mean. We would have worked quite closely together.

Q. Your input - and I know Helen has retired - but the input of people from Medical Records into training for the doctors as they join the Trust, you think if that was formalised as a mandatory session that that would help inform people's use of systems?

A. It would, but let's tackle our current people, never mind new people coming in. I would be thinking along those lines.

Q. So bring them in for refreshers?

A. Yeah.

Is there currently provision for a 'refresher' training session for clinical staff on administrative processes e.g., charts, tracking. pathways?

……..

Q. Your view that it's an important tool, or potentially important tool, together with something like appraisal which may allow the Trust to better understand what's going on in a clinician's practice, the challenges he or she is facing, issues that perhaps lie beneath the surface which have not yet been identified, all of those things are potentially discoverable through a good, robust job planning process?

A. Mm-hmm.

Q. The fact that this was let sit for so long and never delivered, does that perhaps reflect a failure to understand on the part of medical management the potential wins or gains that can be achieved through good job planning?

A. I think that's fair, yes.

Q. Is there any ongoing work, or any work in light of what we know happened in Mr. O'Brien's case, around job planning?

A. Yeah. There's constant work with job planning in terms of working with our local negotiating committee and providing training sessions, and lots of things to try and see how we can support clinical managers because it is an important task, but also ensuring that it's a doable ask for them. But yes, we are trying to put a lot of effort into -- because job planning is also a tool to attract doctors to the Trust, and to use as a retention tool as well. So, we are looking at how job planning can be used imaginatively. It's a professional contract between consultants and their Trust, but to use it in a way that we can actually use it as a retention tool and an attraction tool as well. We are looking at it from all of those aspects.

The importance of training to a good standard all those involved in job planning and drawing up professional contracts.

Q. Why do we have a situation where, from some witnesses who put their hands up to do a medical management role, whether it's clinical director or associate medical director, why does it appear, at least in some situations, to be the case that senior medical managers are coming in when they don't have the right amount of time available to them, haven't had training, obviously are unable to attend important meetings –

A. Mm-hmm.

Q. -- why does that continue to be a problem and one which, if I may say so, the Trust has just had to tolerate or accept?

A. I think the difficulty is medical management posts are not commissioned, they are not funded, they are not resourced. The responsibilities, I think, have extended significantly in recent years as a result of, you know, all of the different processes that are put in to manage and that they are responsible for and the demands on the service. Our workforce plans, I don't believe, have taken into account, I suppose, the fact that we need clinical managers leading and that, therefore, then takes them out of their clinical practice. I think the demands on the hospitals are so significant that that's a very challenging thing to do. But if it was properly commissioned and resourced and training associated behind it, then I think you would get individuals who are -- you know, we are seeing now adept fellows

is a thing which has been established where junior doctors are taking time out of their training scheme to buddy up with a line manager and work on leadership projects, which is a really good positive step forward we wouldn't have had in the past. So that gives an introduction to management, but that probably needs to continue and have the opportunity that you are not just a consultant one day and clinical director the next, but there's actually a formal process and career path for clinical managers to follow

Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers?

Q. You also mentioned that there are no standards for a clinical leadership but there are standards, aren't there? The GMC sets out standards. There's the Federation Medical Leadership and Management Standards; there's a range of competencies. Is the Trust attempting to bring some formality to those competencies in in its training programme, or is this also still work in progress?

A. Yeah, I think that's something that's being considered in terms of some of these development programmes for clinical management leadership structures. That has been covered in previous leadership training programmes. I think when you have a cohort of staff and changeover of medical managers, it has to be ongoing continuous thing.

Recognising that there will always be an element of staff changeover - are systems lined up and the training in place to make sure that all new staff are up to speed with the relevant standards?

A. At that stage there was no corporate programme for training staff on incident reporting, risk management, because if you don't train staff on how to report an incident, you get a lot of unnecessary work later on, you know, if they grade something either catastrophic that wasn't; or vice versa, you can miss the importance. The coordinator should also have a role in terms of themeing your incidents that are coming in, and really pushing near miss reporting. We just weren't doing any near miss reporting at that stage. You want to get your near misses reporting done because that's your opportunity to fix systems before there's harm done. That wasn't happening; there just wasn't the capacity to do it.

How widespread in the Trust is training for staff on incident reporting and near miss reporting?

Q. Again, the system for spotting what the Trust has called irregular prescribing, is it down to the alert pharmacist on the ward spotting the problem or is there a more sensitive way that these kinds of issues could be spotted if they were to occur again?

A. Unfortunately, at the minute it is still down to alert staff, whether it is the pharmacist or obviously the nursing staff or other medical staff. Our prescribing system in Northern Ireland based on wards and medicines administration system is paper-based, so there is no way of sitting back and having an overview. Now, I'm sure you have maybe heard already from other witnesses about Encompass that is coming. It's unfortunate. Back in 2015, I was sitting on a working group. They were going to introduce electronic prescribing and medicines administration system to all Trusts back, I think, 2015. In 2015/2016 that work was stood down because they thought at that point Encompass was going to come quite quickly and there was no point in investing in a standalone system when a bigger system was going to knock it out, you know, knock its position. So, that work was stood down. Today, we still have a paper-based system until Encompass starts in the South Eastern Trust later this year. If you have a full electronic prescribing system administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It

would allow you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having alarms ringing, shall we say, that there was something unusual happening.

With the Encompass system being introduced later this year in the Trust, have training opportunities for all staff using this system been mapped out ensuring that the training is accessed before its introduction?

……

Q. In terms of staff -- I know you mentioned that the sister had meetings and there would be conversations around governance but, more widely, did you have a sense that staff across all disciplines, ancillary staff, had an awareness of their own individual responsibility around governance to alert the appropriate people if they had concerns?

A. I think the ward sisters had and the ward managers had. I would have done direct face-to-face training with them on Datixes, but –

Q. How often did you do that?

A. So that would have been done probably every few months. It would have been either me or Carly or David, the two Band 7s, that would have run that training with them.

Q. Just to clarify, Datix training every few months with staff on the ward?

A. Yes. Whilst they didn't get it every few months, they would have got it once, you were rolling out the training for staff to attend. It wasn't very well attended, you might have had maybe five or six people there at training.

Q. So was it optional?

A. It wasn't in their mandatory training, and perhaps it should have been. It is in maternity, mandatory training for midwives.

Q. Do you think that would help if it was mandatory?

A. I think it would because when I first came into post, I think there was a negativity around putting in a Datix. It nearly seemed to be that you were reporting somebody if you put in a Datix. You know, in maternity, that was the case. I had to change the attitude to staff and say, you know, hold on a minute, this is not about a person or an individual, this is about a system and process, so we need to be looking at this, Datixes are not used as oh, I am reporting somebody because they did this and, you know, putting a negative slant on it. I would have seen Datix submissions as a positive because they were recognising there was a risk there, they were escalating the risk there and we were doing something about it.

What is the SLT's view on Datix training being mandatory for all staff on the frontline?

So where Tracey was saying Governance wasn't fit for purpose and it felt like she was saying there wasn't enough people -- it's not an add-on, it's an in the job/on the job role. And while they were writing the Datix, the on the job people, they just weren't following it through and addressing it, and that takes time and culture and support, and it felt -- it feels now, reflecting on that, it looks like it was too early then. To me, it's still an issue today. When I work with my teams, it's still an issue to have that challenging conversation with your consultant colleague, but we know that we have to do

it and it's more instilled that it is required to be done and that's probably from all the learning that we've gained in the intervening ten years.

Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?

……..

Q. And within your role, I suppose, specifically of governance. It is notable as against SAI investigations you haven't felt able to say anything in terms of strengths?

A. The challenge at the time was significant. There was a large backlog of SAI reports. They weren't able to be progressed in a timely manner. And the patient and family engagement isn't what I would have wanted for those patients and families.

Q. Yes. You point out the core weaknesses: "Staff do not have sufficient training to make them confident with the SAI process, particularly for chairs of SAI panels and it is difficult releasing staff to attend SAI meetings." That's difficult to your staff or operational staff?

A. Operational clinical staff.

Q. Yes. Is that then pointing in the direction then of particular problems with the SAI process? Was it almost facing a situation of near collapse because of these problems or is that too strong?

A. Collapse is maybe strong but there was a significant backlog of SAIs, I think at that stage probably about 33. The small team, myself and one other at the time, it was a challenge for us to be able to support all of the chairs, help draft the timelines, help with drafting the reports, supporting the chairs and supporting the members of the panel. And again to getting the teams released to have the meetings in a timely manner and support them in writing, you know, finalising the reports, it was a huge challenge at the time.

Is there currently adequate time, training, and resource now in place for staff conducting SAI's? If not, what is the plan to address this?

A. That I think is really relevant to this process? It mentions training and support. Prior to me undertaking those SAIs, I did not have any training. So, I recall being asked by Eamon Mackle to Chair the first, chronologically whatever the first SAI was that I did.

Q. That was –

A. I can't recall which one it was.

Q. Yeah.

A. But I sat in the office reading the e-mail and I thought "Am I really ready to do this? Do I really know how to do this?", and I batted that back to Eamon in a conversation and it was kind of - the answer wasn't "you'll be grand", but it was to that effect.

Q. Yeah. I was going to ask you about the training, and maybe that was a convenient but accidental point to stop on.

A. I've subsequently had training.

Q. Yes. You outline in your statement, 19.4 for the panel's reference, that you completed training in structured clinical record reviews in 2021.

A. Yes.

Q. As well as root cause analysis training.

A. Yes.

Q. The Inquiry is very interested in the nuts and bolts that make up the aspects of the SAI process. Training in 2021, you did your first SAI, so far as this Inquiry's concerned, in 2015?

A. Yes.

More evidence from the Inquiry about the need for proper training before taking on roles that relate to patient safety and quality care. Is this aspect now being audited?

Q. There is training associated with Datix or for users of Datix, is that primarily targeted at those with investigation responsibilities?

A. There are two levels of training and they were instigated by the Directorate Governance Coordinators at certain points. There was training in relation to general governance which would have touched on the Datix system. And then there was also training in relation to someone who is investigating a Datix incident and how they work their way through that process and what elements they should consider in their investigation. That was sporadic in its nature. And in my current role now since 2019, whilst in 2019 there were a number of sessions organised but when Covid kicked in then those were put on hold. So training now is just on an ad hoc, on request basis.

Q. And it is not mandatory for Datix users?

A. It's not mandatory, no. But it's something that I feel that should be mandatory. It's an IT system that's used by the Trust and I think that that system should be supported with appropriate IT training.

Does the SLT agree that it would be appropriate for all clinical staff to have mandatory training in the most recent Datix system?

Q. What is the buy-in with consultants in all of that? Do you work parallel with them to identify training and deliver it or is this nurse-led training?

A. The consultants, yes, do buy in with the training. I think the consultants would value if they do do the basics first. And they would like the nurses to look at where service provision is, where there is a need for the service. Yes, they are very open and managers are very open if there is any specific training that needs, such as if they need to be sent for a flexible cystoscopy course or if they need to be sent for the non-medical prescribing, the consultants are very supportive. And also the Nurse Managers would be, there would be support from the Nurse Managers as well. There is also training at present for myself and that would be for the transurethral laser ablation. A girl had come out to assess the Urology Service and they had recommended that this would be an ideal opportunity for the Urology Nurse Specialist to be trained.

Q. What stage is that at? Is that something there has to be separate funding sought for or what way does that work?

A. There will be funding for the equipment and there will be funding for training. The company will provide training and myself and Jenny, who will be trained in this, will be sent to centres in England to be trained up and to assess for the transurethral laser ablation. We will also have consultants will assess our competencies and we will probably have sign off competencies to be able to do this procedure.

Q. But your view is that the Trust are motivated for this to go forward?

A. Yes, to bring this forward. Because this will reduce patient waiting time. If they have small bladder cancer reoccurrence, rather than be on a waiting list we can provide this nurse-led service. Also, there are maybe patients who are not fit for general anaesthetic, so we can provide the service for those group of patients.

Has the funding stream been identified for this training? Have staff been released to access the training?

Q. So if we move to the preceding page, TRU-303440. And this is an email sent to you from Patricia Kingsnorth, who we know is the Head of Governance. She sends it to you and copies Martina in and Fiona Reddick. And she says: "Hi Patricia, many thanks for agreeing to assist with the SAI process. We have a number of cases to be discussed and will measure them against the existing pathway. Can you be available to meet with the review team on Thursday, 10th September at 9:30am in the meeting room, Trust headquarters." And signs it off, "Many thanks, Patricia". So that was the start of your involvement in the process?

A. That's right.

Q. And that was the first meeting that you attended, that was your first introduction. I just want to ask you in general terms, we have looked at the notes and we have looked at the minutes and we have discussed this, in relation to your introduction at the meeting, did anyone set out your role and what was expected of you and what you brought to that particular process in relation to the make-up of the team?

A. No. I never had any information of what my role was to be with the team. I gathered that because I had experience of a urology CNS from another Trust, and a lot of experience, it was to sit on to see if there was any key worker involvements. But I was never given any task to say this is the expectation we would like you as being part of the Panel for the SAI process.

Q. When you say key worker involvement, was it indicated to you that that was the purpose for you being involved, was the key worker issue?

A. No, I don't think it was the purpose of why I was involved. I think it was the purpose because of my experience and what I could bring to the SAI. But there was no criteria or no particular road plan was given to me.

Q. Did you have any knowledge at that meeting or after of the terms of reference of the SAI?

A. There was no terms of reference was formalised at the first meeting. But terms of reference was formalised following that first meeting. And they were written both by Patricia Kingsnorth and Dermot Hughes.

Q. Did you have any input into those terms of reference?

A. I didn't, no.

Q. Do you recall those terms of reference Doctor 1?

A. Yes, the terms of reference were referred to Doctor 1.

Q. Now you had no previous knowledge of SAIs or you had never been previously involved in any?

A. No, I had no knowledge of SAIs. I wasn't involved in any or I had never been the subject of an SAI. I never had any training either with an SAI. However, I do note that my role was just to sit on the Panel. It wasn't to be a chair or a governance part of the SAI. But no, I had no previous experience.

Q. Just so we get a feel of it. Something that we're not familiar with, but the SAI, was there a feeling that everyone was an equal member of the team and everyone brought a different lens to it or what was your feeling about it?

A. My feeling about the whole team, I wasn't given -- only my -- I felt that I didn't have a lot of input into the team. I would have liked to have maybe had more of an input. Such as with my experience and my experience of being a key worker and an experienced Urology Nurse Specialist, I felt my input would have been better if I could have liaised with families and with patients along with Dermot and Patricia Kingsnorth. Because I could have maybe found out more information, I could have spoken to the patients, I could have found out -- because the particular issue and it would tend to be that there was no key worker involvement, I could have maybe spoken to the families and maybe found out more specific information. My role really was to look at the likes of the patient administration system, the appointments process, the DARO, the protective review, but it was never anything such as, you know, being involved with the patients or the families.

Q. So it was more data-led?

A. It was more data-led.

Q. You were good for figures rather than facts of processes?

A. It was more of timelines, you know, timelines of patients' appointments and was there a key worker at that clinic and when was the patient seen, was there a letter typed for that particular episode, that was more of my involvement.

Q. Now you have been through that process as a team member, do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?

A. I think it would be useful if training was to be advised for anybody who wishes to sit on an SAI process. Also, too, it would appreciate what type of SAI is it, is it a Level 1 or 2 or 3. And also, too, what each team member brings to the SAI, such as the chair of the SAI or the governance person of the SAI. But I do think it would be a very useful training for anybody who wants to sit on an SAI process is to do the two-day training.

‘Do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?’ What is the SLT’s view on mandatory training?

Q. Now in relation to your involvement in the SAIs, is there anything else you would like to add that might assist the Panel in considering whether the effectiveness of SAIs generally as a governance tool or what you think, as having been on a team, might help beyond what we have already discussed, is there anything further?

A. I feel, obviously, training is very important for the SAI. I think even informing a person what the SAI is about. When I attended that meeting on 10th September, looking at the SAIs then I realised or worked it out that it was about Mr. O'Brien. I think it is good to be notified what the SAI is about because I did find the SAIs was very, very comprehensive and very complex. A lot of it was very emotional because a couple of the patients did -- I felt was very emotional about a couple of the SAIs. And I think, too, counselling, if somebody could maybe be very upset with regards to an SAI, because

a patient could have catastrophically been harmed and maybe counselling may be something to consider.

Q. Some sort of outreach around patients who have been involved in that process?

A. Sorry?

Q. Some sort of outreach in relation to patients who might have been affected by the SAI process itself?

A. Yes, for the patients been affected by the SAI process. And also staff as well, staff could value from counselling.

Is support offered currently to patients and staff affected by the SAI process?

…….

"The post of specialty lead is a taster role for those who want to try medical management out. The post may become a stepping stone to a wider management role or may prove to be as much as the post-holder wishes to take on for a longer period." So you stopped at that rung in the ladder. You didn't use it as a stepping stone to elsewhere –

A. Correct. I didn't want to climb up the management level.

Q. Yes. In terms of the role, were you remunerated for it?

A. Yes. I was given 0.5 PA.

Q. Did that adequately reflect the time that you devoted to the responsibilities of the role?

A. I don't think so.

Q. Were you supported administratively or otherwise in the role?

A. My secretary did any typing that I needed.

Q. In terms of, if you like, training for the role, support in that direction, did you ever receive any specialty lead specific training?

A. No. I trained myself and to what I thought was needed.

Q. Were you given any guidance as to what might be needed?

A. No. But I also wasn't told that I was doing something wrong, if you know what I mean -- if I was going up a wrong pathway, that's what I'm trying to say.

Q. Over the years -- and it was 20, approximately, years for which you held the role –

A. Yes.

Q. -- did anybody at any point press the pause button with you and say "You're doing this particularly well, but you're not doing this particularly well"? Any meetings of an appraisal-type nature focusing on specialty lead?

A. No.

Has there been a recent audit of all the posts in the Trust that require/should require training and if corresponding appraisal of the post holder has taken place?

How frequently is such an audit carried out? Have actions from the previous audit been implemented?

Can the SLT assure the public that there is a high standard of training and appraisal for all its clinical and management staff?

A. One of the things we did achieve is to regularise the M&M Chair position into an appointed position, interviewed for competitively, appointed and given half a PA a week, a small amount of time but, nevertheless, previous to that the M&M Chair had been a volunteer. I also thought that was a very good idea as a way of introducing newer and younger consultants to medical leadership. Because my idea of that medical leadership, which I tried to explain many times, is not about being the most senior doctor, it's about making things happen, making good things happen. So we did that and I was very pleased with that.

Are there currently good and accessible pathways for newer and younger consultants to gain training and experience in medical leadership?

Q. It is no doubt very difficult, to coin a phrase, to teach an old dog new tricks, if that's the sense of what you're communicating –

A. Yes.

Q. -- about him in terms of the use of the word "idiosyncratic". Is there a responsibility on the part of clinicians to move with the times to try to embrace new practices and new ways of doing things?

A. I think, yes, ideally that's what should happen. I think the key relationship in urological surgery is the consultant surgeon and the patient. I think that there is a sort of tryst between the patient and the urologist. When things go wrong, it is the urologist that gets criticised. I think over the passage of time we've seen more and more people deployed into the team who facilitate - the nurses, the radiologists, the radiotherapists, medical oncologists, etcetera - but the key relationship is that urologist with the patient. Some more senior urologists have been understandably reluctant to let go of their own special management of the patient; they feel uneasy about delegating their care to nurses who may have a slightly different view. You know, there's a sense of wanting to keep the patient to yourself because you're the one who carries the can, really. So I do understand where Aidan is coming from, but I don't think it helped his practice.

Q. Yes. I mean that sense that you've picked up on of keeping ownership of the patient, would you regard that, certainly in 21st Century urological medicine, as a bit of a blind spot?

A. It probably is, yes. I think what we've seen is the development of all sorts of individual specialties within urology - stones, cancer. I mean, in my case I only looked at prostate cancer patients in the last five/10 years in my practice. You do need the assistance of other people because you no longer have the necessary knowledge. You can understand why some people feel reluctant to delegate or to hand over the ownership of the patient. I think that's what happened in Aidan's case.

Where best could effective discussions take place around the idea of 'ownership of the patient' in clinical practice?

MHPS

Q. Is there then a possibility of looking at having external people dealing with MHPS procedures? Would that be a good idea?

A. It would be a -- if you were asking me what one thing would you want to change in the system, it would be that one thing when it's a complex -- I mean there might be times when it's, you know, when it's better not to do that. It's degrees of difficulty. When it is complex and sustained over a period of time and despite previous efforts over many -- you know, a long period of time, and it's quite systemic, then, yes, external -- to me external review or external process has to be the most objective way to deal with this and to deal with it as quickly as possible.

Does the SMT think this would be a good general principle to apply going forward – having external people dealing with MHPS procedures?

Q. Maybe we can just formally bring this to the screen. WIT-33938. At paragraph 29.2 you say that: "On reflection, I do recognise that the screening of concern stage should have been undertaken by the Clinical Manager rather than myself." And that your actions were outside the agreed guidelines.

Can you guarantee that all the current investigations in the Trust are operating within the agreed guidelines and the MHPS?

……..

Q. Just in summary form, for the Panel's note, WIT-26299 to 301, you have set out what you consider to be failings generally –

A. Yes.

Q. -- in your Section 21. You've indicated you felt there was a lack of respect for non-clinical managers in doing this role?

A. Yes.

Q. Is it still the situation at the moment? Do you know if non-clinical managers are still expected to undertake this kind of oversight and monitoring role?

A. With being out of the role now, the operational role since June 2021, I couldn't comment on that at all.

Q. Was it up until that point, June 2021?

A. Up until that point, yes.

What would be your assessment now regarding respect for non-clinical managers taking on roles in the delivery of MHPS?

Q. In your witness statement, for the Panel's note at WIT-26315, you expressed a view that you don't think that Mr. O'Brien should have been allowed back to work so soon and you called that a mistake. Can you give a bit of context to why you have that view?

A. It's just back to what I had said previously. This is in hindsight, I didn't say this at the time, but it is a reflection when I was doing my Section 21, I think the investigation should have been a wee bit further. At that stage it hadn't even really started. I think there needed to be more of a -- you know, to extend it to talk to the likes of the people I'm saying there to say what other areas do we need to look at. It was a decision made inside a confined group of people without actually expanding it out. It's a bit like everything -- just back to what I said there, you know -- any of the rest that go through disciplinary, they would be properly investigated before allowed back to work.

There is the principle of equity and due process being equally applied to all undergoing a disciplinary process and a return-to-work plan – this seems to not have been the case with Mr O'Brien.

Q. The doctor who is under discussion, what is the appropriate point to tell him or her that there are issues being discussed both within the organisation, obviously, and externally if you are seeking advice from NCAS? Mr. O'Brien obviously was wholly in the dark about these meetings, the September meeting, the October meeting?

A. Yes.

Q. Only on 30th December is he told about this long-running process?

A. Yes. In fairness to the clinician it should be whenever there is a case being discussed. I mean, back in September, you know, I think the appropriate point in time at that stage was to be flagging to him in September that, you know, the Medical Director, Director of HR, you know, and the Operational Director had an awareness of this and there was a screening done. Yes, absolutely, September time, in fairness to the clinician.

Is this now standard practice?

Q. It would have been as simple as: Mr. Gibson, you said this to NCAS, what did you mean by it and who told you about it? And a judgment then could have been made about whether further questions were merited outside of the room amongst fellow clinicians perhaps or within the service.

A. Yes. That's correct. I think there is learning from that in terms of ensuring that at every meeting -- and I think, I mean that's absolutely what we have now in terms of a proper timeline of cases and attachments of NCAS advice and attachments of legal advice, so you have the whole picture when you come to discuss a particular case. That's what was missing here.

Is there monitoring evidence that this is now the case?

Q. Finally then, you described the improvements in MHPS reporting. I think, you, yourself, suggest that's the tip of the iceberg, really, in terms of understanding all the informal issues and all the improvements you need to make. So I think from what you said that's been helpful in terms of increasing the discussion engagement at Governance Committee and, hopefully, at the Board in due course. Have you seen any other improved engagement that fits along with the Just Culture kind of idea at Board level as a result of the work that you have had to do for this Inquiry and the work that others have had to do. Have you seen anything else filtering through that would be helpful for us to know about?

A. I think from a Board perspective, I mean there's very much that openness. There's the openness to bring problems at a much earlier stage and I think that is very much welcomed. I mean inevitably across different services, even Acute Services, there is issues and it is very much a full disclosure, there's an openness, there's engagement at an early stage to say "this is what we're dealing with". The discussion is had. There's the challenge there. There's the follow-up there. I suppose I'm seeing more of that.

A key message that should remain on the front page of Trust business - 'There's the openness to bring problems at a much earlier stage and I think that is very much welcomed'

Q. Have you anything to suggest to the Inquiry in light of your experience about how a Trust operating within the rubric of MHPS can ensure that when issues such as those that were raised in 2016 and into

'17, how they can be translated into Terms of Reference which encompass other areas of the practice that perhaps aren't known?

A. I suppose, looking at this e-mail, which I've never seen before, but looking at this e-mail and the case that you have outlined in relation to the retained swab, I suppose I would have assumed that when one was screening, one would have looked at adverse incidents, never events, things like that that had occurred in the past, I would have made that assumption. But I do have to preface that by saying I have no experience of screening, I don't know if there are limitations to time frames. I really don't know how screening happens and, therefore, I really don't feel I am the best person to comment on that.

Is there clear guidance in the Trust on a thorough screening process before the Terms of Reference for an investigation are agreed?

'I believe there is an element of lack of clarity within the framework but also lack of clarity within the roles and responsibilities among various peoples. There is a designated director, nonexecutive director, as well, and there is a Case Manager, and then there's a Case Investigator who is doing the case, who is trying to explore what's happening. I believe there needs to be much more clarity in roles and responsibilities'

Q. I think we spoke earlier about the issue of dedicated time and just to perhaps go back on that again. Is it your view that an MHPS investigation of any complexity does require dedicated and focused resource, both in terms of the Case Manager and the Case Investigator, and perhaps also the HR support, in order to ensure that the process works itself through in the most efficient manner?

A. Yes.

'I have reflected on the overall MHPS process and I think this is one of the improvements we should make as a healthier system. These types of investigations require quite a lot of input both from the clinicians and from the HR point of view, and requires additionality. Therefore, it has to be recognised as an additional piece of work, and additional time and resources should be put in place'.

……..

Q. Just finally from my perspective. You've offered some reflections on the MHPS process generally and your role in it. One of the things you've said in your witness statement -- this is at page 903 of your bundle, not the core. WIT-31999. You say at 23.1 that on reflection in your view, the MHPS process could have been more proactive. Proactive in that context means what? Proceed with greater expedition or efficiency?

A. I suppose I was thinking on my experience and my reflection since then. The MHPS process was implemented and there were a number of elements. My reflection was that all of them or most of them contributed into the MHPS process; the framework document itself, then how it was implemented in the informal stages, the formal investigation, and post determination, but also how the resources were allocated, what was provided, what was the training element, the experience, the expertise going forward, the interaction or the interface of the Trust own going into the MHPS Framework, that was all part of my thinking. In terms of proactive more towards clarity of the framework or the document or the policy, but also clarity of roles and responsibilities, clarity of entry and exit points in the process, and clarity of taking it forward. That's what I meant by proactive.

Q. I'm glad I asked because there was more to it than simple efficiency. It's a wide-ranging concern you have. You go on to point out the absence of dedicated resources, and you give the example of

your own role as case manager being an add-on to your other day jobs, which were more than one, as we know. Anything further you wish to add to that?

A. I think the dedicated time or protected time is vital in terms of doing these investigations. We know now it took much, much longer and it's still was going on and on. It was initially thought to be for a few months. I was already doing a busy clinical practice but also in a managerial role. Then I took over the Interim Medical Director role, which was also very busy, without any proper induction or hand-over. So, I felt that in my particular role as case manager, it took a significant amount of my time, not only just the time but also it had a greater impact on other elements going into the clinical and my managerial roles. So, I felt that what needs to be put in place if this is to be done in a correct way.

Is protected time now a standard provision for those carrying out a specific investigating role?

Q. Also within this document he is explaining his commitments to the Urology MDT and MDM. He is putting this to you as a context for the work which he is doing and by way of explaining how there weren't enough hours in the day to do the work, all of the work that was expected of him. Do you accept that this wasn't appended to your report?

A. Yes, it wasn't appended.

Q. And it wasn't otherwise referred to in your report?

A. Well, the document isn't referred to but the additionality of his work is referred to in the report.

Q. In what way?

A. In his respondent statement that I think we just referred to there, Mr. O'Brien indicated that he was doing significant additionality in relation to his work, and was doing extra clinic -- extra theatre sessions.

Q. Yes. That was his statement where it's referred to?

A. Yes.

Q. Why didn't you append the evidence, this example of evidence provided by Mr. O'Brien to your report?

A. Because I think -- I felt that including it in the statement, that this was the mitigation that he was putting forward, was sufficient. I didn't feel that it was -- I felt the point of mitigation that he was making was something that can be made to the Case Manager, it wasn't one of the Terms of Reference. Therefore, my view was it wasn't necessary for that to be appended. There were, as far as I knew, lots of appendices as it was already, so I didn't feel that it was necessary.

Q. You are describing a conscious thought process to deliberately leave this out of –

A. Yes. I didn't include it. I didn't feel it was necessary to include it.

Q. So, Mr. O'Brien is setting out mitigation for the alleged shortcomings in which he is working, and of all of the evidential pieces that you are provided and you append to your report, you decide to leave this one out of account?

A. I think there were other pieces of evidence that Mr. O'Brien provided in relation to some of his private patients, for example, that I just felt it wasn't necessary. It was included in his statement that he was doing a lot of additionality. I felt that doing additionality, whilst I understand why he did it, it was still my view that he had a responsibility to do the job that he was asked to do.

Q. Is there anything in your report that suggests that you took into account the content of this document?

A. I considered Mr. O'Brien was a very busy man who opted to do surgery rather than do his administration. The issue in relation to most of the Terms of Reference were in relation to the administration of his -- in relation to his work.

Q. You didn't consider it to be unfair not to include this evidence?

A. I did not.

The importance of fair and accurate contextual representation in investigations.

Q. Just coming on to one of the things that you have been asked about extensively. I am not going to go into the detail, you will be relieved. But private patients, the issue of transfer between the NHS and private practice is always fraught with difficulty and most Trusts have a policy that says if you see them privately, and you want to see them in the NHS for any reason, you have to transfer their care to the NHS, and you shouldn't be transferring them back and forth as you wish, and that must all be documented. Now, whatever is the case with the private patients in this situation, I can't see evidence that all of that happened robustly. My question to you is, is that a general problem in the Trust, do you think? Have you got any awareness of that? Do people pay enough heed to the rules and regulations around this, because it is quite clearly set out in the GMC guidance that you mustn't give private patients an unfair advantage. Have you any comments about that?

A. I think managing private patients in the Trust has become a much more robust system latterly. I think there have been times in the past, particularly historically, where the Trust would not have had robust systems in place because a lot of consultants wouldn't have been involved with private practice; some people were seeing people outside of the Trust. So I do think there probably weren't robust systems in place historically. I believe that's not the situation currently.

'I believe that's not the situation currently'

Is this an accurate statement?

Q. Because obviously, doctor, where we had in this case a lengthy investigation, it took some 18 months to bring it to a conclusion, and where it didn't identify the kinds of shortcomings that were to come to life in 2020, the public will obviously be concerned about the MHPS process and whether it is fit for purpose for discovering these kind of things. Or perhaps the reflection is the MHPS is only as good as the people using it and if they don't take effective stock at the beginning, then it's not going to deliver the kinds of outcomes that are important from a Patient Safety perspective.

A. Absolutely. MHPS is a flawed process; there are many flaws in it. We could sit down and have a long discussion about how it could be improved. At the end of day, it is a process and if we don't follow it, it's not much use at all. So, it's not rigorously followed. It also doesn't replace common sense. You know, you still need to apply common sense occasionally. You know, yes, there are terms of reference and investigators are expected to stick to the terms of reference but that doesn't mean they can't listen to anything that's told to them.

As MPHS is currently being revised – is all the learning from the Inquiry relating to MPHS being fed into the process? What are the plans to update and roll out training for all staff on the revised MPHS?

Q. Yes. My other point is when you are speaking about your initial discussion with the senior decision-maker, i.e. preferably the Medical Director, once that had been done and you'd sorted out an action

plan, do you think you would have had to have spoken again with the Medical Director, or would someone like a clinical director who has more operation knowledge of the problems would be a good person to talk to? I suppose what I'm asking does it always have to be the most senior decision-maker or can you go down the sort of food chain later?

A. I think that's probably reasonable. Certainly at the beginning, we need to have a discussion, I think, with somebody who can take decisions and decide the way forward. Yes. When you are just monitoring progress, I suppose you could, as you say, speak to someone whose a bit more operational, with the proviso that if we say, hold on, there's a big decision to be taken here, it's not working, you can go back up the ladder

There is a relevant place for gathering monitoring information in real time at 'the coal face'.

……..

Q. Now, there has been some evidence given to the Panel around the necessary confidentiality of the MHPS process and some of the perhaps barriers or challenges that puts up in relation to sharing of information, it's important for good governance.

A. Yeah.

Q. Do you have a view on the appropriateness of information not being shared to maintain confidentiality?

A. I respect confidentiality but I believe that when there are an operational team working, or there is an operational team working on issues that are referenced in that report as needing to be further addressed, and people referenced like the Assistant Director, I think they are entitled to have that information shared with them so that they can be fully informed and be part of that, and that wasn't the case. So yes, I do believe there should be a sharing with the appropriate people.

Confidentially vs intelligence and learning from the MHPS process – is there a guideline in place that addresses this? Does it need updating?

……..

Q. Tracey Boyce has said in her evidence to the Inquiry that there was this disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team and she says from what I understood at the time they had to be kept totally separate. However, with the benefit of hindsight, she thinks that a joint approach would have been beneficial. So, for example, the SAI concerning patients, the five patients, might have been expedited rather than taking the guts of three years. A more of a joined-up approach would have led to a more efficient and perhaps a more universal learning. Do you have any view about that?

A. My understanding is that the two processes sit separately, one is in relation to the professional management of the doctor, the other is in relation to learning from a clinical incident. I think as a governance coordinator you are aware of lots of very confidential, very sort of information and it would be good to understand other processes that are going on within the Trust to help triangulate all that information and perhaps share between the two processes so that you have got a very robust rounded learning from what was happening at the time.

Is it still the case that there is 'a disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team'? Is there a move towards triangulation of information?

Q. You've also mentioned in your statement that the guidelines were a way of effectively encouraging good practice, because they would be audited, and you thought that that would allow then perhaps any issues to rise up to the surface.

A. Yeah.

Q. That was one of your motivations as well.

A. Yeah, retrospectively, it would have been good to audit. There are many audits it would be good to do, and particularly from an MDM perspective, you know, there are a number of things we would like to look at. I think it would have taken probably precedence in moving the service forward more than Bicalutamide 50, but actually, yes, it would have been good to take it to a year time point after the guidelines to see were they being complied with.

Q. I mean, you know, if I asked you the question "How do you know people are adhering to all the guidelines?", how would you know?

A. I think when they come for their opinion and you're seeing a trend of non adherence, that's the flag for concern.

Q. But there's no systematic look at that, you don't think?

A. No.

"How do you know people are adhering to all the guidelines?"

Is there now an auditing system in place that measures adherence?

…….

Q. Can I ask you to reflect, in light of the support that Mr. Suresh appears to have received, in terms of Mr. O'Brien's practice - and we're going to look at a number of issues, and perhaps you can only address the issue generally at this point, because much depends on the gravity with which the issue is understood from a patient safety perspective, there's obviously whether there's full knowledge around the issue - but in terms of looking back on Mr. O'Brien, he came through an MEPS process and then there was a return to work plan, and I know from what you've said that that was largely hidden from his colleagues. Do you think, from a team perspective, Mr. O'Brien could have been better supported with the practice difficulties that he faced?

A. Yes, and I've said so in my statement. I think it would have been much better if those issues, and I realise there are sensitivities around some of them, but certainly I think if the medical managers had of discussed with us as a team of consultants the particular issues, and allowed us to understand the breadth of issues, but then also to formulate a support plan, a network, if you like, as to how Mr. O'Brien could return to the team and practice safely. It would also have given us greater oversight going forward as to when, if there were any dips in performance, or non-adherence to agreed behaviours, then we would have been able to identify that at an earlier stage.

Q. We'll maybe unpack some of that as we go along. What do you identify as being the, if you like, the block or the obstacle that was in place that prevented the development of that kind of approach?

A. So, I had no knowledge or part to play in the return to work plan. That was developed without input from the whole team. It was developed, as far as I understand, from the medical management side

and with some input from the Head of Service, from what I've read subsequently. So those people held that information. It wasn't shared with us. I think if we had of been aware of what they were monitoring and how they were addressing any shortcomings, then we would have been in a position to assist.

Taking these comments on board – has there been a discussion on what a full range of consultation looks like before developing a supportive return-to work plan?

Q. We have been discussing the MHPS process and what recommendations that we might make, and I'm just wondering what your view might be about that. Do you think there is a role for a specialist team to do this kind of work?

A. You can't tag this on to the work of a CD. It was very difficult at the best of times but for all of 2012 I was utterly overwhelmed by two smallish -- no, two normal -- if you like two normal MHPS ones and a massive one that went on a year and involved challenges from the legal profession, which took me a year to do because of all the challenges. But it can't be done on the back of a CD role. It has to be a team. It also should be a very experienced team, and it shouldn't be people who know each other. That's not great, either. The suggestion, obviously, is that it should be retired people. I think -- well, I won't be doing any.

This issue of adding to the already demanding clinical role - engagement in the MHPS process has been raised several times in the Inquiry. What is the current thinking on the MHPS process being carried out by an experienced team preferably whose members are not currently employed be the Trust?

……..

Q. I suppose my question's perhaps a little bit broader than being specific to your assistance that you provide. Do you see any merit in the Trust having a formal or a structured approach to new consultants to allow them to understand exactly what's expected from them in their role, as regards, for example, administration, discharge, the processes by which they engage with wider ancillary staff within the Trust?

A. So, again, when I started in Belfast Trust, that there was a programme of training as a junior consultant. But that only happened after I was appointed and then it was, I think it was like one day of training per month for the first six months - I think it was called the CLIME sort of training, C-L-I-M-E. I can't remember what that stands for. But that was sort of part of being a new consultant, how you were introduced to the governance structures and how the Trust expected you to run your practice. But certainly, bringing that into higher training so that when they start that they have a better idea of what's expected I think would be beneficial.

Is there a formalised, structured training in the Trust around what's expected of and from registrars and new consultants in relation to their role?

Oversight Group

Q. There has been a lot of mention of the Oversight Committee in the discussions that we've had. What was your understanding as AMD of the actual role, purpose, status, hour, of that Committee? Was it something that everybody understood well or?

A. No, not at all. It was basically -- it wasn't really a committee

Q. So it was -- how did you see it then? Can you give us your view of how that operated?

A. This was a committee that looked at Maintaining High Professional Standards, GMC issues, and it was the Medical Director and it was the HR. The HR role, as I understood it, my experience of HR is they don't take responsibility. They give advice, they give you options, and then you make the decision, and then they ensure that due process is followed, ostensibly so it is fair but really so there is no chance of any comeback in any appeal or legal process. Then there's a Director from whatever division is involved. But these are medical issues so the divisional director really has less of a call.

Q. So as Divisional Medical Directors it is my understanding in looking at the minutes that there was no attendance at these meetings even when it involved something in your division; is that right?

A. You mean for me?

Q. Yes?

A. No.

Q. So it was done without you?

A. I was never involved, ever, in Oversight Committees. That was always at Director level.

Q. What's your view of that? The appropriateness of that?

A. Totally inappropriate. But you need to have -- if you're going to have a Clinical Director there, they need to be someone who is prepared to be robust and to be prepared to be robust. I think for a Clinical Director it would be difficult. I think for an AMD it would be easier.

Is there currently an Oversight Group/Committee? If so, what is its purpose and what roles make up its members? Is there a transparent operating process?

Are steps being taken to make sure the current operating structures within the Trust are clear to all who work in the Trust?

…….

Q. It was the role of the Oversight Group to ensure that that was done in a way that was consistent, fair, transparent. It was a quality control type function as opposed to an investigatory screening or decision-making function?

A. That's how it was envisaged, yes.

'It was a quality control type function as opposed to an investigatory screening or decision-making function?' Is this still the understanding of the purpose and function of an Oversight Group?

Q. But one argument may be that the terms of reference are an issue for the Human Resource Manager and the Case Manager rather than as a collective approach by the Oversight Group. Do you have any views on that?

A. I suppose what I would say around even the Oversight Group and the matters of roles and responsibilities and the function and how the Oversight Group functioned, while it's documented there, there were probably varying views in terms of what actually in practice was the role of that group. So, what I understand in terms of this is that the clinical manager, in terms of the individual who ordinarily would become aware of the concerns and raise the concerns, in this instance that role essentially was a number of people, including probably the Medical Director, who was becoming aware of issues coming out of the SAI. So, that nice clean process of who identified the concern, who screened the concern, who then was the commissioner or the decision-maker around the need to go

forward with a formal investigation, in this instance that was, in my view looking back over the documents, probably more the Oversight Group at that particular point in time. Because those decisions around needing to exclude was happening with the Medical Director, I suppose taking advice of the HR Director and involving the Operational Director. In terms of how terms of reference, I suppose, should go forward, I'm not sure that the Case Manager in practice has done that. Should they do it? Quite possibly.

Q. Is it possible that your answer could be interpreted as saying that the collective expertise of the Oversight Group would be beneficial in informing terms of reference?

A. I think in practice that is how it operates. These matters are difficult, they are complex, they are challenging to start off on that track. It generally is the collective experience of a number of folk in terms of trying to get this on to the right path as such. So I think, yes, the answer to that is yes, it's generally a collective input from a number of people who have a level of expertise.

How is the Trust addressing and improving the need to have a clear understanding of the roles, responsibilities, and lines of communication in the carrying out of informal and formal investigations?

Dr Swart -Q. Another thing that comes out when you listen to the various witnesses is there was very poor knowledge about the workings of the Oversight Group amongst quite senior medical managers. It seems to me it was shrouded in secrecy which is actually the opposite of what people are aiming for these days. Is that a fair observation? Was that by design or accident?

A. I think it was a fair observation at the time but I'm not sure it was by design. I think it was more that over the course of those years between 2010 and up to the point at which, for example, Mr. O'Brien's case commenced in 2016, there was probably a handful of cases. There wouldn't have been huge numbers. The involvement of the Oversight kind of progressed in terms of what their role was. I don't think there was any deliberate intention to keep that shrouded in secrecy, but the numbers of individuals across the organisation who would have had a touch point with an MHPS process was very limited. So, it just wasn't known.

How are the principles of transparency and role clarity applied to Oversight Groups now?

……..

Q. Yes. We know, and perhaps it is more for Dr. Lynn to comment upon, that the Oversight Group made a decision at its meeting on 22 December to exclude for the duration of the investigation, as it was described in their decision. That was to be subsequently revised. The second part of their decision was to have a formal MHPS investigation. But then the advice was sought; the advice was then sought from her on 28th December. In general, while there's nothing to prevent that approach, you consider that to be the wrong way round and unhelpful?

A. I would agree. It is the wrong way around, it is unhelpful. What's the point ringing us (NCAS) if you want us to rubber-stamp a decision you have already taken.

Q. Now, there is a relatively complex evidential picture in terms of what happened next. I don't particularly need to go into that with you and it might be unfair to ask you to comment, but it is the case that no contact was made with Mr. O'Brien in respect of those issues until December, and late December, 2016. I don't wish to build in the complex ingredients to what was going on on the ground but, in general terms, where there are shortcomings or perceived shortcomings in a practitioner's practice, whether that's a conduct issue or a capacity or capability issue, and where the Trust has sought advice from you, or NCAS in general, it would be good practice, would it not, to advise the

practitioner that these engagements are happening so they are no longer behind the scenes, they're upfront and direct with him?

A. I absolutely agree. As I think I may have said earlier, in later years we actually wrote specifically in our letters, we put in a phrase which said 'please make sure you share this with the practitioner', because we were come to a realisation that that wasn't happening in many cases, and it clearly didn't happen in this case. It is a sort of fundamental principle of justice that if you are being accused of something, you have a right to know what it is and who is accusing you. So yes, they should be involved early and informed of their ability to phone us. Quite often we would find out that that had happened because the practitioner would phone us and we'd have a chat. Yes, it was disturbing to discover that Mr. O'Brien didn't know anything about this until quite sometime later.

'It is a sort of fundamental principle of justice that if you are being accused of something, you have a right to know what it is and who is accusing you. So yes, they should be involved early and informed of their ability to phone us.'

Does the SMT agree with this principle and having the willingness to apply it going forward?

Q. Could I put a perspective to you which goes something like this: Mr. O'Brien is, it appears, plainly in the dark that all of these events are taking place behind the scenes in respect of him. These matters directly concern him. On the one hand, we have NCAS advising that Mr. O'Brien needs significant support to be able to address these matters, and these matters are allowed to drift with no action being taken, no discussion with him. Then we get to the Oversight Group meeting on 22nd December, taking a decision to have a formal MHPS investigation and exclusion of him - and views may differ about his response to the letter of 23rd March - but he has not been engaged to do anything about his shortcomings and he has not been provided with any support to address his shortcomings. Is he entitled to feel aggrieved about that, in your view?

A. Yes. With hindsight, absolutely. I mean, the whole process of any dispute or any member of staff who is underperforming, or viewed or deemed to be underperforming, is about two-way communication. So yes, with hindsight Mr. O'Brien should have been spoken with, should have been advised of what was happening; what had happened and what was happening.

How would the SMT assess itself now on its ability to engage with both parties in timely, meaningful communication when it comes to an informal and formal investigations?

Management

Q. The criticism that emerged from MHPS, that there were systemic failures at all levels of management across a range of issues – was that conclusion drawn to your attention on a formal basis?

A. No

Q. There was a recommendation that there should be an independent review of management actions in this context. Were you interviewed or spoken to in the context of that review?

A. No

How is the learning and actions from Reviews, both internal and external, currently being monitored throughout the Trust – are you happy with the robustness and effectiveness of this system?

A. Mr O'Brien's secretary had not been escalating information. Secretaries can be loyal to consultants.

How is this being addressed?

A. A significant amount of our time at managerial meetings were spent on performance, to meet targets etc. This misses other important aspects like the quality of output.

Would this be an accurate reflection of managerial meetings now – is this being monitored?

How would you describe the current relationship between medical management and operational management?

…….

Q. Now you have said in one of your statements at WIT-26290, just for the Panel's note, that you felt there was an overreliance on you as you had an already demanding operational day-job and that the system failed when you were on sick leave, seemed to fail when you came back as well, but do you feel that you weren't supported in trying to take on this role as well as all the other things you had to do as Head of Services?

A. I suppose I'm the sort of person that just says, probably, yes, and just gets on with it. I do think there was always an overreliance on me in the sense that everybody perhaps used the working relationship that I had with Mr. O'Brien to get things sorted rather than people tackle it because we did get on -- we were amicable to each other. I could never change him because he was sort of very set, stubborn in his ways. With regards to support, I probably -- it's my own fault, I probably didn't reach out for, you know, to say; "I'm struggling with this", I just did it. I had a demanding job, would have worked easily 15 hours a day, and then on call, acute on-call on top of that, but, you know, always tried to get it done. So from my point of view, I probably didn't reach out and ask for support, but I do think there was an overreliance on me, on reflection.

Effective line management includes checking on the wellbeing of staff.

The importance of clear messaging being actioned through the appropriate channels.

A. I had to trust my colleagues, that's what they were there for. I had to trust my AMDs, my ADs, the Clinical Directors below them. They had a job of work to do. I was doing loads –

Q. You also have to manage them, Mrs. Gishkori.

A. Yes. Yes.

Q. You have to, because you're at the top of pyramid, say to them –

A. Operationally, yes.

Q. -- you have to say to them, do you not: 'Listen, this is a doctor who appears to be struggling. His struggles are causing potential harm or patient risk. I want this addressed, and I want it addressed quickly, and I want you to report to me with how it has been resolved'. At no point did you receive assurances of that nature; is that fair?

A. Only after September Oversight Meeting. That was whenever I really took the issue into my own hands to try and sort it out.

The monitoring of good quality and patient safety clinical care can be missed in a healthcare system where professional working relationships are 'sticky', good governance can suffer as a result. Awareness of these issues should be regularly scanned for and discussed. Team building exercises built into strategy.

A. I suppose in my mind, at what point does the MHPS procedure start? It could have been there wouldn't have been any further investigation after the Oversight, but with hindsight and looking back, yes, I think that's a fair point, that the local clinician being involved at the start would have been more likely to have that information to hand. I think that's correct.

Note the importance of gathering information from all relevant sources at the early stages of an investigation

A. On a human nature I have had to investigate colleagues, it is a very uncomfortable place to be and you have to put aside your personal relationships and go on your professional training. But it's a difficult, it's a very difficult thing to do. But it is a core part of the Clinical Director's job. It would have been normal practice in our Trust from the Clinical Director to have been the case investigator.

Q. If you are putting your hands up to take on the role of Clinical Director and receiving the salary or the pay, really it comes with the territory, difficult though it is.

A. It does. Mr. Weir had done this before and done it very well. I appreciated his reluctance, but I was, at that point, convinced that the best person to conduct this investigation was someone with local knowledge of the team.

Recognising the difficult challenge of investigating a colleague – be careful to put in adequate support for both the investigator and the person who is being investigated.

Q. Just on that. You can develop your answer, but if you could answer these as you go. What do you put that down to the fact it was allowed to drift through informal channels for so long? Was it deference to Mr. O'Brien and a reflection of how he was viewed as an experienced practitioner who was a good surgeon, an excellent surgeon, perhaps, and these issues were perceived as being more on the administrative side and not likely to cause too much harm to patients?

A. I think that's part of it. I think also a reluctance for people to put themselves in the firing line of criticism by a very senior colleague is part of it as well. Perhaps a lack of experience and knowledge of the potential remedies that might have been available. As I've said in my statements earlier, that there was a great lack of knowledge amongst even the senior medical staff around MHPS and other processes and how they would function. So certainly an education component to how that could be improved. There was some experience in the Trust in the past, as I now know, some of these issues had been escalated but they hadn't been addressed formally. So there was a feeling of what's the point of doing that again? That's part of the reason, I think, why people were reluctant to escalate, because they had seen it hadn't worked in the past.

Q. Maybe that's a bit too oblique for me, what do you mean by that?

A. In years gone by some of these issues, as I now know, had been raised at different stages but they didn't seem to have been brought to a conclusion or definitively addressed. I think there was knowledge within the system and within the teams that had happened, so what's the point in trying again? I think that reflects a naïvety and a lack of knowledge about potential remedies that can be very effective when implemented properly. That's where we'd like to be. I think earlier intervention would have potentially fixed these issues at an early stage and prevented us getting to this stage. In my experience, it is always a mistake to not intervene formally in these type of situations because they always get worse, they virtually never get better.

'I think earlier intervention would have potentially fixed these issues at an early stage and prevented us getting to this stage. In my experience, it is always a mistake to not intervene formally in these types of situations because they always get worse, they virtually never get better'

What is the SMT's view on this comment?

Q. Job planning has been mentioned by quite a few people. I've looked at quite a lot of the information. It doesn't seem to me that the Trust job planning process included, as mandated, team objectives and individual objectives, and any kind of capacity information built in. Is that correct? Or was that a place where that happened?

A. I think that is largely correct.

Q. Why was that then?

A. Well, I think it was one of the things that had been allowed to slip. We had a quite highly developed electronic system for the application of job planning.

Q. I've seen it. I've had to use it.

A. I'm not sure it was that helpful, really, because it did away with some of the face-to-face interactions where you can have a more meaningful discussion around that. There was a review of job planning just before I left. We were doing a lot of work around that at the time. We had a job planning task force looking at various different ways to improve the process and to improve the outcomes from it. That was still ongoing as I left. We had had a specific issue within Surgery, actually, because of the multiple changes again of the leadership roles in that Department, and the surgical job planning was probably the worst area in the Trust. There were other areas where it was quite good and regularly done and meaningfully done. But I personally don't know that the electronic system we had was really much of a help. In some ways it was a hindrance.

……..

Q. Let's just come to Mr. O'Brien in a moment. In terms of management, Dr. Khan, if I can ask you this: Who do you think bears the lion's share of responsibility for this omission to effective monitor over a period of months?

A. I suppose it falls to many people. On reflection, the action plan was heavily reliant on one person and that should be a broader, much more robust monitoring of arrangement for the action plan. I believe without anyone's intention, it fell through the system in terms of monitoring when one person who was mainly responsible was off sick for a period of time.

'On reflection, the action plan was heavily reliant on one person and that should be a broader, much more robust monitoring of arrangement for the action plan'

Is there currently Trust guidance on effective monitoring arrangements of action plans in informal and formal investigations?

Q. But just on the role of NCAS, did you find that Dr. Lynn's input was helpful and - a second element to the question - were you, in a sense, of the same mind with regard to the particular importance of an action plan?

A. I did, I did. At that point in time I discussed with Grainne about how it can be challenging in terms of having a right kind of a balanced action plan, and how can we ensure -- therefore, she indicated we

have a team where we can help you, we can advise you, the Trust, in terms of putting together the action plan. So I must say I was very much encouraged to involve NCAS in forming the action plan.

Q. We can also see from her advice that she recognised in what you were saying the fact that a conduct issue had arisen and that a formal conduct process was likely. I know that ultimately Mr. O'Brien disagreed with that and presented a different analysis for the purposes of his grievance. Just to be clear, did you interpret Dr. Lynn's advice as indicating to you that a conduct approach in lightly of the findings of the investigation that you were reporting to her could be recorded as appropriate?

A. As part of putting together my determination, yes, I did obviously receive the advice and I considered that. That was my own conclusion anyway. But as part of that, yes, NCAS advice was very comprehensive and it was very useful in that regard.

Note – the constructive role and input of NCAS

Q. What, from your perspective, were you seeing when reading this about the shortcomings of medical management? What should they have been doing but weren't doing?

A. I suppose my experience as Associate Medical Director before and as part of the Interim Medical Director, I was mindful of the shortcomings in the succession planning, the resources, the roles and responsibilities of all of that. That was the reason why one of the three key priorities I took as part of the Interim Medical Director was to start a process of looking at the professional governance structures in the Trust and the whole medical leadership structure. As part of my role as Interim Medical Director, we produced a paper to the Senior Management Team, SMT, for reviewing medical management or medical leadership structure. The other element was about the whole Clinical Governance and how it fits into the bigger picture of governance structures and supporting the clinicians and managers. But also highlighting and raising and providing the assurance to the system was also something I was mindful of and entrusted at that point in time. Therefore, I started another piece of work which I put in the statement report.

Has the learning from these documents been integrated into the working of the governance structures?

Q. Isn't that the very point? You were convinced, you tell us, by Mr. Young's analysis performed in 2017, yet, two years earlier, armed with the e-mails that Mr. Haynes sent through, it appears that although he had knowledge as a senior manager, he didn't perform any analysis, and yet you have managed to find your way to conclude that senior managers appear not to have known if private patients were an issue**.** Is this again, Dr. Chada, a failure on your part to follow this issue through to a proper conclusion and, in doing so, appearing to reach a conclusion that really wasn't consistent with the evidence that you received?

A. I think, as I have said earlier, it was a lengthy and complex investigation with lots of information and audit sheets and copies of patient lists and a lot of paperwork. I didn't feel that widening that further was necessary because I felt that the information that I had to draw those conclusions -- as I have said, I felt that the information I was being given was that up to this point when it was formally sat down and looked at, that it was more hearsay, that there was an explanation for when patients were moved. I felt there was a lot of confusion about when patients were added. I felt for those reasons, it was reasonable to accept that the Trust weren't clear and, therefore, that idea of knowledge as opposed to hearsay, that's the difference.

Q. So –

A. That's my view. I accept the Inquiry might view that differently.

'Is this again, a failure on your part to follow this issue through to a proper conclusion and, in doing so, appearing to reach a conclusion that really wasn't consistent with the evidence that you received?'

Knowledge vs hearsay.

Q. In terms of Dr. Khan's determination, you were in a sense a stranger to that. You weren't provided with a copy of it, it wasn't discussed with you, you had no input into it for obviously correct reasons. I think you have expressed the view that it might be of some assistance to know what determination was being reached and the view that has been taken of your report?

A. I think I raised that -- I was trying to be helpful to the Inquiry bearing in mind the Inquiry's Terms of Reference, and I have raised that in my Section 21 response. I just think from a learning point of view, you know, doctors audit regularly and we are expected to audit regularly and to consider what it is we do and what the outcomes are. Therefore, if one of your roles is to be a Case Investigator, for example, knowing how that report has been received and what action has been taken on foot of that report, actually I think is a learning opportunity rather than for any other reason. It's not that I should have any input into the Case Manager's determination, I appreciate that's completely separate and should be, but it's really about getting that feedback so that, if you are asked to do this again, that you can improve and you can consider the areas that perhaps could have been done better, or if questions are raised at a later stage about the investigation, that you actually get some feedback about right, okay, you know, I could change that part of my practice**.** Because it's about improving. So it was an issue about improving performance really, not just for me but for any Case Investigator.

The principle of 'closing the loop' where possible can provide good learning and improving practice opportunities. Alongside building and valuing teamwork.

Q. Whenever you say you were asking orally for updates, what would have encouraged you? Did you have a regular timeframe in how you sought an update? How would you have managed it from your own perspective?

A. I would have been looking roughly for monthly updates because I wouldn't have wanted it to be extended over that extended period of time. I needed to have a handle on where the investigation was. So for that reason, you probably can see there is a pattern to those e-mails that are coming through, and they are generally on a monthly basis.

Q. Do you feel that you should have done something more formal than perhaps raising it orally, as you have described?

A. If I was doing this again, I would have been looking for regularised meetings with HR, with the Case Manager, with the Case Investigator. I know Siobhán would have been, as it were, second-in-command, so Siobhán would have done, I think, a regular meeting, a formal meeting on a monthly -- if it could be arranged, bearing in mind -- but I think that's part and parcel of the learning that comes out of this, that as a non-executive director, it would have been good to have those formalised meetings, to sit down and seek, well, where are the hiccups in the process.

Q. At the time, and, as I say, we are talking now about in and around March 2018, over a year since the investigation started, at the time did you not think we need formalised meetings or we need something to formalise this to try and combat the delay?

A. Honestly, no. That was not within my mindset at that time. I thought that by contacting and meeting with both Mrs. Toal and with Mrs. Hynds, that we were tackling that particular issue

'If I was doing this again, I would have been looking for regularised meetings with HR, with the Case Manager, with the Case Investigator.'

Would the SMT consider introducing this idea more formally?

Q. Thank you. I can identify with a lot of your views and recommendations having had the privilege of multiple interactions on most of these things. It is my observation, particularly in the Southern Health Care Trust, that there was a huge fear in relation to managing doctors, some of it because they had this view that everything had to be done under MHPS; rather a lack of understanding about what I would call normal medical management. Much like in the old days, you just called someone into your office if you were Clinical Director and said come on, we can't do this, and if they don't do it you write them and email, a letter and help them do it, you don't think you have to go down a big framework. But it is still management. Now, I don't think there's a good understanding about this, certainly at the Southern Healthcare Trust at the time this happened and probably in other institutions. Whose role is it to deal with this in your view? Where does the responsibility lie and is it a combined one, and is that something that NCAS could help with since you see what happens when it goes wrong?

A. Yeah. I mean, one of the problems is the way we get into medical management, which is usually by accident. There's not really a lot of lot of -- in recent years, the faculty of medical leadership, or whatever they're called, and other people have provided a bit of training, but there's precious little training out there for people to be medical managers. You're absolutely right, they sort of get scared by processes like MHPS. It's not helped by defence organisations who scare them as well. They don't realise, as you say, you can apply common sense and just do it. Quite often - I mean back to what I think I said earlier, particularly with conduct issues - the best advice I can give is just do what you would do if it was someone else. What can we do? There needs to be training. Whether that's for NCAS to provide or somebody else, I'm sure NCAS, if you asked them nicely and paid them enough money, they would do it.

Q. Do you think it would be helpful to have a warning in the MHPS Framework to say 'by the way there is normal medical management'?

A. That wouldn't go amiss. That wouldn't go amiss.

Q. Because actually the number of times people, in any experience, would come to me and say we have doctors, we have to use this, and I would say no, it's common sense.

A. I agree with you.

Can the SMT give some guidance on the place and use of 'normal medical management'?

A. Now, I do appreciate Dr. McAllister in October, and then Mr. Weir, both went off on sick leave, and maybe with hindsight that was a missed opportunity to sit down and have a discussion about Mr. Weir's plan and the possibility or the reality would it ever be -- would life be given to it, and should we have a rethink and revisit the decision of the September Oversight Committee meeting. But that never -- and that's just me with hindsight. But those discussions never took place.

How does the SMT monitor the situation when those in senior positions involved in investigations are off sick?

Q. Of course. The point, I suppose, I'm asking is if Mr. O'Brien sees 12 patients at a clinic at the SWAH on a Wednesday afternoon but only two or three letters are dictated and come back to his secretary, what is she to do with her knowledge that he hasn't dictated on the remainder?

A. So, my expectation is that she would speak to Mr. O'Brien and say the clinic in SWAH, of the twelve patients seen, you've only dictated on three, where are the other nine? Then there would be an outcome from that. If there was no outcome, then I would expect her to have escalated that to her services administrator.

Q. If he's telling her, for example, I don't need to dictate on those now, they're not urgent or whatever, there's no expectation that she should take that anywhere else; her relationship is with Mr. O'Brien?

A. Well, yes, and I don't underestimate the relationship between the consultant and the secretary but also she has a responsibility to escalate to her superior, not least because if she's not dictating Mr. O'Brien's work, what is she doing.

Recognising the important working relationship of trust between the consultant and their secretary, how will one of the messages from this Inquiry be underlined - advising secretaries of their responsibility to escalate to their administrative line manager issues that do not meet the guidelines?

Q. You have said in your statement at paragraph 26.3 that Mr. O'Brien instructed his secretary not to use DARO. Was that something that was reported to you or did Noleen Elliott tell you that directly?

A. Noleen Elliott told Colette McCaul, who was her line manager at the time, and Colette McCaul then told me.

Q. Was there an expectation that Noleen Elliott - we discussed this slightly earlier - would follow the guidance that DARO was the system in place? Or was there an expectation that she would use systems to better reflect the clinic practice of her consultant?

A. Well, it's a very tricky one but I believe the secretary should be listening to us because we are the admin people and you should be following your instruction from us. However, I understand it's very difficult because she worked very closely with the consultant; you see them as 100 times more important than we will ever be. But you have to follow process and you report to us.

Q. But did Noleen Elliott have any appreciation, as reflected in your statement, that to not do that, not to follow DARO, may result in tests being not followed up, results not being followed up or patients coming to harm? Do you ever get the sense that she was aware that that was a potential?

A. She may not have thought of it that way.

Q. Did you know her to have any workaround? If she wasn't going to use DARO under the direction of Mr. Mr. O'Brien, did she develop any other system for keeping an eye out for tests that needed done or results that needed followed up?

A. Not that I am aware of.

Q. So, as far as you are aware, by not using DARO, there was no system in place between her and Mr. O'Brien and the patients that were seen by him for monitoring follow-up with tests or results?

A. As far as I'm aware.

Q. Now, she did then start to use the code?

A. Yes.

Q. How did that come about, that she was able to comply with it? Was that a conversation with you?

A. I'm pretty sure I had a conversation with her and told her that she had to take her instructions from us, which is not an easy conversation to have but it's the way it is.

Q. I think you have said in your statement at WIT-60388 that you spoke to her on at least two occasions?

A. Yes. I definitely remember, but I have no evidence, I definitely remember 'you need to listen to us when we tell you'.

Q. Was the second occasion because she didn't listen after the first one?

A. Possibly. I can't totally remember.

The need for regularly messaging and empowerment of staff (both clinical and administrative) to operate within Trust Guidelines and processes.

Thank you for your very clear statements today. Two things, really, jumped out at me. One was your statement that "consultants are a hundred times more important than we will ever be". The other one was "we had no significance". Now, I think that's quite worrying, especially from someone who clearly has passion for their job. What do you think the root cause of this is, and do you have any suggestions as to what should be done about it? Because all the evidence, Patient Safety evidence, internationally shows that having strict hierarchies where people feel unimportant isn't good for safety. Can you just give me your thoughts on the basis of how that felt and what you think should be done.

A. Our structures relating to admin are weak and they don't really have a position in the Trust, in my opinion. Now, this is my opinion.

Q. That's what I am asking. Yes, that's fine.

A. I think until admin be given their place, their rightful place, it will not change.

Q. What does that feel like as a member of staff? What impact have you seen on that feeling?

A. Well, I actually think it's got worse over the years. I actually think admin did feature quite a bit years ago, it's actually gone downhill. But it's very disappointing. Some days I wake up and I think, well, I am coming to the end of my career so whatever they like.

Q. Does it cause problems with recruitment and retention of staff, does it cause increased sickness rates, mental health issues? Have you seen any of that or are people just grinning and bearing it?

A. I think there's a lot of grinning and bearing it.

'Our structures relating to admin are weak and they don't really have a position in the Trust'

What is the SMT's view on this statement?

.....

Q. You speak about learning and improvement in your statement. We don't need to go to it but it's at WIT-85932. You have given some bullet points of the way in which communication and action planning could be improved. Some of these focused particularly on practical application of your skills to the system, if I can put it like that. You have said that one of the ways in which the system could be improved is to enable clinical nurse specialists to have access to a managed DARO list. Could you just explain that a little bit?

A. So, this is a list that secretaries hold for the consultants. I think the actual terminology is Discharging Awaiting Review or Outcome. These are patients waiting scans or a blood result to come back. I'm thinking more of this in terms of my nurse-led work as a safety net for that. At present, I don't have any way of monitoring, apart from me keeping it all on a spreadsheet and revisiting it every week. If I have ordered a scan for a patient, currently the radiology scans don't come back to the nurse that ordered them, they will come back to the consultant. They don't populate in my ECR automatically for sign-off. I now have it set up that my PSA bloods come back to me, so I don't have to go, and not waste time but use time to find them. They are populated on a list, a sign-off list that I can just go to, but the same doesn't happen for the scans. It's just another layer of safety that could be there and prompting me that to look for that.

Q. So you might order the scan as such but the result goes back to the clinician?

A. Yes.

Q. Would it be something that might assist if the result were to go back to both you and the clinician?

A.Yeah.

Is this an idea that the SLT agrees with, if so, what are the steps to implementation?

Q. Just in relation to the concerns overall, you say that you feel "I should have been made aware of the aforementioned governance concerns within Urology." Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

A. Absolutely, and then there's a balance to be struck.

Q. But if you had have known about issues sooner, what difference do you think it might have made?

A. For a start, you would have had more of an awareness. Referring back to the two cases that we discussed, I think I would have handled those very differently had I had an awareness that there were issues in and around those processes.

Q. And handled differently how?

A. I would have went to my lead nurse and my Head of Service also.

Q. So, you would have escalated the issue?

A. Yes.

'Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

Absolutely, and then there's a balance to be struck'

How does the SLT define this balance and then communicate it throughout the Trust?

Q. How would you explain that? Is that explicable, that issues would be troubling management for, let's call it several years, and yet nobody saw fit to elevate it on to a formal process until 2016? How is that explicable? Does that tell us that managers didn't understand? Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated? What's your best assessment?

A. Potentially a factor of all of those, I think. I mean they were aware there was a Medical HR Department, so I think that that shouldn't have -- we should have been contacted, and I don't know the reason why we weren't. I think there's some work we need to do in changing that culture, that you know maybe there's a feeling if you contact HR, they're going to escalate things to a formal matter whenever it's not necessarily about that. You know, there's lots of positive things that can come from an MHPS process, it's not a negative thing. There's lots of supportive measures that can be considered; there's lots of structure and framework that can be put around to support individuals to get an early resolution. I think there's maybe a fear that if you tell HR, that it's like pressing the button, a nuclear button, and things will be escalated. Maybe that's what we need to ensure is not engrained in thinking. I'd like to think that's not a case now, we are contacted very regularly by our clinical managers about issues just for advice and reassurance in terms of how they are handling things. But maybe back then, there was more fear around that all.

'Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated?'

Is there an element of fear that still exists in the Trust when it comes to dealing with the shortcomings of some clinicians?

Q. I was going to start with that one. Just following on from that, is there a single person in the Trust who is leading any sort of, you know, big idea, innovative approach to recruitment for medical staff specifically? Where does that sit?

A. Well, it probably sits within our HR Director's remit in terms of, you know, we do have recruitment campaigns –

Q. But have you got a big strategic idea –

A. Yeah. I think it's something we are looking at.

Q. That the Board is involved in? I mean, this is a Board issue really?

A. Of course.

Q. It is so significant. Is that there or –

A. We have it listed on our Corporate Risk Register in terms of our ability to recruit medical staff.

Q. Have you got somebody saying I am in charge of this?

A. Yes. Possibly not.

Is there a plan to have a lead in the Trust with this responsibility?

Q. The other thing that has come out is a sort of secrecy and mystery and all of that, but also a reluctance to manage doctors, not just not to ring HR, which you have described as perhaps due to fear of process. I am presuming you are implying that HR is trying to be less scary in that regard?

A. Yes.

Q. But there also seems to be a general reluctance for doctors to manage doctors, for managers to manage doctors. Is that something you have observed, and why do you think that is?

A. Yeah, I think it probably has been something -- I guess medical staff are -- they are so used to being autonomous workers and independent workers. But it's difficult. I mean, it's not something that I think

-- I think it's a journey that we are on in terms of ensuring that they are managed in the same way as anyone else would be managed, and I think that's important.

Q. Do you think that's improving? A. Yes, I definitely do.

Note - the importance of continuing this journey of consistency, transparency, fairness, and equality with all the staff in the Trust.

Can I just be clear because it's perhaps my misunderstanding of the language used here, but it seemed to me that you talked a lot about escalation. To my mind, escalation is where you move something up to somebody more senior so that they can do something about it. Sending it back to the head of service, to my mind, is really not escalation. Is that not just sort of, well, you know, this is your problem, you need to deal with it?

A. Do you mean the head of service within the specialty?

Q. Within Urology, yes.

A. Generally, whenever I was escalating any issue, that would have gone through to the operational support lead, to the head of service and the assistant director within that area.

Having raised an issue to be escalated in the correct sequence, what is the guidance on action when the issue remains on this person's desk and goes no further?

Q. "What we really need in the Trust is the recruitment of a radiologist with an interest in general urology, someone that can partake in the GU Service and attend and take the MDT. The only way to achieve this is to make a real attempt to recruit by putting out interesting job plans that offer more than the bare minimum, mentions of flexibility, offsite SPA, more than 1.5 SPAs, recruitment and retention premia. I remain unclear why the Trust does exactly the opposite and how it expects to recruit in the circumstances, which leaves me, as a sole practitioner, which is not safe and not recommended by the College." So you're explaining yourself in fairly strident terms.

Q. Did you ever get direct feedback yourself on this point that you're making, that we need to, as an organisation, make the role more attractive, to be more proactive in our recruiting strategy?

A. No, I don't think so. I think this was something that I suggested a number of times over the years and I didn't get any feedback.

How does HR review the quality of its recruitment strategy and content of job adverts?

Q. The inquiry has heard some evidence about I suppose the difficulties faced by medical managers, those in the AMD, CD Clinical Lead cadre; busy clinical practices but also a heavy job description that goes with these managerial roles?

A. Very much so.

Q. Any particular reflections to offer on how that might be done better?

A. Again, I suppose it came back to when I put the proposal in about giving protected time for, particularly, clinical staff to focus on governance. I would still have that opinion, either that or maybe outsource some of it to - what I am doing at the moment - recently retired people who are still experienced enough that they can bring their recent knowledge to Chair SAIs and take that pressure off Trusts. But I think the Assistant Directors were slaughtered at the time, and they still are in terms of their workload. So things like this were a tiny -- I know they weren't -- in terms of significance, they

weren't tiny but in terms of their massive workload. Also, the Assistant Directors as well would have been carrying a one-in-six on-call rota on top of their day job. In terms of the operational management of the hospital and the out-of-hours and weekend period, there wasn't such a thing as compensatory rest for that level of staff. It was massive. Even though, yes, for those poor patients, it's a huge impact, in terms of the daily workload, trying to find time to focus and keep on top of meetings and things, it was just huge for the Director and the Assistant Directors as well.

Q. Is there a sense or do you have an experience of is it left to those in operational management to give informal nudges to clinicians to get things done, and get things done better if there were shortcomings, but really it's up to the medical management, the AMD, to take more decisive action if the operational managers are not able to achieve a successful outcome, and at least exhibited through interactions between some medical managers and Mr. O'Brien, there has been a slowness about taking robust action so that things are allowed to drift. Is that part of a culture that you recognise more generally?

A. I wouldn't call it a culture as such but it is probably a symptom of how job plans and things are arranged in terms of obviously the medical staff, their focus is their patient-facing activity. Obviously the operational staff see the issues starting, and they see -- the admin team and the governance would have known that maybe a panel wasn't meeting, so they would have nudged. Actually if then there was some reason that there was a decision not to meet, they couldn't make the consultant meet or run that panel, because they weren't in any sort of line management control. So it had to go back to the medical management line if the nudges weren't working.

Q. Yes.

A. So, it was out with their scope of control to make it happen

'I suppose it came back to when I put the proposal in about giving protected time for, particularly, clinical staff to focus on governance. I would still have that opinion, either that or maybe outsource some of it to - what I am doing at the moment - recently retired people who are still experienced enough that they can bring their recent knowledge to Chair SAIs and take that pressure off Trusts.

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What are the criteria for the SLT in considering the potential for outsourcing some of the Trust's work to ease the pressure on workload?

Does the view 'I think the Assistant Directors were slaughtered at the time' hold true in the Trust currently?

The Panel have heard some -- as you say, the Chief Executive post was a position held by numerous people over the years. Did you think that was a particular cause of concern for you as a director?

A. Oh, it definitely was. I mean, of course it is. The senior team needs -- for me, it was about trying to redefine. You know, I changed what I did. I think I mentioned in my witness statement as well in terms of trying -- as each Chief Executive comes in or is trying to navigate their paths, their vision and how they wish to have things done, a director with the responsibility for planning and performance et

cetera, I would have been working differently and trying to drive forward the vision of the Chief Executive and work closely with the Chief Executive. So, that was a challenge. It was a challenge also because it wasn't just Chief Executive changes. You'll have heard from some of the other evidence, I am sure, but we did have changes to our senior team in terms of creating a new role in the Director of Nursing, and different things that were shifting. For the matters pertaining to this Inquiry, the assistant director team and the Acute Director was a very stable team as in it hadn't changed over that period of time, but there was a lot of change and movement within it. I mention also that within the Governance team, and I think Tracey Boyce's evidence yesterday alluded to that in terms of quite a lot of changes in that as well. So, all of those changes do make it more difficult. There has been a lot of expertise lost and experience lost.

Q. It is also the case that some of the changes brought about by new Chief Executives can also be beneficial?

A. Oh, absolutely

The senior team in the Trust has seen significant personnel role changes in the last ten years with the potential loss of corporate memory. How is the SLT addressing the challenges in nourishing and establishing stability and consistency in senior post holding going forward?

Q. When they are on their third or fourth time ringing up, what kinds of things did they say to you?

A. Well, a lot of it was frustration. It was frustration too on my part because there was nothing we could do. I think they accepted that, that it was out of our hands.

Q. Was there ever a time, for example, when you could liaise with some of the nurses or someone else to talk to them, because a lot of them would have had quite clinical complaints, I would think, and they would need someone to talk to. Were there any discussions about how that might be managed within urology, as far as you were aware?

A. We were never actually advised that we had the nurses there for a backup. That was never something that I was aware of, and I don't believe any of the other secretaries ever transferred to the clinical nurse specialist.

Q. What do you think; do you think that would have been helpful?

A. Well, I know now that that is expected and, yes, it would be very helpful. But at that particular time, those clinical nurse specialists were up to their eyes with work so they didn't need patient calls as well. You know, they were under-resourced as well.

What is the view of the SLT on CNS's being available to support secretaries when patients are frequent callers?

Q. "This incident demonstrated that the secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every attendance on a timely basis. I would have expected that Noleen Elliott, Mr. O'Brien's secretary, would have been following up with her consultant Mr. O'Brien to advise that he had not dictated on clinics. Also I would have expected that when she was aware of delays in dictation, she would have brought that to the attention of her service administrator, Andrea Cunningham. If this had happened, this would have been apparent on the backlog report and would be visible to myself", and those others she mentions. Do you accept that criticism, that this was an aspect of your role that you should have been performing?

A. Not really, no. As I said I looked -- I believe that that backlog report was a secretarial backlog report. I was never told that I was to highlight the backlog of a consultant on that backlog report. There was that mechanism of that 3D report that was already in the system for the service administrator to see what was outstanding.

Do all the secretaries in the Trust have a complete understanding of the full purpose and requirement of the Backlog Report?

Katherine Robinson is reporting to Anita Carroll, "see the attached list". "This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome to some of these patients. There is a risk that something could be missed so I am escalating to you although I know that a lot of the time Mr. O'Brien knows himself what has to happen with patients. Unfortunately this was not highlighted on the Backlog Report."

We have just looked at an example of what a backlog report looks like. "The secretary assumed we knew because there has always been issues with this particular consultant's admin work from our perspective. As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality. The secretary also advised that at present Mr. O'Brien is working is some of his backlog admin report as he is off recovering."

'As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality'

How regularly is the Backlog Report being monitored for adherence?

Q. If that patient had been on DARO, the service would have had visibility of the fact that results had come in from radiology; isn't that right?

A. That's right, yes.

Q. And would have had visibility that those results hadn't been actioned because the case still remained on DARO?

A. Yes. So our service administrator -- the narrative, should that person have been on DARO, how I would have validated that DARO would have been "result with Mr. O'Brien to see and action". Now, that happened on a regular basis but our service administrator never came back to say why has this not been actioned, so I'm not sure whether it would have went anywhere. All right, it would have been noted on the DARO but whether those sorts of things were ever actioned, I am not concerned -- I am not convinced that they were.

Is the monitoring of DARO a watertight system in practice?

Q. Yes, but what I'm saying is regardless of whether the patient is on a tracking system, if you as the secretary see something untoward in the result, do you have any role - I am thinking here from the perspective of an additional safety net - to get the thing moving with the cancer tracker?

A. No, no. No role, if that's what you are saying.

Q. You had no role in that respect?

A. No. I never referred anything to the cancer tracker for MDT discussion.

Post Inquiry – will there be a refresh on the role and responsibilities for all secretaries within the Trust?

……..

A.I have no problem with inquisition or curiosity. In fact, I would be known to be of that style myself so I have no problem with that. I agree with the Chief Executive, it's right that a Medical Director is inquisitive and holds people to account. From an Acute Assistant Director perspective, I believe that the style of previous Medical Directors had been as operationally facing or involved as Dr. O'Kane would have been. They would find it difficult to get used to where does the operational bit take over and where is the responsibility of the Medical Director, and I think there was some of that behind it. I do think there are different personalities in any team and there probably was a bit of feeling annoyed and maybe a bit defensive as a result of that, but that incident in 2019 just wasn't as clearcut as described there. With regard to the model within Acute, the model in the organisation for clinical and social care governance was devolved, and still is actually because it hasn't actually flipped yet. Therefore, the information that is held within directorates from a governance perspective is the same as the information that's held in Older People and Primary Care or Mental Health Directorate and so on. It isn't in the responsibility of one person to have that information. Anne didn't even work in Urology Services, for example, she was in the medicine side of the house. That information was shared at our governance meetings, at our Acute governance meetings. The actual collective leadership structure I talk about in my statement talks about the Clinical Director and the Divisional Medical Director and their professional accountability line to the Medical Director. So, there are a range of mechanisms to interact and get information, and a range of fora that allow us to share that information. There would have been no evidence, and no awareness certainly from my perspective, that anybody would have withheld or made it difficult to get information.

From a governance perspective - are there currently clear pathways to allow the maximum information flow in all parts of the system?

Q. You have mentioned about there being various people in your post prior to you taking that up. There was turnover at that level, turnover at Chief Executive level. Now, obviously some individuals like Mr. Carroll and Mrs. Corrigan were there for the duration of events as they unfolded from early 2012, 2014. What impact do you think the turnover of staff at a high level like that has on good governance management?

A. Very definitely, the turnover definitely affects our governance arrangements, and the styles definitely affect our arrangements in terms of -- I mean, if I use the example of Dr. O'Kane again. When she came in, right from April '19, she was very proactively following up issues of concern from a governance perspective that perhaps could have been dealt with at an earlier stage. But she was a very proactive mover and shaker in terms of clinical and social care governance. She'd also come from Belfast Trust and had experienced a different model of clinical and social care governance, so therefore she probably saw flaws in our system which I would imagine prompted the clinical and social care governance review. I think there have been significant changes made over her tenure to date that are about trying to improve some of those vulnerabilities and some of our systems and processes. So I think some of it is about style, but definitely an impact of change in personnel at the different levels.

Have all the recommendations in the Clinical and Social Care Governance review been implemented?

Q. Just to point more widely in relation to the relationship between HSCB - SPPG as it is now - what is the nature of that relationship, and do you have any views on how that relationship might assist better governance in a Trust generally?

A. Well, in many ways it was a holding to account relationship in that the services were invested in, we were the provider of those services and we were reporting on that. But where there were issues of concern or escalations, either we were escalating to the Commissioner or issues that the Commissioner wanted to discuss with us, there wasn't really -- there wasn't really much solutions coming from commissioning side of the house. You know, you would have been guided with some novel approaches that maybe we could take or whatever, but we weren't really getting much traction, especially with regard to backlogs and waiting lists and waiting times, despite efforts to try lots of different ways to bring that about. The relationship was respectful and proactive and we could have had discussions about new investments, so that was all very healthy. Some of the discussions around what else we could do and the holding to account bit were a bit frustrating because we didn't really develop new approaches. We might have had a bit of non-current investment or a contract development with the independent sector, there was always something we were moving forward, but we weren't really turning things around despite the two-way processes.

Is this still the case?

A. But I did act on that in terms of I knew the governance review had taken place from 2019. We were waiting on the outcome of that, hoping that it would give us some sort of acknowledgement that there was capacity issues for the volume and scale of what we were dealing with in Acute. I did put in post a Quality Improvement Project. To me, quality and governance are very interlinked, so our Quality Improvement Project dedicated some time to the Assistant Directors to actually look at some of the gap areas they were most worried about, like action plans, and implementing recommendations post serious adverse incidents, and dealing with some incidents on the Datix system.

Q. That's one of the things that Mr. Carroll actually refers to in this paragraph, the inability to deal with action plans, the implementation of recommendations following serious adverse incidents, or to deal with the volume incidents that require active management and the complex complaints that required attention.

A. Mm-hmm.

Q. Now, what was the scale? There's quite a breadth of governance concerns around that. Did you ever get underneath what the scale of all of that work was? For example, what were the number of complex complaints that required attention; what were the SAIs; which standing; what recommendations were awaiting implementation? What was the detail behind that?

A. So, we got that detail every month. If you notice in the Acute governance papers that came, we would have got how many complaints are outstanding, how many are awaiting answer, which Assistant Director is sitting with or which Head of Service? So we would have known through the Governance Coordinator where there was glitches in the system that we needed some action. When we had a Serious Adverse Incident Review, we did have an action plan that was pooled together with the Clinical and Social Care Governance Coordinator to outline the recommendations of that review. What we were missing was has it been actioned? Has it been implemented? When was it implemented? How can you evidence it was implemented? They weren't missing it all the time but we didn't have a clean sheet in terms of we had a thorough process end to end for that action plan and implementation process. So, that was the focus of me trying to put in place, number one, the Quality Improvement Project and some of the areas around that, but, more importantly, getting funding secured for a Band 5 Governance Officer for each of the Assistant Directors, who would be their person who would work with them and hold their hand to keep a bit of momentum going within the Directorate.

Q. Those posts were filled before you left, were you?

A. Yeah.

Q. Were they two Band 5s?

A. No, there was four. There was one for each division.

Q. They actually tried to follow through on the outworkings because what this paragraph seems to suggest is the systems are effective in bringing the issues to the surface by and large –

A. Yeah.

Q. -- given that we are here, but that the actual remedial work and outworking of what's needed to make sure that doesn't happen again is the stage that has some hold-up?

A. Yes. The purposes change in learning. To bring about the change in learning needs capacity, and that's what we were missing. We had some capacity in different job roles. I mean, I think somebody said last week Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it. We were missing a wee bit of momentum. That's why both the quality project and the Band 5s for each AD, and now in place, were to try and accept that there was a reason to be kept awake at night and we needed to do something about it.

'So, we would have known through the Governance Coordinator where there were glitches in the system that we needed some action'

With a band 5 now in place for each AD – are there any remaining 'glitches' that need addressing?

'Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it.'

Q. If we could just go to the terms of reference of the review at WIT-35726. The purpose of the review, it's "Terms of Reference Southern Health and Social Care Trust Governance Review". It says: "The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on Patient Safety and that helps people learn. The objectives: The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like. It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach through the organisation**.** It will include a review of both clinical and social care governance. Specifically, the work will include gaining an understanding of the current governance structure and processes in place; meeting stakeholders to identify what works well and areas for improvement; undertaking a benchmarking exercise to identify best practice; review of existing and draft documentation, including a new governance assurance strategy. The outcome will be a written report outlining key findings from the review, and recommendations." The governance assurance strategy, did it ever come to fruition?

A. I don't believe I ever saw one.

Q. In relation to this clinical and social care governance review in September 2019, what was your understanding of the background of this particular report? Was this something that the Trust did every now and again or there was a specific reason?

A. There had been a couple of reviews in earlier years since the Trust had formed, I think it was 2012 and 2015 potentially. Again, I think it was following Dr. O'Kane joining the Trust, seeing some vulnerabilities, potentially assisting with the potential of a better model, actioned by the Leadership Centre. June Champion was the Leadership Centre author was carried out the review. She worked, in fairness, intervening teams and relevant stakeholders to make sure she put together a comprehensive report

The report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 Findings and Analysis, and are broadly categorised under the following themes: Work governance, culture of being open, controls assurance, risk management strategy, management of SAIs, complaints and legal services, health and safety, standards and guidelines, clinical audit, morbidity and mortality, learning for improvement, Datix, clinical and social care governance structures. A summary of the recommendations is provided in appendix 1."

Q. Now, your involvement was on the SMT in trying to implement some of the recommendations. You mentioned about the operational risk versus corporate. I wouldn't call it a struggle because I am not sure that's a word you would use but was there a tension between the competing expectations or demands that perhaps ultimately led to the delay or the failure to implement these recommendations?

A. Yes**.** I think the time-lag doesn't help when there's a review happens in August '19 and, a couple of years later, or three years later, we are still moving forward with it. You then have pockets of developments to try and strengthen where we are now as opposed to the root and branch review being implemented. However, I think changes that have been made have been felt and felt positively. Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you.

Q. So, there was a degree of flexibility built in?

A. Yes. We were evolving, we were learning on our feet and it really was governance in action, how do we keep this as safe as possible with patients at the centre.

Q. Do you think it might be helpful to have a toolkit for incidents like this where there are lists of suggestions, different routes, built in flexibility, a checklist of things to make sure they are done?

A. Absolutely.

Q. Would that be something that might assist?

A. I think because of the Belfast experience and because at the end of a lookback review, one of the stages is the outcomes and the recording of the learning, I think there's a natural opportunity there to learn and to share a lot of the tools and processes that we adopted.

Q. Giving the timing of this report and the September 2018 recommendation in the MHPS about an admin review, and this clinical and social care governance review then coming after that, was there any thought given that this was a possible vehicle by which that admin review could fall under this

umbrella and perhaps gain some learning from that, given the independence of June Champion and, as you say, the requirement for the MHPS recommendation to be independent?

Q. There was also learning over and above Urology Service in those. What was the position on the roll-out of those recommendations or their implementation by the time of your retirement; can you recall?

A. When I retired, there were nine out of the eleven delivered and the other two were embedded but subject to audit; we needed to evidence that they were effective. So all eleven are now implemented. I have to say that that process was extremely innovative because we had -- this wasn't about a Urology Department, this was about learning for the whole organisation in Acute Services. So, we had medicine, we had everybody sitting around that table taking responsibility because function of their MDMs, for example, was something that had read across. We had a really good process, and we had a subgroup and we had designated tasks that the different people around, say, job planning or audit, whatever, would work through and develop with the groups. But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work.

Alongside the learning from the SAI's, there have been several significant reviews in the Trust in the last 10 years, each with recommendations. Added to this will be the recommendations of the Urology Public Inquiry Report.

Going forward:

- what are the plans to review and bring some clarity, standardisation, and consolidation to all these recommendations?

- then to move through to systematic action and implementation?

- what is the SLT's view of developing 'a toolkit for incidents'

Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it.

A. Mm-hmm.

Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting?

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture standing back a wee bit, I think there's somebody thinking, no, there's a different way to do governance, I think, not just a series of tick box exercises.

How can the SLT shape the narrative post Inquiry so that this momentum can be maintained?

Q. Yes. Dr. Boyce has suggested that -- if we just pull up her statement, TRA-05849. If we just go to line 4, please. I'm asking her why you wouldn't take on this direct interfacing role with Trudy Reid, and you have given me an account this morning of why. Dr. Boyce's perspective on it was that you were

overwhelmed with the post, it was a massive post, "and also there was maybe a level of inexperience in terms of governance, leading governance in a very big, very vast ranging Directorate." She says, "I think the fact that I was there and had already been doing it sort of allowed [you] not to maybe take it back fully." The downside of it, she explains, is that it made her nervous on your behalf because obviously: "Then Esther was going into Senior Management Team, the Corporate Governance meeting and so on, without that interface so I was always nervous about how she could then represent and talk about her risks and so on." Do you recognise that there was this risk of a gap if you weren't as fully committed to the governance aspects as Tracey Boyce says you ought to have been?

A -- So yes, I was uncomfortable and I felt extremely just unsupported in terms of -- you know, if you feel supported when you are in a swimming pool with rubber rings and everything and everybody takes that away, you feel a little bit adrift.

Are there any people in current senior leadership roles who are not carrying out their full brief?

'Q. The Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that'

Is this a trend that is still happening? If it is, how is it being addressed?

Q. And, in that role, what were the challenges? Was it a straightforward matter to implement these radical changes to how governance was to be done within the Trust?

A. No, it was really tricky. It was -- I mean, it was a bit like the performance era and that takes, it takes time, it takes consistency, it takes -- no, it was very difficult. Was everybody accepting of these processes? Did people want to add this on? I mean I have read in other evidence where in -- after my time in 2016/2017, they talked about giving additional PAs to consultants or 0.5 of a PA. We didn't do that at the start because we wanted to see: Can we buy you into actually this is part of your job role anyway? Now, there's a tossup between adding on a bit and paying you to do it, or you winning the hearts and minds and saying "This is part of my role anyway." I mean -- so, the whole thing just takes time to slot together, not just -- I mean, IT's not my thing, but, even that, but it was interesting reading people's statements about the use of IR1s and, you know, saying "Oh, well, I wrote the IR1" and it nearly felt like they came to an end-point there. No, the IR1 is to flag -- "I need to then talk with my line manager, they need to come back to me, we need to see what we're going to do about it." But they felt like they had discharged their duty just by doing it. So we hadn't got the culture there yet. It wasn't there yet**.** They hadn't the ownership.

It takes time for people to realise that governance is your business and somebody is not going to do it for you.

Is this understanding of governance widespread in the Trust today?

……..

Q. Another feature of some of the cases that we'll look at shortly is, I suppose, the delay from - let me not call it a delay - the passage of time between incident and final report. Obviously you have a lot of steps in the middle, you have to assemble the material, get the timeline, get the screening done and then research, interviews, analysis, drafting, maybe multiple drafts, lots of steps till you get to the final report. Some cases have taken three years to produce an outcome, again can you, in the generality,

not necessarily referring to any particular case, but what is the problem there in realising the prompt delivery of an SAI outcome?

A. I suppose that's one of my sort of greatest regrets, that many of the SAIs took such a long time. It was essentially resource, resource of the governance team, myself and a small team, the number of SAIs, the complexity of some of them, the timelines, then diary management, sometimes getting a Chair. So if you start from the initial, we screen, we have to decide there is an SAI, we have to decide who the panel is, who the Chair is. There were challenges in always getting chairs, particularly if there was an external Chair required. Then organising the meetings, getting the diaries aligned. If we had to interview individuals in relation to the SAI it was getting their diaries aligned as well. So steps, small steps all along the way all slipped over time and unfortunately and regrettably the SAIs took too long.

Q. Yes. I suppose more often than not you're looking to an experienced clinician to Chair an SAI?

A. That's correct.

Q. Perhaps a clinician with other clinical and governance commitments; was that part of the problem, getting clinicians, who are no doubt to be thanked for putting his or her hand up to do the SAI when it is undoubtedly something that they maybe wouldn't necessarily have wanted to do? Is there a solution to be found? Have you thought about whether there is a better way of doing it, rather than calling ad hoc on clinicians out of the blue, perhaps, to become involved?

A. So the clinicians all have very busy clinical schedules and they did the SAIs within that diary commitment that they had. So that is why one of the governance structures looked at having some time set aside for people to be -- for chairs to have that half PA a week to help facilitate governance and SAIs. The other element was to have professional chairs, for want of a better phrase. And the Trust now does have some people who Chair SAI meetings, that's their -- that's what they do, they have the time and the commitment to be able to do that.

Q. Because if we start with the principle that the SAI review is taking place in order to provide learning and an opportunity to do better in the future in respect of, for example, a clinical issue or a behavioural issue or a technical issue, whatever it might be, the learning obviously has to take place in a considered environment, you don't just rush out with the conclusions right away, it has to be considered and thought about. But three years down the line or two years down the line is, would you agree, not much benefit if there is a real problem there that needs addressed?

A. They do need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So two years is too long.

‘Conducting SAI’s need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So, two years is too long.’ With the learning from this Public Inquiry on this matter – how is the SLT responding?

Q. -- inefficiency, that there is also an aspect of individual working styles and differing case mix. So: "If a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters, then inevitably the waiting list will grow more quickly than that of a colleague who lists chronologically."

A. Yes.

Q. Was that a problem?

A. It's still a problem. Because, you know, if you look at our current waiting list, the patients who are waiting longest are waiting for bladder outlet obstruction surgery, there is the occasional Nesbit's that's waiting. So clearly other cases have been picked ahead of them. I didn't make the comment when you put up the data of the waiting lists, by the way, but if you look at that in great detail you'll see that there are differences across the team.

Q. Yes.

Is there clear guidance on surgeons choosing to take cases in a chronological order? How regularly is this audited?

……

Q. So Mr. Mackle appears to paint a picture of resistance and difficulty in trying to persuade the consultants of either the need for change or the recommended pathways for that change. He names Mr. O'Brien as holding out particular views that seemed to be contrary to the direction of travel the Trust wished to go down at that point. First of all, is that your recollection of the tone and content of those meetings?

A. Those meetings were certainly set-up to make the changes and when the changes happen in any Department, it was quite a major change which was going to completely change the practice and working of all of us. So there is going to be a certain degree of resistance, there is no doubt about it. But our point throughout the meetings and which I would still maintain was, if we are going to change we should change it with all the resources provided, with all the infrastructure provided. You can't just be saying that you start an MDT, one example, and just go and find out how you do that. No, you need all the other job plans of the so-many-other consultants. If you call it resistance or obstruction, look, it's a two-way traffic. Management, if management want a consultant to work in the new way of working, then they should be able to provide the proper infrastructure, proper resources, and if those resources are not available or scarce, then it is not a resistance, I will certainly feel that my patient will be -- the safety of my patients will be compromised. So if Mr. Mackle thinks that that was resistance, then I'm afraid I disagree with that. I certainly said that we are happy to make changes. You'll see from my email to Alison Porter, sorry, my letter to Alison Porter that we did start at MDT. We did ask for a red flag system to put up. And we did express that we are happy to send the pelvic surgery to Belfast, but this is not the way it has been done. It should be done with communication. So there was certainly a lack of communication from the review implementation on the start.

It did improve once we started the Steering Group meeting. I'm not aware that they were playing with us, if Eamon Mackle was challenging and Gillian was going around different, that is the way of management. But certainly we speak what we felt at the time is correct for the betterment of our patient. I'll not recognise that it was a resistance, I'll say that it was an insistence to provide us the resources for to setup all these new changes.

Q. If I could summarise your answer in the sense that you felt any objections that came from you were based on patient priority of their care and their needs, and you felt that your justifications for responding in those meetings in the way that you did, you were driven by patient –

A. Of course –

Q. -- putting your patient first, and that any interpretation of those objections by you as being obstruction, or any other resistance, is one person's interpretation rather than what your intention was. Would that be fair?

A. It would be fair. Can I give you an example to explain that, why it is felt. Suppose you are Mr. Mackle, I am Mr. Akhtar, you ask me 'Mehmood, from tomorrow you are going to see 12 patients in your clinic, five of them will be a cancer patient'. I will certainly say, I said 'Mr. Mackle, I'll be happy to see that, but I need this, this, this thing'. Will that be a resistance? Because I don't feel safe that five cancer patients should be seen in my clinic back-to-back with seven other patients. As Alison also accepted in the letter, there was delays in the clinics because cancer patients take a longer period of time. So will it be a resistance? No. It will be asking for the resources to run a better service. That's what my point is.

'Management, if management want a consultant to work in the new way of working, then they should be able to provide the proper infrastructure, proper resources, and if those resources are not available or scarce, then it is not a resistance, I will certainly feel that my patient will be -- the safety of my patients will be compromised.'

As the Trust presents a new vision and strategy that may have an impact on ways of working – it will be important to understand the range of impact it may have on the delivery of clinical practice and put in place good communication pathways and the resources necessary to support the adaption.

Q. We'll come to the specifics of that in a moment. I just want to ask you about the Serious Adverse Incident review process, which is prefaced by the incident reporting mechanism or Datix and look at those as tools of governance. To what extent over the past ten years have you directly used and encountered incident reporting into serious adverse incident reviews? I ask that question in separating it from your exposure to them through the Patient Safety meeting, and clearly, completed reviews come on to the Patient Safety meeting agenda and are discussed. So that's the question?

A. I certainly use them and I am certainly using them more, particularly if I find a stent that's been in too long, I certainly will do an IR1 so that we're aware of it. I have done perhaps not as many as I should do, well "should do", I have done several over the years. But perhaps I should have done a lot more but I can't give you details on them. They were not, obviously, serious. They were probably operational measures on a ward. I think I did one -- once a patient, I was concerned about fluid balance management on a ward and I did an IR1. That's one that comes to mind, but I don't know what came of it.

Q. Yes. Well I think that's, I suppose, one of the points that I wish to explore with you. The responsiveness of the system in terms of telling the informant, you being the informant in that context, what has happened, what is the outcome. Let me come to that in a moment. You said, maybe, over the years, "I could have used the instant reporting mechanism more than I did". Your caveat being that they weren't terribly serious incidents. What was the culture around that or the understanding of when you should be using it. Were you encouraged to report incidents when they arose, particularly where they affected Patient Safety?

A. I don't know if anybody -- remember anybody saying "you must do this". Perhaps as you go through your career you're aware that if you see something that's not right, it must be reported. But I don't think anybody said you must report -- not like now, you must do a Datix on this. It is just something instinctive. In other words if it is not right, you should report it.

Q. You're not suggesting this was A Trust where, if you like, the requirements for reporting were regularly emphasised or publicised. You know, there wasn't an effort to create a culture of, if you like, utilising that system to bring forward shortcomings in practice or in service?

A. It's difficult to say. I don't think we are constantly reminded about it. Perhaps the Trust assumed that we would do it because we knew the system was there. But, yes, I think nobody was concerned about policing us, I think.

Q. Is there a sense that it was cumbersome system or an awkward system, time-consuming system to use to put the complaint into the pro-forma that we've all seen that comes with the IR Datix arrangements?

A. I preface this by saying I'm not using it as an excuse: Certainly I thought it was cumbersome, it wasn't user friendlily. I suppose the other thing was, as you said, you didn't get feedback. It went into a black hole and that was it, you never heard of it again, unless it turned into an SAI or something. So that probably might have been an issue as well. If you knew that you were reporting something and you got something back and it said -- but when you just report something and never hear about it again, there probably isn't the impetus to keep doing it. But that's not a justification for not doing it. That's my thoughts as I'm sitting here.

Q. Yes. I suppose if you've gone to the trouble of opening your eyes to and realising that there's a concern or a problem there and you make the effort to put that in writing by engaging with the system, you're saying it would make sense to obtain a letter back or a quick email back periodically saying, yes, your concern is credible or correct, and this is the steps we're taking and, ultimately, that's are the steps we have finally taken and these are the conclusions we have reached?

A. I think the system would be better. Then you would -- I think people would sort of think, well, something is going to be done about this. So, yeah, I think the system would be better if there was an outcome sent back to the person who reported it.

Is a yearly audit being done to check how effective the system is in reporting the conclusion back to the person who raised the concern and/or completed an IR1?

Q. Mr. Glackin makes the point -- and this is at paragraph 31.1 of his statement, WIT-42307, 31.1. He says that in his opinion: "...senior managers did not work well with Urology. Engagement with the Department by Clinical Directors, Medical Directors, Assistant Directors and Directors For Acute Medical Services was very limited and infrequent, in my experience. I do not know how much job planned time they had allocated to management activity." So that may be a factor in the degree to which they engaged. But it does seem, if we just use Mr. Haynes' correspondence as a means of litmus testing this. He, presumably with the knowledge of the team, is clearly dissatisfied on behalf of patients, that not enough is being done to break this theatre capacity impasse. You say that more recently they have come up with initiatives, Daisy Hill, Lagan Valley, thinking a bit more imaginatively. Upon reflection, would you tend to agree with Mr. Glackin, indeed Mr. Haynes, that not enough energy came down from senior management to recognise the real risks for patients here?

A. Absolutely. I mean -- you know, if what we're doing now was done several years ago, you know it may have changed things somewhat. When I was referring to getting on with managers, I was probably talking to Head of Service, Martina Corrigan, higher up than that I certainly had no, or very little, if no engagement personally with any of those people.

Q. Yes. Have they any visibility in any meaningful sense for you as a consultant?

A. For me personally,

Q. Obviously you've referenced these initiatives, Lagan Valley, Daisy Hill, you have operating space there for patients that are fit to go there. Do you get a sense that over your ten years in-post, the

ability of the Service to deliver for patients within the catchment area has improved, has it got worse, or is it more or less the same?

A. It's still the same because our referrals are going up ten percent a year as well. So referrals haven't stayed static. I mean if that stayed static, you could probably would see a difference, but everything is increasing, so it's hard to say. We're doing more imaginative things. We're extending ourselves more. But there's more coming into the system as well.

'Q. Do you get a sense that over your ten years in-post, the ability of the Service to deliver for patients within the catchment area has improved, has it got worse, or is it more or less the same?

A. It's still the same because our referrals are going up ten percent a year as well'

Does the SLT agree with this assessment? Are there further options that are currently being explored to try and meet the demand for services?

Q. So you've had a lot of detailed questions about things that have happened. I'm quite interested in your observation of what you actually thought of the medical management and leadership structure at the time, if we talk to '16/'17 this was all a big issue. How well did that work? How well did it not work? Do you have any thoughts as to what the problems were there in terms of how it interacted with you as a practicing clinician or any other thoughts, because you haven't had a formal medical management role, and you've referred to that a few times? So what do you think about it all?

A. So, Mr. McNaboe approached me on the corridor one day, and he had recently been elevated to AMD, and he said to me "Do you want to be CD of Urology?" It was a short conversation.

Q. Yes.

A. No, thank you.

Q. Why?

A. Because I don't feel that the people who are taking up those roles are adequately supported and resourced to deliver them, and you'd be set up to fail.

Is there currently a fully developed resource in place to support and equip potential candidates for medical management and leadership roles? If not, what can be done to achieve this necessary standard.

A. I mean, the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated. So, I mean, the team in Daisy Hill, I was seeing them on a regular basis, I was meeting them in theatre, and so we were chatting about things in the tea room, but there were no tea-room conversations that I could have with the clinicians or the people in Craigavon. When I did meet with management, it was in an official meeting.

Q. And given your role also covered urology in Craigavon, was there any -- did you have anything set up to engage with those clinicians or staff that might have informed you in your role?

A. There were meetings in Craigavon, in urology team meetings, but I found it very difficult to attend those, because if I attended a meeting at Craigavon, I would have to either drive there and drive back again, which took up all my time, or attempt video conferencing, which really was not very successful.

'I mean, the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated.'

What steps are being taken to make sure current senior management staff in the Trust who are not based in Craigavon are fully integrated?

A. Yes, I got support. I remember being with Gillian Rankin, talking about these things in the Acute Directorate. The response of the Associate Medical Directors was yes, but again, that's very interesting but do you realise what we're asked to do.

Q. Just to be specific, what were they being asked to do?

A. When I told them that I was going to change the M&M system into a Patient Safety system, and that there would be eventually patients working with me in the oversight of it, but in the first instance we would invite a nonexecutive director to, you know, gently introduce the idea that that should be the case, my argument was, well, it's better to have that debate in the Trust and being, if you like, questioned by Trust Board, rather than, if you like, a more embarrassing intervention by the Coroner much later or an. So that was the argument, really that we should really focus on these things. I'm not sure if it was much different than any other Trust.

Has the intention of 'patients working with me in the oversight' of the Patient Safety system been delivered? If not, what is the SLT's view of implementing this idea?

Q. Clearly in the 2,000 or so pages that you've read and your conversation with a colleague, you formed an opinion of Mr. O'Brien. I just wonder if you would share some of these views; that he was someone who worked in isolation rather than as a team player?

A. Yes, I think he obviously did. To his detriment, I think, to the patient's detriment. He didn't seem to want to collaborate with his colleagues as well as he should have done, especially the radiotherapists in Belfast. That would have been -- a close relationship would have been ideal. And he had his own way of doing things and perhaps was reluctant to change. I think a lot of energy has been wasted in battles about who should do the triage and who should be the urologist on call and the urologist of the week, and how should we run the MDTs, instead of dealing with the issues. They were allowed to sort of spiral out of control. That does raise the issue, if you have a problem within a department within a hospital, it shouldn't be left just to deteriorate further and further and further and end up with an inquiry. A lot of these problems could have been addressed and dealt with at a much lower level than what's happened now.

Q. You may well be right and we'll certainly be reflecting on that when we come to write our report.

'I think a lot of energy has been wasted in battles ……instead of dealing with the issues. They were allowed to sort of spiral out of control.'

Is the SLT currently aware of any areas of practice in the Trust where this statement could still be found?

……

Q. Clearly, within your statement, your first statement, you reflect that over the years of your career the volume of administrative work has increased exponentially, you say without a corresponding increase in time allocated to address it. You give some examples, no doubt by way of example rather than comprehensively, of the type of administrative work that you had to undertake: Triage of referral letters, correspondence with GPs, discharge letters, results sign-off, attendance at and preparation

for audit, to name no doubt but a few. Administration work was a challenging feature of your role, is that the point that you are wishing to get across?

A. Yes, it seems to -- it doesn't get detracted, it always seems to get more in volume and in content and in time to have it done.

Has the time allocated for administrative work for clinicians been recently audited to see if it is adequate and if adjustments need to be made?

Q. One of the things you said today was around as clinical lead you can't know everything, which is clearly true. You only know what people tell you or what data you are provided with. What is difficult to see is what discussions did you have and did it lead to any data to help you with this in terms of complication rates for operations, blood loss, return to theatre, efficacy of pre-op assessment, these kinds of things. Did you sit down as a team to say we need to have some measures to know if our care is safe, we need to decide what those are and can someone collect that information for us. Did you do that?

A. We do have an audit department. It was –

Q. I know that but did you, as a group of clinicians, say this is what we think matters for urology?

A. Okay. I don't think so.

Q. And do you think that would be helpful?

A. Absolutely.

Q. Did you have any direction from what you might have called, I think you referred to it as the higher echelons, in terms of what kind of things you should be looking at in terms of quality?

A. Yes. We certainly have this through our Patient Safety Meeting now, that's –

Q. Has that changed in recent years?

A. Our Patient Safety Meeting is fabulous now. If I may say, it was a breath of fresh air to have all the young consultants coming when Mr. Glackin arrived, he took charge of that and did a marvellous job.

Q. But you still don't have these measures?

A. No. But it is our audit and our audit department has improved considerably. There's now an audit coordinator and we have -- where we would have had maybe one or two audits a year, we now have a specified list that we go through. Some can be maybe more complex. Some are short-term snap audits. It's very audit driven now at the moment. For the last two moments I have been at, our audit tracker has been at them and we have discussed all of that. And, in fact, our Patient Safety Meeting used to always start off with deaths, morbidity, then audits and any other comments. Now Mr. O'Donoghue has switched it round completely. The first things discussed on the meeting are the audits and the morbidity because our mortality patients are, well touch wood, are fairly predictable.

Q. We hadn't heard about that. It's good to hear that covered?

A. It's really good. I'm very impressed with what Mr. O'Donoghue is doing with the system.

Q. On the more mundane side, a basic patient safety issue is things like writing a letter to the GP, doing the triage, following your guidelines, looking at results, and I get the sense that it was too easy, in the past anyway, to do the wrong thing in some of this. Therefore there wasn't really a track on whether

everybody got a letter, whether everybody looked at results. Now, you showed us a little scorecard for results which is clearly an improvement and I would imagine some other metrics will come. But this business of the culture where it is too easy to do your own thing is key in patient safety, as I'm sure you're aware. Why do you think there was this tolerance of people just doing what they liked a bit?

A. It's the pressure of the volume of work to get through.

Q. Just that? Who should sort it out? We talked about the Trust, but where do you think the responsibility lies for ensuring these things are not tolerated. Because they are very basic patient safety things, really?

A. These are within the department yourselves. And if it's not being done then maybe a stern conversation is maybe required, or a specific sort of focus on these things at a departmental meeting saying here's what we want to –

Q. Do you think there was enough emphasis from the top of the tree on these things as opposed to targets, money, waiting lists, whatever?

A. There could have been more support from above, probably, yes

'Q. But this business of the culture where it is too easy to do your own thing is key in patient safety, as I'm sure you're aware. Why do you think there was this tolerance of people just doing what they liked a bit?

A. It's the pressure of the volume of work to get through.'

Does the SLT consider that the existing checks and balances in the system are sufficient to prevent a similar situation occurring when it comes to 'doing your own thing'?

Trust Improvements

Q. You've reflected already, I think, this morning, that standing back and looking at this there was a failure to follow the steps set out, whether you look at MHPS itself or the local guidelines and, in particular, giving you a role which really didn't belong to an operational manager both in terms of the screening report and contacting NCAS. They were roles, really, for a medical practitioner. Do you think, in terms of your experience of matters subsequently, that the Trust has learnt any lessons from this, the way in which this process was handled?

A. There has certainly been huge improvements. I think when Dr. O'Kane came in as Medical Director, I think she saw quite early, in terms of managing doctors in difficulty, that there needed to be a much more structured process and she put that in place in partnership with Vivienne Toal. I think that has been, in my experience, much better because of it. So, yes, now I think that Maria saw it almost in advance of this process of the Inquiry starting because I think that the Doctors in Difficulty Oversight Group commenced, I couldn't say when, but certainly not long after she came in to post. It was one of a number of things that she did to bolster. So, yes.

It would be helpful as an interim response before the Inquiry conclusions and recommendations are available (next year?) for the Trust to map out key learning points and how the system – processes and practice, have been addressed and altered. For internal and external audiences.

……

Q. Of course NCAS can always give you advice to cause you to change your mind. Is it not much more logical to seek their advice in advance of any decision so that you can weigh up that advice and take up the various factors they are suggesting you weigh up and then reach your decision. Have you not done it the wrong way round?

A. Possibly. All I can say is, as I have said before, this was a Christmas holiday, New Year's holiday, things were moving very quickly. You know, it would have been difficult to have choreographed all the moves. This would normally have been the way, in my experience, we would have operated, both in this Trust and in other Trusts, that an intended direction was taken, then you would have consulted NCAS in the light of that. I could see it probably better to speak to them first, but that was not the normal way it was done, in my experience.

Reinforce clarity on the optimal point of when to consult with NCAS.

Q. Again, taking into account that this Inquiry has to reflect and maybe make recommendations around this, have you any thoughts about that? Is there a need to streamline the process? Is there a need to -- I don't mean that you're not professional -- but a greater need to professionalize the process in the sense of making it somebody's specific responsibility?

A. Yes. I could share you a few thoughts on that. I mean, I mentioned before that for the individuals the Case Managers and case investigators have protected time in their jobs to do this, being expert enough to have received appropriate training to be appropriately resourced with administrative support, and HR support at the times they need it are all challenges within the health service at the minute. If that was improved, that would help a lot. From my own office, at that point the Medical Director's office was essentially composed of myself and, in relation to these matters, Mr. Gibson. It was very underresourced to provide this. I had highlighted this issue before I left the Trust with a paper to try and bring forward appointments of more staff to help with this, in particular, with Deputy Medical Director posts, one of whom would have a specific focus on this area. But it wasn't possible for that to be supported at the time for financial reasons. So, yes, absolutely. You were trying to do this on top of an incredibly busy and challenging job. At that time I seem to recall we had a -- I'm not making excuses for myself, I'm just painting the context in which this is being done -- we had a major issue with the Emergency Department in Daisy Hill Hospital which was having to be completely restructured and was at crisis level. There was a crisis in the breast care surgery system where we had to get a regional approach pulled together to try to ensure patients were not left wanting in the Southern Trust. There were so many issues going on. This was a relevantly small part of the Medical Director's job and, to be honest, did not have the manpower, the time, required to focus on this. But I think the main issue that would have made a difference would be protected time, training and admin support for the case managers and the case investigators, because they are the ones actually carrying out the investigation. It would have been helpful for me to have had a bit more support but, to be honest, I think the bit that would really make the difference would be the time and training for case managers and case investigators.

Is there adequate protected time, training and admin support for case managers and case investigators now within the Trust?

Q. That leads me to, you'll be glad to know, the final question that I want to put to you. As someone with the experience that you had of MHPS, and you described at the outset of your evidence to us that you were a founding member of the Faculty of Medical Leadership and Management, and that has been your career path, largely, if you had to sum up one thing, what do you think was the cause of things going awry here? Because it is quite clear to us that things did go awry.

A. Inappropriate deference based on status rather than ability

Has this equation shifted to a more balanced perspective?

Q. So there was to be an Inquiry into or an assessment of what was in these backlogs?

A. Yes. An "assessment" is probably the better word, as opposed to an "investigation". Because an investigation would have required the appointment of investigators and that certainly was not something that we talked about.

Q. If we could just very briefly go back to the record of the meeting on 13 September please at TRU-00026. These words "formal" and "informal" were bandied about in this context and I just want to take your view on this. There is reference to a formal letter being sent to Mr. O'Brien on 23 March, the letter we discussed earlier. Again, your reflections on that word. Let's see what we can establish here, there was no formal process commenced in March 2016.

A. No. No. But I think, again, I think where the "formal" word has come in, it was probably the first time. I think it was the first time that ever anything was documented to Mr. O'Brien. So that's probably why there is maybe some confusion over the formality. I think there was a level of formality there by putting the concerns on paper.

Q. Yes. So, by contrast to what we know had now taken place in previous years of ad hoc communication with Mr. O'Brien to ask him to improve or do certain things, this was putting a degree of formality around a request for the plan on the four issues that had been raised?

A. Yes.

Q. But you're not suggesting, and as far as you're aware, this Minute isn't to be taken as suggestion that you or the organisation with Mr. O'Brien was within, kind of, any formal structure or system or process?

A. That's right.

Have a clear understanding of the difference and application of an assessment, an informal investigation process and a formal investigation process.

Q. If we scroll up the page, we can then see that this Ping-Pong ball gets batted from you to Martina. Then from Martina, scrolling up the page, to Michael, and then Michael takes the view, going up the page, scroll down again, please. Michael Young eventually expressed a view, I'm not sure what the reference is. Go to TRU; I am just trying to find my note, Chair. Go to TRU-274729. That's it there. Right. Okay. So Martina is inviting Michael Young to speak with the clinical director, Colin Weir about the issue. Does the issue ever come back to you?

A. No.

Q. Should it have come back to you?

A. No. I think it should have been filled in. An IR1 Form should have been filled in. I think that's what should have happened.

Q. I realise that there's many hands on this?

A. Yes, I suppose are you asking me should I have gone back to close the loop?

Q. Well, did you ask anyone for an IR1 or did you not see that as your role?

A. No. I didn't. It would be within my role to ask for an IR1, but I didn't do it. I didn't close the loop.

How important is the principle of 'closing the loop'? What does this look like in practice?

Q. I asked the question from the angle of whether you, as the practitioner leading the investigation, or the Trust who owns the process, if there is impact on the practitioner as you describe, whether the delays that seem to punctuate the process -- perhaps inevitably because of complexity or whatever else -- can that be better managed by the investigator or is there a need for better support by the Trust for Trust for the investigation in order to move it along with greater efficiency?

A. I think Maintaining High Professional Standards is not fit for purpose. I suppose the reason I'm explaining this is that in terms of Maintaining High Professional Standards, it's my belief that the investigation is done to the best of your ability within time constraints that are available, and I'm not sure that that's the correct way to carry out an investigation if you want a more robust outcome. I'm not sure how much time this Inquiry has but I suspect that time has been set aside -- in fact, I know that time is set aside specifically for it. No time is set aside for Maintaining High Professional Standards investigations in terms of my job plan, or in anybody else's. I mean, I was assisted by Mrs. Hynds, and no additional time was set aside for her either.

Q. Mm-hmm. So, the picture emerging from your evidence so far is that you, a senior practitioner, with perhaps more experience than most in the role of an MHPS investigator -- you have gone through four investigations -- you are asked to do this; can you refuse, in real terms

A. Yes.

Q. -- or is it part of your nature perhaps to assist the employer where you can, despite the pressures?

A. You can refuse. This is done as a voluntary additional activity. It's not my nature to assist the employer. It is, however, my nature to ensure that patient service, patient care, quality of service to patients, is considered and regarded with seriousness.

Q. Don't apologise. A moment or two ago you used the word "robust", a robustness. This is what I took from your answer. I can't bring it up on front of me as I stand here, but what I took from your answer is that these pressures on your time often led to a lack of continuity in the investigation process, leading you to be concerned as to the robustness of this investigation; is that right? Is that what you were wishing to convey?

A. Yes. I think as doctors and lawyers, one of the things that's difficult is setting things down and then picking them up and then setting things down. None of us, for example, like to be involved in proceedings which, you know, go on for a week and then they disappear and then you come back and in the middle of that, maybe the next day, you are doing something else. That made it very difficult. There were some delays in this investigation which were of my own making because, I was, as I have explained earlier, very busy through this year. It was an unusual -- unusually busy year. Some of it was of my making. Some of it was of other people's making. But in the sum of it, you are looking at something, something comes to mind, you think oh, yes, I must look at that again but then you are not looking at it again for maybe another month. I think that isn't helpful, which is one of the reasons why I think if there was, for example, a day a week set aside, you would always be coming back to, right, how far have we got, what are we doing with that? It would help with time scales, it would help with prompts. Whereas, for example, when you are waiting for witness statements to come in and so you are sort of, well, I can't do anything further until those come in, I have got all these 101 other things to do so I will go and do those, you don't keep things to the forefront of your mind in the same way, which I think is unhelpful.

Q. In terms of your approach to this role, given your experience and your training, did you feel yourself well-equipped for it?

A. Yes.

Q. But that has to be set in the context of the strains, I suppose, of your everyday professional life in terms of fitting it in and doing it efficiently?

A. Yes. I mean, I think I had the appropriate training and the appropriate approach and appropriate seniority. If you are including in the appropriately equipped whether I had the appropriate time and resource, then no. I felt I was an appropriate person to do the investigation and, if I was doing it again, I suppose the issue would be of support.

'I think Maintaining High Professional Standards is not fit for purpose' Understanding that maintaining High Professional Standards is currently undergoing a review process – is the Trust taking all of the learning from this Inquiry and feeding it into the Review process?

Q. Would you agree with me that if there are administrative-type shortcomings in one area of a clinician's practice, it would be within the obligations of a Trust and its decision-makers to set the terms of reference wide enough to enable you, as the investigator, to explore whether those administrative shortcomings exist elsewhere?

A. I suppose it's the balance between earlier things in NCAS, which is about not making this so wide that, number 1, the investigation is unmanageable, and number 2, that you are just saying I am going to look at all practice and see if I can find something. I think it's about -- my view is that, yes, of course screening needs to be properly carried out, of course it does. But I think if there are specific areas of concern that have been raised by managers or by SAI reviews or by complaints or by patients, well then, those are the areas, and issues around those areas certainly. I don't think it's a well, let's look at everything. I suppose, Mr. Wolfe, and I have said earlier, you know, Mr. O'Brien's colleagues and managers, certainly who gave evidence to -- who I was involved in interviewing, were certainly very clearly saying that they had no concerns about his clinical practice, you know, other than, you know, the potential for patient negative outcomes because he wasn't doing things like triage which he didn't agree with. You know, as I say, people seem to think that other areas he was spending lots of time on and those seemed to be clinical areas.

Q. They were answering questions within a particular framework, the framework being your terms of reference.

'Would you agree with me that if there are administrative-type shortcomings in one area of a clinician's practice, it would be within the obligations of a Trust and its decision-makers to set the terms of reference wide enough to enable you, as the investigator, to explore whether those administrative shortcomings exist elsewhere?'

In the light of what has been revealed so far in the Inquiry, what would the SMT's response be to Mr Wolfe's question and Dr Chada's response?

A. As I explained, the process was Mrs. Hynds would type it up the statement, she would send it to me, I would compare it to my notes, I would make changes, I sent it back to her. All of that was being done without, for example, admin support. You know, Mrs. Hynds, I'm aware, was typing these herself, which I think I highlighted in my Section 21 notice, that here was a very senior person within the Trust who was spending evenings typing up things, which I felt wasn't a good use of either her time or my time. Perhaps what wasn't helped was Mrs. Hynds doing it, sending it to me, me adding bits to it

because that, of course, causes delays with every person that needs to sort of look at it, and then it went back to the person and then they had to check it and send it back with any amendments. So, it was a slow process. I absolutely accept that at least some of those delays were down to me and some of those delays were down to lack of administrative support.

Q, 'So, it was a slow process. I absolutely accept that at least some of those delays were down to me and some of those delays were down to lack of administrative support.'

Note the recurring theme of the need for more administrative support by the Trust when Investigations are being carried out.

Q. I think you probably were aware of that, or certainly some of your colleagues were. Patient 16, if you just want to glance at the cipher list. If we pull up TRU-01366, 23rd December. You can see the name in the attachment line. We're familiar with that SAI which started life as a complaint from the patient's daughter in December of that year, and there is consideration being given there to whether this falls within the SAI process. I raise that simply as another example in order to seek your reflections on maybe what are you doing now, perhaps, that's different when you sit down to compose Terms of Reference to ensure that they are sufficiently broad, without doing injury to fairness or doing injury to the notion that this cannot be so high, wide and handsome that it becomes meaningless.

A. Yes, I think the difference I see now, and probably Dr. O'Kane has brought this difference to it, is the questions around, so what else do we know? What are the complaints? What are the litigation cases? What are the SAIs? So you're on, you know, there's a range of data that you're trying to gather a picture around whether a job plan is in place, an appraisal is in place. It's trying to build a picture outside of just what you are kind of currently dealing with and I think that's helpful.

Q. When looking at this and listening to my raising of a potential criticism around how the TR were developed here, do you rely on the hindsight defence to say, 'we simply couldn't have imagined a need for a broader set of Terms of Reference'?

A. No, there were things we should have checked at the time. I don't look at it, oh, you know, now we know what we know. I think there were questions that we should have been asking. There were other problems we should have sensed at the time, and we should have checked those out. For me probably one of the biggest lessons for us as an organisation is around that problem sensing and how attuned we are to that.

Highlighting the role of problem sensing and asking 'other' questions to gain a broad picture.

Q. When do you say he was first alerted to the fact that the four-week timeframe both recognised in the guidelines and the MHPS framework was not going to be achieved?

A. I advised Mr. O'Brien of that at the first meeting we had with him on the 24th January.

Q. Did you ever follow that up in writing or in an email or send around to everyone else and say, look, I know we have these deadlines or these aspirational timeframes but given the issues that are arising, can we set something that's more realistic. Was there ever a discussion around managing time in a realistic way?

A. With the Oversight or with the Case Manager?

Q. Yes.

A. No, I suppose there wasn't. There was an acceptance that four weeks was never going to be achievable and that it was a matter of trying to progress as we could progress, given the capacity and

workload issues that we were facing into. So no, there wasn't that discussion in terms of what was a more realistic time scale.

Going forward, what mechanism is in place to ensure timescales involved in investigations are realistic? Unrealistic timescales will inevitably result in failure.

Q. As I say, the other meetings that were recorded you had with Mr. O'Brien, 9th February 2017, 30th August 2017, 6th November 2017 and 1st October. You said that you couldn't look at those initially. Have you had the opportunity to read through those subsequent to that?

A. Very recently, in fact. It has taken quite a while for me to get to the point of opening those. I just simply didn't want to open them. I felt that for me, you know, to share them this length down the road was entirely fruitless. I had absolutely no opportunity to determine whether or not it was accurate or otherwise. I suppose I struggled with that for quite a bit of time. I think the thing for me as well is that had the request been made, there were options to -- there were options that -- it would have been something that would not have been -- that would not have been dismissed. We agree this, we do this quite regularly. We don't do it all the time, again it's a capacity issue. If somebody feels they want a particular hearing or meeting recorded, we facilitate that, and that would have been facilitated that had that request had been made openly. I think it was the covertness and the underhandedness of this that was really impactful on me.

Are there a regular 'support check-in's' in place for all the witnesses in this Inquiry?

Q. Going forward, would you also be of the view that things could have been sooner?

A. Absolutely. I say absolutely and I caveat that again with they should have been done -- I would say rather they should have been done sooner. Could have been done sooner was the difficulty and that was the challenge, because of capacity and workloads and other priorities and all of those other competing priorities. Should that be Mr. O'Brien's issue? No, it shouldn't, that's for the organisation to deal with. So it should have been done more timely. I suppose if you're asking me could it have been done more timely, again I go back to all of the challenges that were being faced with at that point in time in terms of workload and other priorities.

So, whilst I -- you know, in terms of accepting carriage of this case and support to this case, knowing at the outset that capacity was going to be a huge issue, that's a really significant learning point for me. I believe, going forward we have to set the appropriate times aside and the resources to these things in order for them to be done in the way they need to be done. And to avoid the impact of lengthy investigations on the subject of investigations.

Resources and capacity did not meet the expectations of the MHPS Framework and the Trust Guidelines – what is the Trust's strategy to make adequate provision for future investigations?

Q. From an Employee Relations perspective, when you see other aspects being added along or considered like the private patients issue, did it trigger in you any curiosity that perhaps there needed to be a bit of a deeper dive into what the potential problems were, or the problems that were in existence were at that time? Did you think let's have a proper look at this, there's other issues coming up as we go along?

A. Is the question pointed at broader issues than what was in the terms of reference?

Q. And also whether it triggered any curiosity in you to think maybe we need to have a look at wider issues here. There's an opportunity perhaps to not focus just on this but to look at things that are arising, that have been suggested. You've heard that through Dr. Chada's evidence?

A. I have. It is something, you know, even outside of here that I have reflected on in terms of was there opportunities. Obviously now what we know in 2020 wasn't in front of us at the time of the MHPS investigation. I suppose it's that consideration of should we have known or could we have known? I suppose the only thing I can say on that - and it's probably very much mirroring Dr. Chada - it's really hard to describe. We were meeting with individuals as part of this where not only were they not telling us there was a clinical performance issue, they were telling us very much the contrary. I think I'm quoting Michael Young here as the clinical lead who was describing Mr. O'Brien as a very competent clinician, who was describing him as somebody he would want his family to be treated by. That was the flavour of the witness evidence as we went through, that, you know, the problems here were about not getting things done but if you were the patient who got in front of Mr. O'Brien, I suppose the message we were getting at that time was you're going to get a very, very good clinical service from Mr. O'Brien, and he's a very good clinician. I suppose again on reflection, I think that's where we have looked at this and said it's all this stuff around Mr. O'Brien's clinical practice, that's the problem, and haven't probably gone and said -- and that curiosity that you're describing, we didn't go fishing. I suppose I'm very conscious that we don't do that. We don't do that in any investigation. I mean, you look at what's in front of you, you look at what's coming up in terms of where your evidence is pointing you. Witness evidence was not pointing us in that direction, and that's the only explanation I can give for why we didn't go broader and look at the broader piece.

Is there scope to add in a clause to the Trust guidelines that can facilitate looking at a broader picture if a 'deeper dive' would be thought to be of assistance to the investigation?

A. I think we are learning, and that this is the one learning we should be taking forward, the clarity of roles and responsibilities; who escalates it; who should be acting when. At the centre of all that - I think we're talking about so many other elements - but the centre of all this is our patients; people, you know, our community. So we need to work around that and the process has to be right, the system has to be right, the support, the organisation -- and I'm not talking about, I think this is not about Southern Trust, it's about our whole system. We need to work to improve our system. We need to see an improvement going forward.

What plans are in place to assimilate the learning from this Inquiry and where appropriate, share with the wider system to influence improvement in the delivery of person-centred care?

Q. Thank you for that. If you could pick one or two learnings from your experience and from your observations of the experiences of others who were participants in this MHPS journey, what would those learnings be? Would they be resources, for example?

A. Well, as I alluded earlier, I think there are multiple factors. My experience was everybody was trying their best but not working as a team. I don't think we were working as a team; which should be. Again, team not necessarily means one team has roles and responsibilities, who is the leader, who is taking ownership, and where it goes next. There's a system, and processes weren't there to support us. When I say about the systems and processes, it's about the resources, it is about the environment; all of them were not there at that point of time.

How is the Trust 'role modelling' the principle of operating with a collaborative team approach to investigations?

……..

Q. Did you have any support and did you ask for any support? Was anybody identified for you? Bearing in mind this has been quite a difficult investigation, it will have taken its toll, and again was there a mentor or somebody you could be signposted to to bounce ideas off who was independent?

A. Psychiatrists are required to have a mentor. It's one of the things that our college recommended. We always did it informally anyway but it's a formal thing now with the college. I would always have had people that I would have informally sort of discussed things with or if I was having difficulty with. In terms of support, from that point of view, from sort of an emotional point of view –

Q. No, I am talking about practical support rather than the emotional side?

A. From practical support, no, not really. Mrs. Hynds was very helpful and, as I say, would have done a lot of the admin work in terms of tracking things down and sending e-mails. I would have talked and she would have typed, you know, in terms of putting things together but no, no practical support outside of that. I had a secretary who is absolutely wonderful, but my secretary was already assisting me in my Associate Medical Directorate role, and my clinical role which was a very busy role, and I didn't feel it was appropriate to expect her to add to that.

Q. I am thinking more of a senior critical friend of some sort. These investigations nearly always cause problems of some sort and one's own experience is always limited. In retrospect, would that have been helpful just to ask you some critical questions along the way?

A. I think in retrospect, that would have been helpful. I think one of the difficulties, and I've mentioned it already, is the lack of expertise in doing these. These are not something that we do in our everyday practice. I think I'm -- I mean I don't know and the Trust could probably comment on this, but I think I have done more than most, so I'm not entirely sure who I would have leaned on for that. Absolutely, I think in retrospect that would have been extremely helpful.

What is the Trust's view on providing a senior critical friend for investigators in formal investigations?

Q. Then you received another update from Mr. O'Brien to Dr. Khan. This is on the 21st October 2018 and Dr. Khan says that new concerns have emerged. Did that concern you from again a patient risk or a patient safety perspective?

A. Of course it did, I have no doubt about that. Again the issue in and around that was my perception - and this is just my perception - that there were at least two, if not three, processes that were going on at the same time. There was the Trust Board business that was happening; there was the MHPS process that was going on; there was my role in that. How they linked and meshed together, I found to be most difficult. I knew there was an obligation on the designated person to report to the board, I saw that, but I didn't see the opportunity to do that. There was no history of MHPS being reported to the board during my time, and my understanding is that in the history of the board, there was no reporting process into the board or into governance. Now, that has changed significantly over this last year, year-and-a-half.

Q. In what way has it changed?

A. Now there is a report that comes to governance, which looks at it in very general headline terms. It's looking at progress being made and, therefore, there is an opportunity for scrutiny and for challenge against each of the cases that are listed. Before that, there was no opportunity for that to happen.

This is a change that should be logged as an active improvement of process.

Q. Obviously with the budgetary constraints that Trusts have, and we know that the Health Service have at the moment, what would your view be on a regional resource perhaps provided by the Department of Health where you have a pool of people with requisite experience and expertise who could be drafted in externally to a Trust.

A. That would work, that would work. Interestingly we have a similar sort of model in HSC at The Beaches where they have a number of consultants. I'm actually on their list of consultants of people who are available to do things like SAI investigations, etcetera. So they could expand their repertoire to cover performance investigations, so that would work. But yes, that's a good idea; externally commissioned but available

Maybe the Southern Trust could facilitate a meeting with the other N Ireland Trusts to discuss the merits of developing a regional resource that can be called on when needed to assist in investigations.

Q. At this stage you're offering the Trust perhaps some information on how to set up that process. The first paragraph I'm particularly interested, about four lines down where you offer the suggestion or advice: "The investigation should not be an unfocused trawl of Dr. 18665's work...." What was your thinking in offering that advice?

A. I think it's very important to have terms of reference which reflect the allegations that have been raised. I know this was discussed in some detail this morning with my colleague, but the other thing that I did talk about was a lookback, and I think that's something that people don't think so much about. So, had the lookback been done, probably the information would have been found at that point which are supported adding to the terms of reference. When we do our training, this is something we talk about a lot, the investigation should be to a focused terms of reference. Patients coming to harm is obviously the main priority, so you don't want to have to investigate huge -- I mean, the investigation took them some 18 months. You don't want to make the job any more difficult than it already is. But the patient then lookback focuses on if there are any issues for Patient Safety. That might have flagged up that there were other issues that should come into an investigation and could properly have come into an investigation had there been a patient lookback.

Q. You do, quite rightly, point out that your advice doesn't stop at the words "unfocused trawl". If goes on to suggest that if there are concerns about adequate treatment or adequate records, this could be managed separately with an audit lookback to ensure that patients have the appropriate standard of care. Are you proposing, in fact, a separate process, a parallel process?

A. Parallel but separate, yes, absolutely. Because if you give that job to the case investigator, it would be far too broad. It's a priority, obviously, to identify any patients that have been inappropriately managed.

'Had the lookback been done, probably the information would have been found at that point which are supported adding to the terms of reference'

What would a parallel investigation involve? Is this an approach the Trust would like to use in future investigations?

The MHPS determination resolved that there should be an independent review of administrative processes. I want to ask you about that. If we could have up on the screen, please, AOB-01923. Just scrolling down the page, please. Under Final Conclusions/Recommendations, it said that: "The investigation highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services directorate. The report identifies that there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr. O'Brien. No

one formally assessed the extent of the issues or properly identified the potential risks to patients". Is that a conclusion with which you agree?

A. Yes. I don't think that's unfair.

Q. Arising out of that and what he says there at the bottom of the page, he says: "I recommended the Trust carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes". Now, we know that recommendation had not been addressed by 2020 and then there was, I suppose, a flurry of activity in the summer of that year to get the process moving. When did you first become aware of this recommendation?

A. It certainly was in 2020. Maybe early 2020.

Q. In terms of your contribution to it, can you help us understand what role you played in the review?

A. It was towards the latter end of probably 2021. This recommendation was picked up by Dr. O'Kane in terms of progressing it forward. Dr. Donnelly and Dr. McCullough were asked to take this forward and to draft a model or a proposal which would meet this recommendation. So, I have to say what was done by Dr. McCullough and Dr. Donnelly, and subsequently by everybody else, did not, in my view - I haven't listened to Dr. Khan - did not capture the essence of what Dr. Khan wanted to happen, even though despite many eyes and many fingers over it

What has happened to the draft model/proposal in response to Dr Khan's recommendation?

Does the SMT agree with Mr Carroll's summary that the draft model/proposal does not capture the essence of what Dr Khan wanted to happen?

Q. I want to come to that aspect of the narrative later. Could I ask you this just in terms of the impossibility, as you put it. There is always an opportunity, is there not, to work in a different way to bring different methods, different levels of intensity to the task at hand. Your colleagues, and you may look unfavourably at their approach to triage, but whatever standard they brought to it, they were getting it done, they were processing the cases. As the SAI suggests, they were in many cases organising investigations, moving the thing along. It wasn't just a traffic light system, as I referred to it yesterday, for some; perhaps all of your colleagues. Why could you not evaluate what you were doing in order to fit within the demands on your time and the resources available to you?

A. You know, I think that for years I had been doing that. I think you indicate that there's always a possibility. I think it had come to a stage that it was no longer sustainable. I think language is very, very important. I thought that Mr. Haynes, when he was writing to Esther Gishkori in October '18 when he was considering resigning from the post as AMD, he talked about the Trust's "institutional blindness to unmeetable expectation". There comes a time when you have to say this situation I have found, all I was dealing with was I have found it to be unsafe, I cannot do it to the extent that I believed it should have been done. That's what I stated.

The Trust's "institutional blindness to unmeetable expectation".

Is this a sentiment that could be experienced in the Trust today?

A.I think there's a role for external input, whether it's as an NED or whether it's in some other advisory role, in order to get two parties at a stage where they're considering - now I'm not talking about issues like criminal or other really serious issues, I'm talking about these kind of performance issues or whatever you label them, to get people around the table to try to address it

There are some considerable advantages to having external input to facilitate discussions, provide an analysis and assist with recommendations in informal and formal inquiries.

Q. Do you think that's something that might be helpful if the issue around documentation, confidentiality, patient data, was specifically addressed at induction for doctors so that they understood the way systems operate to allow them to engage with them?

A. Yes, I think it would be useful.

Does the SMT consider this to be a good idea? If so, what steps can be taken to implement it?

……..

Q. "If I or others, while working as a Cancer Tracker MDT coordinator Band 4 or as Cancer Services Coordinator Band 5, raised any concerns that were identified as a serious adverse incident, I do not recall being advised of the outcome of any investigation if it was logged onto the Datix". This, you say, was due to being a Band 4 or Band 5, and it was your understanding that you did not need to know. So that I can fully understand, hopefully I've got this right, you might have raised a Datix incident report, we've seen one example already and I think you cite other examples?

A. Yes.

Q. You've raised them because of a concern that clinicians providing a service to patients which impacts on your service were maybe - this was the reason for the investigation - were maybe not doing their job properly; there had been some issue or concern, perhaps a delay, leading to an impact or potential impact for the patient. Is it not important that you should know how such reports have been dealt with so that you can learn –

A. Yes, I would agree.

Q. -- for the future?

A. Yes, I would agree with that. I think it is very important for that information to be passed down so I was aware and I could also make my team aware, because if you don't know what's happened or what's went wrong, how do you fix it?

The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked?

Q. You have also said that the CNSes are now allocated to the consultants' result clinic. When did that process start?

A. That would have started when we came back from our period of redeployment in probably March '21. At the same time, the managerial duties were taken over by the manager of Outpatients. Basically, my managerial duties were taken over by Outpatients, and the manager of Outpatients was responsible for managing the other staff. That freed up the nurses to be able to be more proactive within that role. What happens now is night and day as compared to what would happened at the beginning of my tenure. So, we get the schedules through, we know when the clinics are happening. Usually because I can do the e-roster from my previous role, I have kept that on for just the CNS team. So, once we know what clinics are running, I can allocate a CNS to that clinic. What the CNS does in the morning or the afternoon of that clinic, she has the clinic list in front of her; she will screen through using ECR; she will know exactly how many patients require the key worker input; she will have all her information sitting, and indeed she will be proactively in the consultation with the patient, the consultant, and family.

Q. That's expected that the nurse is in that consultation for the results?

A. Yes.

Q. Is that a result of two things, the reduction in the admin duty appointment of someone to take over those duties –

A. Yes.

Q. -- and also greater resources for CNS?

A. Yes.

The success of a nurse-led intervention – a development in practice and a good news story. How can the SLT/communications department relay 'good news/constructive developments' to the Trust - boosting morale and narrative?

Q. You have reflected as well at paragraph 24.5 of your statement that when you raised matters through the escalation process, you didn't receive any response. Typically you were, if you like, out of the loop or kept out of the loop in what was being done or what had been done. Do you feel that more feedback to teams on the ground carrying out your kind of role would have been useful?

A. Yes. It would have been useful to know -- obviously we don't need to know everything that's going on and some of those things were confidential, but it would be -- even just to know that, you know, we are dealing with it and take our reassurance that we are dealing with it, because there was a feeling that we were continually escalating things; we were, if you like, adhering to our side of the process but we weren't really sure what was happening outside of that. So yes, it would have been nice to know that.

Note – another witness expressing the importance of 'closing the loop' when they have raised a matter through the escalation process.

Q. "I believe the previous governance arrangements relating to the Cancer MDTs were not sufficiently robust to identify the issues in Urology." "A cancer MDT administrator was appointed in January 2022. They are now leading on establishing robust governance arrangements around the cancer MDTs."

A. Yes.

Q. And that's in place. How effective are all of those posts, those additional posts, how effective are they in bolstering or reassuring you around governance?

A. Those are very effective, you know. They can run reports to give us an assurance that when decisions are made at MDT, that, you know, we can now monitor the outcomes and assure ourselves that those outcomes are actually happening.

Q. He does mention that the peer review process was stood down during Covid and, at the time of his statement, had not recommenced. Has that recommenced, do you know?

A. Not a formal commissioning of peer review or peer review visits; that isn't happening. However, in the absence of that, I think it's good practice to continue to monitor our MDTs against the measures that are there. So, you know, our service improvement will continue to monitor our quoracy, monitor key worker role. That work will continue to happen, even though it's not properly commissioned or we do not have formal site visits.

Are the plans for peer review and peer review visits to start again?

Q. Yes. The SAI made some recommendations about how things could be done better. I suppose if you didn't appreciate that things weren't entirely optimal, then you perhaps didn't appreciate the need for improvements but I'll ask the question anyway. Have you noticed any change in the MDM environment since these issues emerged in 2020/'21? Have you noticed things being done differently? For example, is the team -- is the membership of the meeting better supported in any way, is it better organised, is the discussion any different?

A. A lot of it's similar but there seems to be more emphasis on particularly making sure the patient has a key worker. That's one thing, or a nurse who's kind of looking after that patient. That's something that I have noticed, there's been more emphasis on that. Maybe some other things but I can't really put my finger on them particularly. But there just seems to be maybe more structure and...

Q. Yes. The Trust have carved out a new role for the person on the management side, if you like, who attends. So it's now an Angela Muldrew who is the MDT coordinator. It is said of her that her time, she's now better enabled to give more focus and more support to the needs of the MDT. Is that something you've observed from your role or do you think that's more recognisable in the hands of a urologist?

A. Yes. I think the urologists would know more.

The have been recent improvements in Urology in the Southern Trust - in meeting quoracy at MDT, the appointment of a second radiologist, the appointment of an MDT coordinator and the addition of more CNS's. These developments will have contributed to raising staff morale and improving the delivery of patient safety and care.

Q. Is there anything within the current system that allows you, the radiologist, or the tracker or any other responsible person to know that the clinician hasn't yet actioned the report?

A. Yes. So, this is what I mean by more recent changes. These are things that are being worked on. As we currently are, there is no way of knowing what's happened.

Q. So, there is a mechanism by which you can check to see administratively whether your report has gone out, you do the dictation and it's checked. Then does an administrator, a clerical person, issue that for you?

A. No. So, if the report goes automatically electronically, it just goes out, straight onto automatic, straight onto the electronic care record. There is a paper report sent as well at some point. It will be a little bit slower, obviously. That's done by the administration staff. If there's a flag put on, then that's when the administration staff would be involved as well. They would send the email to the referrer.

Q. So, as we stand in 2023, where do you think the gaps and the improvements are necessary?

A. Well, there's lots of improvements that -- I mean, there really is a lot of improvements that are possible, from using, you know, mobile devices to be able to alert consultants; you have to be sure who's covering and you have to make sure that the report goes back to someone who's actually available, not someone who's on leave; or there is a safe mechanism for someone else to check if someone else is away. There has to be an acknowledgment of reports; when you receive them that you have to acknowledge that you've received them. If there's recommendations, then someone has to check that those recommendations have been followed, or if they have not been followed, why they have not been followed. Lots of back-up, admin staff to do all these tasks of reporting and checking. So there's quite a lot of change.

What are the SLT's thoughts on these suggestions?

Is there anything else you would like to say or want to cover while you're here?

A. No. Other than, you know, I'm very sorry for the position that we're in and it's a source of deep regret for me for that. In terms of some of the work that's going on now to address maybe improvements, and particularly the governance link, I think some of that is going in the right direction. We described the governance report. One of the things I had started, and it's maybe just because as I'm talking now - I don't think it's in my witness statement - some things that I think is important in terms of relationships and stability within the Trust and the leadership and bringing together information, is, I had, as you know in my witness statement there, some responsibility around the quality improvement sort of agenda. In particular, in 2016 I had established a quality improvement steering group, which was intended at that time to do what the systems don't do yet, which is a bit more triangulation of information and insights from a number of sources. That group had been established, but it never really got full traction because of the changes in personnel, et cetera. It continued to meet. But I think there is something there in terms of learning around, aside from just data driven - which is important - data driven indicators and change and bringing information together. But the relationships particularly across the professional disciplines, that steering group we had established had the Head of Social Work, Head of Nursing, Head of Medicine, with a key indicator around enabling our workforce. One of the thing that was described, I suppose now that you have asked the question, I did hear some evidence from Marc Williams. One of the comments he made is that the organisation didn't encourage people to improve services. I would disagree with that quite strongly. I think the point of establishing the quality improvement function within the organisation was to do just that. We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted. In the first year of establishing the improvement team, Dr. Wright and I had established from the governance agendas, and in particular the complaints data, around issues around communication and, at that time, infection prevention control. We did a campaign with staff on a broad spectrum of encouraging people to do improvement projects, and we committed in support of 15 projects in that year, taking information that was coming from governance. I think that's something that could still be done more, that there could be a bit more done in that space.

'We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted'

Has the SLT updated its approach to quality improvement projects?

……

Q. Does that apply for the MHPS process as well?

A. So, we would never have known about an MHPS, definitely not. It wouldn't be something that would be shared at my level. It would be kept with a tight cohort of people.

Q. Does that apply even if the learning or some of the issues that arise through the MHPS have a direct impact on your role and governance and perhaps patient care? Are you not informed of anything about the outcome of an MHPS?

A. Unless there is a staff member that has been -- their contract has been terminated, I wouldn't know.

Q. Did you ever share that or mention that to anyone and say is there any way we can get beneath some of the more formal procedures that actually can highlight aspects of governance that need improved? Were they conversations that were had at any level?

A. No, because I didn't know what I didn't know at that stage, if you understand what I mean. So, it wouldn't have been on my radar to ask that question.

Q. By the time you had left the Trust, was there any movement in thinking that that sort of issue needs to be looked at, that there perhaps is a wider benefit from a governance perspective in bringing other people inside the tent, as it were, so that learning in an anonymous context can be rolled out?

A. Not in that context. Having said that, I was aware of a Medical Director's office contacting me and saying, you know, has so-and-so -- is there any complaints or any SAIs involving this staff member? But they weren't -- you were just asked to check out if there was any incidences with that. There was no information coming back, if you know what I mean, to say look, this is what's happening in that case. It might have prompted you - that's only just before I left this started happening - that would have prompted you, oh, is there something going on? But you wouldn't have had any detail on that and you wouldn't have had any context where that's concerned, because very often the information was purely from they are revalidating, or it's for their appraisal; not necessarily that there's an investigation going on.

'Q. Do you think that there's a way of sharing information with you at your level as the coordinator, Governance Coordinator across Acute Services, that would allow you to carry out your role more effectively, assist in the protection of patients with a reduction of risk, and also anonymise sufficiently to maintain the confidentiality of the individuals involved?

A. I think so. I can see the benefits of it if you were aware there were other issues because then you are kind of joining all the dots, aren't you? You don't have all the dots to join otherwise.'

What is the current policy on sharing anonymised information and learning from MHPS/SAI's with the Governance Coordinator across Acute Services?

A. You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well because, very often, instead of looking at, well, that's a human factors issue, people still have that kind of blame 'oh, you never guess what so-and-so has just done. That needs to stop. For you to have openness and transparency and good learning coming through, you need to accept we are human, human factors, people make mistakes; this is the mitigation we put in place; this is the learning that we put in place so that the whole stigma of being involved in a serious adverse incident is removed. Because there is a stigma for staff that are involved in it, they are quite stressed about it and they think that people are pointing the finger at them. Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well.

'You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well'

'Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well'.

How can this narrative be reinforced throughout the Trust?

Q. "I also believe there were too many individual processes, MHPS and/or insufficient joined-up thinking. For example the details of the MHPS process were kept confidential".

We raised that point before. The first point, there are too many individual processes?

A. It's not just MHPS; there's obviously nursing and midwifery processes as well. Any health professional, allied health professional, have their own professional bodies that they would have investigations through. Also, HR have another process for other staff as well. You know, you have got your conduct or your capability processes or your disciplinary processes and things like that. They don't necessarily all marry up and feed into each other. That's what I meant by that.

Q. Have you any suggestion as to what the answer may be or are you just identifying that those individual processes perhaps be joined-up thinking, and anything that would unblock that would probably be helpful?

A. Yes.

Q. Then you say at 22.6: "We should be an organisation with an effective corporate memory so that when an adverse incident happens, that learning is not only shared through the division or area of practice but extended to all areas within the Trust. Lessons must be learned by all teams, and action plans from recommendations should be kept live and revisited at least annually to prevent reoccurrence. Too often learning from adverse incidents is shared and there is some learning for a few years, then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems reoccurring." The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate.

A. Mm-hmm.

Q. But your suggestion is that when you lose people who remember things, everyone thinks they are starting again?

A. Yes. Yeah.

'The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate'

Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?

Q. You have said this previously but just to give you an opportunity to say anything else about it: "A deficit in one area of practice should provoke curiosity and require sampling of other areas of practice". We can see in the timeline there's a possibility of that thinking pre-MHPS, post-MHPS September 2019, 2016, 2017; there were signposts perhaps along the way. Do you acknowledge that that should have been the lens through which things were looked at various parts of this journey?

A. I am a great believer in always lift a stone, don't take it on face value, and I don't think we took that opportunity as an organisation early enough

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern. Also patient information and patient involvement. We have a statutory obligation, actually, to involve patients right from design,

implementation and evaluation of all of our services. I think the Task and Finish work showed even when patients and relatives had been through a difficult time, they engaged with us, they trusted us to try and improve our services. I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public.

'But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work'

'We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services'

'I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public'

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go though to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'

What are the next steps to move towards this goal of inclusion, partnership, and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'

Q. Absolutely. Another thorny thing that's come through from a number of people, and it's on your Risk Registers at the Trust, is about standards and guidelines. Clearly a lot of bureaucratic things are involved when you try and make sure they have been read and the Department has looked at them. It would appear that there has been no systemic way of ensuring that when a standard and guideline is adopted, there's any kind of measures of whether people are actually using it. Is that correct?

A. I wouldn't say it's entirely correct. Caroline Beatty, who let the standards and guidelines work in Acute Services for many years, has now moved to corporate. She has moved to corporate because there was an acknowledgement that she had a best practice model - that was also acknowledged in June Champion's report - but that it needs to be corporate. A lot of standards and guidelines don't relate to Acute, but there's a lot that relate outside of Acute and there wasn't the same focus.

Q. But how would you know if a consultant wasn't following it?

A. The audit and the checking and the role of the change leads is critical here, for them to be able to evidence for us. I am back to the issue of clinical effectiveness and clinical audit and we need more of it.

Q. I think you would agree that we don't actually have any measures of the clinical outcomes in specialties, for many specialties. There are in some but certainly not in many surgical specialties.

A. Yeah.

Q. Has the Trust fully embraced that now, do you think? It's not very easy just to put it in if you recognise the deficit, but is there a full recognition of that?

A. I think they are on that journey. I think they are starting to think even MDM outcomes for different specialties is part of that.

Q. But MDM, it's still the same thing in that you are following a guideline?

A. Yes, but I still think there's a piece of work to get us to a watertight place.

'Clinical effectiveness and clinical audit and we need more of it. We don't actually have any measures of the clinical outcomes in specialties, for many specialties'

This is key information that is needed for quality and patient safety – can this audit process be embedded across all specialities with a timeline for action?

Q. You understand that one of the focuses for the Panel is the governance system and processes that allow decision-making, I suppose, to be tracked back to origin. This seems to have been a fairly relatively important discussion that was going to slightly change the route by which triage was going to be approached, and certainly there's some contested evidence now around what was expected to be done. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely, because I know from the meeting with Mrs. Burns, I did put it in writing with regards to the plan with Mr. O'Brien not triaging. But I have looked back and I have never actually shared information with regards to the GP, the default of the GP prioritisation, which is now, you know, a regret. But then again, I don't think it was, you know, for me to do it because it wasn't my decision. It was a decision made by two assistant directors in discussion with a director, so I absolutely agree, we should have had minutes from that meeting, albeit even if it was an e-mail note.

'Q. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely'

Is the messaging clear throughout the Trust on the importance of documenting all decisions taken and circulating them to the relevant people?

……..

Q. Ultimately it seems to come to this, you use this word which we're hearing a lot about, triangulation, "triangulation of risks was therefore challenging". You seem to put a lot of store by the need for good data access and good data analysis; why was that? Why is that?

A. Very simply, it's really challenging to identify risk when you can't see it from the different systems all aligned. So you may have a large amount of information but to identify from one system to another to another and pull that all together is really, really challenging and without being able to pull the information together you don't get the overall picture and, therefore, you can't see the overall risk. So some of the issues that had been identified, you know, with good data systems may have been easier to identify. But again it's as good as the information we put in so, therefore, making sure that your staff have the appropriate training to make sure that they know how to identify risk, how to fill in an information form so that you have got a clinician name to identify if it's a clinician or identify if it's a specific issue in relation to a medication or the sort of recording of the deteriorating patient, all of that is really, really vital to be able to really identify the risks that we have.

Q. Do you know whether - obviously long out of the job you were doing in Acute Directorate - do you know whether the picture has changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?

A. It is still a significant challenge. The systems haven't changed that much. If you look at the demonstrations of the new Datix system that's available, you can put everything from your incidents,

complaints, litigation, safeguarding, audit, recommendations, everything can go on it and be potentially triangulated and have reports coming out of that. So we don't have the most modern version of that. In relation to audit, again we need to continue to develop a system to put our audit recommendations on. And data analysts are really challenging to employ and we have a very limited team of probably one person. And again even having IT specialists who can put applications across data to, such as one of the click applications that will pull information from one or two systems into a report that is pictorial, for example, again there is a challenge with being able to resource those people within the organisation.

'Has the picture changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?'

What needs to change in the immediate, mid, and long term to confidently triangulate risk issues within the Trust?

Q. It's been suggested to the Inquiry that perhaps the most significant impediment to moving SAI cases forward is the availability of the lead responsible officer on the review, who is inevitably a clinician?

A. Yes.

Q. And usually a busy, committed clinician; is that something that is just inevitable or are there ways of driving momentum and encouraging expedition that you have now recognised that perhaps weren't a feature of some of the cases we have seen?

A. Yes. Well, I think when you're using a working clinician, that will increase the length of time, because if they have not got protected time to carry forward this SAI review, we are really depending on their clinical commitments and trying to fit this in around that. What we have been doing since 2019 is doing a lot of the preparatory work, in that we are writing the timelines, we're making the packs. So we're doing some of the groundwork for the Chairperson in advance of the first meeting. Obviously they'll still need time to prepare for the first meeting and review the information that they have available. But I find that that can quicken the process.

Is there now in place the provision of protected time for the Chairperson of an SAI panel?

Q. So, you are reflecting back out of your own experiences of Chairing or leading three SAIs, and more widely, is that fair?

A. Yes. So, my own experience is that they do take too long. And for the reasons I've outlined, I think that is not helpful. Because if there's quick learning needed then you're not getting that out there as it should be, you know, across the organisation. Secondly, when an SAI report comes down through the governance structure to the M&M patient safety meeting, for instance, what you get is basically a set of recommendations. It's often very difficult to contextualise those recommendations, to put them in a scenario where the people in the room understand, you know, this is what has happened and this is why we're making these recommendations. And another problem that I think with the recommendations is that I may Chair an SAI, Mr. Haynes may Chair an SAI, Mr. O'Donoghue may Chair an SAI - and this has happened in our department - and we all make slightly different recommendations on the same kind of core issues. I think it would be better if the SAIs are conducted by a team of people who have knowledge of what other recommendations are being made, so that there is a consistency in the recommendations. So, it is not infrequent when you are drafting the agenda for the patient safety meeting to have several SAIs coming down through the governance team, and really we don't have time to fully consider all of the recommendations and all of the nuances arising from those SAIs. So, there are other ways of sharing that information. You know, you can do

case review type presentations at M&M meetings or similar learning events, and I know that that's used in other specialties. And it's probably more effective than just providing us with a summary of recommendations.

Has there been a recent review of how effective and efficient the structure is in running an SAI Review, its recommendations and cascading the learning? Have the suggestions in the witness's response in the above paragraph been considered?

Q. I'm sure the Inquiry is interested in, I suppose, the nature of the governance relationship between these two centres. In essence it's one patient, and while they're going to different facilities, they probably think, right, globally this is my care package, so they will want, I suspect, to be assured that if things go wrong on either side of those centres that it's being well managed so that you are alerted in Craigavon if Belfast thinks things are not as they should be and vice versa. Is that a relationship - is the relationship one that works in that way?

A. I don't think that there is enough sharing of information across the cancer network here. I think that -- I can't recall what's been provided on a unit basis from the centre data demonstrating timelines and pathways. I can't recall that for either bladder cancer or prostate cancer. We've had a recent exercise whereby all of those units providing kidney surgery have participated in a project. So I have participated in that at Craigavon on behalf of our Trust, and my colleagues in Belfast and Altnagelvin have participated as well, and I think the Ulster. So that's the kind of work that we need to do. So, I think it's somewhat frustrating to hear things being thrown back at the units when, indeed, the communication coming the other way from the centre could be better.

Are there current plans in place to continue to develop collaborative relationships and roll out continuity of care pathways across different centres?

……..

Q. The subject matter of the email is "Stent Registry", that you have just mentioned. Do you recall if that was developed, if that was something that came into place as a result of you having identified that there were stents that hadn't been removed, but also that they hadn't been referenced in the discharge letter?

A. I don't recall the invitation of a stent registry, no. I mean this was brought up in a meeting, and everyone agreed, yes, there should be. But I don't recall a stent register was, you know, started at that time.

Q. Do you recall if there was any clarity at that meeting about who would take that forward? Who was to take that idea and make it a reality?

A. No, I don't recall particularly, yes.

Q. But your recollection is that it didn't happen or you don't remember it?

A. No, if it happened I would remember it, but probably it didn't happen, yes.

Q. Do you remember if any of those two cases progressed to an SAI? Do you remember any of that information?

A. No, I don't know the outcome of that, actually. I filed the incidents and I didn't get any feedback -- it is not just to I think going back, I think filed about five or six incidents, and I did not get any feedback of those - the outcome of this review.

Q. And in relation to you having identified it and reporting it as an incident in the first place, is it your understanding that then others would look at that and take a view as to whether it met the criteria for an SAI?

A. That's right, yes.

Q. And if that were to happen then perhaps someone would speak to you about it to get more facts?

A. That's right, yes. Exactly.

Q. And did anyone ever come to you to get more facts about that?

A. No.

Has a stent registry been introduced? If so, is there evidence that the system is running smoothly?

Q. So when you came, for example, did you have a whole session as part of your induction on how to deal with serious incidents, or how the incident process worked at Craigavon? Was that explained to you?

A. No. No, there was no proper induction, but I picked it up as work along.

Q. Was there a regular learning from serious incidents throughout the hospital? Did you have any part in those events?

A. That was my main emphasise. Like I myself reported a few incidents.

Q. Yeah.

A. I didn't get any feedback on those. So the wider circulation I feel that any lessons learnt from anything should be circulated to all, those 11 team, not just only to the particular consultant or clinician or staff.

Q. So you didn't get personal learning, but also you weren't aware of general learning activities made available to you?

A. That's right, yes.

More evidence to support the need to overhaul the SAI system in the Trust.

Q. So different settings, different cases, different clinical issues. Common denominator was a failure to provide for or to conduct preoperative assessment. The Inquiry is interested in this issue generally from a governance perspective. In terms of your own practice first of all, I mean where you're encountering a case for theatre, whether with or without significant co-morbidities, is it the practice of you and your colleagues, to the best of your knowledge, to use a preoperative assessment format?

A. Yes.

Q. To the best of your knowledge has the situation improved in governance terms since any of the cases that I've touched on here?

A. So the capacity of the preoperative assessment service has improved over time. Certainly back in 2015 they wouldn't have had the same capacity that they have now. But my recent experience is that the capacity is still some way short of what it needs to be. Even if lists are provided in a timely manner, the pre-op team are still struggling to get people through the pre-op process ahead of surgery. So that

still leads to problems because it may mean patients being cancelled because they haven't completed that process, and that's what would happen, they would be cancelled.

Q. Yes. Well, I was going to ask to what extent are you aware of a culture where risk taking is tolerated? Clearly it might be suggested that the cases that I've, the examples I've referred to shouldn't have proceeded?

A. So I think, you know, particularly with - and I'll just refer to the number. The learning from Patient 91.

Q. 91, yeah?

A. Right. That obviously had a profound effect on how we operate in the Southern Trust. So every patient who is having an endourological procedure, that means a telescope into the urinary tract, is having an MSU beforehand, and the results acted upon. So there are still patients where that is not happening ahead of time quickly enough, and those patients are getting cancelled as a consequence.

A. We deal with a very comorbid population of patients. So not all of them have their preoperative assessment with a nurse, some of them have a consultant led preoperative assessment by an anaesthetist, and the purpose of that for those patients is to get a very clear handle on their comorbidity and what the expected complication rates would be, mortality, predicated mortality rates. So that's all documented very thoroughly in a clinical letter by the consultant anaesthetist, and that would then be a two-way conversation between the consultant anaesthetist from the pre-op clinic and the operating surgeon. So that happens a lot. And as you can imagine, there are times when between you, the anaesthetist and the patient, you have to come to an agreement as to what you're going to do, because not every patient is optimally fit.

'My recent experience is that the capacity is still some way short of what it needs to be'

What plans are in place to support and deliver a robust preoperative assessment service?

Q. We have heard quite a lot about waiting-list management and how it's done differently, perhaps, in Southern Trust. I mean, what was your view of the -- being sent Excel spreadsheets of all the patients under your name every week or every period to try and sort out -- I mean, did you think that you needed more help in that respect, or what was your personal view on that?

A. My personal view is that there now is a urology booker –

Q. Yes.

A. -- and you need administrative help to fulfil that role because the waiting lists are so large that they can be a little bit overwhelming; you are thinking, right, who do you pick and how do you operate? The obvious thing everyone says is, right, well, it's the person who is last on the list. The reality of that is, it isn't the case, and the reality is you need a three-pronged approach and then it is very time consuming. So I give an example of PCNLs, is, I can't just take the exact last person, but I'm very aware of them and I plan to then do them, but I have to update their imaging, have to see them in clinic, because time has changed that person, their comorbidities in the situation. So you have to be very mindful of taking the next person who is due on the list, and, at the same point, you have to say, right, who on this list is going to come to harm? Who is hiding in that list that needs to actually be next on that list? And then the third thing is, you have to be aware of, well, what happens if you have cancellations? You need to maximise the resources you have. So I have been very clear on having a shortlist of people I can bring in very last minute who I know are really well and aren't going to cause the anaesthetic department -- and I know their urines will be negative when they get tested, so the

list is used. So you have to do it in three different approaches to try and maximise, one, your resource and also try and tackle the problem.

Q. So when did that schedule come in?

A. So the schedule had started in the past few weeks.

Q. Right. So, up until then, it was purely down to the Urologist to sort it out?

A. Yeah.

This new post of a Urology booker dealing with long waiting lists is a positive development and will help consultants address some of the large administrative challenges they face.

Q. If we could start with your statement again at WIT-51697, at paragraph 7.2 you're reflecting again on governance. You set out, I suppose, what might be regarded as a pretty traditional view in terms of governance in urology. "As a clinician, it means following GMC guidance of safeguarding high standards of care by maintaining competency and revalidation, monitoring of risk and, if a concern is identified, to respond promptly and manage." You say: "Mechanisms need to be in place to provide quality assurance for accurate, timely and reliable data that can derive constructive information for continuous improvement or identifying concerns." In your experience, whether as a consultant or as the clinician lead, were there sufficiently robust processes in place to provide reliable data in this context of improvement and risk?

A. I think the introduction of the Datix system in principle is a good mechanism of identifying problems. An issue with the Datix system, I find, is that it can be a bit on the cumbersome side to fill in, but that's a process thing. But as part of identifying issues, I think it has an important part to play, whereas before we had the Datix, it was hard to amalgamate enough sort of information to identify a trend.

Q. Yes?

A. It's how the Datixes are then put together to get the trend -- I'm afraid, I don't know, I'm not part of the screening mechanism or knowing how a Datix works further down the line. I'm afraid I don't know enough about that.

Q. Have you ever seen fit, whether as a group of people looking at any particular issue or as an individual wearing your clinical lead hat, perhaps, ever seen fit to ask for the generation of a report using Datix data?

A. I'm glad you asked that question because I haven't seen a report. It seems to be information going in and the only thing that you see coming out are individual sort of cases, as opposed to a trend being seen. So I haven't -- I've wanted to ask that question, actually, of, you know, can there be an annual appraisal or an annual sort of statement of what comes out of Datix. Now, unless that is coming, I don't think I have seen it. I may be wrong.

'I haven't seen a report. It seems to be information going in and the only thing that you see coming out are individual sort of cases, as opposed to a trend being seen. Can there be an annual appraisal or an annual sort of statement of what comes out of Datix?'

Can the SLT update clinicians on this issue? If it is the case that there is now an annual appraisal of Datix data - is the learning from this process reaching the relevant staff?

"Safe cancer patient care and pathway tracking is usually delivered by a three-pronged approach of MDT tracking, consultants and their secretaries, and urology specialist nurses." So, it is portraying, at

least in public sector NHS medicine, the use of the nurses as part of a three-pronged approach to Patient Safety, ensuring that the appropriate steps along the care pathway are being taken. The last sentence of the paragraph there is the important one. If we go over to DOH-00126 and if you go to page 105, Prof. Kirby. It's saying that the use of a CNS is common for all other urologists in the Trust. I'm struggling to find it. The sentence I want is in my note so I'll just read. It is on that page: "The absence of a specialist nurse from care presented a clinical risk". What is meant by that is the absence of the nurse meant that there wasn't that -- absent from the equation was that additional level of security to ensure that things got done. We've looked at an example with Patient 1 or Service User

A. You've agreed with me that that was a case that should have made its way back to the MDM for two reasons. It didn't make its way back to the MDM. If a nurse had been present in that patient's care, he or she would have seen that deficit, potentially, and ensured that the patient's case was discussed in that way, perhaps with Mr. O'Brien, and then arranged for the case to go back. Is that a fair understanding of how a nurse might assist in the avoidance of patient risk?

Are there clear guidelines on when a case should be brought back to the MDT for discussion and guidance?

Q. If you are prescribing off licence, you have an obligation to explain to your patient and record why you are doing so?

A. Yes.

Q. The efficacy of the approach must also come into question in terms of its optimalisation. A patient receiving 50mg as a monotherapy may be receiving some benefit but it's not the optimal benefit, and that's why 150mg is realised as the appropriate approach?

A. Yes. I would agree with that, yes.

Q. You have suggested that perhaps one thought around this -- we'll have to ask Mr. O'Brien -- a patient struggling with 150 or he suspects he might struggle with 150, there are side-effects so we'll use 50, that view is not uncontroversial, is it? The dosage may not be terribly relevant to the question of side-effects?

A. Well, a good question, really. I don't think anybody has actually studied the incidence of side-effects of 50 verses 150. There are no trials so we don't know for certain. But I suppose empirically you could argue that giving three times the dose is likely to produce more side-effects. The dominant side-effect is gastrointestinal side effects, which I think one of them, Patient A, got, and gynaecomastic breast enlargement that is quite troublesome with patients with Casodex. I don't know if anybody knows whether that's more likely to occur with 150 than 50. The effects on PSA is stronger with 150.

Q. I think we are all familiar with that, perhaps. My question was in terms of the guidance, the licensing?

A. Yes.

Q. I know they are two different things. Is there an indication, whether in guidance or as per the licensing, for, if you like, a prescription, a lifetime prescription of 50mg of Bicalutamide?

A. No, that's not a licence indication. But, as I say, doctors do treat patients off licence. You can treat patients on what they call a named patient basis. Before we had a licence for Sildenafil, Viagra, I prescribed it for thousands of patients off licence with a named patient basis, because while we were waiting for the licence to come through, they were desperate to get hold of it. That's what we did. Mr.

O'Brien, he could be criticised but I think it's not a -- what's the word? -- not negligence to prescribe that dosage. We need more information about why he choose to do that but you could ask him about that yourself.

Has a current audit been done of off-licence medications that have been prescribed in the Trust? Also, an audit done into whether the patient has been fully informed.

……

Q. That is my question to you, really. Who do you feel is leading that? You've described the consultants coming together, the Trusts coming together, do you feel there is a political mandate for this now to happen and do you have a clear sense of how that is being supported by, say, the Chief Medical Officer's Office and Public Health, and the Commissioners? Is that clear to you?

A. I think that everybody, both in urology and in general, know the direction of travel. We've had the Donaldson report, the Compton report, Bengoa report -- numerous reports that have said what needs to happen. I don't know that Stormont in itself will actually make that happen because they've had 15 years before it collapsed to make it happen, and it did.

Q. What do you think would make it happen? I`m just interested as a clinician in the service.

A. I would like Chris Heaton-Harris to close down numerous A&Es. That`s what I think would help. You know, because the political parties will not do that because of the outcome that would be in their own constituencies. Whereas someone who wouldn't have the same political back -- what's the word? -- blow-back from it then could make that decision. We've seen it happen in terms of other things, that the politicians can't agree to do it and therefore you need someone from Westminster to make that decision for them. Personally, I believe that what needs to happen with the Northern Ireland Health Service is that there are far too many acute units, far too many A&Es, that some of those need closed. And I don't believe, even if you have a health minister and Stormont up and running, that that decision will be made. In my view, the only way that will happen is if Westminster say, Right, you are spending far too much on health, you need to make your system more efficient, and the way to do this is to close down this, this, this, this and this.

Q. I think that`s an interesting perspective. I think, looking at this from the point of view of the Urology Inquiry, touches on all of these issues: what happened to the Donaldson report, the Bengoa report, what is going to happen next. However, I think what you've said to me is, partly as a result of pressures, partly as a result of learning to work differently during COVID, and certainly assisted by the GIRFT report, there is the backbones of a plan which, if properly implemented and taken forward in what I would call a delivery plan as opposed to an aspiration, would assist greatly, in your view, in taking urology and, by implication, other specialties at the same approach further? Is that what you`re saying?

A. It certainly will improve things. At the minute there are pressures in every urology unit and we have to work together in order to improve that. The progress that has been made in Craigavon with the complex stone service, it shows that if you have the right people involved and the right resource behind it, that you can actually create an exceptional service. I honestly believe that's what it will be. There's no reason why the other aspects of urology and other specialities could not do the same thing if they had the same support and the same resource put into it.

'The progress that has been made in Craigavon with the complex stone service, it shows that if you have the right people involved and the right resource behind it, that you can actually create an exceptional service'

What are the SLT's thoughts on taking this example of service improvement and using it as a stimulus and encouragement for other aspects of urology and other specialities to move in a similar direction?

Q. Could I ask you just a practical question. Do you think that enhanced or advanced triage could be effectively undertaken by personnel other than consultants?

A. It could be undertaken by a Clinical Nurse Specialist, certainly, with wide experience, I would have thought.

What is the current guidance in the Trust on Clinical Nurse Specialists carrying out advanced triage?

Q. Yes. Is there anything about the current working practices of the MDM that you would change or improve if it was within your gift to do that? Particularly in the area of Patient Safety and the governance of the actions that are part of the everyday life of the MDT?

A. Well, it certainly runs much better now. I certainly welcome people looking on, making sure that -- the cancer tracker is ensuring that the patients are going through the system effectively. I think our Clinical Nurse Specialists also are actively involved with the patients and they're also another failsafe mechanism, and they are ensuring that patients are going through the pathway effectively. So there's lots of people that take part. I think, certainly, the nurse specialists, because they are the key worker for the patient and they make sure the patient goes through the system as well.

The recent development and appointments to two new roles in the Trust - the cancer tracker and the Clinical Nurse Specialist, has had a marked effect on the efficiency of service delivery and the quality of continuity of care for patients.

Q. The Inquiry must have put an enormous strain on everybody in the department, I imagine. What benefits have you seen, if any, so far, and how do you think you personally could use the learning from this Inquiry for the benefit of the department going forward?

A. Well, I suppose results -- whether it is because of the Inquiry or just has evolved over time, I mean they are now coming electronically. We have a little tally of how we're doing. So that has improved. You know, it's -- we're not dependent on bits of paper. Even the bits of paper we used to get come as PDFs to us now and we sign them on line. That's become more secure rather than having bits of paper floating around. I think, certainly, we've got more Clinical Nurse Specialists. We had eight or nine. So those numbers have gone way up. So I think things are certainly improving.

Q. Those are some specific things. What about, you know, your feeling that you maybe slightly more empowered to raise things for long-term strategic planning of services. That has been a huge problem for a long time in terms of demand and capacity. This has really come to the forefront. What opportunities does that bring for you as a group of urologists?

A. Well, we have a meeting once a month. We can certainly talk about that or if we have any ideas, put it on the agenda for discussion.

Q. Do you recognise it is your role to do that? I think what I've seen a little bit of, people thinking somebody else is going to do something?

A. Some people are better at big ideas than others.

Q. Of course.

A. And some people are grafters. But I think –

Q. Because actually you have a lot of good things going on, is my observation.

A. Absolutely.

Q. What I am trying to say is how you can use this and have you thought of it in this way?

'A. There's no inhibition. It's a very encouraging department. I mean, it has all these issues but as a department itself, it encourages new ideas and it is quite receptive to new ideas. It functions very well. MDT functions well. It's not an unhappy place to work'

Can this constructive personal account from the Inquiry be reflected in the SLT's response to the Inquiry and relayed back to the department?

2. Quality and patient safety

None of the 9 SAI's had a clinical nurse specialist

Is the provision of Clinical Nurse Specialists regularly monitored now?

Patients and families want to know the depth and breadth of the problem – the why and the how as well as the what has happened. How is this being addressed and communicated?

A. Patients are partners in care. The culture aimed for is such that a patient and/or a member of staff can raise any concern at any time.

Is this currently the case?

A. Patient related outcome measures were not presented at Board level or in governance reports

How are they tracked now?

A. Consent in cancer is critical for good care. Patients fully understanding the options that are open to them – these discussions need to be supported.

Currently – do the clinicians in the Southern Trust have a clear understanding of the

consent process?

How is this being monitored and audited?

A. Best practice and good practice – letters sent to GP and preferably copied to the patient – explaining the options available to the patient and reasons for selecting a particular course of action. The patient should have the opportunity to correct or qualify whatever is written. Doctors making notes about consent is essential.

What is the Trust's current policy on this?

Are patients receiving letters and results now as standard practice in the Southern Trust?

Q. What is the standard of care?

How is it communicated now to patients, families and throughout the Trust?

Patients in SAI's did not know nurse specialists being available to them was standard care.

What should a patient expect?

A. An MDT process that's fully quorate and fully functional, appropriate support and CNS's who will have their name and number. Patients need to know that they will be supported through their cancer journey.

The patient experience and the patient pathway into medical practice – how is this audited now?

A. I think the amount of energy and time and effort that went into performance left less time and capacity for a deeper focus on patient quality outcomes. Probably 80% of your energy went into doing performance

What would you say are the percentages now?

Q. As you look back now, can you see that right from the beginning there was a very clear Patient Safety issue here?

A. Yes. I can.

There was a marked lack of awareness and sensitivity to the key thread of Patient Safety throughout the period being investigated by the Public Inquiry. Also, a lack of focus and regular audit of patient experience, their journey, and outcomes. How is this different now?

Timeliness is a patient quality issue and a patient safety issue.

……..

Q. Just from a perspective of how things operated, I know you said that Mrs. Gishkori indicated that there was a line of communication and there was someone between you and her. Is it the case that you wouldn't have felt comfortable just going to her door and rapping the door and saying, 'this situation has arisen. I can't get my hands on an AD, and I need to discuss that'. Was there, in effect, a barrier to you for doing that?

A. Yes, I felt that. Not with the other Directors. I suppose that was the difference because we said I was there from 2009 to '21.

Q. How was that barrier presented to you? Was it said to you that you shouldn't do this or that you did do it and the response was not welcoming? What was it that happened that made you reluctant or to know that you couldn't do that?

A. Not long after Mrs. Gishkori started in the role, and I was used to just popping in to the office to her personal assistant, Ms. Stinson, I would have said to Emma, 'are they free?', because you obviously wouldn't just knock the door and then go in, which is what I have done, you know, right from the start. This particular day I just said I just need to give Esther the heads up on something. I knocked the door went in to Mrs. Gishkori. She said, 'I'd prefer this didn't come from you, it came from an Assistant Director. I'm clear that the lines of communication is Heads of Service, Assistant Director to myself'. That was near enough at the start of it. I was a bit taken aback because I had such a good relationship with the other Directors, so I was a wee bit taken aback.

At what point does the need to keep to the strict escalating line of communicating concern become a block to a patient care and safety issue?

Q. I just wonder if I could ask you, generally, on those issues, given the length of time over which you had an awareness -- you and others had an awareness of varying degrees of concerns around those issues. Was there ever a point from 2010 when it was realised that these had the potential to impact on patient care and safety?

A. I've had quite a bit of reflection on this. I suppose pre -- the notes at home, the un-triaged, un-dictated, was always classed as being admin issues, wrongly for me now. On reflection, I didn't associate that with Patient Safety up until probably 2016, and it really hit home with me personally whenever, in 2017, I recovered the 783 letters and one of the patients, I think Patient 13 maybe, one of the patients actually was just a couple of weeks younger than my own husband, and the first line of the letter just rang alarm bells with me. Even though I'm not clinical, the fact I worked for 35 years in the Health Service I have sort of picked up some clinical terms. It was that realisation that because of what had been classed as admin was really Patient Safety and, you know, that patient became part of the 2016 -- sorry '17 SAIs. Up until that I would have said they were admin issues. When you read the report it says "admin issues" but it was obviously a Patient Safety, on reflection.

'It was that realisation that because of what had been classed as admin was really Patient Safety and, you know, that patient became part of the 2016 -- sorry '17 SAIs. Up until that I would have said they were admin issues. When you read the report it says "admin issues" but it was obviously a Patient Safety, on reflection'.

An important realisation and principle for admin staff to take from this Inquiry.

Q. Was there ever a suggestion that the plan could have been updated to reflect those findings that there were gaps in, potential deficiencies in oversight?

A. No.

Q. Did you feel that you could have brought that to anyone's attention, to say, 'well, we may ostensibly be covering this potential lacuna, but the work I have done or the work that's been undertaken shows a vulnerability for emergency and day case patients'?

A. To be honest, I didn't actually look at the ins and the days at that stage. I was concentrating in the midst of a very operationally challenged busy job and trying to make sure that the four areas that I had been tasked with, that I monitored them. In hindsight, yes, I should have thought of that, but I didn't.

Heightened awareness of the quality and patient safety lens is fundamental in every operational and clinical areas in Healthcare Trusts – what measures are you putting in place to achieve this?

Q. At that time, what was the sense of Patient Safety issues and was the Oversight Group as sensitive to those risks as it needed to have been?

A. No. We weren't as sensitive as we should have been. I think, actually Esther's paragraph there, around, you know, this lifelong commitment, built-up single-handedly, this narrative around him being an excellent surgeon, an excellent clinician, that was the prevailing sort of form at that stage. It probably desensitised us to the risks from an administrative point of view. It was as if they were two separate things and they shouldn't have been.

Q. I know that, you know, we will maybe come on to your reflections later, but I think we can have a snapshot of that now, I think there's a sense in your reflections that this prevailing narrative about his excellence as a surgeon created a form of a blind spot to more urgent and more effective action. Is that fair?

A. Very fair.

Are there other types of narratives that can potentially hide the sensitivity to the importance of Patient Safety issues?

Q. Upon reflection, you could have gone back to NCAS and said, 'listen, we have this grievance. You had previously written to us on 21th September to advise us on how a new action plan could be developed. We now have this grievance. Can we do the action plan in this context or is there another way around it?' That kind of advice wasn't sought?

A. No. No, it doesn't appear to have been. I think there's -- part of, probably, the issue as well and some of the challenges around this, Dr. Khan was both the Case Manager and the Medical Director at that point in time. There wasn't that other set of eyes on this too. It was one and the same person, which certainly didn't help because you didn't have another set of eyes from a Patient Safety perspective, I don't think, on it.

When a Case Manager has another significant role in the Trust at the time of the investigation is there provision now for another 'set of eyes' to input on a patient safety perspective?

Q. "There was also, I believe, a view by many that Mr. O'Brien was an otherwise excellent clinician which resulted in a failure to grasp the real significance of the link between poor administrative practices and patient safety. I was not experienced enough to challenge this thinking at the time and both of these points have provided significant learning for me as a result of this case." Maybe that says it all, but feel free to add to that, if you wish.

A. Yes, I mean, if you just scroll back up, please. Yes, that bit around the complexity in most part linked to the fact that his administrative practices had not been addressed over a number of years. I think back to what I was trying to say around the informally and how we need to really, really focus robust processes around that informal stage. In this case I think views were probably entrenched. Trust seemed to have disappeared. There were tensions between, probably, Mr. O'Brien and a number of others. I think that, in itself, just inevitably maybe made an informal process in 2016 almost kind of doomed to failure, maybe right at the outset. There needs to be a willingness, I think, on both sides, for both parties to be able to make the best use of that informal process. Back to the psychological safety of the practitioner, I mean it is absolutely critical in all of that. I suppose that's what I was thinking about that. If we move down a wee bit, please, if that's okay. Yes, I think I've said this on a number of occasions just around the poor administrative practices linked with Patient Safety. I mean, that's really, really important.

How and where is this message being flagged up currently in the Trust?

Q. So just to finish for today. You're saying as a Senior Manager, you have a Clinician who you know is placing patients at risk if he's not doing triage. You've seen Patient 93's case come through the system. At this stage do you know that Patient 10's SAI is coming through the system?

A. No.

Q. You don't know at this stage. But nevertheless, you and those around you must have known that failure to grapple with this was placing patients at risk?

A. Again, not wanting to repeat myself, but that level of analysis was never done. I think it was always that this was Mr. O'Brien and his admin issues, and this was a plan that Dr. McAllister felt he could bring over the line.

The patient safety lens was not applied.

Q. In terms of setting terms of reference, can I broaden this out as I think it's probably an important issue. The Trust has told the Inquiry through its witnesses that, in 2020, a range of issues relevant to Mr. O'Brien's practice were discovered; the Trust considers those matters to be shortcomings of

practice. This was investigated through a number of processes, including nine SAIs. Now, the MHPS investigation set off in 2017 and didn't identify the kinds of issues that were discovered in 2020. The question, I suppose, that arises is should other aspects of Mr. O'Brien's practice have been the subject of MHPS investigation when you took up the reins? In light of your experience across a number of MHPS processes, can you help us at all in terms of the development of terms of reference; how is that done; could it be done better? The public will want to know why an investigation that took so long under your watch didn't get to find what was there perhaps to be found, and was only found two or three years later?

A. First of all, Mr. Wolfe, I didn't know about the additional issues raised in 2020, I'd already left the Trust by that point. I suppose what I would say is that terms of reference -- so, how this process works is that there is an initial screening process, and then terms of reference are drawn up and then a Case Manager is appointed and then a Case Investigator is appointed. I have used the phrase earlier but I think it is relevant, this is not a fishing exercise. You know, terms of reference are clearly and specifically and very often precisely written. Really, the Maintaining High Professional Standards document indicates that actually - and I think the NCAS document actually takes that even further, makes it more clear - that you are not there to start looking at every aspect of a doctor's work, you are there to look at areas which have been specifically raised as an issue. However, during the process, if somebody comes along and says something to you which rings bells, well then, of course it's your responsibility as an investigator to raise that with the Case Manager. I have identified, I have highlighted already that on one occasion that occurred and we raised it. But I was quite shocked by the findings that came out in 2020 because we had no inkling through the investigation - and I understand you will get evidence, you will receive evidence from Mrs. Hynds as well, I expect she will say the same - but I had absolutely no inkling. In fact, quite the opposite. The information that I was being given by almost everybody was that this was a good clinician who, in fact, was overinvolved; spent too much time with patients; wanted to do advanced triage, you know, look up blood results, look up imaging, send people off for other investigations, you know, before, you know, progressing to seeing the people, the patients. The information I was receiving was that there were no clinical concerns.

‘But I was quite shocked by the findings that came out in 2020 because we had no inkling through the investigation - and I understand you will get evidence, you will receive evidence from Mrs. Hynds as well, I expect she will say the same - but I had absolutely no inkling. In fact, quite the opposite’

It is very important in terms of patient safety, to spend the appropriate time to get the Terms of Reference for an investigation right.

…….

Q. Thank you. Last question. This whole Inquiry and everything that we have heard about in your investigation is overshadowed by the huge problem with waiting lists in Northern Ireland. The waiting times are so long that there's a sense that that overshadows everything. That doesn't mean that people shouldn't do their job responsibly, as you have alluded to. But are there any very senior level discussions as to how people should minimise the harm to people on waiting lists generally? I can't see any evidence of that in any of the Trust documentation. Did you have discussions about that as Associate Medical Directors, for example, because when times are this long - Mr. O'Brien has a point - patients will come to harm?

A. I know at meetings there would have been discussion about trying to verify waiting lists, for example, by writing out to people, you know, 'do you still require this appointment and things like

that'? I think a letter would have gone back to GPs to say this person has been added to the waiting list, it's a waiting list, if the situation changes please contact us again. In terms of whether the waiting lists were being scrutinised to look to see whether something -- people needed to be pulled out and moved or whatever, I'm not aware of that. Mental health, where I work, is a bit different, urgent things are very urgent. It's a little bit different because of the type of morbidity and the risk of mortality that we deal with. I'm afraid I probably haven't fully answered that question. I'm not sure that I am able to.

'But are there any very senior level discussions as to how people should minimise the harm to people on waiting lists generally?'

Has the SMT had the opportunity to discuss this?

Q. Even though there's potentially, as you say, no history of things like this coming to the board, it could be said that ultimately, as a board member, you still have the responsibility to keep patients of the Southern Health and Social Care Trust safe. Whenever these concerns -- I don't know if you think this was at the time when you started to have concerns about patient safety or if it would have been earlier, but whenever that came to your mind did you not think to yourself the board needs to be informed in some way, whether that be in a way that keeps the other aspects of the investigation separate from the board so that the board would be made aware that there was a potential risk to patient safety?

A. There is no doubt in what you are saying. Whenever these other aspects were being uncovered, then I understood that the investigation was going to expand even more, and that did concern me. The avenue for how I was going to inform the board and governance, I didn't see that avenue because I had no history of that happening and whenever - I think I mentioned this earlier - whenever I asked at a general level, look, I am concerned about job plans, I am concerned about appraisals, I am concerned about safety, in terms of the specifics of this case, then there was almost 'we don't do that, we have to wait, it might contaminate, if you want to call it, the investigation'. So there was a misunderstanding both in terms of myself and in terms of -- well, I can't speak for my colleagues. In terms of myself, there was a misunderstanding in terms of how I could feed into the board and the opportunities to feed into the board. Again, I will come to this is a learning for me. I come back to guidance for the nonexecutive director. I think that needs to be clearly stated that this should be the case. It wouldn't take too long to draft up a booklet for prospective designated persons to make the role more explicit and to give them the structures whereby they can operate within, and what the expectations are.

'It wouldn't take too long to draft up a booklet for prospective designated persons to make the role more explicit and to give them the structures whereby they can operate within, and what the expectations are.'

If the SMT agrees, how soon can this be done? There are to be new appointments soon to the Board and a booklet (as described) would be a useful part of the induction process.

Q. I think as a NED, your first MHPS investigation was particularly challenging, if it's any consolation. Mostly the involvement isn't of this degree and I am sure people have told you that already. You quite clearly made a big point about the clarification of roles and responsibilities, and everyone involved in this process has made similar points. There is clearly a need to define that. That's pretty consistent down all levels of the Trust, actually, in terms of who was doing what in regard to this issue. Another feature which has come through quite clearly from our witnesses is that there's a huge emphasis at the Southern Trust on performance targets. I think one of your Acute Medical Directors put it as I would not say that quality was overtly discarded. But many people have said the focus was on performance, performance, performance. I think this is because of the waiting lists and it's understandable. Equally,

as a board member your prime responsibility is also for patient safety, and the fact that the board was unaware of all of this for such a long time seems to me to be quite a significant issue. You weren't the only board member who knew about this, the Medical Director knew about it, and yet it wasn't raised with board members for a discussion. You feel you didn't have a route. This says something about the culture of the board. What was your experience as a board member of the relevant priority of performance quality and finance and so on? Would you accept that perhaps there's some learning in this in terms of patient safety being more of a priority issue?

A. Yeah. It's an interesting question simply because the board within maybe this last year, year-and-a-half, have created another subcommittee which is a performance subcommittee.

Q. Mm-hmm.

A. Probably in direct response to the waiting lists, I would suggest. However, I Chair the Patient Client Experience Committee, and coming through there there is a marked interest in quality and in the patient experience. I haven't really been asked about this but there was an occasion where ironically I had to attend the Urology Department within the Trust, and I used the opportunity to ask some questions. As a result of those -- and I did declare that I was a nonexecutive director, by the way, it wasn't a subversive thing - and I used that opportunity to ask questions. As a result of that, I brought I think it's the lead nurse back down to the Patient Client Experience to describe what the patient experience was in terms of the quality of experience that they were actually getting out of Urology. My query wasn't as a direct result of being involved as the designated NED. In answer direct to your question, I think there's a balance within the Trust in terms of performance and quality. We try to address both of those. There is a direct input or interest in performance because there's a Performance Committee and they do a lot of drilling down. The quality bit of it is done through the Patient Client Experience where we look at SAIs; I would look at concerns and complaints; we have the HCAT; we have Care Opinion which is looking at the quality of the experience. So, that's part and parcel of what we do. So there's a balance; I would argue there's a balance to that.

How often is the narrative and focus at Trust Boards monitored to make sure there is a balance between the quality of patient experience and performance?

Q. Is it not the case when you think about it or reflect back on it, the fact that triage wasn't being done, except for red flag referrals, that was known for some time; that's what you were being told in September. To the extent that a failure to triage raises the potential for patient jeopardy, is that an issue that ought to have been recognised and grappled with earlier, even if it didn't lead to a formal investigation?

A. On reflection, yes. On reflection when I think about it now, failure to triage must involve some risk to patients, and the fact of the subsequent SAIs and things proved that. Perhaps I should have probed that a little bit more with Simon when I spoke to him. Whether that would have changed the advice is a different question.

'Failure to triage raises the potential for patient jeopardy'

The application of the quality of patient care and safety lens is central to all the work of the Trust and should be kept on the front page.

Q. Another thing I think it would be helpful for your observation on this, the administrative issues, as they were called in this, are really very extensive, yet there was a blindness because people felt it was totally unrelated to clinician capability. In your experience is there quite often a link between very

severe administrative issues, conduct and capability, or do you think it's possible to separate them like this, like they have done?

A. No. Actually, I suppose I have to confess, reading through this bundle I was getting increasingly irritated by referring to these issues as administrative because not writing notes, not triaging patients on time, not writing letters to GPS are not just administrative issues in sort of the way that -- you know, it's not the same as not having, you know, put your parking sticker up on the car. It is a different type. This goes to the core of clinical care. Because when you're a surgeon, only a little bit of your work is cutting, the rest is it is what has been referred to as administrative in this. There is an overlap. People who are bad at one area of their practice are often not terribly good in other areas as well. So, yes, there is a connection and an overlap. I suppose if I was to criticise myself, probably in that discussion about Simon Gibson I should have majored a little bit more on that.

'This goes to the core of clinical care'

A clear understanding of the relationship between the consistent delivery of clinical care and administrative efficiency is an important principle to underline throughout the Trust.

Q. While there was various, perhaps, attempts in the Trust to start some type of informal process or engage with Mr. O'Brien, for one reason or another Mr. O'Brien was spoken to in March 2016 and then wasn't actually spoken to again by senior management in the Trust about these concerns until the day after this letter. What are your reflections on that with regard to the advice you offered to the Trust here? Would you have offered the same advice that a formal process was now to follow had you known no one had spoken to Mr. O'Brien for some nine months at this stage?

A. That's a difficult question. I think it was very regrettable that nothing substantial had been done but I must say that the matter -- you know, he should have had the opportunity to address these issues. And I think had he been given the opportunity, things might have been different but I still felt that the allegations were quite serious on a first off. There was the real potential for harm here. And if you scroll down the letter further you'll see about a chart appearing, that troubled me greatly. You know, I was -- I thought, you know, that the allegation there is that, you know, the unspoken allegation, I suppose, is that that chart was brought back by him and I thought there was something, you know -- well, something unprofessional about that if, indeed, it had been him that left the chart back.

Q. Again, the complicating factor here is whether you were or were not aware of Dr. Fizpatrick's advice. But definitely in September 2016, Dr. Fitzpatrick, on looking at a very similar set of concerns, advises that the Trust, at least in part, should engage in some sort of informal process - he doesn't use these words, I'm paraphrasing - or a supportive process with Mr. O'Brien. Your advice here, at the end of December, is that a more formal process is now warranted. What exactly had changed?

A. Well, even with the benefit of hindsight the SAI is worrying the Medical Director enough that he wants to formally exclude him, you know. So, presumably his situation has changed between September and December and he's the one that's medically qualified and possibly better qualified to make that judgment than I am, in those circumstances, with the SAI.

Q. I might just ask you to expand on that. Is there any suggestion there that there was a bit of a power imbalance between you and Dr. Wright here?

A. I think we have different skills. I don't have any difficulty challenging people where I think it's inappropriate, but if they are worried about a clinical issue, a specific event - and I haven't seen this SAI myself, you know - I think that does make you reflect in the world in which we live. You know, if he's so worried that he wants to formally exclude him. You know, it would be easy for me to say now

maybe you should have done an informal process, but I think if patients are being harmed, well then, you do have to bear that in mind as well

'But I think if patients are being harmed, well then, you do have to bear that in mind as well'

If patients are being harmed should never be a secondary thought in the work of the Trust – the application of the quality and safety lens is central to the work of the Trust.

Q. I suppose in light of what we have just talked about when you mentioned risk there in particular, was the issue of patient risk and lack of awareness about the location of notes something that was ever discussed at those meetings?

A. It would have been raised but because of one of Heads of Service was over security and catering, the other was sterile services, Katherine and the secretaries and the booking, we were a very diverse group. Some of my issues might not have really been relevant to them, such as the catering issues wouldn't been relevant to me. It would have been more generic terms that we would have made discussions about.

Q. What about on your one-to-ones with Anita Carroll, would that have been the opportunity, I suppose for you and Ms. Carroll to discuss risk? I am conscious that we are framing it in that way now but were those words actually used? Did anyone say this is a patient risk, there is a risk of harm, this is not just a notes issue? Or was it we need to get these notes, we need to find them, we need to get them in?

A. I think our big drive at the time would have been we need to get the chart.

How is the SMT checking the implementation of the message throughout the Trust – that clinical and administrative work must include continual awareness and accountability for patient safety and risk?

Q. You, as the head of this, we talked this morning about -- looking now at staffing and the impact of you getting an insight into your day-to-day, the Panel can see what you were juggling. Also, then when there were issues and you had senior management telling you to not progress those issues, how did that impact on you?

A. It was difficult because you wanted to keep your managers and ultimately your staff motivated. You wanted to keep yourself motivated as well. You just had to get on with it, but I always had a stance of you never ask your staff to do something that you wouldn't do yourself, so I would -- I've covered minor injuries, I've done a nightshifts in ED, I have filed charts because when you were at your very crux, you just couldn't sit in your office and see your staff suffer. So, my managers and I would have actually went onto the shop floor.

Q. So, people were shown goodwill; could it be described as that?

A. Yes.

Q. That was to try and keep the system going?

A. Yes.

Q. Heather Trouton says: "The culture of Acute Services was a culture that was focused on performance and financial efficiency". Do you agree with that?

A. Yes.

What is this balance now in Acute Services between patient quality and safety, performance and financial efficiency?

Q. You have also said that "the processes need to be seen as systematic ways to prevent harm". I had touched upon it earlier that it could be seen maybe by the consultants that the systems were a way of monitoring what they did, but you are saying that they actually are trying to provide a fail-safe so that issues of harm don't arise?

A. Absolutely.

Q. So it's a perception issue as well, it's a bit of a change of mindset; would that be right?

A. Yeah. Very possibly.

……

Q. What was the impact of delays in returning triage for you and your staff, first of all?

A. It was a lot of chasing up for the red flag appointment team because they were constantly checking what was coming back in, updating their spreadsheet. If they're still outstanding and they still maybe would have escalating again that these are still outstanding. The trackers then would have been updating the CaPPS System, linking in with the red flag appointment team. It probably would have caused a lot of emails back and forwards trying to track the progress for each patients. And still being mindful that their clock was ticking and you were trying to get the patients in to be seen.

Q. So, against the background where there are all sorts of pressures, as you have described –

A. Yep.

Q. -- this was an added difficulty that you could have done without?

A. An additional pressure, yes.

Q. Was there a concern that delay risked harm to patients?

A. I don't think at that point, no, there wouldn't have been. It would more just to get the referral back just to get the patient seen in clinic. As I say, at time investigations could have been questioned by the time the referral had been returned.

An example of how an incomplete task in one part of the system can have knock-on effects on other people in delivering their roles and most importantly on the care of patients.

Q. And you agree that there should have been a key worker allocated?

A. Absolutely and I struggled with trying to determine why that wouldn't be the case. I did note, on looking back at the evidence, that some of the patients were admitted through the Emergency Department and that progressed, you know their diagnosis. We did not have the resource to check who was on the in-patient ward at any given time. If patients were admitted through ED and were diagnosed with a cancer of whatever nature in relation to Urology, we depended on the consultant or registrar to let the CNS team know that, so that we could go up and meet them with their family and bring information to them. And we have done that on occasions, we would hope with additional resources and the way we are planning things now that we can do, you know, there is more improvements to be made in relation to that.

Has the loop-hole of patients who come through ED onto a cancer ward been addressed in relation to having access to a key worker?

Q. You reflect on those cases in your witness statement at 7.28. You say: "I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done. From my perspective, I feel I could have been better informed regarding what had or had not been done about my concerns". In this regard, those were concerns that hadn't actually been raised with anyone beyond Mr. Haynes?

A. Correct.

Q. You didn't raise them with Martina Corrigan –

A. No.

Q. -- or with anyone within your own line management in nursing?

A. Yes. And with hindsight, I think if I had to do that again, that's what would have happened.

"I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done''

Important recognition of the anxiety that patients can endure on waiting lists.

Q. We have seen that letters weren't automatically copied to patients from the doctors, but we get the impressions that the nurses usually did do that; is that your experience?

A. Yeah. I know within my nurse-led clinics, I would always copy the letter to the patient. A number of the consultants do this also.

Q. Is that happening more now, do you think? Not universally, possibly.

A. I think it's the same as what it had been, yeah.

What is the SLT's line on the policy of patients automatically being copied in to letters from doctors?

Q. You mentioned a range of KPIs. Do you ever see those KPIs for the cancer nurse specialists or does that go as well as?

A. For the nurses in my area of responsibility, yes.

Q. What are the recurring themes from that, if you had to summarise it for us? You know, they are doing a lot of very important work; are there some recurrent issues coming up from their KPIs that you have had to take on board in terms of making improvements, for example?

A. I think one of the KPIs is regularly doing a holistic needs assessment with patients. You know, yes, when patients have a diagnosis, they want to know what's happening to me, what's my treatment planned, how long can I expect this to last, and then obviously, you know, when patients get to the end of their treatment, we, at that point, try to do another holistic needs to see, do an end of treatment summary to see what the key issues are moving forward and how we can support those patients living with and beyond their cancer diagnosis.

Q. Does that go to a Trust committee on patient experience, or how do you –

A. Yes.

Q. -- report upwards on that?

A. So, that would go to our PPI Panel within the Trust.

Note – the important value to the patient and the clinician of conducting a holistic needs assessment with the patient

Q. You've reflected in your statement - I needn't bring it up on the screen but it's WIT-60286 - that you received support from urologists in relation to your expressions of concern around the standard of the independent sector work.

A. Yes, I think that's true. My memory is not very clear on that but I do remember some of the urologists not being too happy about the reports, yes.

Is the SLT happy with how the Trust monitors the quality standards of any services provided by the independent sector in the Trust?

Q. You got into this helping governance out roll particularly because of your background, I think, in the patient safety research, and governance alongside that. What was the biggest thing you learned from that research? Then, if you had been able to do something really that would have made a big difference in the Trust, what would that have been based on that, because it's bound to have changed your outlook considerably.

A. Hmm, that's a good question. Probably for me, the thing I learned the most was the value of near miss reporting or no harm incident. I think for me that was one of the biggest things because the number of times when you look at something serious, for example if you take the case of the -- the thing that really got me interesting was the case of Wayne Jowett, if you know it?

Q. Yes, I know it well.

A. So, that piqued my interest way back in 2000 in terms of how that could have happened. When you read into his case, he was the tenth child or adult to die as a result of that incident. The fact when you start to look into that and you get into the background to that, the number of times there have been near misses with heterocycle chemotherapy like that, where luckily someone had spotted it. To me, that was a big driver for me in all the work I did, to try and encourage staff to tell you when it nearly happened. For the staff, particularly telling you about something that nearly happened is a lot less scary than having to come forward and say someone has been harmed, so it was win-win. It was win for the staff; they felt more comfortable telling you about it. Then for the Trust, the organisation, you had that opportunity to fix it.

Q. What would you done with that, if you had been able to? Do you see that as something that could have made a difference to the culture at the Southern Health Care Trust, and what were the barriers for doing something like that?

A. I think the barriers were resource. As I say, the vast majority of incident reports we got, harm had occurred, or a level of harm. You would have needed a big resource in terms of training, encouragement and facilitation of staff. I think it would have rolled as it did, we found in pharmacy. Once staff understood what you were trying to do with near miss reporting, it wasn't scary, they could see the benefits, it then took on its own role, because certainly you'll have seen in some of my papers, we started a newsletter –

Q. Yes, I have seen that.

A. -- in the medicine safety. They used to be called cheese news, which was very -- we had a wee cheese thing on it but we changed that. Staff looked forward to getting that. Again, we were trying to

be proactive, what nearly happened, and share with them, make it interesting news articles, fun, to try and pique their interest and get them to look forward to reading it every week

How can the SLT impact a shift in culture in some areas of the Trust where staff are encouraged and supported to move from a reactive approach to a learning and proactive approach to patient safety and quality care?

A.The other area, and again under Mr. Devlin's Chief Executive accountability meetings, I think, yes, you will have had that in your witness statements as well. There was, again albeit you could say it is siloed in the sense that it is looking at specific directorates, but it was certainly aimed at, we created those dashboards to try to say well what the safety indicators, what are the quality indicators. So my team were very much around trying to enable that. As I said it is a corporate role to try to enable the optics on some of that and governance was a part of that as well, as well as other indicators that come from finance and HR. So it was to get a broader look at the challenges in the organisation. But, given the scale and size of it, I think there are certainly opportunities. And why I mention, perhaps, in my last comments there around the likes of, whatever it is called, quality improvement, steering group. Certainly I know when Dr. Khan was acting in the medical role, he says we could build this to become some sort of safety quality oversight group. And it didn't need to be producing just reports, it needed to be relationships, insights, putting things on the table and trying to make connections. So I think there is something more that could be done in that space. Whether that could actually be replicated at other levels given the scope and span of the organisation into particular service areas, something like that I think would be useful.

What is the view of the SLT on this comment?

What further realistic plans regarding safety and quality improvement can be moved forward into action?

……

Q. Just a couple of clinical things. I was interested with your experience in the obstetrics and gynaecology life before the last job, and the comments you made on trigger lists and near-misses and things. Looking back with all your experience, how do you think we could use that, especially in urology but perhaps surgical disciplines?

A. Certainly I would feel in a specialty like surgery, you could have a trigger list as such that you can -- I mean, our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again. Then, from that then there's rolled out learning in theme of the week and things like that, you know, that is ongoing and is live and it keeps going. I can see how transferrable that is for Urology, looking at your near-misses. Your near-misses are a sure sign that your system is weak, and putting measures in place to see how you can prevent that happening because a near-miss one day is an actual event the next.

‘Our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again.’

Can this idea of a trigger list being used as an audit tool be applied to other areas of clinical practice in the Trust?

Q. Just before I move on, Patricia Kingsnorth had indicated that the staff turnover and the transient nature of staff in a Trust can cause concerns and challenges for good governance. Would that be a view that you would agree with?

A. Well, it's a view that I agree with but it's also evidence-based, so we know that where you have high turnover of people into an area, they may not be familiar with policy, with procedures; they may not be familiar with the working environment or the operating procedures; there isn't the same continuity of care for the patient. A lot of that translates into service delivery issues. There were issues with, for example, how we measure quality in the nursing care that we delivered, and there were a range of issues in poor performance that were directly linked to that high flexible agency and bank staffing. We were able to compare that with other wards where there were stable core staff and they weren't such an issue. The management styles, capability issues, there were a range of issues ongoing but very definitely linked to high turnover and workforce concerns in that ward.

How regularly is patient safety and the quality of care monitored and audited on wards that are experiencing a high turnover of staff?

Q. In the absence of any report or product that you can point to, and I have to say the Inquiry is unsighted on that, can I suggest to you that you did not, nor did the Oversight Committee, engage in any assessment of the risk to patients in terms of what had been uncovered?

A. I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly. A risk assessment at this point, sometimes you write a risk assessment to make sure you understand what risks are going to be, but at this point in time we knew exactly what the risks were.

Q. Did you? Because it wasn't until 2017, when the other clinicians in Urology sat down and began to look through the untriaged referrals, that a picture began to emerge that in excess of 20 cases, the referral into the system was wrong and triage would have led to an escalation of the referral from routine or urgent into red flag. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?

A. Until the consultants, which you say is January 2017. I wasn't, to be honest with you, sure of thatdate but that's when they started to do the waiting list initiatives and look at the triaging. The patients were then seen by them. Yes, you would be quite correct in saying that.

'A. 'I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly'

Q. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?'

What learning can be taken from this (and actions if needed) to ensure that the principle of assessment of the risk to patients is always paramount in clinical practice?

Q. Do you have any observations as to the reluctance around that because it is a quite a good safety net?

A. It's a really good safety net and it's really interesting that you raise that because in my field now, we're in specialist palliative care - I'm the Director of Specialist Palliative Care - specialist palliative care is very much about the patient and family understanding where they're at.

Q. It is.

A. That there is, you know, active treatment to undertake and how are we going to see this through? So, we have regular debates in our governance forum about giving the patient and family the letter. My clinicians today are extremely reluctant about that.

Q. Why do you think that is?

A. Well, they tell me that it is because of some sort of protection for the patient and the family and from the clinical -- and I regularly tell them, 'If I am your patient I want to know every single detail for myself please.' So, they come from at it from, like, you know, we're protecting our patient but really, I think it's just the thought of getting used to actually saying out in black and white where you're out. They haven't just reached that point yet. And they are very good, my clinicians are very good at breaking bad news, they're very good at having those conversations but they still can't write it down.

Q. That's different from writing it, isn't it?

A. Yes, very.

This is an issue that has come up several times in the Inquiry – can the SLT clarify the guidance across the Trust on patients receiving letters after appointments recording their treatment discussions and plans?

Q. But at least from that time, you had on paper an identification that clinical risk was in your mind, would that that be fair?

A. That would be fair, yes.

Q. Given that, and your knowledge of that and your awareness of that and your operational head on, if can put it like that, was there ever a sense that you needed to speak to your medical counterparts and say, "This isn't just our problem operationally, it isn't a notes and records or a record-keeping problem, this actually has the potential for significant impact." Did anyone cross the potential divide and say, "We need your help sorting this out"?

A. From my perspective, I would have escalated and I would have had quite a number of conversations with regards to them issues with Mr. Mackle mostly so, and Mr. Young would have helped me out with sort of clinical issues that I would have felt that I wasn't able to address. To cross that, I didn't -- I don't believe I ever said -- it was quoted to me so many times by managers -- this is always an admin issue -- clinically, Mr. O'Brien is brilliant and we have no issues with it. Like, for example, Mr. O'Brien was his Clinical Director and one of his quotes is "If I had to come in, I would have had no issues coming in under Mr. O'Brien." So I think that clouded, wrongly, my judgement -- I have reflected on this -- in that I felt there may be an issue because nobody else did and that's my fault, I should have escalated it further. But it's one of those things that when I was escalating it or and thinking it and saying it in a letter and then it was removed, that it was me was thinking it was, where it really wasn't, if that makes sense? I'm probably not saying that very well.

Q. I think Vivienne Toal said something similar. She said "His excellence as a surgeon blinded us to the issues" -- I paraphrase her, but would that be a view you share?

A. Yes, yes. And I think it was everybody else sort of, you know, in and around and sort of up/out would have said that, that there was no issues clinically and it was all admin.

Post Inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

Q. Do you think that this particular example is something -- I don't mean the case, I mean the process -- the failure, and you might be right that it's relatively isolated, but is that something of such significance that it just has to be got right and, therefore, it has to be monitored?

A. It could be that, in hindsight, you could say that. But if you have -- if the vast majority are coming back and saying "Yeah, we do this" and there's peer pressure and we're saying "Tell your people you really must do it" and "Your CD and your AMD says you must do it" and "It's good patient care" -- "I don't know" is the answer. There's a line somewhere and in hindsight is a wonderful thing, isn't it.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

How operationally robust is the role of peer review and peer pressure in maintaining patient safety and quality standards throughout the Trust? How regularly is this audited?

……..

Q. I was just going to ask that. Was audit not viewed or how did things become so skewed that audit wasn't viewed as an integral part of quality improvement?

A. It should be. But the resource went to focus on quality improvement training, supporting the quality improvement as opposed to supporting the audit element of that.

Are all elements of quality improvement being addressed in the Trust now?

Q. Yes. When you talk about risk in this context, I suppose the risk that follows from being unable to proactively pursue governance issues, spell that out for us, what does proactivity mean in this context? Can you give us an example or two and what risk flows from the inability to pursue it?

A. So if we take some of the elements of governance. If we are looking at SAI reports, having them be able to be addressed and identify learning at an early stage and the recommendations be implemented and audited just to ensure that they were appropriately implemented is one risk. So delay in learning; delay in implementing recommendations; the inability to audit to provide assurance; to ability to provide frequent and robust training to teams in how to complete a Datix appropriately; how to identify risk; how to mitigate that risk again was another challenge and would have been a risk.

Q. Was it the case that, although you're talking the language of risk to Mrs. Gishkori, that while sympathetic, she didn't appear to be able to provide complete solutions, she talked about some initiatives that were tried, but did she appear to get it, that there was real risk here?

A. It would have been really challenging for her not to have got it because when you bring the number of outstanding SAIs, when you highlight the inability to audit to the level that we would have wanted to, it would have been really difficult for her not to have understood that risk. The challenge of providing the staff would have been a challenge from a financial perspective. But, again, how that was escalated outside and up to SLT I'm not fully aware of.

It is a key message in ensuring patient safety to listen well and pick up messages.

Q. Do you think the Trust continues to remain vulnerable to an inability to bring together different strands of information, some might call it intelligence, around the practitioners who may be putting patients at risk?

A. I think, because of the systems that we have in place at the minute, the Datix system, while it has improved, the ability to triangulate all the information is still a challenge. And again without good data analytics to help pull all the reports together, to evidence the trends, it could remain a challenge and does remain a challenge.

What immediate steps are being taken to provide good data analytics to mitigate the risk to patients?

Q. A couple of things, well first of all if I can just ask you about Datix. It has been updated but you're not on the newest system, why is that? Is that a resource issue?

A. I would imagine so. I can't say for definite but I would imagine that is, and there would be a cost associated with that as well.

Q. The new Datix that is currently in operation, is it any less cumbersome to input the information than the previous one?

A. Not really, no.

Q. So would you accept then that in some ways it is perhaps not fit for purpose?

A. Yes, you could say that it is not fit for purpose.

Q. I mean, obviously the easier it is for people to make a report –

A. Yes.

Q. -- the more likely they are going to do it and if they are put off by a cumbersome system that requires a lot of training and that isn't particularly user friendly then it's not really going to be the most effective system, is that fair?

A. That's a fair point. But on reflection you still need to capture the key essence of what the incident is in a factual and concise manner.

Q. I accept that entirely. But if you're having to tick a box, if you're logged out after a certain period of time, then those are things that surely with the IT skills that people have nowadays could be improved?

A. Could be rectified, yes, I agree.

Is the current Datix system user friendly? If not, what can be done to rectify this?

A. So, I think the key to managing patient safety concerns is appropriate escalation. So, I think if a trainee was raising a concern with a clinical supervisor or educational supervisor about a patient safety concern, I would expect the CS or AES to raise that with the Clinical Director of the service and then escalation as appropriate. So, to me, it comes back to the heart of how you manage clinical performance concerns and about early -- you know, if there is escalation, that it's dealt with appropriately, people in senior positions respond to that appropriately and investigate it appropriately.

Q. And in these particular examples, rather than generically, what would be best practice to happen, given the information that I've read out, the information you've provided to the Inquiry? If this were the case and you had spoken to Mr. Young, do you consider that these are cases that should trigger an approach by him to act accordingly to perhaps explore your concerns to speak to Mr. O'Brien, to speak to a colleague? Do you think these pass the threshold for necessitating some governance action?

A. So, I would have expected him to have a conversation with his Clinical Director. And, you know, these were patients who were on the ward, these were patients that he would have been aware of, you know, on the joint ward rounds. So, irrespective of whether or not he remembers me talking to him about it, he would have had sight and visibility of these patients.

Q. And also would it be right to say irrespective of whether you're right or not in your concerns, there's an obligation?

A. Absolutely.

'So, I think the key to managing patient safety concerns is appropriate escalation'

Do all the staff in the Trust have a clear understanding of the appropriate escalation process? This is an important strand of practice that keeps patient safety to the forefront.

Q. But in terms of what should be done around reviewing that case for learning –

A. Yeah. I mean I think what they saw demonstrates is that the number of people involved in this discussion didn't adhere to process. The process was to report this as an IR1 and allow that process to run its course. In parallel, the patient could be seen clinically and treated.

Q. Yes. One of the things that's probably overarching a lot of what we'll discuss in the course of today is the, I suppose, the appetite for challenge and the - how that feeds in to the safety culture. I pick that example. I suppose you would agree with me that it doesn't reflect well on –

A. I think there's an initial misstep of not doing the IR1. If you had done the IR1 at the very beginning you wouldn't have this issue of the round-robin discussion going on, it would have gone through the correct process.

How can the importance of reporting an incident, where appropriate, as an IR1 be understood, re-enforced and engaged with as a positive step in maintaining a safety culture throughout the Trust?

Q. Yes. I think you referred yesterday, or I referred you to the point you make that patient outcomes and the data around that is now perhaps more very recently beginning to be used, is that the kind of stuff that's –

A. Yeah. So I think there are other specialties that we can learn from. Orthopedics have had patient related outcomes for a long time, and I think that that's something that we could definitely, as a specialty, adopt and adapt to our needs. You know, the Trust could invest in very simple things like

surveys of patients to ask them what has happened every time somebody comes into the hospital, you know. How was your experience? Did you have a complication? Well, the patient is going to tell you if they had a complication. So there's a very easy way of picking up morbidity, you know. There are other safety systems that other Trusts that I have worked in have used such that you cannot get to theatre if your VTE assessment is not completed. You cannot prescribe medication on the system unless you have put in the patient's weight and their VTE status. So, these are safeguards that are built into the system to allow safe practice.

Are comprehensive patient surveys been routinely used in all the specialities in the Trust? If not, are there plans to introduce them, audit them, and share the learning?

Q. I mean, do you have a sense, as the lead of the MDM, that while systems are always vulnerable to human error, that safety nets, if I can describe them as that, are as robust as they need be, or do you have any lingering concerns that keep you awake at night in this context?

A. At this period of time in 2018, we didn't have resource to properly audit and quality assure what was happening, and we had flagged that up as a concern. We now do have that resource. So as I spoke about earlier today, we run a check on random cases every month to ensure that outcomes are actioned.

Is there regular monitoring and awareness across the Trust on how effectively its 'safety nets' are functioning? How quickly is there a response when vulnerability is flagged up? Has this been recently audited?

…….

Q. He reflects here, there's just a number of points but one which you can perhaps help us with. He says: "It has increasingly become a common occurrence for no ward rounds to be undertaken by the urologist of the week over a weekend. It has been reported that one whole week went by in recent months without one ward round being conducted by the urologist of the week." He says, and this is perhaps a point that you can help us with directly: "As often as not, I have begun my urologist of the week without hand-over from the previous urologist of week and ended it without the next urologist of the week being present." So I suppose that latter bit might be you?

A. I would disagree with that totally, because I always met him and we discussed the patients. So I would disagree with that.

Q. Yes. So I think you've said, just to be clear, for the first year and a half after the introduction of the UOW model –

A. Or in until he retired, because he would always follow me, so I would always have met him and discussed the patients.

Q. So I think urologist of the week model came into place in late 2014, early '15?

A. Yes, within a few months of me starting there.

Q. Yes, and he retired in July 2020?

A. Yes.

Q. Is that about five years?

A. Yes, so it's probably longer, yes. Yes.

Q. So you succeeded him on urologist of the week rota?

A. Yes.

Q. For five years?

A. And if there was some reason that I couldn't get to it on a Thursday, we would certainly have a phone call and discuss the patients.

Q. Did you consider whether it was a phone call or participating in the, if you like, a joint ward round, the incoming and the outgoing, that was an important patient continuity of care and/or safety mechanism?

A. But a phone call you can equally talk about the patient equally as well, than spending four hours walking around a ward. If it's commoner to do the ward round, but if for some reason one couldn't, it was a phone call.

Q. Has it now moved to a phone call completely or comprehensively?

A. Certainly, I think that it is, that it's a phone call, yes, and it's equally as effective.

Is there a regular check taking place on the quality of hand over at all levels on the wards throughout the Trust? This is an important patient safety and quality issue.

Q. Yes. What I'm sort of poking at a little here is, I'm asking you a question I suppose about the effectiveness of the patient safety meeting. It is an ideal forum or opportunity to corral the problems and identify the learning. But I'm anxious to, I suppose, take your view on whether that is sufficient if there is a disconnect between that and the implementation of the solution?

A. I suppose the patient safety meeting can make recommendations and inform the appropriate people, but it can't police it. In other words, you know, if something is sorted, it can come back to the Patient Safety meeting. But I don't think the Patient Safety meeting is well enough resourced so that -- you know, I'm doing it now, so I can't go and chase up all the time that something is being done. You know, I depend on people to contact me and say "we have now done this". But I don't have either the time or the resources.

Q. In terms of -- I mean, one can imagine that those clinicians attending the Patient Safety meeting are in a good position to articulate, I suppose, their concern, their alarm, their worry about any issue of practice that comes there. Are there listening ears in terms of those on the governance and/or management side? Are they present at the meeting so that they can hear this alarm, worry, if that's how it is to be characterised in terms of any particular clinical issue?

A. Yeah, and very often a Head of Service comes to the Patient Safety meeting. We now have audit people at it as well. You know, we have a good turnout of medical professionals, nurses, doctors, at the meeting. So it is a good forum for discussion, discussing concerns. I think it is effective, albeit slowly effective. But it is, things do change ultimately. Maybe not as fast as we would like, but they do change.

Is the SLT happy now with the efficiency and effectiveness of the Patient Safety Meeting? Are there any further steps that could be taken to enhance its effectiveness?

A. Well, I remember discussing this patient. So it wasn't just the stenting, it was having the MSUs before the procedure as well which we felt was important in this particular case. The fact there was no MSU, I think that was the one that we really concentrated on.

Q. Okay, so the absence of MSU is a cardinal sin in that context. But, equally, I think it's a point Mr. Haynes makes in correspondence with management in 2018, the delay in managing this patient back into the system for delivery of extent removal or replacement or whatever it was, was not helpful. So has your Patient Safety meeting, in the context of this case, and you were particularly told to look at Recommendations 5 and 6, did it grapple with that delay issue?

A. We were all made aware that we should submit data if the stent has been dwelling more than one month. So all the recommendations were discussed. They weren't written there, but they were discussed.

Q. So back to the top of where we started: In terms of solutions to the stent delay issue, clinicians are being taught to look more imaginatively at whether a stent is required and, if it is required, to assess whether a stent with a string can be used?

A. So if it's appropriate, yes.

Q. But there will be cases where it is not, and I suppose what the Inquiry wishes to understand, because we've seen quite a number of stent cases, and that is why I am spending so much time on it, what can you say about today, October 2023, that could re-assure the public that they're not going to get into difficulty with indwelling stents staying in too long and being forgotten about by clinicians who don't have it on a management plan?

A. Well, as I said, we're probably putting in less stents because if we're putting in stents with strings, the cohort of patients that are waiting for stent removal is less. We are doing, as I said, primary ureteroscopy. So if it's feasible we're treating the stone when the patient comes in acutely, rather than putting a stent in and bringing them back at a later date for treatment of that ureteric stone. Three is, a recording is better in that we now have two codes, a code whether there's a stent in or whether there's a stent not. So we are aware on the database that a patient has a stent in situ. We have a Scheduler appointed in the last few weeks who now takes pools lists and so -- or pools the patients. So the next person with availability will get that patient Our correspondence; so I do and my colleagues, so when we do our letter from theatre, we document that there is a stent in place, and that's always documented. I'm sure that the registrars do that as well. Our Waiting List Form is done at the time of theatre. It's an online form now, or the "green form" that we keep talking about, it is now online and it is done and sent to the secretary at the time, after the operation, and it's marked clearly that there's a stent in place and the date it was put in. And we're acutely aware of it as well. We do Datixs if the stent has been in more than a month. So we have lots and lots of ways to try to prevent it happening.

‘What can you say about today, October 2023, that could re-assure the public that they're not going to get into difficulty with indwelling stents staying in too long and being forgotten about by clinicians who don't have it on a management plan?’

Does the SLT have up-to -date information on how many stents remained in situation for over a month in 2023?

Now, that brings me to another point that I've made I think in my witness statement. There is a quantum of work that it is safe to deliver, and if you are funded for a team of seven consultants, and you've had various locums coming in filling posts and then they leave, and you're then back down to a team of less than that, perhaps four and a bit as we are at present, the Trust is expecting four and a bit to deliver the workload that was previously delivered by more people. That's not safe.

‘There is a quantum of work that it is safe to deliver’

Can the SLT assure the public that all its consultants are operating within safe levels of practice?

Q. Would you have expected, as Clinical Director, to have been made aware of governance issues that arose that may impact on patient care and patient safety and patient risk?

A. Yes, I think I was.

Q. You were or you would have expected to have been?

A. I would have expected to have been, yes.

Q. You've said that you have listened to the Inquiry, and you are obviously more knowledgeable, perhaps, now about the issues than you were at the time, I think that's probably self-evident from your statement?

A. Yes.

Q. Just on the back of your last answer, where you said you would have expected to have been told, the issues that you've heard brought to the Inquiry's attention, are they issues that you would have expected to have been made aware of during your tenure as Clinical Director?

A. Could you specify some of them?

Q. Well, some of the issues around triage, for example; I know you had some basic knowledge of that, but the extent of that issue, would you have expected to have been made aware of that?

A. I think so, yes. I was made aware of it and I did address it. But I'm trying to think of some of the other things that were -- like, the retained swab, I wasn't told about that, or the Bicalutamide, I wasn't told about that, and I am not sure that it was widely known outside of his clinical practice, I don't know, but...

Q. Were you aware of any MDM recommendation divergence?

A. I was aware that the radiologist wasn't there and that they were trying to recruit a second radiologist, but I didn't really notice the missing pathologist, to be honest, because I was on the other side of the screen.

Q. Well, that's a slightly different question now, that's about quoracy and capacity.

A. Yeah.

Q. And specifically in relation to MDM recommendations that may have been diverged from post-MDM, was anything like that ever brought to your attention?

A. No, it was never brought to my attention.

Q. Now, when you say that they might have been brought to your attention, or in fact I think you said they should have been brought to your attention as Clinical Director, any issue that raised a potential patient risk?

A.. Other issues might have been drawn directly to the attention of Mr. Mackle, for instance, and I might not have been involved because of my remoteness, so it's possible that I missed out on things. There were other things that were presented at M&M and I would have picked those up if I was there.

Q. Now, you've mentioned Mr. Mackle. Would you have expected him to have told you some of the issues that he became aware of?

A. I think so, but I would -- because we didn't meet all that frequently, it is possible that some things didn't get mentioned, but I would have thought, yes.

Q. Was there a sense that the person on site - for example, Mr. Mackle based in Craigavon - was there a sense that he was better placed to deal with those issues and, therefore, you just expected him to do so or he expected you to do the same in Daisy Hill?

A. I think there's a little bit of that, yes. I mean, I sort of dealt with everything in Daisy Hill and there's very little that we didn't sort out on site because just the practical issue of being there, and I expect the same thing happened on the Craigavon site. If I wasn't there, the information sort of got to Mr. Mackle before it was going to get to me.

'There were various pathways for governance to go through. For instance, some things were raised as IR1s, that was a pathway I was not involved in at all, so I wasn't made aware of any IR1s, even the ones from my own site. They went through a different pathway, through the AMD and the CD, assisted by, I think, someone from ENT, which someone -- kept changing, but I wasn't involved in IR1s so I never knew about those'

'Various pathways for governance to go through' – unless governance pathways are streamlined, and communication is clear there will be an increased risk for patient safety. How confident is the SLT that streamlined pathways and clear messaging are being delivered throughout the Trust?

Q. You've said that you weren't a core member of the MDM and there was some discussion about what would happen if a recommendation was made by the MDM and then, after discussion with the patient, there was a change of plan and you said that it should be referred back to the MDM. In any case, should that be recorded somewhere, even if it is not referred back to the MDM?

A. Well, if you change -- let's say, for example, as an extreme example, the patient was in palliative care and it was totally impossible to prescribe what you had been asked to prescribe. I think you would record it in the notes. You would certainly record you made a change of plan. If it is a regular just change of plan because of patient choice, that should come back.

Q. That should come back to the MDM? Just in terms of -- would you accept that the one case that you had to deal with in terms of Mr. O'Brien relating to the charts in the bin, that was a formal disciplinary process which proved to be effective. You had then to deal with him on an informal basis in terms of the charts at home and the triage, and we now know that those -- while you may have thought had borne fruit, in fact hadn't. Is there a lesson there to be learned about how to approach these matters?

A. I'll accept that.

How recently has the role and the protocol of MDM's been reviewed? Is the SLT confident that the guidelines are operating smoothly throughout the Trust?

Q. Yes. I suppose we've received evidence -- and this is 2011, so the Inquiry is looking at, obviously, a broader period than that -- but we received evidence that might suggest on one view that the measurement of quality, a sense of inquisitiveness around quality wasn't necessarily there; wasn't party of the operations and culture of the Trust maybe as the years go on. Did you get support for what you were trying to push? If you did get support, how was that manifested in activity terms?

Is there currently a greater 'sense of inquisitiveness around quality' throughout the Trust?

Q. We've heard from, I can't remember now which witness, but basically with the drive to meet targets, that was where the focus was, and you've sort of confirmed that today. Is it fair to say that Quality got lost and the Quality metrics and the need for Quality got lost in the need to meet targets?

A. In general, I would say to me it felt it was submerged. It was meant to be there, everyone agreed it was the right thing to do but it was always 'but we've got this other thing to do first'. I mean, the reform of M&M into a Patient Safety system, I would consider that a big achievement. That was exhausting. No one told me to do it, no one particularly helped me with it except, you know, Anne Brennan, Stephen Wallace and a few others.

Q. I'm thinking more now at Board level. Because the focus was so constantly on performance, do you think that the whole issue of quality of service was lost? The consideration of it was lost at Board level?

A. It was put on the long finger, I suppose, is the better term. That's good when we get round to it. I mean the simple things were infection control, because that was the one area where I had a lot of control over. So, you know, introducing bare below the elbows, the proper isolation of patients, changing behaviours, doctors not have dangly things hanging over patients and so on, proper insertion and checking of IV lines, we did get good engagement with that. We had a team of infection control nurses, they had the imprimatur of the Medical Director behind them and we also had the ability to audit compliance. In small ways in very obvious things like that, because if you don't do that, you're going to get a C. diff outbreak or a Norovirus outbreak, or you're going to get wound infections -- sorry, not wound infections but IV line infections. So, there were certain wins. We were, and I say we, we had infection control nurses doing audits. At one stage we actually brought in PPI, Personal and Public Involvement. I don't know if we got round to it but we had two people from the community offering to help us with the audits. To me, that was a good success, where you can actually make changes but it takes quite a bit of an effort.

Q. It took effort but perhaps not money?

A. You do need resource. As I said earlier on, there was an awful lot of arguments about money. You can get into the trenches over this. The arguments should be about capacity and demand. As I say, capacity should be never running at 100 percent and then you can do things. So, the argument augers back from central government is we're putting money in, but you have to measure demand which was increasing. Our capacity was being squeezed in terms of efficiency saving, so the mismatch. You had great sympathy for frontline staff on a ward, a ward sister, and the pressures they were under. Even small things like, you know, cutting back on the hours of a ward clerk who should be taking, you know, administrative tasks off the ward sister was a false economy. There were pressures coming from everywhere. I was very aware of that more in infection control than anywhere, more than any other things, because it is a very direct, obvious thing that you can measure and look at. People did work with us. In fact, at one point we were the highest performing Trust in the UK both with regards to C. diff infections regarding peripheral lines. So, I can't be too hard about them, they did work with us when they could.

‘Q. Because the focus was so constantly on performance, do you think that the whole issue of quality of service was lost? The consideration of it was lost at Board level?

A. It was put on the long finger, I suppose, is the better term’

Can the SLT and the Trust Board currently provide the relevant evidence to show that there is now a good balance in the quality of the service and performance delivery in the Trust?

A. You would have to ask Mr. O'Brien himself why he was so beloved of the 50mg dosage. That seems to be his preference. There is some effect at 50mg, it is not a treatment that has no value and no impact. Just 150mg would work better and has a licence for it, but doctors often use medications outside their licence; it is not at all unusual for doctors to do that. The 150mg dosage does have more side-effects than the 50mg, particularly breast enlargement, hot flushes; those two things. The use of Casodex, as I mentioned before, is potency preserving and doesn't give some of the other quite dramatic side-effects of castration therapy using LHRH analogue. So I think Mr. O'Brien certainly could be criticised for the use of that drug. I can't explain why that's -- why that was his choice, but I don't think you could say he was negligent in using that. It's not the wrong treatment, it's a less than ideal treatment. Remember, the background of prostate cancer is highly controversial because you can go from active surveillance to radical prostatectomy with robots and so on. Open prostatectomy, radiotherapy with hormones and now high intensity focused ultrasound and all sorts of new treatments coming in, many of which don't have licences for that either but patients are getting them. Prostate cancer is one of the most controversial treatment areas out there clinically, and Mr. O'Brien had his own idiosyncratic way of dealing with it. But I can see that would bring him into conflict -- well, into disagreement, not conflict maybe -- with radiation therapists in Belfast, which probably explains why Mr. O'Brien seemed quite reluctant to refer his patients into Belfast for radiotherapy. That reflects his desire to keep his own patients under his own care, even if it is a bit idiosyncratic. Again, reading from what I have, it seems to me the patients seem to buy into this with Mr. O'Brien. They trusted him. He must have been a good communicator with them. I'm not sure he would have explained absolutely the pros and cons of all the things he did, but he seems to care for his patients to a great extent. But he was using idiosyncratic ways of treating them that he may or may not have explained to them.

'That reflects his desire to keep his own patients under his own care, even if it is a bit idiosyncratic'

At what point does allowances for a consultant's idiosyncrasies become a safety and care risk for the patient?

Q. Would you accept from me, perhaps, that having excellent knife skills does not an excellent surgeon necessarily make?

A. No. You do need the administration, the communication and the surgical dexterity. So, there is an issue there with Mr. O'Brien.

'Would you accept from me, perhaps, that having excellent knife skills does not an excellent surgeon necessarily make?'

The Chair of the Inquiry gets to the heart of the matter with one strike!

……..

Q. A few questions which were really around safety culture, safety culture, governance culture, whatever you like. It is quite a complex area and it comes from both ends, it comes from the department, it also comes from the Board, it is the government to some extent. It is all about how things work rather than what processes you have. Just as a starter on that, there's a lot of evidence that the way you work together as a team, the way you support colleagues, the conversations you have, the openness with which those conversations take place is the softer part of safety culture, which is critical. Without that you can have lots of systems, but people don't necessarily give of their best. In terms of the safety culture of your department, I'm struck by the fact that there were quite a lot of serious patient issues in terms of just letters, triage, results, pre-op, even I might say the efficacy

of the WHO checklists in terms of I would say these pre-op issues should come in the first phase of that. What is your view as to why some of these issues weren't really discussed openly in the first place and, also why, when there was a significant issue when you were sat down in 2017, in the January, why didn't you all individually speak to Mr. O'Brien and why didn't you talk to each other about the atmosphere in the department and how what needed to change to improve this. What is your feeling about the cause of that?

A. There wasn't a negative attitude in the department. I think we all got on well.

Q. If you got on well, why didn't these things come up?

A. Apart from Mr. O'Brien, perhaps. The rest of us got on well. I think it was probably a difficulty -- I think to use a phrase, and it wasn't something I experienced, but a phrase Mr. Haynes had used, a challenge to challenge.

Q. Do you think it was just that?

A. It is probably not as simple as that, I suspect. I think it is probably a complex situation that has arisen over a long period of time.

Q. These are really critical issues and it is never just one person. One person may be a catalyst for things not being totally open, but it's clear that these things didn't regularly get discussed in the way that I would expect. I mean, I can't envisage a department where you have somebody excluded, coming back to work, all these serious issues, and no frank conversations. I can't envisage that. So it does indicate there are some barriers there. You say the rest of you get on. Do you recognise the fact that building trust among everybody is critical for patient safety?

A. Absolutely. If you get on, you can speak to people. You can -- and you are not afraid to bring -- if you're having problems, bring it up. So, no, I think it is very important.

Q. And you have said a few times you can't just do what you like, you can't just do your own thing and yet this was tolerated. Now that, I suppose, you would say is the challenge to challenge issue. Who, in your view, should be dealing with that? Were you clear, for example, on the respective roles of the clinical lead and the Clinical Director and people going up the hierarchy? Did you have a clear view in your own mind about who should be picking up some of these issues, which were evident to various people, even if they weren't totally joined up?

A. Well, I assumed, more than assumed because I can see in the evidence that lots of people had been trying for the last 20 something years to get somewhere, not successfully in the slightest. Whether people should have been more forceful in getting things agreed –

Q. Do you have a view as to where that responsibility should sit?

A. I suppose ultimately these things sit with the Medical Director and come down. I mean, he's obviously not -- he or she is the last person in the chain. But...

Q. Is that right or should there be more interaction? How much interaction did you have with people, say, like the Medical Director?

A. I have had no interaction with the Medical Director. I think, serious issues going on like this, you know, would certainly, and the Medical Director would have been aware of it. But no, there are several people in the chain before the Medical Director who, from what I have read –

Q. But were you yourself clear on it, I know you have read some things now but at the time did you have a clear picture in your own mind of who did what?

A. Well if I had an issue I would probably have gone to Mr. Young first. I would also involve Martina Corrigan. That would have been my direct contact

Q. Okay. There's been a lot of favourable comment about the change in the Patient Safety Meeting and the improvements that have happened, which is clearly good. But you said a couple of things today. One of them was it only gets to the Patient Safety Meeting if something goes wrong. And you've also said you weren't sure how something should get to the Patient Safety Meeting. So I just want to ask you about whether any efforts had been made to support the department to look at data and information in a way that would actually give you a bit of a heads up. So, for example, you have a nice little scorecard about results. That is helpful if consultants are provided with that. My own experience is that is usually done on a comparative basis and consultants are quite competitive so they don't want to be in the red, whatever it is, you know. You can do it with triage, for example, you could do it with pre-op assessment compliance, you could have done it with the glycine issue. Have you had any support as a department in terms of developing those sorts of metrics to be automatically collected for you? Time to stent insertion would be another one?

A. Yeah, the clinical governance department, the manager of the clinical -- comes to all our Patient Safety Meetings, she has been coming for the past year, has been guiding us in audit and has been –

Q. This wouldn't necessarily be audit. This would be automatic data. Has anybody had that conversation is the question?

A. No. But it is something I may visit and add it into the Patient Safety Meeting. I think it would be useful. I will speak to clinical governance about it.

Q. It just helps to build trust?

A. No, I think it is certainly something I will add in.

Has this conversation with clinical governance taken place and what has been the outcome?

Q. The other aspect of patient safety which has increasingly come to the fore is the patient's role in understanding about their own treatment and in asking questions. Now, you mentioned that you copied letters in England and not here because it wasn't done and I know it is not mandated in Northern Ireland. What's the barrier? Why are people not keen on it? You yourself didn't seem to be that keen.

A. There's no barrier, really. There's nobody said you shouldn't do it. It just wasn't done, but there's no barrier.

Q. Would you agree, it is another check. If you are supposed to have a scan and you haven't had it, you'll be on the phone, won't you?

A. Saying that, I copy results to the patient. But yeah, but I do say to patients, you know, I do summarise at the end of the consultation, you are having this, this, this and this –

Q. I know?

A. -- but it is not written in a letter and I think certainly perhaps I'll change my practice.

Q. I can remember when it was introduced many years ago now and lots of people were resistant. But actually, it seems to have brought benefits generally?

A. I think it is not something that would bother me, it is just something I will do.

This issue of writing letters to patients has been raised several times during the Inquiry – going forward, can the SLT develop guidelines/policy and recommendations for clinicians in the Trust?

3. Culture and behaviour

'You can create policies and procedures and evidence-based practice, but unless you get the culture right, the rest just falls away' Adrian James (President of the Royal College of Psychiatrists)

A. The culture not such that you can raise difficult matters in MDT meetings. Not the openness required.

Is this currently the case?

A. People had concerns but didn't have a meaningful way of escalating them

Developing a culture of challenge and escalating appropriately – how is this being shaped now?

A trend of there being knowledge of a problem but not the appropriate escalation steps were taken

How is this process being tested now?

Consultant practice – independent practitioners with a lot of autonomy are difficult to challenge in the management line and in the medical line

Medical management line – do clinicians feel comfortable to challenge now?

Q. You are – the Inquiry might consider, pertinently explaining that there was a culture within which you had to work, which involved, as you suggest here, trying to work around deficiencies rather than go to the root cause, sort out that root cause and provide a lasting solution

Does any of this culture remain in the Southern Trust?

Mr O'Brien had a long history of 'an intermittent nature of compliance' – do you have in place an effective screening mechanism to pick up this behaviour now and requiring it to be addressed?

Patients are partners in care.

How is this principle being integrated into the culture and strategy of the Trust?

Where and how often are your Trust values highlighted and measured?

- Working together
- Excellence
- Compassion
- Openness and honesty

……

Q. As a general point, you mentioned that there were several meetings with Mr. O'Brien that had been recorded without your knowledge.

A. That's correct.

Q. I just asked you what your views were on that?

A. That's right. Yes. Sorry about that. I suppose the three with the colleagues, I was angry about, but there was other people in the room with me. The one that annoyed me was on the 9th January when I agreed to meet Mr. O'Brien outside of the hospital. I facilitated a meeting in his car when he was handing over the outcome sheets and advised me of the letters in his drawer. So I actually feel quite violated about that, that a colleague would, on a one-to-one basis record me because I don't know what he expected me to say or do. The other three meetings, it's very obvious from listening to them that there was an agenda of Mr. O'Brien's because the meeting is steered to the areas that he wanted to talk to us about.

How 'visible' are the values and required behaviours and consequences circulated within the Trust?

Q. I just want to probe that relationship a little bit more, if you don't mind, both in relation to the communication aspects and also any impact her style of management or your style of engagement with her may have had on the culture of dealing with issues as they arose. When you say that her approach was different so that it perhaps wasn't open door that you had been used to, as Head of Service, what impact, if any, did that have on your day-to-day operation or ability to seek help or to make decisions?

A. Working with the previous Directors it probably did hinder because if you had something -- like you needed to give a heads up on something, for example, the Emergency Department was really, really busy and you needed to know was it okay to open -- you know, bring in extra staff to open a bay, you couldn't go in to her to ask her that. She had always said if you needed to highlight anything to me you just needed to go to one of the other ADs. If Mr. Carroll was not about I would go find one of the other ADs I wasn't directly reporting to, for example Mrs. McVeigh, and sort of speak to them. I suppose I sort of got used to it because she had been there for a while but didn't have the same relationship and, you know, didn't feel that I could go to her if I had to escalate something.

'The culture of dealing with issues as they arose'

How is the Trust currently promoting and monitoring this principle?

Q. Is there any way that your work on the Just Culture and so on is intended to flatten that hierarchy a bit and not keep everything in services?

A. Absolutely. And I think in terms of from a collective leadership perspective we have much more work to do on that, but I think, you know, recently in the past number of years there's much more a sense of needing to work together and we are each other's safety net, really, and seeking out help, seeking out support from a corporate perspective, as opposed to trying to keep it from within because they don't really want anyone to look at that.

'We are each other's safety net' – what does this look like in practical terms?

Q. Is there any work, do you think, to be done around the culture that creates that kind of, I suppose, fear that you are describing, or sense of foreboding?

A. I have been involved in governance work in the Trust beyond this where we did governance teaching in a multidisciplinary way. It was very interesting, as doctors, watching how difficult it was for secretarial staff and admin staff and even nurses to some extent to feel that they had a role in raising concerns. You know, it was very interesting to go along to some of those meetings where we were

encouraging people from every level to raise concerns and to be aware of their responsibilities in doing so.

How frequently is the importance of raising concerns addressed in the Trust? How robust and secure is the whistle blowing route to the Chief Executive?

A. I suppose the point I make in terms of the support and accompaniment from, you know, an individual who is legally qualified, I think that only serves, again, to further legalise and put an adversarial process into play as opposed to an open, transparent, candid process about what has happened. So, I think there's challenges with all of those things as part of the MHPS. If we are trying to move in the direction of that restorative just and learning that we are in Northern Ireland, I think that's going to be a challenge alongside MHPS, but work that needs to be done.

Is work being done now in the Trust to address what a restorative, just and learning process looks like in practice? How is this being communicated?

…….

Q. Around these issues, and it's a bit of a theme through aspects of Mr. O'Brien's shortcoming, there's an appreciation from management that there's something of a problem, but I suppose the refrain that you pick up on and is punctuated through your report is a limited appreciation of the extent of the issue. It's almost we knew there was an issue but, shock, horror, was it really that bad? While we talk about missed opportunities in your report, what were you thinking - even if it's not in your report - what were you thinking about the state of management in terms of the regulation of Mr. O'Brien's practice? Be in a position to know the extent of it?

A. I thought that the management struggled to manage Mr. O'Brien. I thought a lot of that had to do with the type of person that Mr. O'Brien was, his seniority; there were a number of factors. But I thought managers struggle to manage him and I formed the impression that they were afraid of him.

Q. That is perhaps an odd thing to say for us looking into this. Did you get any sense of why they were afraid of him?

A. Well, I think some of this information, I'm sure, is in the report but the impression that I got was that they had attempted to -- they had attempted to manage Mr. O'Brien in the past, had not been successful in doing so. Rightly or wrongly or whether it's urban myth, I'm not sure, but the information that I was being given was that they felt that Mr. O'Brien would complain or would go down a legal route or wouldn't pay a blind bit of attention anyway. So, I got the impression that -- that was my impression, and certainly I appreciate you are going to speak to these witnesses, but my impression was that they felt unable to manage him and they felt restricted in their attempts to manage him because of how he might react to that.

Is there provision/requirement for all the staff in the Trust to access training on the Trust's values and how they apply in the workplace?

Q. In this case, and I'm sure you found it in other places, there clearly are multiple issues with the whole investigation, with the whole interaction with NCAS but it seems to me that they basically ignored lots of things in terms of the NCAS advice. That's what it appears to me. I don't know if it was entirely deliberate or if part of it was accidental but it indicates as a cultural problem, I think. In your experience over the time you've been doing this, what are the cultural issues at play that cause this sort of attitude? Or do you not think there are any?

A. Oh, there are. First of all, I think you pointed this, there's this fear of -- you know, they treat doctors differently when they shouldn't. They're just employees. And doctors, many of them often think they should be treated differently, which doesn't help matters. Doctors are senior people, they're well-paid. Many of them, particularly surgeons, are fairly dominant. So those are all issues that make it difficult to manage doctors. You're absolutely right, there are a number of cultures around. I mean, there's a terror of MHPS. If you look, for example, there's the formal and informal processes in MHPS. Everybody is terrified to go to the formal processes, whereas actually there's not that much difference.

Q. Would you agree all of that needs to be more clearly defined, because people seem to have got their knickers in a twist about it?

A. Yes, yes. They do. That's a reasonable suggestion. Yes, they have. They've got really messed up with it. They get terrified of going "formal", whatever that means. As I say, I'm not entirely sure that there is that much difference because you are still applying common sense; you're defining the concerns, investigate concerns, you're deciding what to do about it.

What initiatives can the Trust introduce to help to address the historical culture where medical employees are viewed and treated differently?

Q. The opposite was true in this case. Everybody was saying he is a great clinician, he's a great surgeon, there's no problem there. That seems to have blinded people to perhaps doing a more focused trawl. Is that one of the problems that there are in terms of carrying out these investigations? I think Dr. Wright summed it up by saying it was -- I'm paraphrasing what he said but basically it was an overreliance on deference?

A. Yes, I think that's fair. I mean, this is somebody who was very senior. He had obviously done great things in the past and he had set up the service and run it and there was significant deference to him. Certainty from my experience, having spoken to Mr. O'Brien, he's an awfully affable, pleasant fella. All of those things would make it more difficult for people to suggest that there was an issue with his practice, yes.

Q. Is that all the more reason then, where you do have someone of that seniority and that reputation, that it is important to bring in someone external to lead this investigation?

A. Yes. Again, an external person won't be blinded by the fact he's the most senior surgeon and he has been there forever and everybody likes him. They will stick to -- they will actually do the investigating. I'm a great fan of external investigators because they don't have the baggage that comes with being part of the organisation. Also, if they are externally commissioned, they are on a commission, they are going to do it on time, they are going to do it in whatever timeframe you agreed with them.

The Trust values, principles, and standards apply equally to every member of the Trust.

Q. But the other side of the coin, Mr. O'Brien, is that with Patients 11, 12, 13, 14, and 15, you put those referrals in a drawer and didn't take any steps by way of triage, any variety of triage, and they went on, each of them, to develop cancer in circumstances where the information on the referral, had it been looked at, would have led to an escalation from routine in one case, urgent in four of the cases, to red-flag. Do you accept that?

A. I do accept that, yes.

Q. Do you accept that failing to triage routine and urgent referrals creates a risk of harm and in some cases may lead to actual harm?

A. Of course.

Note - having this understanding did not result in a change of behaviour and approach by Mr O'Brien

Q. It might be akin to navel-gazing to ask you to comment on something like that, but there is a theme in the evidence received by the Inquiry to date, sometimes colourfully reflected in the evidence, that you were beyond challenge because of your status. And we saw yesterday, perhaps, over a period of years, an informality to the challenges directed at you to put your house in order. And here, some might suggest, is another example of this, putting it on a longer finger and a more informal approach than the Oversight Committee has. I suppose, reducing this to a question: Did you have a sense or did you make it your business to create a sense of untouchability?

A. I've been -- no. I've heard people answer you with a short answer. The short answer is no. And I've been bemused and amused by this deference thing and that I'm unchallengeable, and I hope I haven't come across as being unchallengeable. And irrespective of whether or not people were of that view, these were serious concerns that they did have and they needed to be addressed, and that can only be done by challenge. But challenge can take place in the kind of collaborative manner that we have already discussed. And I think, actually, that she -- I think her sentiments are perfect because, you know, I did build up the service from scratch, single handedly, and it does -- in that context, and for good, let's address this. Now, whether it took two months or four months or six months was immaterial. Frankly, 189 charts remained forever undictated. But that's, you know -- the process that ultimately did take place didn't address all of the issues. So, there was a better way of doing it and I agree with her sentiments. But it doesn't infer for one moment that I was not challengeable.

There seems to be a lack of insight into the evidence on the part of Mr O'Brien just what a challenge he presented to others in the Trust.

Q. Thereafter, what was the reason for recording conversations and meetings? Because, for example, you had Mr. Michael O'Brien in attendance with you at many of these meetings. So, in terms of an ability to report back to Mrs. O'Brien what was going on, you didn't need to covertly record conversations for that reason? A. That's true. So what was the reason? So we got on, think on 18th January, the note of the meeting of 30th December with Ms. Hainey and Dr. Wright. And, you know, even though Dr. Wright described her as a professional notetaker, we saw that there were inaccuracies and on first hearing me say that anyone might consider is it not just a little bit of nitpicking, but the one thing that really offended us both was this note that on 30th December my wife had said, in quotes, that "at the end of a long career, that this is how you are repaid". And that was not said. So, I came to appreciate that no matter who's there, it is the convenor who produces the note. And the note cannot be depended upon. Now, I do appreciate the sense of intrusion and violation that can be felt by anybody at the receiving end and I wish it proved not to be necessary to do so. However, when it comes to my meeting with Martina Corrigan, I have read the transcript of that meeting many times where I have gone over again and again and again how it is recorded that the majority of the 668 have been processed, the outcomes have been done. In fact, very often not only has the outcome been registered, but the operation that was the outcome may already have been done. All of that. So, I found, actually, that I had very, very good reason, ultimately, to have a reliable record. In fact, when I look back I very, very much wish that I had a record or a recording of the meeting of March '16.

Q. At no stage did you seek permission from –

A. No.

Have the people who were recorded by Mr O'Brien, unbeknown to them, received a personal apology from Mr O'Brien?

Q. Now, you've support in your view around the difficulty of getting things done when there are different chains of command. If we could go to WIT-12157. This is from Heather Trouton. I may have the page wrong but I have the extract here which I'll read out for you: "Both the Head of Service and I as non-medics found it very difficult to challenge Mr. O'Brien's clinical practice. We were reliant on his clinical colleagues to provide that clinical challenge, and this I believe did come but only at a later stage when a number of new consultants came into post who had experience outside the Trust and outside Northern Ireland who knew what was acceptable practice and what was not and who were not afraid to speak up". The actual detail of that extract is about clinical practice but I think the point reflects what you're saying, non-medics dealing with medics. Was it your experience that that was something that didn't happen?

A. Yes.

Q. Do you think that that was a culture thing as well, that there was a culture -- not perhaps just in this Trust but there was a culture that only medics could deal with medics?

A. I think, yes. Short answer, yes.

Is there still a culture where only medics deal with medics?

Q. No. Okay, thank you. In a similar vein, do you think the people in senior management of the Trust actually understood the issues of Records on the ground? How much contact did you have in terms of being able to explain the reality in where you work, as we have indeed heard today?

A. I just don't think it would have been held -- it wouldn't have had the profile that meeting the targets, meeting the financial stability, having beds for patients. I think Records fell a lot lower down in the pecking order.

Q. You have described about, I think you called it silos - other people have used the same term - where you felt that the reporting lines were separated from each other, different levels of staff. Quite a lot of people have described an inability to challenge medical staff. Did you feel that medical staff were treated differently from other staff with respect to discipline; disciplinary procedures, for example?

A. Well, they definitely would have been treated much different to my staff.

Q. How did you feel about that?

A. Well, I think it's unfair. We are all members the Trust and we are all on the payroll.

Q. What do you think the disadvantage is of that atmosphere in terms of patient care?

A. There is a lack of control then at the top if the consultants have one way of working but it doesn't match or marry with how the Trust wants to take forward.

Q. Where does that impact, do you think? Where do you think the impact is felt in the end?

A. Well, I suppose ultimately it would be with the patient.

Is this tension still there in the Trust - with a 'lack of control at the top' where some consultants have one way of working but it does not match or marry with how the Trust wants to move forward?

Q. Now, we don't need to go to it but you had sent an email to various staff, and the Panel will find that at WIT-60590, and it was on that issue of secretaries doing private work during working hours and to remind people that that wasn't permitted. What was the extent of that problem? Was that a significant issue or was it something that rumbled on and you had to, every now and again, remind people of their roles?

A. I think it was an issue that came up every now and again, and perhaps - I can't remember now obviously - but perhaps Medical Records Manager may have said to me, look, some of your secretaries are getting these charts and we know they are for private patients. This is not necessarily O'Brien, I am talking about other people as well. It wasn't a huge, huge issue but every now and again people needed reminded, you know, you're not supposed to be in here, rocking up doing private work, do it in yourown time; we've enough to be doing. Do you know what I mean?

Q. Would it only be made known to you if somebody came along and said, look, I know X is doing that, or was there another way in which you might know private work is being done on NHS time?

A. No. The main way is actually by people telling us or Medical Records informing us, or whatever. That was really the main way. We didn't have -- like, there is a report that can be run for private patients but it wasn't something we would have had time to do; let's see who is doing private work and let's catch them out. It wouldn't have been on your radar.

Is the SMT confident that no private work is being undertaken now in Trust time?

Q. It's about the secretarial, Consultant, line manager dynamics. Sometimes there appears to be a tension between the secretarial role and who she should be listening to, if I can put it like that, or who she should take direction from?

A. Yes. It's actually a very difficult group of staff to manage because obviously the vast majority of secretaries want to keep in with their consultant, if you like, and their consultants would be very supportive of their secretary, et cetera, et cetera. They do have a close working relationship. Then we are this crowd that comes along, actually, you are actually supposed to be listening to us. A lot of the time nobody is interested in us, do you understand me? The consultant is the big guy here, we are not.

How can the SMT challenge and address the power dynamic in the delivery of person-centred care in the Trust?

Q. Now, we have talked about the DARO from 2010 and the e-triage 2017, and the problems persisted before then. Did you get a sense that Mr. O'Brien was struggling to adapt to new systems of work?

A. No.

Q. Because, as you have explained, the DARO system was a secretarial function and the triage was done by the other consultants. Did you feel there was any systems disconnect for him that perhaps might have been a training need? Anything like that ever discussed?

A. No.

Q. Do you think there was too much tolerance or deference shown to Mr. O'Brien's work practices?

A. Way too much tolerance.

Q. Yes. The other thing I wrote down was bypassing systems. Now, why does this happen, do you think? What is the root cause of that? Is it frustration, is it people have fear of speaking up and tackling it?

A. I think it's purely out of frustration and trying to get the job done.

Q. Do you think that has improved at all recently? Has there been any positive impact of this dreadful pressure you must feel as a result of the Inquiry? Have you seen anything that –

A. I think there's definitely a willingness to change things and there's more of a willingness to probably listen a bit more to people like me. I hope that's carried through when the Inquiry finishes and it doesn't all fall. I mean, my experience of our Trust is very much - and I know I am not going to be popular saying this - but if there is a problem, sure we'll recruit somebody at a very high level. That's not what solves the problem. Quite often it's down at the foot soldiers.

Underlining the importance of operating a listening, inclusive and partnership approach at all levels and strands in the Trust

……

Q. Obviously the mischief which the monitoring plan served to address was the question of can exclusion be avoided, can Mr. O'Brien be brought back to work and enabled to work his job plan in a way which the Trust considers to be safe. From that perspective, did the monitoring arrangements allow yourself and Mrs. Corrigan to have confidence that things were going in a relatively safe direction?

A. Yes, I think that would be fair to say. I think in the length of time -- and I would say we monitored him far too long, but in the length of time we did monitor him Mr. O'Brien, for those aspects that we were monitoring, largely they were kept in check. So yes, I would say -- and where there was deviations, bar the one in October, on October 18th, they were picked up relevantly quickly and dealt with and escalated to the case manager.

Q. You say he was monitored far too long. What do you mean by that?

A. Well, I suppose to have anybody on a monitoring plan from 2017 until you retire in June 2020 - although we stopped monitoring him when COVID hit in around March of 2020 - it has never been my experience that you monitor them essentially for three years, you know, and you are monitoring the same thing all the time. Again, with hindsight and 20/20 vision, I think we should have brought the Oversight Committee meeting back, we should have met more regularly. There should have been greater oversight from the Oversight Committee in terms of, you know, what position we were at six months in, 12 months in. I know the parallel process was going on in terms of Dr. Chada and Dr. Khan, but I can't help but think, sitting here now, it may have been helpful and we could have brought about another way of monitoring Mr. O'Brien. I don't know what that was but I think to monitor someone, just simply monitoring someone for three years can't be seen as a success.

Q. What were the aspects of it? You say we didn't meet to review the arrangements at any point. Thinking about how it did work in practice, what are your thoughts on it? If you had been given the tools to change it or revise it in any way, what would you have introduced?

A. Well, I suppose the first thing - and you've made reference consistently today to it - we didn't communicate with Mr. O'Brien. That's the first thing. This was consistently poor. We should have. I think there should have been, particularly after the 26th meeting, again there should have been oversight as to have all those actions been completed; and that wasn't done. Then I suppose just in terms of meeting with Mr. O'Brien, see how he was getting on. Then continue to monitor those aspects

that we felt still remained clinically important. Also asking him, you know, his concerns, his stresses, his worries and what we could do as an employer to help along that. We didn't do any of that.

'We didn't communicate with Mr. O'Brien. That's the first thing. This was consistently poor.'

Have the guidelines on regular communication between parties and consistent monitoring been reviewed and reinforced in the light of this experience?

Q. In light of what we know was the Trust's purported concern to get these charts back, and you have a situation where one of your managerial colleagues is seemingly, and for reasons we can explore with her, endorsing a continuation of the status quo ante, how does that sit with you?

A. Well again, it undermines the principle or the purpose of the March 2016 letter, in that the Trust felt it appropriate to formally write to Mr. O'Brien asking them to action the four elements of what was documented in the letter and for him to come back with a plan. In fact, Martina was a part author of that letter to Mr. O'Brien. I suppose what I would say to the Inquiry is that it undermined that letter and the purpose of that letter.

Q. The fact that the letter had been issued... Just to focus on this issue of the notes - nobody had rapped his door again to say, 'March letter. You were told in clear terms, get these notes back'. The fact that that doesn't happen and then we have this, Mrs. Corrigan endorsing retention of the notes for the purposes of allowing him to dictate, it reflects an inconsistent practice at best?

A. I wouldn't disagree with you on that. It doesn't read very well.

The importance of clear and consistent messaging.

Q. If I might tease that out little bit with you. Most doctors would prefer to be managed by their peers, by people who understand the job you have to do. So you would have a different view?

A. It depends, actually, what the management team is. You know, we had -- we had a small team. I was a lead clinician of the Urology MDT. So I played a management role. Our department had a lead clinician in Michael Young. I appointed, when I was lead clinician of the cancer MDT, Tony Glackin to be our governance lead in that role. So, yes, we can manage one another, but with regard to –

Q. The line management.

A. Yeah. You can take that so far. I think that when you get up to Associate Medical Director - and I have seen it too many times over the years - there may come a time for any individual in that role, where they have to toe the party line rather than the role that they used to do. And some people stepped down from that management role because they couldn't do so and others have toed the party line. So, I think I'm speaking a truth and I'm speaking it in moderate terms. I preferred the situation where you went along with your shopping list and even though I got frustrated after a few years as to the productivity of it, I preferred there was an honest separation, go along, this is what we need, and whoever it was would say, well you're not getting it and we can't facilitate that and so forth. Now, whether there's some bridges across the water that's another matter and how they should be is another matter. But –

Q. That's your view?

A. -- that's my view.

'John Templeton being the Chief Executive, because he always said he was just a clerk whose job it was to facilitate doctors and nurses and other professionals looking after as many people as possible who

were in need of it. And I think that, you know -- it's been alleged I wasn't a team player. When I read that I wanted to ask well I wonder which team they're talking about, because I felt that I was a team player very much with my colleagues, both medical and nursing. But was I a member of the Trust? Was I part of that team? I was to varying degrees. Was I part of management? No'

It would be helpful to provide, post Inquiry, some clarity on what it is to be a member of the Trust.

Q. Around these issues, and it's a bit of a theme through aspects of Mr. O'Brien's shortcoming, there's an appreciation from management that there's something of a problem, but I suppose the refrain that you pick up on and is punctuated through your report is a limited appreciation of the extent of the issue. It's almost we knew there was an issue but, shock, horror, was it really that bad? While we talk about missed opportunities in your report, what were you thinking - even if it's not in your report - what were you thinking about the state of management in terms of the regulation of Mr. O'Brien's practice? Be in a position to know the extent of it?

A. I thought that the management struggled to manage Mr. O'Brien. I thought a lot of that had to do with the type of person that Mr. O'Brien was, his seniority; there were a number of factors. But I thought managers struggle to manage him and I formed the impression that they were afraid of him.

Q. That is perhaps an odd thing to say for us looking into this. Did you get any sense of why they were afraid of him?

A. Well, I think some of this information, I'm sure, is in the report but the impression that I got was that they had attempted to -- they had attempted to manage Mr. O'Brien in the past, had not been successful in doing so. Rightly or wrongly or whether it's urban myth, I'm not sure, but the information that I was being given was that they felt that Mr. O'Brien would complain or would go down a legal route or wouldn't pay a blind bit of attention anyway. So, I got the impression that -- that was my impression, and certainly I appreciate you are going to speak to these witnesses, but my impression was that they felt unable to manage him and they felt restricted in their attempts to manage him because of how he might react to that.

How is the SMT going to respond to this narrative when questioned by patients and the public?

Q. Do you find your line manager very accessible to you if you have any issues?

A. Absolutely. We are lucky in that we have a very supportive line manager. We don't always agree and we argue and we debate whatever but yes, very supportive.

Q. So there's always an opportunity for you to bring things up?

A. Yes.

Q. Do you find that that works both ways. If you need to be told anything - and we will look at an example you have given later around biopsies, I think that's a current issue - generally is communication that might impact on any of your operating systems normally very good?

A. No. Communication is extremely poor but not from my line manager. The fact is communication is very poor, I think, from all the Heads of Service in Acute, which I would have a lot of dealings with. My work very much involves a lot of them. If you think of Martina Corrigan is the Head of Service for Urology, ENT, she wouldn't have been -- she would have been actually okay in keeping you informed. But say there are other people in charge of surgery, maternity, medicine, whatever, they don't always keep you informed in a timely way. Sometimes they do, sometimes they forgot, sometimes it's the OSL

people forget actually we need to be told certain things. But that doesn't necessarily go to Anita for Anita to tell me, that actually should be from them to tell me directly.

Q. Is that is that sometimes because people don't know they need to tell you, or can that be personality driven - some people are poor communicators?

A. I think it's a mixture of everything. And people are extremely busy and they just don't think, but then we would be kind of saying to them, look, you didn't tell us about this, you really need to.

Has the SMT sought current evidence on the quality of the lines of communication with all the Heads of Service in Acute?

Just to follow up on that last question. We have heard about particularly Mr. O'Brien's reluctance to change his working practices. Would you be of the view that unless people know the reason why they are being asked to change, you are not really going to tackle that reluctance?

A. That's a fair point.

Q. So, it again comes back to the communication issue, and if people don't know why they are being asked to do something, they are not really going to understand that it's a good thing. As you say, this was something that was - the DARO system, for example - helpful to consultants but unless that's explained to them, they might not actually see it as something beneficial?

A. Fair point, yeah.

Clear communication is necessary to ensure everyone is on the same page and has the same understanding of operational processes and the request for compliance.

……..

Q. Just last question. There was some discussion about letters being copied to patients. What's your view of that, because I was interested to see that you frequently copied your letters to patients –

A. Yes.

Q. But that wasn't commonly done?

A. Yes. It wasn't a practice that everyone done, in the same way when you were sitting in with various consultants at uro-oncology clinics, people work differently. Some people wrote down the majority of the consultation; others would have dictated that immediately after the consultation. So, people practised differently, but you had to be in the room to know what the practice was.

Q. I guess that's my point. Do you think it is important that patients do get a copy of their letter, is a more direct way of –

A. They are one of the main members of the team that's making the decision, they have to be engaged in it. Any virtual clinics that I am doing, they will get a copy of that letter.

How readily are patients in the Trust perceived by staff as being one of the main members of the care team?

Q. Do you feel that when you do raise concerns around that or any aspect, do you feel it should be the case that it’s fed back down, if I can put it that way; that you are told, even in broad terms, of any learning from that?

A. Yes. I think it's part of the process; the process is cyclical. If it doesn't come back round and you don't know what happened, it's sort of -- it defeats the purpose, I think, because learning -- it's all about learning and being transparent and knowing what happened.

Q. Just on that point, there has been talk about the SAIs obviously yesterday. Was there any formal learning identified for the CNSes as a result of those, for example, nine SAIs?

A. I think, as I said, comparing the CNS role in terms of key worker then to now, absolutely. It's a more robust system, it's a more proactive system. There is now a person within Cancer Services that is in charge of audit, and they would send us a retrospective list at the end of every month of all the new diagnoses from that month. We appoint a CNS each month to cross-check that with the key worker activity so we can identify if indeed any patient doesn't have a key worker and rectify that.

An example of learning and action from SAIs being effective – such examples could be shared regularly throughout the Trust to evidence the value of a learning culture.

'we want to create a more restorative learning culture moving forward. I think for me the importance of establishing and addressing risk to prevent any harm, and how that has to be done robustly, cannot be understated how important that is. If that's managed well and robustly, then you can potentially then come to an agreement as to how to address issues and manage issues in a structured formal way but maybe not necessarily through, you know, formal sanctions'

Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT?

Q. Another issue which has come through really in most of the MHPS witnesses was around a certain lack of transparency at the time that that happened. What I am talking about is nobody really knew much about the Oversight Committee; they weren't really sure what happened when matters were escalated up and senior people were talking about it. I think in your statement, you've emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing. I think the training that we have just rolled out has very much covered that in terms of making people aware of what the Oversight is, what the purpose of it is and what it's all about. But yeah, I think it's a journey about embedding some of that culture and some of those messages right across the organisation.

'Q. You have emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing.'

What measures are in place to test the current position in relation to transparency, fairness, and openness? How frequently is this audited?

Q. "What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?" And you say: "I do not think that management take concerns seriously within the Trust and often fail to act or do not communicate that they have done so. I have previously raised, for example, in regard to the duplicity" - is that duplication –

A. Yeah.

Q. - "of investigations and that hasn't been acted upon. When one raises an issue, usually a response is not received. "35.2. Many issues I raised in regard to radiological practice through the Radiology Clinical Director and the Radiology Service Manager which are not specifically neurological are not addressed by managers and opportunities for the improvement of patient care and efficiency are lost." You give examples of SPA entitlement for service improvements, and teaching. "Such issues are raised infrequently as I do not think time raising them is not well spent." Then at 35.3 you say: "There is scope for improvement in radiological practice. Managers need to acknowledge each and every issue raised with them and state how best the issue could be dealt with, rather than appearing not to engage at all." You finish by saying, "Areas of improvement should be discussed with clinical and nonclinical managers and a plan made to make improvements to the service." Does that reflect your experience over 15 or so years, doctor, that you are articulate in raising concerns from time to time about issues affecting your own practice, your service and its impact potentially on patients, but you seem a little despondent that the culture generally doesn't seem to direct responses by to you?

A. I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to. I tend to find that, in the Southern Trust, I think there are so many big issues, major issues, that managers are probably dealing with many of these in their limited time, particular clinical managers, the limited time for managers are dealing with these things. So, things that I raise that are comparatively minor are probably just ignored, because there's no time to deal with them. I think that's probably what happens.

Q. Apart from giving you responses, can you think of any ways, any vehicles, any structures that aren't currently in place that might, with little effort and little resources, be put in place to improve things?

A. I think the problem is that we have -- the supporting professional activities, which as you probably know, is part of the job plan or things other than clinical work, of which it's kind of recognised that 1.5 is the minimum, and that's really for personal revalidation and, more recently, is supposed to include some teaching, but it doesn't include service improvement. I think the Trust is very unwilling to give individual consultants additional SPA time for managing a service. So, any improvements that you wanted to do a service you would do in our own time. I don't think there's been -- there hasn't been much encouragement to give consultants additional time, certainly in radiology anyway.

‘I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to’

What plans are in place to address lack of engagement and to boost staff morale by underlining the importance of listening and communicating clearly?

Q. Even so, you said a few things that indicate that the relationship with management, as you call it, wasn't fantastic. Who do you regard as management? Who is management? Do you mean the service administrators and people down that end? Do you mean the senior management of the hospital?

A. Well, the service administrators and then up to Katherine Robinson. Yes, that is who I see as my management.

Q. And that is where you feel that it wasn't very helpful. Do you think the Trust as a whole creates an atmosphere where all the staff feel valued?

A. Not particularly, no.

Q. Why do you feel that? What do you think the source of that is? I am sure they wouldn't set out to be like that.

A. I don't know how to describe or why it has went that way. I think everybody is just running about chasing their tail and nobody has time for anybody.

'Q. Do you think the Trust creates an atmosphere where all the staff feel valued?

A. Not particularly, no. I think everybody is just running about chasing their tail and nobody has time for anybody.'

Think about the importance of and how to 'be present and available' in interactions with staff amidst a busy workload.

……

A. The issues of changing the behaviour of the consultant team to meet the required new-to-review ration of patients, and new clinic templates in Outpatient clinics to increase the day case rate and lower the inpatient elective workload and to meet the BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the the requirements for change tailored to each individual's practice.

A. You expect people working in the Health Service to automatically understand about safety and to learn whenever there are processes going on which are not in the best interests of patients as seen by most of the world. So, it is difficult managing somebody who has a view that whatever they are doing is the safest thing, despite the rest of the world disagreeing with that.

Are there any current areas in the Trust where there are difficulties in bringing about behaviour change?

A. I think the journey that we were on in terms of embedding the culture of if an incident occurs, recognise it as an incident, discuss it, report, let's learn from it.

Q. Yes.

A. That learning process, and making sure that the culture was around learning from an incident as opposed to let's hide it, we don't want to know about it or own up to it, that journey of opening the culture was a journey in progress. That's a really, really important organisational journey. That's what

the core thrust of the corporate review of clinical and social care governance was about. I am sure you have heard about that and seen the documents around that. That was absolutely the core of what we were seeking to do. As you well know, it takes a long time to change a system. That required all of the staff working day in, day out in the wards and Outpatients in every which part of the hospital to embrace that culture, to recognise. I mean, there were still times when a senior leader, a senior clinician would come to me and say, 'by the way, I quietly want to tell you this has been happening for a long time, nobody has been prepared to own up to it but did you know', and you go gulp, deep breath time, 'right, what do we need to do'? So that's –

'The journey of opening the culture was a journey in progress' – post Inquiry, what does 'opening the culture' require at this stage?

- 'There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame.

- Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed?

A. An impression I formed, and information that other people gave me as well.

Q. Yes.

A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, it was very, very plain. I was bullied to within an inch...

- At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands.

- I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place

- Eamon Mackle told me they were drawing bets of how long I would last'

This narrative is now in the public domain and can be interpreted in several ways. The SLT may need to address the themes that are raised on two fronts – for the staff in the Trust and for patients, carers, and the public interface?

Q. Can I ask you this: Was it your sense that by the end of your time in the Acute Directorate, governance, in terms of its capacity and resourcing, was in a better place than what you found at the beginning, or was it treading water?

A. Ever so slightly. Every so -- well, we treaded water for a long time. It was ever so slightly better but, to be honest, whenever I left, anything was the last thing from my mind so I didn't even think about governance when I was going away. I was looking forward very much to working with Patricia Kingsnorth because she, to me, had exactly the same idea and I knew I could -- we could have -- and she was very proactive in Maternity. So, it was slightly better. Certainly the language that I used in my meetings about governance being important, and trying to bring on board. But, as I said to you before, you know, the culture was performance, performance, performance, and I don't know that I did very much to change that as an individual.

'The culture of the Southern Trust when I joined was performance, very much performance driven'

How would the SLT describe the current culture?

'There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so'

How can team working be enhanced in the Trust?

The biggest thing that was maybe just pie in the sky for me was changing the culture in relation to governance. Culture eats strategy for breakfast. If you are going to ask me what I learnt, that's the biggest thing.

'Culture eats strategy for breakfast'

Has the SLT adopted the priority of establishing a constructive and empowering cultural lens before delivering the detail of forthcoming strategy?

A. I believe in terms of communication, there were silos. In terms of management that would have been above me, people didn't necessarily follow their roles and responsibilities. That was actually a trend right across, and I would say that to you. Roles and responsibilities, for me, is every bit as important as following up a procedure. I need to know what my role is but I also need to know what your role is so that we don't overlap or I don't do your job, causing conflict and concern. There was an awful lot of dissatisfaction in that. I believe it's because people didn't know what their roles and responsibilities were and they just did whatever they thought on the day.

Q. Where do you see the responsibility for fixing that as lying?

A. Well, whenever it's a culture, it's very, very, very difficult to fix. It would needed to have come corporately from the top on down. It would needed to have been -- you see, you can't make somebody do something unless they believe it's right to do. You know, me making people believe, from my very, very small part I discussed it, discussed the importance of -- and it's not even hierarchy, it is just communication lines. I didn't mind talking to whoever in the canteen or whatever, but as long as the information that needed to be passed up and down went through the proper lines.

Recognising the key role of good communication flow throughout the Trust as a tool in changing the culture.

Q. -- the understanding of what is to be done. I mean, does that -- I mean, looking back on it, do you think these what might be described as teething problems or difficulties were just inevitable, or was there training shortcomings in how the Trust went about it?

A. I don't think -- I don't recall the detail, to be honest, of the training and the rollouts. What my -- what I recall was, we were at a time when, you know, for example, 2014, Francis was -- they were accepting the Duty of Candour and it was so broad -- we still haven't got it in Northern Ireland! So, like, we were at a zero or minus starting point, so we were, like, building our culture. And it was very similar to the challenges that you faced at the start of the performance culture. And while people said the, you know, the written IR1s, you know, went into a black hole, that was great when they could say that. When it was popping up on their e-mail that they had an IR1 notification and needed to do something with it, clearly history tells us, for example, in 2014 there was a backlog of unopened IR1s! So it didn't change the -- it takes time to change their actions and their responses. You can put in all the systems you want, but you have to build a culture where -- and I think it was just very early in those days and it was very early in Northern Ireland as well -- across the UK because Francis was only just coming out and, if you look back now -- if you look at it with a 2023 lens, it's

completely different. But that was a different time and we were learning different things, so I think -- I don't think that -- I honestly can't tell you the detail that went into the rollout. I mean, certainly we were writing -- "writing" is the wrong word. We were producing 450 IR1s a month across Acute in 2014 when I look at the reports, so I don't think we had any -- we didn't have -- obviously, the quality of those and what they were reporting, you could dive into that. But I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?". And you can put in the system, but it doesn't necessarily mean that people are going to change their role and responsibility and how they view it.

'I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?".

'A. It demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities.'

Is the current messaging in the Trust consistent, empowering and across the board when it comes to the requirement of a clinician's individual responsibility, accountability, and action?

Q. And recommendation 4 related to the use of timely discharge letters?

A. Yeah.

Q. And she makes the point in 3 and 4 -- this is page 10: "We are relying on people to do the right thing, which is the weakest safety net..." -- and she asks the question: "Did the team consider anything stronger in terms of making sure this didn't happen again?" So, for example, alerts for unread Radiology reports/ monitoring of discharge letter performance. So at least one of those aspects, the Radiology is something, as I say, you were familiar with and the Inquiry is by now familiar with the history of that through a number of incidents and with a number of patients. Are you able to assist us at all -- I know the final report was signed off in August, you weren't there, but was there any attempt in your time to correct those two issues in the context of this case?

A. No, because, as far as I was concerned, we hadn't got the right conclusions yet, and you have to get the clinicians to own the conclusions. So I can't implement things like -- I can't -- you could -- you could try and tell them to do something about unread Radiology reports, but they would have to accept that and then go and do it. Monitoring of discharge letter performance is interesting and I think the concept of how much -- these are senior people, these are senior clinicians. Telling a patient -- telling a GP how their patient is doing and what's happening with them is probably, in my book, quite basic. Do you need me to check that you are doing that? At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"? And I guess these are senior people, they're senior clinicians, this is in the best interest of that patient in front of them and -- yeah.

Q. I suppose, what you're putting your finger on is the extent to which the organisation can afford to place certain issues on trust by reference to professional obligations?

A. Yeah.

'At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"?'

How is the SLT building this narrative into current culture?

Q. You also mention that there needs to be a clear management structure as there's no line of accountability for clinicians?

A. Yes.

Q. Would it be more that there is a line of accountability but that it wasn't actioned properly?

A. There was -- yeah, that's a fair point and I suppose listening to Mrs. Burns yesterday too, it was interested to hear that at that stage they were only all new and they weren't used to the challenge part of it. But I suppose it's something to ask the clinicians but I don't ever think they considered the clinical end as their managers. It was more to do with, you know -- like they nearly seen me not as their manager as such but as part of the team. I was the go-to person as opposed to, you know -- now, their job plans and their appraisals, etc., etc., I couldn't have become involved in and they would have pulled other people. I just think there's that disconnect for the clinicians, albeit the people who are in post, they don't seem to go to them.

How is the SLT addressing the ongoing need to facilitate a culture within the Trust based on respect for the different roles and responsibilities of all employees in the Trust in the delivery of quality care and patient safety?

.....

Q. And a lot of the things you mention are the outworking of clinical governance, the end product, coroners and medical negligence, civil claims, learning from perhaps the wrong end of the telescope. Do you consider that there is -- well, what part do you think that culture in a place has to play in both the triggering of governance and the effectiveness of any action taken?

A. I'm going to answer the -- in answering the question it's quite complicated, but in 2018/19 in Belfast, I brought in a system based around the measurement and monitoring of safety, and it was based on a document written by the Health Foundation in 2013 by Charles Vincent. And basically, it turns your organisation into a problem sensing organisation, where you ask really profound questions, like: Are you safe today? Are your systems reliable? Are you learning from past harm? Are you looking forward to see where there's going to be issues? And we've adopted that in Belfast as a way of thinking and about how we problem sense, and I think that you're right, you have to learn it from harm, but it is - it tends to be reactive. What we try to do is shift that thinking into how can we make sure we're safe today? So the out-workings of that are daily safety huddles, right the way up to executive team, ehm, weekly huddles where divisional teams come together and they review all their safety data from the previous week and look to, you know, is there any immediate learning? Is there anything that needs to be raised as a concern?

Because I think I said earlier on, at the heart of any safe system is staff feeling safe to raise concerns and be open, and be open when things go wrong, and when things do go wrong, that they will feel safe and that they won't feel that they're going to be blamed. Because we're all human, we all make mistakes, and it's important that we accept and acknowledge that we will make mistakes. But it's how we learn from it. And I think how we make our clinical governance even better is how we focus on how we learn, because that can be difficult sometimes to make sure that you put systems in place that engineer a change.

On a scale of 1 to 10 what is the SLT's estimate of where the Southern Trust is at in terms of it being 'a problem sensing organisation'? How can this approach be fully interpreted and applied across the Trust?

Q. Now, you spoke to Mr. O'Brien and he mentioned that he had discussed this case with a urologist in the United States of America. I don't suppose you remember the name of the urologist?

A. No, but his response stuck in my mind. Because, you know, I remember asking him and I remember him saying somebody else had raised this as an issue and he had spoken to somebody in the United States of America who said in the circumstances it was a reasonable course of action.

Q. And he didn't say who the other person was who had also perhaps shared your views, who had expressed the same view?

A. No. I mean, I think that, I suppose I felt brave challenging him and I got an explanation back which was, it was difficult to argue with.

Q. And you don't recall - you can't say whether you spoke to Mr. Young about this issue or not? You just don't recall?

A. So, undoubtedly, you know, because of the joint ward rounds, I would have expected that Mr. Young would have been aware of some of these patients. And when I did raise concerns with Mr. Young, as I've said in my statement, his response was "That's just Aidan".

Q. And what did you take that to mean when he said that?

A. It's hard to know how to interpret it. But I felt I was speaking to another consultant and raising an issue and that was the response. And, again, you look back and you think 'I'm a second year trainee, I don't know everything about urology, I'm working with senior consultants, maybe they think this is acceptable'.

The importance of addressing the cultural power imprint/imbalance in clinical teams, particularly in terms of delivering safe patient care.

Q. And do you think that the culture within an organisation and within departments, and even within clinics, has a part to play on whether people feel comfortable raising governance issues?

A. I do. Yeah, I do. And I think looking back, you know, when I think when I arrived here from London I didn't know anybody here, I was very, you know, not quite isolated, but certainly didn't know how things worked. So that takes a while to get - not just to understand the governance structures, but also to understand exactly, as you say, the culture. Just coming in from it cold, it takes a while to understand the culture.

Q. And the two parts of that maybe are the confidence of the person who needs to speak about something and also a listening ear or a willing recipient of that information?

A. Yes, both of those things, exactly, yeah.

Q. What would make it easier, in your view, for junior colleagues, or indeed any colleagues, to raise concerns such as this?

A. Yeah, I think first of all, it is a culture where everything gets discussed in a friendly, non-confrontational manner, and essentially just leading from the front as a more senior consultant now, I certainly would encourage open discussion in our peer chats when we're discussing patients, and we

try not to have a hierarchical approach to that, but we do bring -- I have a lot of experience now, so I bring that to the table. But we really try and create a culture where junior members of staff feel empowered, and that's really just by having a friendly attitude to how we operate.

Q. And have you had to talk to colleagues over the years informally about issues maybe just that you needed clarity on or were concerned about? Have you had experience of that?

A. Sure. Certainly as Clinical Director that would be a weekly occurrence, yeah.

Q. And as Clinical Director, is that something that, in your experience, has brought about the necessary change, or have you had to then instigate formal governance processes?

A. There have been occasions where formal governance processes were required. But as I say, for the most part a more informal discussion solved a lot of things.

The importance of senior consultants 'leading from the front' in developing a friendly, non-confrontational tone in open and transparent discussions. Establishing a culture of listening and empowerment of junior staff.

Q. Do you think it should be mandatory that patients are copied in to all letters?

A. I think that's becoming the culture now. I have some issues regarding certain circumstances, especially where the patient has got very short survival who don't want to know about that.

Q. Yes.

A. So there are some challenges. But overall, yes, I think patients, and patients, with the new IT systems coming, will have full access to their health records. So I strongly support that.

Q. What do you think the barriers to that have been?

A. I think cultural and paternalistic approach to medicine over the years. "Doctor knows right".

One practical way of moving the provision of medical care on from a paternalistic approach will be to provide patients access through IT, to their medical notes and copying them in to the letters relating to their care.

……

Q. Moving on from that point and looking at your experience as a total, in all of your experience as a Consultant Urologist, is it your view that the culture within an organisation and the way in which people communicate within that culture can have an impact on Clinical Governance, either positively or negatively?

A. It can have, as a person from outside, a negative effect on the Clinical Governance. There is no doubt about it that if you don't take all the people onboard before deciding or making decisions or providing resources effectively, certainly it will have some effect.

Is the SLT aware of any current areas within the Trust where staff feel they are not onboard with the decision-making process in their area of practice?

Q. So when you met at the beginning of January 2017 as a team, and you were told about the exclusion of Aidan O'Brien, and you describe the shock you had at that meeting, and I can well understand that. What were you told as a team about who you could talk to about it and where you could get support with the Department and so on? Who dealt with that with you?

A. Nobody.

Q. Who do you think should have, apart from you wanted a senior medical presence there, which I understand, but you know, who did you regard as your first medical manager go-to person for something like this? Because this is a huge deal for a department.

A. Yes, I agree. I think the first port of call should have been the CD.

Q. So did you feel you could go to your CD?

A. No, the CD was in the middle of the issue, and that wasn't offered? It wasn't. Neither were any other support services within the Trust offered. I've had a subsequent experience, not a pleasant experience, where I was sign posted by Dr. O'Kane, as it happened, to psychology. It was an unrelated thing to what's going on in this Inquiry. And that was useful, probably would have been useful back in 2017. But there wasn't any support put in place for us as a team.

Q. Did you feel you could talk to the other members of the team about it or did you feel it was all totally secret?

A. We would have had chats informally amongst ourselves as to how we were going to organise things and get on with sorting things out. There wasn't really any safe space created for us to vent, because I think some of us

Q. As it went through, I mean this unfolded and, as you know, it all took a very long time to sort out. Did anybody update you as a team? Did they bring you back together and say "This is what's happening now", or did they bring you together with Aidan O'Brien in any way?

A. No.

Q. No. Did you feel you could go and talk to him about it?

A. No, I felt that was very difficult. The period of 2017 was extremely difficult, and perhaps a few years later he would have come to me to talk about clinical matters and he would have sought my opinion about cases. But, again, I felt there was a really big barrier to us discussing other things.

'There wasn't really any safe space created for us to vent'

Is there easy access to support for staff members who are experiencing a stressful situation and needing a safe space to explore the issues?

Q. I get the impression from the totality of your evidence that, well, you did actually say that there wasn't a collegiate way of working. Has that improved?

A. Yes, I think it has, and I think in particular at the MDT it has improved, but I think it's also improved within the consultant body, the junior doctor body, and the nurse specialists that we work with. I think the atmosphere in the Department is better than it was before. So, I think we're in a better place as a team now than we were two years ago.

Q. And if you had to say why that was, I mean obviously this Inquiry being set up, all of the attendant SAIs and everything, I'm sure, as Dr. Swart has said, was very traumatic for the team. Is that sort of out of adversity comes improvement, or what would you say?

A. I think, you know, many of the things that have been identified correctly by others, to give them their credit, Dr. Hughes, others, we've taken that on board and we've implemented the changes and we realise, as a team, that we're in a safer, better environment than we were before. So that gives us

all a sense of achievement in terms of we've turned things around. But also we realise that we're all in it together, we're all pulling in the same direction. And I think that's what has allowed us to move on.

How can the SLT share this positive narrative now in the Trust?

Q. In that respect. As we observed this morning, Dr. Simpson, towards the start of your tenure as Medical Director, you were, I suppose in the context of Dr. Aminu's case that we looked at, you're furrowing your brow and saying, looks like there's a professional clinical governance issuing within urology, and, as you explained this morning, you were seeing that in other places as well. That was an issue in 2011. Fast forward to 2015 and issues that you think you should have known about, should have been brought to your attention because they were unresolved, weren't making it to you. Does that suggest perhaps that, at least within urology, the culture of not disseminating, not communicating, not escalating hadn't really changed that much?

A. That's quite possible. It's difficult to change culture. I would have seen that, I think, in the context of Craigavon Hospital generally going right back to 1992, when Craigavon was its own Trust of the 17 Trusts, which was never a good idea, separate from the community, separate from Daisy Hill. My instinct, both as a consultant starting in 1992 and then Medical Director 2011, was there was that sense of elitism that really might have been partially justified but is not best -- it's not well disposed to, you know, proper clinical governance. For by MHPS, GMC and so forth, the way to deal with these things at the coal face. Healthy teams keep each other right and they set the right culture. It's not reasonable, you know, to expect any clinician of any stripe to be at their best for 30 years. You know, performance will wax and wane, the team should compensate for that. Where they can't compensate, that's the time to escalate. Teams can't compensate whenever the clinician is not working with them. If that keeps going up the chain, then it is clear that by the time it reaches any medical director, then you know there's a much larger problem.

‘Healthy teams keep each other right and they set the right culture. It's not reasonable, you know, to expect any clinician of any stripe to be at their best for 30 years. You know, performance will wax and wane, the team should compensate for that. Where they can't compensate, that's the time to escalate’

Is this a reasonable statement? It reinforces the importance of maintaining a healthy team environment.

Q. As I proceed through today, I'm not going to bring you to every case where there's perhaps an argument that the case could go back. I think the issues may be important on a general level. It reflects, perhaps, an approach to medicine that, I think as you indicated at the start, is not ideal and perhaps now frowned upon in terms of particularly urology; that's our focus, but perhaps more generally. Clinicians, in order to offer their patient the best quality of treatment, need to relinquish ownership of the cases and follow, if you like, the rules of the MDT?

A. Yes. I'm not sure "rules" is quite -- I think "advice" is a better word for MDTs. But yes, collaborative working clearly is preferable to working in isolation, especially these days where the complexity of the treatments that we can offer patients is increasing. But, on the other hand, you know, a sort of counter view is that the patients, especially in urology that we look after, are getting older and more frail. It is not unusual now to look after patients over the age of 100 years. You will often find that what the MDT, in the absence of the patient or the patient's family, will offer standard therapy when, in reality, you need to tailor that treatment to what this patient, individual patient, needs, and the individual clinician who takes overall responsibility for that patient, the urologist who is going to be sued when

the patient puts in a claim of negligence, it wouldn't be the nurse and it wouldn't usually be or the radiotherapist, the radiologist or the pathologist, it is the consultant surgeon, urologist. So you have to have flexibility between MDT advice, which is often regarded as best practice, and then you need clinical freedom to make the right decision for the right patient and then take medicolegal responsibility for that. So, you have to defend what you've done. If what you've done is counter to what the MDTs has advised, then you are taking an individual risk for yourself if you do that. There are plenty of situations where the sensible thing to do is not do what the MDT says but to do what the patient would like.

'Collaborative working clearly is preferable to working in isolation, especially these days where the complexity of the treatments that we can offer patients is increasing'

Is the SLT aware of any consultant currently of whom it could be said 'works in isolation'? How is this being addressed?

Q. One other thing just in relation to -- we were talking about actioning scans. Would you accept that if the waiting lists are long and a review appointment cannot be held as soon as the clinician would like them to be, it is more incumbent upon the clinician to check scans as soon as they come back, or results as soon as they come back?

A. Yes, I mean, ideally what we need is a joined-up electronic system. The technology is there now to do remote consultations, order scans online, look at the results online and, you know, action urgent cases, you know, literally within a few days. It could be done but the problem is that we're dealing with such an overloaded system. It is quite hard to change things within the system because doctors are brought up to do things in a certain way. We were all brought up in the sort of paper era where we had to have the notes and the patient in front of us, but now suddenly all these things can be done online. You can see that there are all sorts of issues. Dealing with the very senior surgeons in the department can be the trickiest issue, really. It is hard to get them to change.

'It is quite hard to change things within the system because doctors are brought up to do things in a certain way.

Dealing with the very senior surgeons in the department can be the trickiest issue, really. It is hard to get them to change.'

Given that evidence-based change can be a challenge – how is the SLT addressing this challenge and is progress being monitored with regard to this 'trickiest issue' amongst senior clinicians?

……..

Q. I suppose when the Inquiry is reflecting about issues such as this, it sees the potential for patient harm and it sees that colleagues in the team are aware of the problem. And on your account it is put into the "too difficult to challenge" box and the problem goes on. And you have expressed it, perhaps, on understandable human terms, I'm the junior consultant, he's the senior, it's difficult. But reflecting on that, and we can look at other issues where that seems to be the explanation for the behaviours, it's not good enough, would you agree, and, secondly, is that -- is these kinds of behaviours, can they be cured, can the culture be changed?

A. Certainly it's not good enough. On reflection I probably would -- if I was in the same situation now I probably would and with another colleague I probably wouldn't let it continue, I would certainly act on it. Can it be changed? You are probably trying to change a personality to some extent. I don't know what Mr. O'Brien did earlier on in his career. I don't know whether he dictated letters in those days, I

don't know. But, certainly, it shouldn't have been left to go on. It shouldn't have been left to fester, as you said.

Q. Your options, you are on, I suppose, the receiving end of these behaviours and your patient is. You are facing into the frustration of not knowing what's going on with this patient and having to dig a bit around the edges to come up with a viable plan. Your option, having faced into this issue, maybe across a number of patients, is to speak to Mr. Young, the clinical lead, or perhaps the Clinical Director, Mr. Brown and/or to complete an incident report. It would merit an incident report, do you think?

A. Absolutely, it would have. I certainly should have taken more action -- I should have taken any action, I should have taken action on the matter because it is a risk and I hold my hands up, I should have acted on it.

Q. For fear that you may think I'm beating up on you, I asked Mr. Haynes -- Mr. Haynes was aware of the example I drew to your attention, Patient 103, he didn't raise an incident report on that. He dealt with it by way of airing his frustrations with Mrs. Corrigan, so that the issue was known about but it wasn't put on that formal footing of an incident report?

A. And I think I probably would have aired it as well and I would have talked about it but didn't do anything formally about it.

'Are these kinds of behaviours, can they be cured, can the culture be changed?'

How can the SLT present this Inquiry discussion to the Trust's workforce in such a way so as to empower individual staff to address this challenge when they come across it and to emphasis the risk to patient safety and care when it is not addressed?

4. Communication

Mr O'Brien's case has been referred to the GMC.

When the GMC give their conclusion, think through the comms that will be required for the Trust, patients and their families and the public.

Q. Going forward, you know, if you have to do all of this again, apart from the things we have already talked about, what do you think the key learning for you personally from this is, from that whole dynamic?

A. In terms of my learning, is around the importance of communication with all the stakeholders from the very get-go. And that, if you do use and apply the policy properly from the get-go, it has the potential to work.

Highlighting the key role of clear communication with all stakeholders from the start and continuing through processes and clinical practice to delivery. How is this being evaluated currently and how recently were any adjustments made?

As a SMT, think through how to support regular messaging to all the Trust stakeholders – making sure that it provides an accurate, constructive and empowering narrative.

With the comms you have currently in place – is it keeping your staff engaged, supported and valued?

How does the Trust capture the morale of its staff?

……

Q. I want to ask this. Are you clear that, notwithstanding the conclusion of the investigation and the issuing of the determination in the autumn of 2018, that Mr. O'Brien was clear and there was clear communication to him that he remained subject of a monitoring arrangement?

A. Okay. There was no clear communication to him that it was to continue. I accept that. Nor was there communication with him to say that it had stopped either.

Q. In circumstances, and we'll come on to look at this now, where the organisation wasn't able, or felt itself unable to proceed with the outworkings of the determination, would you agree that, upon reflection, clear communication around these issues was important given the particular patient-related context that you were dealing with?

A. Yes. When you go back over it all I would not dispute that at all. I would completely agree with that.

Note the importance of clear communication and understanding – when this is poor, the standards for patient safety can be significantly affected.

……..

Q. You have mentioned about a concern that red flag referrals are prioritised and there is a danger that because of that, routine referrals are getting longer and longer with a concern that people are becoming more unwell, having originally been maybe allocated as routine?

A. Yeah.

Q. What's the situation with that now? Do you have any knowledge about how those people are moving along?

A. I think there's still an issue.

Q. Still a backlog?

A. Yes.

Q. But it's your evidence to the Inquiry that if there was that capacity in the CNS, that there would be greater movement along the journey for those patients?

A. Yes. It could only be a positive thing

What interim communication steps for engagement are operating with the lengthy waiting lists in the Trust?

Q. The note of the SAI indicates that the problem was with the clinical nurse specialist, that Mr. O'Brien had expressed concern about that, and the note reflects that he didn't understand the role of a nurse specialist. Just in relation to that SAI meeting note, does that properly in your view capture what you meant?

A. No. I have been misquoted. I've been -- I have been misrepresented.

Q. Well, what did you say and what message were you trying to impart to Dr. Hughes?

A. So, I would have said very similar to what I said in my Section 21. Aidan would have been very particular in his use of language and words, and I think it was just the "key worker" word that he didn't like. It's not -- I don't for one minute think he didn't understand what a key worker was, or indeed

what a CNS was and what my role was, he absolutely did. I believe he did value that role. It's just he could have been very specific about his use of words and language and phrases.

Clarity around language and terminology used throughout the Trust will bring better cohesiveness and messaging.

Q. You have also been on this Task and Finish group. What have you personally learned from being on that?

A. There's a lot of wheels in motion.

Q. Yeah.

A. And sometimes the people on the ground don't get fed back to us as to where we are with things and what is happening.

Q. Because you mentioned a few things. Were the changes made quite quickly to start with? What was the pace? What was the feeling of that meeting; was there a sense of urgency? Or...

A. I feel people wanted stuff to happen more quickly but perhaps the resources weren't there to enable that. But there definitely was willing, whether there were resources as timely as there should have been.

Q. Whose job did you see it to unblock those resources; where did you see that?

A. I saw that happening at a higher level than me.

Q. Did they explain to you how that actually all worked –

A. No.

Q. -- or was that a mystery?

A. Mystery. It was not explained.

Q. Do you think that's right, do you think it should be a mystery?

A. I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions. Yes, I think that could be important, yeah.

Q. Did you and are you taking all of that learning back to these consultant meetings and trying to tell people what's happening? Because the nine SAI Task and Finish group, I mean it's a big deal, isn't it, and it ultimately was a big part of matters of this public inquiry. Did you see it as your role to come back and tell everyone what was going on and were people interested, or did it fizzle a bit? I just get a sense from you that it's fizzled slightly.

A. Yes, I think that would be a fair comment to make. I know I would have mentioned it within our small team in passing but certainly not formally. But some of the consultants are on that Task and Finish group as well.

'I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions'

Taking time to explain clearly a process will reap the benefits of better engagement with it.

Q. If I could summarise. Where the SAI was bemoaning this disconnect between one service and another where it was saying there was a lack of support for the MDT, the response to that has been to carve out a specific role focused on those issues, and that's what Mrs. Muldrew is addressing?

A. Yes.

Q. Where the SAI complained, or concluded, that there was virtually no audit, no monitoring of how this MDT was performing across a range of issues, the appointment of Mr. Quinn is dedicated to that concern?

A. Yes.

Q. Are there any early indications of how all of these changes are bedding down and whether you are yet in a position to say whether noticeable positive changes have arisen?

A. Well, there has been some positive change in that even from the NCAT audit that was carried out on all of the tumour sites with the Clinical Leads, the information that was clearly coming out was that there was no -- for MDT principles around how an MDT should be carried out. We are now developing an MDT principles document, which clearly sets out what's required of an MDT; things like an MDT pro forma that's to be completed to bring your patient for discussion, which brings a much better, you know, information awareness around the kind of things that were going to be discussed at MDT. It's a minimum data set to bring your patient forward for MDT. That's been developed also in partnership with the MDT leads and chairs. A communication policy as well, where there was a felt need that we needed a communication policy. So, responsibilities for each member involved in an MDT process for what they should be doing pre, during and post-MDT in terms of communication out to patients.

What stage is the development of the MDT principles document and the communication policy at?

Going forward post Inquiry, it would be very helpful to oversee the streamlining of language and terminology, values and principles of all the Trust documents.

Q. Do you think that the poor communication allowed problems to exist and persist, such as the ones that the Inquiry are looking at? Do you think the poor communication from Urology towards Cancer Services assisted in creating an environment where problems were not dealt with?

A. I suppose I have used a couple of examples here that I was aware of.

Q. Well, you were aware of the issues around Mr. O'Brien and triage from 2015, I think? Do you recall that?

A. Yes. In regard to red flag triage, yes.

Q. I know that's not one of the examples that you've referred to but if I go back to my initial question. When you saw those emails -- and I'll give the Panel the note for the emails. 2015-2016, referring to Mr. O'Brien, referring to triage, referring to referral, referring to the build-up of patients who were not coming through the system and representing a blockage to get through the care pathway. Did you think that the failure for that information to be properly communicated to you allowed problems to persist in Urology?

A. Probably, in hindsight, if it had have been more joined up communication, that everything was together, it probably would have dealt with things at a much earlier time.

Lack of clear communication adds to a confused picture, delay in understanding issues and taking the appropriate action to ensure patient safety and care.

A. I think there seems to be a bit of a disconnect in what governance inspired to do and what is actually happening. It is just not achievable to have that gold standard.

Q. One of your reflections as well is that management needs to engage more with the workload. Was that a disconnect as well?

A. Very much so, yes.

Q. What could they have done about it, do you think? What should they have done about it?

A. Well, I think they just started to strip away any support we had.

Q. This is on the administrative side?

A. Yes. So we started off with four, I think four audiotypists; we ended up with one, and we were just expected to work harder and harder.

Q. You have reflected in your statement at WIT-76358 that the move to the Breast Service, I suppose, has led to an improvement in your working environment and you find it to be a more effective service. What are the differences that you are observing from a position as a medical secretary in that service by contrast with the Urology Service?

A. It is basically the difference in day and night.

Q. Could you give us one example of how things work better and are better for patients because you're able to do your job as a secretary in a better way to work?

A. Because you had more time to do it, more time to check on things. We attend the MDT meetings so you are very much aware of the cases that are discussed at MDT and you follow it up. It is just a pleasure to work in compared to urology.

It would be helpful for the SLT to continually shape an appropriate and empowering narrative around the realistic expectations of the workforce as it deals with a demanding workload and stretched resources.

…….

The benefit of having the open door policy, having the senior clinicians dropping in and out, the benefit of walking the corridors, walking the wards and spending time with staff to listen. Now, not every member of staff would have opened up about things but many did. When you are walking around the hospital with a cup of tea in your hand, as I always did - it's one thing I haven't got here, is a cup of tea - a cup of tea in hand, it makes a deliberate statement, 'I want to have a chat'. I know people are busy and if you find there's something very serious to talk about, you come back and find a time to have that conversation.

Q. So visibility was a benefit in relationship building and confidence-building?

A. Very much so.

What steps can the SLT suggest to encourage all members of the senior team to become more ‘visible’ and for the SLT to lead by example?

Q. You have said that this was one of the best serious incident investigations you have been involved in. What was about it that made you say that?

A. From a family engagement. I suppose that was my big thing with SAIs, was the whole family engagement bit. The early learning being shared as well as we were going along, because that information was being drip-fed. I can see the restrictions with this SAI very clearly with the benefit of hindsight, but at the same time, I mean, we did look at a systems approach, this wasn't about finger-pointing. This was looking at our structures in place and that's why I feel that was a really good SAI. I think the intention of the staff involved in the Review Team and the commitment that was there, I mean everybody worked so hard. At the same time, that feedback to families, keeping them in the loop, keeping them informed, to me that was an example of good practice of how to do it from a family engagement point of view.

Can this approach be applied to all future SAI's in the Trust?

'Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you'

One of the main ways of bringing people with you is to ensure there is quality and frequency of communication. Some thought needs to be given to this.

Q. Another thing that you talked about, I think, was the admin review. Now, having read the MHPS determination and the substance of it, it's quite clear that people have interpreted that external admin review as different things.

A. Yeah.

Q. If you'd interpreted it at the time and you'd read the statement that there were managerial failings and there needed to be external review, what kind of review would you have envisaged that to be? I know you weren't in charge of it.

A. I think we would have looked broader at roles, remits, responsibility, governance, actions, escalations, evidence of a concern materialising into some process.

Q. Yes.

A. It would have been bigger than is there triage happening or whatever. It would have been literally a root-and-branch review of how our systems working, and have we got the right balance between operational busyness and governing our systems and ensuring the patient is safe in our care.

Q. That's I think how many people would have interpreted that. Why didn't that happen, do you think? What was responsible for that inaction?

A. I think a ball was dropped. There was a recommendation that appeared to look like it was belonging to Acute but, in actual fact, it never said it belonged to Acute. It said independent but it had Acute in the middle of it, so I think somebody thought an Acute will deal with that and it wasn't dealt with. I think also the sharing with the operational team, I know Mrs. Gishkori had it, but Ronan had no idea that there was implications for him as Assistant Director, even for, you know, some of the oversight. I think it's back to the sharing appropriately, even of what had started as confidential type processes.

Post Inquiry – it will be important to establish clear lines of communication for information flow and learning throughout the Trust. Also, to check that everyone has clearly defined roles and understands their responsibilities and accountability. Underpinning this will be the outlining of Trust values and principles and the strategic aims for the next five years.

……..

Q. We had a patient come to the Inquiry to give evidence, his name is Patient 84. You can see, if we just bring it up on the screen, PAT-000225, he directed a complaint to the Trust on 19th September 2016. Without going into all of the fine detail, this was a case where there were -- a complaint where there was a number of issues but primarily and at the heart of it it was a patient who had a stenting procedure. The stents had to be removed. The patient had been given the understanding that they would be removed by a certain date and that date moved and moved and moved until he got into some considerable medical difficulty, had to be admitted to hospital with infection, had to be re-admitted and was not, as you might expect, terribly happy with his treatment, leading to this complaint. And you were at that time responsible for managing or coordinating complaints and we can see, for example, PAT - well it's three pages further on at 228 - we can see that your first step, I suppose, is to send out what I take to be a pro forma kind of response which might be politely described as a holding response or an acknowledgment?

A. An acknowledgment of complaint, yes.

Q. Yes. This was one of these cases where you were unable to comply with the 20-day aspiration. A number of holding letters were issued over the following months, leading to a substantive response on 1st December. If we could have that up on the screen please, PAT-000231. That would have been signed off by Mrs. Gishkori. Now, if we scroll down through it. Just further on down, on to the next page perhaps. When this patient came to give evidence, and indeed in subsequent correspondence in response to this output, he took exception or he explained that he took exception to how his complaint had been dealt with and what was particularly sore with him was that his perception was of being made to feel guilty about complaining because - and he drew this or he was caused to feel this - because he was told that, in essence, the service is struggling to meet demands and cancer patients have to come first, if you like, and that's perhaps contained within that paragraph, commencing: "Mr. O'Brien confirms that ideally patients who have a stent inserted should have this removed and have this performed within four to six weeks later. However, the demand on the urology service is unrelenting, with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway." Just to show you how it was expressed by the patient when he came along to see us, if we go to TRA-00094. He came along at the opening week of the Inquiry and he says that, just scrolling down, he says: "Obviously, when they brought in the cancer patient stuff and, you know, while obviously I have sympathy with them life threatening conditions and things but that wasn't I suppose - you shouldn't be made to feel guilty." In other words, he took it as why are you complaining, there are people worse off than you. Did you draft the letter?

A. The information contained in the letter would have been a direct lift from the information provided by the service area. Having read that now again, I accept that the patient would be annoyed by the content of the letter and I am sorry for that. I can understand where the patient is coming from. I think the attempts to explain the pressures on the urology service have not been communicated as well as they maybe could have been.

Q. I suppose linguistically it's a difficult balancing act, you perhaps want to communicate something of an explanation as to why the treatment has been delayed?

A. Yes. Yes. And that explanation had been given to various other patients who were waiting as well.

Q. Yes. I think what you are acknowledging this morning is that, from his subjective perspective, it's understandable that he would feel annoyed?

A. Yes.

Q. And maybe there is a learning here in terms of how you convey the message?

A. Yes, exactly.

Treating each patient with dignity and respect includes attention to the quality of communication - a key component in delivering person-centred care.

……

Q. I'm sure it's just we all have different ways of speaking and it may be just your own particular verbal tick, but I was struck by the fact that you kept refer to "ideally" things would happen. You used it in connection when you were explaining the risk and benefit to document discussions with patients in the notes. You used the word "ideally" in that sense. But I`m sure that you would accept, would you not, that that is actually something basic rather than ideal?

A. Yes. I think the more that is written down now, the more important it is. You know, for example, the issue of consent. We just used to originally ask the patient to sign the form consent for a TURP, sign it, and go. Now you need a long explanation of what you've said to the patient and what they're committing themselves to. So, things are changing. The better the documentation, the better for the patient.

Q. The better for the patient and, arguably, for the surgeon also?

A. Yes.

Q. Because you have speculated about whether or not some of Mr. O'Brien's patients would not have wanted to travel to Belfast to get radiotherapy. We'll never know because it is not documented in some cases. Whether they would have wanted to retain their sexual function rather than have the particular androgen therapy; we again won't know because it is not documented. So while protecting the patient, it also protects the surgeon?

A. Yes, absolutely right. That's more and more important in an increasingly litigious society.

The importance of accurate documentation – not just driven what by ‘an increasingly litigious society’ but more importantly a record of the quality of communication, the accessible and full discussions and decision making that has taken place between the doctor and the patient.

Q. Then just a final question. This will be obvious to you but could you just make some comments on the value of cancer guidelines, cancer networks and so on in terms of standardising therapy to some degree and so thereby reducing inequality, you know, between the wealthiest, the poorest, the best informed, the worst informed. What have you seen in terms of answers to that. Do you have any comments?

A. I do. They're very helpful. I think that guidelines are guidelines, they're not rules, they're not mandatory. They help us make decisions because, in the end, as I've said several times today, that the patient's choice has to be preeminent, guided by the clinician who understands the patient and patient's family and takes into account guidelines as well as the view of the MDT. So all of these things need to be put into the mix to end up with a patient who is happy with what's being recommended and what treatment is being given to him. Guidelines are very important. I think we're lucky to live in a country where such good guidelines are produced and constantly updated in such an admirable way.

‘The patient's choice has to be preeminent, guided by the clinician who understands the patient and patient's family and takes into account guidelines as well as the view of the MDT. So all of these things

need to be put into the mix to end up with a patient who is happy with what's being recommended and what treatment is being given to him'

How strongly is this message reinforced in the Trust today? Could this quote from Professor Kirby be included on the Trust website?

…….

Q. Now, in terms of your management role, and you helpfully tried to describe it for us on the last occasion, and, indeed, when we were asking Dr. Simpson about the role of clinical lead, he had it might be described as a degree of sympathy for the role. It wasn't particularly well defined, there being no job description, et cetera. When it came to March of 2016, Mr. O'Brien is handed a letter in a meeting which he was asked to attend with Mrs. Corrigan and Mr. Mackle. You knew nothing about that meeting, is that right?

A. Correct. I didn't know about that meeting or a letter or anything had been undertaken. I wasn't part of that process and didn't hear about that until afterwards.

Q. Perhaps that is a reflection of how others perceived the role of clinical lead, that you were kept out of that loop. Would it have been helpful, given what was being asked of you in terms of trying to manage the triage issue, for you to have been appraised of the fact that this process was starting?

A. It may have been advantageous. I had been involved before, helped out, it hadn't worked, it was needing a higher level of input to make it get sorted out. Whether I should have been appraised of it or not or at least know about it is a question, but I wasn't.

Q. Clearly you weren't. But the Inquiry will have to reflect upon how management works, how it did work in this situation, or how it failed to work and whether any lessons are to be drawn from it. So you're cast in the role of clinical lead. We can see not infrequently people are rapping your door to ask you to help out to try to resolve, to take this example, triage. They meet with Mr. O'Brien to discuss triage, amongst other issues, and you are not advised that this process is happening. How can the management of that kind of scenario be improved for the future?

A. It would be improved by involving the full team in the situation, yes. I think I probably should have been at least informed of what was going on.

The importance of clear communication and collaboration across the management and clinical lines of the service when dealing with an issue that straddles both.

Veryan Richards

19/01/2024

Category	Learning / Observations November 2023	USI Terms of Reference (A – G)
1.Trust Board	1.1 The role of Trust Board – what and how information is reported to the Board; a) Are the correct issues brought to the Board, and are they fully and properly discussed? b) Is every Trust Board member clear on their role? c) Are issues alerted to the Board appropriately followed up? How is this reported on? d) Is the challenge/improvement function of the Board applied consistently and appropriately? e) The function of the Trust and understanding of the discharge of legal duty of care. f) The role of Trust committees – reporting, accountability, scope of responsibility. Are these functions clear, and understood by Trust Board members? How does committee business feed into Trust Board? 1.2 Role of Head of Service – scope of service responsibility; ability to manage (particularly Drs). How the role is defined and what is expected of staff? Is the HOS role clearly and realistically defined and is it reasonable? 1.3 How often is the narrative and focus at Trust Boards monitored to make sure there is a balance between the quality of patient experience and performance? 1.4 Is there more clarity now about the Trust Board being kept in touch with progress in an investigation? 1.5 Is the SLT confident that the Trust Board is now receiving and reviewing all the relevant reports and papers in accordance with the Trust's brief? 1.6 How frequently is the importance of raising concerns addressed in the Trust? How robust and secure is the whistle blowing route to the Chief Executive? 1.7 Is there currently Trust guidance on effective monitoring arrangements of action plans in informal and formal investigations?	Terms of Reference B To evaluate the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a "lookback review" of patients seen by the urology consultant Mr Aidan O'Brien (for the period from January 2019 until May 2020). This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the Health and Social Care Board, Public Health Agency and the Department. It also includes any other areas which

	1.8 Is there currently a clear understanding of the role of NED's within the Trust? Also, the role and expectation of a designated Board member in relation to the Maintaining High Professional Standards process.	directly bear on patient care and safety and an assessment of the role of the Board of the Trust
2.Corporate/ Senior Leadership Team LEADERSHIP	**WORKFORCE** 2.1 The senior team in the Trust has seen significant personnel role changes in the last ten years with the potential loss of corporate memory. How is the SLT addressing the challenges in nourishing and establishing stability and consistency in senior post holding going forward? 2.2 Does the view 'I think the Assistant Directors were slaughtered at the time' hold true in the Trust currently? 2.3 How can the SLT impact a shift in culture in some areas of the Trust where staff are encouraged and supported to move from a reactive approach to a learning and proactive approach to patient safety and quality care? 2.4 Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT? 2.5 It would be helpful for the SLT to continually shape an appropriate and empowering narrative around the realistic expectations of the workforce as it deals with a demanding workload and stretched resources. 2.6 Need for clear lines of accountability – at all levels of the Trust and clarity with all staff about what the expectation is – operational v medical management –are the differing roles and responsibilities clearly delineated? 2.7 Corporate Memory – handover. What formal handover is in place when individuals change/move on and roles are replaced; 2.8 Consider the turnover at Director of Acute; Medical Director and Chief Executive Level during the time in question and the potential impact on the wider organisation. Ensure a comprehensive	ToR B

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handover process exists and that this is not a 'person-dependent' process i.e. it's clearly defined with allocated responsibilities.

2.9 Can the SMT give some guidance on the place and use of 'normal medical management'?

2.10 Role of Clinical Directors/AMDs/Div. med directors

Issues:

a) management responsibility;

b) scope of control;

c) levels of accountability;

d) time allowed to deliver the additional workload associated with management role

e) training and support available for these management roles?

f) Should any member of management, to whom a clinician is managerially responsible, should have access to concerns, sanction, restrictions, or warnings?

2.11 The need for a clear chain of command:

a) Escalation of concerns – to MD/CX. How, when, and why?

b) How is this managed/monitored/followed up?

2.12 Role of Head of Service

a) scope of service responsibility

b) ability (or otherwise) to manage (particularly Drs)

c) How the role is defined and what is expected of staff?

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d) Is the HOS role clearly and realistically defined and is it reasonable?

CAPACITY

2.13 The Trust's "institutional blindness to unmeetable expectation". Is this a sentiment that could be experienced in the Trust today?

2.14 What are the criteria for the SLT in considering the potential for outsourcing some of the Trust's work to ease the pressure on workload?

2.15 When the Trust last communicated to the Commissioner that demand continues to outstrip capacity in Urology - what was the response?

2.16 The role of commissioning – explicit agreement and understanding of service pressures? Funding issues? What is the full extent of the relationship and levels of oversight and accountability? Are both organisations clear on this relationship? Persistent issue of capacity/demand mis-match

PROCESSES

2.17 Has the SLT checked recently on the connecting progress between Urology MDT and Cancer Services?

2.18 Has the SLT knowledge of how ready is the system to address 'whole pathway tracking'

2.19 Use of Early Alert – not in 2016 when issues identified with patient records, but used in 2020 when delay processing patients identified.

2.20 What current advice is the SLT giving to the organisation when problems arise that cut across the twin tracks of governance and accountability, clinical and operational?

2.21 'Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date.

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	Do you accept that, that there is a requirement? Absolutely, and then there is a balance to be struck' How does the SLT define this balance and then communicate it throughout the Trust? 2.22 Having raised an issue to be escalated in the correct sequence, what is the guidance on action when the issue remains on this person's desk and goes no further? 2.23 Are there plans for peer review and peer review visits to start again? 2.24 Is the SLT confident that no private work is being undertaken now in Trust time? 2.25 How can the SLT challenge and address the power dynamic in the delivery of person-centred care in the Trust? (eg managerial v operational management of PAs) 2.26 How frequently is the importance of raising concerns addressed in the Trust? How robust and secure is the whistle blowing route to the Chief Executive?	
3. Quality and patient safety	**SAIs AND INVESTIGATIONS** 3.1 Involvement of key staff in sharing of information re: SAI recommendations or other professional management plans. How are these followed up and assurance around implementation given? 3.2 The implementation of SAI recommendations relating to 2020/2021 SAI processes – can progress and changes be clearly identified? 3.3 *Do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?'* Is there currently adequate time, training, and resource now in place for staff conducting SAI's? If not, what is the plan to address this? 3.4 Has there been a recent review of how effective and efficient the structure is in running an SAI Review, its recommendations and cascading the learning? 3.5 Is support offered currently to patients and staff affected by the SAI process?	TOR A & C To review the Southern Health and Social Care Trust's (the Trust) handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice. The Inquiry shall determine whether there were any related concerns or

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	3.6 How are recommendations reported and shared? How does the Trust assure itself that recommendations are shared and implemented? 3.7 The lack of knowledge in relation to the on-going SAI process relating to past/current issues with AOB's practice – not shared through MHPS process. Is there a single resource which would detail all concerns relating to Drs? 3.8 Where does the learning go? Who benefits from the learning? How is learning shared through the organisation? 3.9 *'Conducting SAI's need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So, two years is too long.'* The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked? 3.10 How robust are the plans to cascade and embed the learning from the Urology Public Inquiry throughout the Trust so that a similar statement 'there was ad hoc learning from the SAIs' will not hold true? 3.11 How can the importance of reporting an incident, where appropriate, as an IR1 be understood, re-enforced and engaged with as a positive step in maintaining a safety culture throughout the Trust? 3.12 Does the SLT agree that it would be appropriate for all clinical staff to have mandatory training in the most recent Datix system? 3.13 What is the Trust's view on providing a senior critical friend for investigators in formal investigations? 3.14 How widespread in the Trust is the training for staff on incident reporting and near miss reporting? 3.15 Medical appraisal process – not looking at all concerns related to individual doctors. 3.16 Lack of regulation and oversight of private medical practice 3.17 On a scale of 0 – 10 (being fully integrated) where does the SLT rate the current level of integrated governance?	circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and making complaints To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty.

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	3.18 'Various pathways for governance to go through' – unless governance pathways are streamlined, and communication is clear there will be an increased risk for patient safety. How confident is the SLT that streamlined pathways and clear messaging are being delivered throughout the Trust?	
	3.19 Is the Trust assured that there is a comprehensive process of consent to treatment, and how is this measured?	
	3.20 Has the SLT updated its approach to quality improvement projects?	
	3.21 What is the SLT's line on the policy of patients automatically being copied in to letters from doctors?	
	3.22 Is the SLT happy with how the Trust monitors the quality standards of any services provided by the independent sector in the Trust?	
	3.23 How is the SLT checking the implementation of the message throughout the Trust – that clinical and administrative work must include continual awareness and accountability for patient safety and risk?	
	3.24 What further realistic plans regarding safety and quality improvement can be moved forward into action?	
	3.25 Standards and Guidelines – process and implementation. How robust/measurable is this process? Funding issues and capacity?	
	3.26 What is the current standard of auditing across all aspects of clinical and social care governance? Where standards are low or the auditing process not taking place - what actions are planned to address this? Is this a standing item on the SLT agenda?	
	3.27 Are resources being identified to support the auditing process to ensure that there is implementation of all the actions at ward level?	
	3.28 *'Concerns in relation to Admin practice of medical staff should be an indictor to deficit in patient care'* - is there any audit process which monitors admin performance and highlights issues eg delays in triage	

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	3.29 How Trust performance is measured – referrals, triage, waiting lists etc – are these sufficient? Do they give a good indicator of patient care? Risk assessment tools? Robustness of data? 3.30 Is the advanced triage approach to assessing patients for prioritisation an agreed and recommended approach? Are there Trust guidelines on triaging red flag, urgent and routine referral cases? 3.31 Lack of clinical audit, which meant there was no mechanism available to check on the appropriate and timely delivery of patient care eg referral from MDT to Key workers. 3.32 *'Has the picture changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?'* What needs to change in the immediate, mid, and long term to confidently triangulate risk issues within the Trust? 3.33 Cancer trackers – sufficiently staffed to cover the entire patient journey? What are the current guidelines/funding allocation to support this? 3.34 Is there a process for checking prescribing practice amongst clinicians? Is this a clinical audit issue? 3.35 Has a current audit been done of off-licence medications that have been prescribed in the Trust? Also, an audit done into whether the patient has been fully informed. 3.36 Raising concerns – is action appropriate, timely and are patient safety considerations properly and quickly identified? And how is this assured and followed up? 3.37 Is the current Datix system user friendly? If not, what can be done to rectify this? 3.38 If it is the case that there is now an annual appraisal of Datix data - is the learning from this process reaching the relevant staff? 3.39 How can the importance of reporting an incident, where appropriate, as an IR1 be understood, re-enforced and engaged with as a positive step in maintaining a safety culture throughout the Trust? 3.40 What is this balance now in Acute Services between patient quality and safety, performance, and financial efficiency?	

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	3.41 Can the SLT and the Trust Board currently provide the relevant evidence to show that there is now a good balance in the quality of the service and performance delivery in the Trust?	
	3.42 What should appropriately be included on a Directorate Risk Register, and when should it be included? How would this be evaluated/updated/escalated	
	3.43 Risk assessment tools – what is available and how is it used?	
	3.44 Is this an idea that the SLT agrees with, if so, what are the steps to implementation? (Relates to ability of CNS to see scan results, even if they ordered them)	
	3.45 What further realistic plans regarding safety and quality improvement can be moved forward into action?	
	3.46 Quality of care and patient experience is key in appraisals	
	3.47 There was a marked lack of awareness and sensitivity to the key thread of patient safety throughout the period being investigated by the Public Inquiry. Also, a lack of focus and regular audit of patient experience, their journey, and outcomes. How is this different now?	
	3.48 Delivering 'good customer care' standards towards patients is part of quality patient care. When was the last audit of this done in the Trust?	
	3.49 Is training in the skill of peer review and peer challenge available across the clinical teams in the Southern Trust?	
	3.50 Is there a high standard of robust data to cover quality standards across all specialities? If not, what steps can be taken to address this?	
	3.51 Are comprehensive patient surveys been routinely used in all the specialities in the Trust? If not, are there plans to introduce them, audit them, and share the learning?	
	3.52 *'So, it's the ability to bring back to discuss for the benefit of that patient. But, fundamentally, it's the patient's decision'*. What plans are in place to audit whether the policy/principle of 'shared decision-	

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	making' is being implemented and embedded into clinical practice across the Trust? Where it is found to not be taking place, what are the next steps to address this? 3.53 Has the intention of 'patients working with me in the oversight' of the Patient Safety system been delivered? If not, what is the SLT's view of implementing this idea? 3.54 Is the SLT happy now with the efficiency and effectiveness of the Patient Safety Meeting? Are there any further steps that could be taken to enhance its effectiveness? 3.55 *'The patient's choice has to be preeminent, guided by the clinician who understands the patient and patient's family and takes into account guidelines as well as the view of the MDT. So all of these things need to be put into the mix to end up with a patient who is happy with what's being recommended and what treatment is being given to him'* How strongly is this message reinforced in the Trust today? Could this quote from Professor Kirby be included on the Trust website?	
4. MHPS	4.1 Consistent application of MHPS process 4.2 Are there other routes for managing concerns, aside from MHPS? What other tools are available and are these widely known and accessible? 4.3 Is there adequate protected time, up-to-date training and admin support for case managers and case investigators now within the Trust? 4.4 Have staff involved in the MHPS process been trained? 'A refresher at the point of need might be something that the Trust considers to be entirely appropriate' 4.5 The importance of checking in with up-to-date training when participating in an investigative role in informal and formal investigations. 4.6 *'It is a sort of fundamental principle of justice that if you are being accused of something, you have a right to know what it is and who is accusing you. So yes, they should be involved early and informed of their ability to phone us.'* Does the SMT agree with this principle and having the willingness to apply it going forward? (As it relates to MHPS)	Terms of Reference E To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy.

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	4.7 How would the SLT assess itself now on its ability to engage with both parties in timely, meaningful communication when it comes to an informal and formal investigations 4.8 What is the Trust's view on providing a senior critical friend for investigators in formal investigations? 4.9 What is the plan to monitor the effectiveness in practice of this new guidance document? (MPS guidance) Is the Trust considering the principle and practicalities of doing this? 4.10 What is the SLT's current view on this? If in agreement – how realistic is this approach in today's climate? 4.11 *'Developing skills, developing peers, developing competencies, and developing the expertise in this role requires more than just training'* Is there provision now to extend the scope of the training to include these elements? 4.12 Should non-clinical managers be taking on roles in the delivery of MHPS? 4.13 Is the Trust planning to develop 'a pool of expertise'? 4.14 On appointment does the Trust know an accurate summary of the training already completed by the appointee? (in relation to MHPS training) 4.15 Note the importance of gathering screening information from both the medical and operational strands of the organisation. 4.16 How regularly is patient safety and the quality of care monitored and audited on wards that are experiencing a high turnover of staff? 4.17 This issue of adding to the already demanding clinical role - engagement in the MHPS process has been raised several times in the Inquiry. What is the current thinking on the MHPS process being carried out by an experienced team preferably whose members are not currently employed be the Trust?	

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5. Communication / Information	5.1 The success of a nurse-led intervention – a development in practice and a good news story. How can the SLT/communications department relay 'good news/constructive developments' to the Trust - boosting morale and narrative 5.2 What is the SLT's line on the policy of patients automatically being copied in to letters from doctors? 5.3 Treating each patient with dignity and respect includes attention to the quality of communication - a key component in delivering person-centred care. 5.4 Has the SLT sought current evidence on the quality of the lines of communication with all the Heads of Service in Acute? 5.5 Cross Trust sharing of information – concerns re: practice potentially – how would this work on regional information sharing basis and what's the professional obligation to do so? 5.6 Dissemination of information between MDO and HR; and onward appropriate sharing to directorates – how does this work? 5.7 Has the SLT sought current evidence on the quality of the lines of communication with all the Heads of Service in Acute*?* 5.8 Information Governance and links to patient safety: a) Notes at Home and not available for staff to review b) Information Shared with Private Sector; appropriateness of referrals to PS; complaints process c) Incomplete notes for people on operating lists leading to cancellation d) Emails – the use and content. 5.9 With the Encompass system being introduced later this year in the Trust, have training opportunities for all staff using this system been mapped out ensuring that the training is accessed before its introduction?	**Terms of Reference B**

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	5.10 Policy for the Safeguarding, Movement and Transportation of Patient, Client, Staff Trust Records, Files and Other Media Between Facilities 2006. Has this policy been reviewed and updated? Is training now being given to all the staff that this policy applies to? 5.11 Is training regularly provided so that staff fully understand their obligations and their responsibilities? 5.12 The importance of regular monitoring of processes being carried out efficiently and 'closing the loop' on raised issues 5.13 What interim communication steps for engagement are operating with the lengthy waiting lists in the Trust? 5.14 What plans are in place to address lack of engagement and to boost staff morale by underlining the importance of listening and communicating clearly? 5.15 Streamlining the language and terminology, values and principles used throughout the Trust (including documents) will bring better cohesiveness and clear messaging 5.16 The importance of accurate documentation – not just driven what by 'an increasingly litigious society' but more importantly a record of the quality of communication, the accessible and full discussions and decision making that has taken place between the doctor and the patient.	
6.Culture	6.1 Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT? 6.2 The importance of senior consultants 'leading from the front' in developing a friendly, non-confrontational tone in open and transparent discussions. Establishing a culture of listening and empowerment of junior staff. 6.3 What measures are in place to test the current position in relation to transparency, fairness, and openness? How frequently is this audited? 6.4 Is there an element of fear that still exists in the Trust when it comes to dealing with the shortcomings of some clinicians?	**Terms of Reference B** To identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose.

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	6.5 How can the SLT impact a shift in culture in some areas of the Trust where staff are encouraged and supported to move from a reactive approach to a learning and proactive approach to patient safety and quality care? 6.6 What initiatives can the Trust introduce to help to address the historical culture where medical employees are viewed and treated differently? 6.7 Is there still a culture where only medics deal with medics? 6.8 Is this tension still there in the Trust - with a 'lack of control at the top' where some consultants have one way of working but it does not match or marry with how the Trust wants to move forward? 6.9 How does the Trust underline the importance of operating a listening, inclusive and partnership approach at all levels and strands in the Trust 6.10 There is the principle of equity and due process being equally applied to all undergoing a disciplinary process and a return-to-work plan – this seems to not have been the case with Mr O'Brien. 6.11 How 'visible' are the values and required behaviours and consequences circulated within the Trust? 6.12 How can the SLT address and challenge, where found, the power dynamic in the delivery of person-centred care in the Trust? 6.13 How readily are patients perceived by staff as being one of the main members of the care team? 6.14 One practical way of moving the provision of medical care on from a paternalistic approach will be to provide patients access through IT, to their medical notes and copying them in to the letters relating to their care. 6.15 *'I think a lot of energy has been wasted in battles ……instead of dealing with the issues. They were allowed to sort of spiral out of control.'* Is the SLT currently aware of any areas of practice in the Trust where this statement could still be found?	To examine and report on any other matters which the Chairman considers arise in connection with the Inquiry's investigations in fulfilment of these Terms of Reference.

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	6.16	*'Hierarchy, silos, secrecy, fear, mistrust'* – these are words that have been noted from witness statements in the Inquiry – does the SLT have a feel for how relevant are they today in the experience of staff in the Trust?	
	6.17	*'One-way traffic'* – is it possible to currently identify areas in the Trust where staff feel their voices are not being heard and that the imprint is still one of 'one-way traffic' as opposed to collaborative discussion and decision-making?	
	6.18	*'I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet because it is so difficult. Some people are very difficult to deal with'* Are there any red flag warning signs and issues that are currently being swept under the carpet in the Trust today? What are the SLT's plans to address them?	
	6.19	*'Dealing with the very senior surgeons in the department can be the trickiest issue, really. It is hard to get them to change.'* Given that evidence-based change can be a challenge – how is the SLT addressing this challenge and is progress being monitored with regard to this 'trickiest issue' amongst senior clinicians?	
7.Administration	7.1	How does HR review the quality of its recruitment strategy and content of job adverts? Is there a plan to have a lead in the Trust with this responsibility? (Innovative approach to medical staff recruitment)	**Terms of Reference B**
	7.2	What is the view of the SLT on CNS's being available to support secretaries when patients are frequent callers?	
	7.3	Do all the secretaries in the Trust have a complete understanding of the full purpose and requirement of the Backlog Report?	
	7.4	How regularly is the Backlog Report being monitored for adherence?	
	7.5	Is the monitoring of DARO a watertight system in practice?	
	7.6	Post Inquiry – will there be a refresh on the role and responsibilities for all secretaries within the Trust?	

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	7.7 Lack of clinical audit, which meant there was no mechanism available to check on the appropriate and timely delivery of patient care eg. referral from MDT to Key workers. 7.8 Standard booking processes – is there a need for an independent scheduling team that ensures patients are booked in chronological/clinical order. Removes the capacity for Drs. to book on their own patients with no oversight or challenge. 7.9 The importance of tasks being completed to avoid multiple knock on impacts on care for patients (Tracking) 7.10 Is there a safety net in place now for patients who are not being actively tracked? 7.11 Has the SLT knowledge of how ready is the system to address 'whole pathway tracking'? 7.12 Has the effectiveness of the tracking system recently been audited in all specialities in the Trust? Do steps need to be taken to improve the system? 7.13 The importance of training to a good standard all those involved in job planning and drawing up professional contracts. 7.14 Recognising that there will always be an element of staff changeover - are systems lined up and the training in place to make sure that all new staff are up to speed with the relevant standards? 7.15 *'It is not just about training; it is then about updating your experience and keeping abreast of developing issues'* Can this comment be fed into the current training policy of the Trust? 7.16 Recognising the important working relationship of trust between the consultant and their secretary, how will one of the messages from this Inquiry be underlined - advising secretaries of their responsibility to escalate to their administrative line manager issues that do not meet the guidelines? 7.17 The need for regularly messaging and empowerment of staff (both clinical and administrative) to operate within Trust Guidelines and processes.	

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	7.18	A clear understanding of the relationship between the consistent delivery of clinical care and administrative efficiency is an important principle to underline throughout the Trust.	
	7.19	What is the Trust policy on minuting meetings – which meetings?	
8.Clinical Management	8.1	Are there any interim audit measurements in place on the placement and effectiveness of the key worker role?	**Terms of Reference B**
	8.2	When was the last audit done on the availability of CNS nurses to meet the request of patients to have one accompany them on their treatment pathway? What did the audit show and have there been any subsequent actions?	
	8.3	What percentage of patients currently are discussed at regional meetings due to lack of MDT quoracy in the Trust?	
	8.4	What are the 2022/2023 quoracy figures for MDT meetings in Urology and cancer?	
	8.5	Is there any further guidance that the SLT can give on the challenges of meeting the quoracy standard?	
	8.6	Currently - how streamlined is the flow from individual job planning to the objectives and direction of travel that the service must deliver?	
	8.7	The practice of consultants in following up or reviewing diagnostic results as soon as available - how is the Trust re-assured today that this is the case?	
	8.8	Taking time to establish a clear baseline for the contractual document between the employee and the employer is key to understanding and delivery.	
	8.9	Has the loop-hole of patients who come through ED onto a cancer ward been addressed in relation to having access to a key worker?	
	8.10	Has the Trust recently reviewed its policy on appraisals, job plans and revalidations?	

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	8.11 Has there been a recent audit of all the posts in the Trust that require/should require training and if corresponding appraisal of the post holder has taken place? Have actions from the previous audit been implemented? Can the SLT assure the public that there is a high standard of training and appraisal for all its clinical and management staff?	
	8.12 *'I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. You can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, is somebody doing a lot more work than somebody else and what are the reasons for that?'* What is the view of the SLT on this approach and plans for implementation across the directorates?	
	8.13 The importance of post holders having a full description and understanding of their role with a clear line of management accountability. How is this monitored?	
	8.14 Is there clear guidance on surgeons choosing to take cases in a chronological order? How regularly is this audited?	
	8.15 Lack of awareness of historical issues of concerns in relation to AOB – Concerns are not routinely shared (is there an obligation that this should happen?) and knowledge sits with individual staff. The entirety of issues with AOB only become organisationally apparent after the PI announced. Could this still happen?	
	8.16 Is there regular monitoring and awareness across the Trust on how effectively its 'safety nets' are functioning? How quickly is there a response when vulnerability is flagged up? Has this been recently audited?	
	8.17 On a scale of 1 to 10 what is the SLT's estimate of where the Southern Trust is at in terms of it being 'a problem sensing organisation'? How can this approach be fully interpreted and applied across the Trust?	
	8.18 Where is information stored and how does the Trust ensure that relevant staff have access to information? Is this line management/medical management?	

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	8.19 Failure to identify clinical shortcomings/patterns of behaviour involving a significant number of events over a prolonged period of time – the ability to triangulate or surface information which may have led to these issues identified earlier. 8.20 No effective Trust system to manage and track the administrative processes of individual consultants. 8.21 Job planning for MDT members – process does not fully reflect the hours required to properly fulfil the function of the MDT. Who is responsible – chair; treating clinician? 8.22 What constitutes good patient care, and how does the Trust evaluate and measure this? 8.23 *'Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided'* Moving towards a high standard of auditing throughout the Trust should enhance safe and quality care for patients, and give assurance to staff and the public. 8.24 Are there any interim audit measurements in place on the placement and effectiveness of the key worker role? 8.25 The importance of having a face-to-face job planning meeting. 8.26 Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers? 8.27 What consideration is being given to provide adequate time for more aligned working between non-medical managers and medical managers? 8.28 Do you think that is something that might be helpful if the issues around documentation, confidentiality and patient data was specifically addressed at induction for doctors so that they understood the way systems operate to allow them to engage with them? Does the SMT consider this to be a good idea? If so, what steps can be taken to implement it? 8.29 Are there current plans in place to continue to develop collaborative relationships and roll out continuity of care pathways across different centres?	

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	8.30 How can the SLT actively support the Trust's clinicians as they aim to deliver safe care for their patients while at the same time psychologically experiencing the pressure of long waiting lists for consultation and treatment? 8.31 Has there been a discussion on what a full range of consultation looks like before developing a supportive return-to work plan? 8.32 Is there a regular check taking place on the quality of hand over at all levels on the wards throughout the Trust? This is an important patient safety and quality issue. 8.33 Is the SLT aware of any current areas within the Trust where staff feel they are not onboard with the decision-making process in their area of practice?	

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Part 4.0 Public Inquiry – notes and reflections (days 42 - 49)

Day 42

Mr Wolfe questioning

Ms. Vicki Graham

Q. Did you ever obtain an explanation or seek an explanation as to why these periodic and repeated delays with return of triage were occurring?

A. I don't think ever I got an explanation but I always know either Martina or Wendy, they would have been linking in directly with Mr. O'Brien to try and get the referrals and we had to wait for them to return, or re-request other referrals then to try and get them triaged. But that wouldn't have been that often, to be honest.

Q. Because you were sitting in the Cancer Service and not in Urology Service, was there a sense that you were powerless to do anything more than simply escalate –

A. That's all. We had to follow the escalation policy. Once you had done that, it was just a matter of keeping an eye and waiting for them to return.

Q. What was the impact of delays in returning triage for you and your staff, first of all?

A. It was a lot of chasing up for the red flag appointment team because they were constantly checking what was coming back in, updating their spreadsheet. If they're still outstanding and they still maybe would have escalating again that these are still outstanding. The trackers then would have been updating the CaPPS System, linking in with the red flag appointment team. It probably would have caused a lot of emails back and forwards trying to track the progress for each patients. And still being mindful that their clock was ticking and you were trying to get the patients in to be seen.

Q. So, against the background where there are all sorts of pressures, as you have described –

A. Yep.

Q. -- this was an added difficulty that you could have done without?

A. An additional pressure, yes.

Q. Was there a concern that delay risked harm to patients?

A. I don't think at that point, no, there wouldn't have been. It would more just to get the referral back just to get the patient seen in clinic. As I say, at time investigations could have been questioned by the time the referral had been returned.

An example of how an incomplete task in one part of the system can have multiple knock-on effects on other people delivering their roles and most importantly on the care of patients.

Q. Could I just bring you then to the overarching SAI report. If we go to the section on governance and leadership, WIT-84302. It says in the third bullet point, it largely repeats the sentiment we've already seen, that: "There was no system to track if recommendations were appropriately completed". Can you see the sense, from a tracking perspective and from a patient's safety perspective, of having a tool, whether it is a live tracking device or whether it's some form of audit to be in place, to bring the monitoring of the treatment further along the line?

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A. I can definitely see the benefits of it. If it was properly resourced and the functionally within CaPPS expanded to allow you to track a patient through -- say, they had a bladder cancer through maybe multiple occurrences or stuff like that, there definitely would be a benefit for the patient.

Q. In light of what we heard from you in evidence earlier this morning, would I be correct to form the impression that given the resources that you had at that time within tracking, it wouldn't have been feasible to do much more given the resources you had?

A. I would agree, that's totally right. The tracker were under immense pressure with increased workload. They were struggling to track what they were commissioned to track, you know, 31-day and 62-day to first definitive, let alone a whole patient's pathway for years.

How are realistic expectations of staff working in the Trust set, monitored, reviewed, and adjusted?

Q. The incident report which I showed you there, the essence of it was that it appeared that a direct referral had been generated in your place in the Southern Trust but hadn't been received or dealt with in Belfast, and it took a GP to write in a year later and raise the alarm. Can you help us to understand what might have gone wrong there?

A. I suppose because -- I don't know the case exactly but I suppose one thing that could have went wrong is they had hormones commenced, their first definitive, then oncology referral was generated from the Southern Trust. Therefore, because they have been closed in CaPPS, they wouldn't have been tracking that to see that they had got the referral. It's the only explanation that I can give.

Q. But again, not knowing the case –

A. Yes.

Q. -- and I know we're in a sense speculating, but in terms of any case going that route, you've outlined the kind of correspondence that must be generated –

A. Yep.

Q. -- at your end, at the Southern end?

A. Yep.

Q. If that is not responded to for whatever reason, Belfast Trust have a computer problem or somebody is not doing their job properly or whatever it might be, what is the alarm bell in that situation; what is the safety net?

A. In my time I don't believe there was a safety net there, but looking back now, there needs to be one, you know, to follow up those patients that aren't being actively tracked. But once we have done our -- to me it is with the consultant, the patient is the consultant's responsibility. Because oncology referrals would also have been generated, it just wouldn't have been say a CaPPS oncology referral, most consultants would have followed that up with an actual written letter to oncology that maybe contained more information on that referral than the CaPPS referral.

Is there a safety net in place now for patients who are not being actively tracked?

Q. "If I or others, while working as a Cancer Tracker MDT coordinator Band 4 or as Cancer Services Coordinator Band 5, raised any concerns that were identified as a serious adverse incident, I do not recall being advised of the outcome of any investigation if it was logged onto the Datix". This, you say, was due to being a Band 4 or Band 5, and it was your understanding that you did not need to know.

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So that I can fully understand, hopefully I've got this right, you might have raised a Datix incident report, we've seen one example already and I think you cite other examples?

A. Yes.

Q. You've raised them because of a concern that clinicians providing a service to patients which impacts on your service were maybe - this was the reason for the investigation - were maybe not doing their job properly; there had been some issue or concern, perhaps a delay, leading to an impact or potential impact for the patient. Is it not important that you should know how such reports have been dealt with so that you can learn –

A. Yes, I would agree.

Q. -- for the future?

A. Yes, I would agree with that. I think it is very important for that information to be passed down so I was aware and I could also make my team aware, **because if you don't know what's happened or what's went wrong, how do you fix it?**

The learning from completed Reports and investigations in the Trust is important for all relevant staff to be able to access in a timely manner, to discuss and to learn from. How rigorously is this checked?

Ms. McMahon questioning

Ms. Kate O'Neill

Q. I just want to read out the extract from the bottom. "The Review Team regard the absence of specialist nurse from care to be a clinical risk which was not fully understood by senior service managers and the professional leads. The Review Team have heard differing reports around the escalation of this issue but are clear that patients suffered significant deficit because of non-inclusion of nurses in their care"? Next page: "Statements to Urology Cancer Peer Review in 2017 indicated that all patients had access to a key worker, Urology cancer nurse specialist. This was not the case and was known to be so. Just so the Panel is clear in your evidence, you don't agree with that?

A. So, my understanding of that is that on the Craigavon Area Hospital site all patients had access to a key worker but not for the satellite clinics. And that was an issue that was known to senior members of the team.

Q. So, the setup itself didn't facilitate access to a key worker but you're understanding is that the access to the key worker within the clinics within Craigavon –

A. Yes.

Q. - operated properly in your understanding?

A. In my understanding if we weren't present we were definitely accessible. And in terms of reassurance, if it's appropriate in relation to that, a member of the nursing team opened, literally opened Thorndale unit in the morning and a member of the nursing team closed it in the evening. They didn't leave until the last patient left because the emergency trolley needed locked away et cetera, et cetera. So there was access to a trained member of staff at all times.

Q. Now, the Inquiry have heard from some patients, the patients experience –

A. Yes.

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Q. - of individuals and just give you two examples of that?

A. Okay.

Q. I don't need to go to these, just in summary form can be found for parties at TRA 00243: "The daughter of Patient 1 confirms he had never been assigned a clinical nurse specialist". And the daughter of Patient 5 describes a difference that a CNS made at TRA 01917. And says: "I wasn't aware of the existence of clinical nurse specialists or their role or function and how important it was until it was mentioned at the SAI meeting". And then I read up on the role and function and recognised that, you know, I think, you know, people say "why did you not complain?" If you don't know what the baseline expectations are in terms of what you're entitled to, then you don't complain. If we had known that, if that hadn't been done, we would have followed that up but that was not indicated to us at any juncture. Now there are two experiences of patients. Separate from that, did you ever receive a call or complaint or any information that a patient hadn't received either a followup link with the CNS or a key worker allocation?

A. Not in relation to a followup or there was no escalation from consultants or otherwise in relation to key worker followup for any patients. It was distressing for us to hear this information brought to our attention in 2021. It was a shock to hear it and think some of the kind of sentences that were recorded on that day of things that the nursing team said were said out of that environment of "how did this happen? How did this take place?" I read the testimony from the family of Patient 5 and I think there's nothing that demonstrates the need for a key worker as clearly as they can, when they had it with the first diagnosis, no key worker and I think I met that gentleman and his daughters in the summer of 2020 with Mr. Haynes when the second diagnosis occurred and would have had engagement from that point forward.

Q. So you didn't know any of those patients initially?

A. No.

Q. - until the SAI process?

A. Yes.

Q. And you agree that there should have been a key worker allocated?

A. Absolutely and I struggled with trying to determine why that wouldn't be the case. I did note, on looking back at the evidence, that some of the patients were admitted through the Emergency Department and that progressed, you know their diagnosis. We did not have the resource to check who was on the in-patient ward at any given time. If patients were admitted through ED and were diagnosed with a cancer of whatever nature in relation to Urology, we depended on the consultant or registrar to let the CNS team know that, so that we could go up and meet them with their family and bring information to them. And we have done that on occasions, we would hope with additional resources and the way we are planning things now that we can do, you know, there is more improvements to be made in relation to that.

Has the loop-hole of patients who come through ED onto a cancer ward been addressed in relation to having access to a key worker?

Q. The way in which different consultants operate then involved the nurses being flexible, I suppose, around when they were available and how they became involved in the part of the pathway?

A. Yes, yes.

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Q. You've said in your statement about the different ways that the consultants interacted with the patient to give them information about the CNS or the key worker service?

A. Yes.

Q. And that can be found at WIT-80962. And I'll just pick out a couple of examples. You said Mr. Glackin may have given out the pack with the contact number himself. Mr. Haynes generally requested that the patient wait until you were available. Mr. O'Brien may only have invited you into the room if the patient required nursing intervention. For example, addressing change or referral on to another service such as the community continence team or the palliative team.

A. Yes.

Q. So it seems they all had individual approaches to how they managed their own practice?

A. They all had variations in it, that's correct.

Q. You mentioned when you were made aware of the SAIs you were, I think, you were surprised?

A. Absolutely, I think I was astounded is the word I used.

Q. Astounded?

A. Yeah.

Q. And when you got that report, I know you had a meeting with Dr. Hughes in February '21, we'll come on to that, when you saw the report in March 2021 –

A. Yes.

Q. - was that the first time that you saw it altogether?

A. Absolutely. When we met Dr. Hughes at the end of February my astonishment came from the background that this process had been going on for three or four months in terms of investigating the SAIs. And on reflection I would think that after one, if not two, but definitely if three people were identified as having no key worker, perhaps there was an opportunity there to engage with the CNS team or say to the CNS team, "this is becoming a feature here, is this widespread? Is this something you know about? Can you do anything about this?" So, I was a bit taken aback that we didn't hear anything of that until the outcome of the SAIs were ready to be signed off as such

Q. "Dr. Hughes advised there are nine patients in the review and they were not referred to nurse specialists and three have died. He advised families were not aware of nurse specialists. He feels nurse specialists should have been embedded". Then you have said: "Kate O'Neill advised at MDT that nurse specialists should have been advised if available. She advised there was an audit done from March 2019 to March 2020. 88% was given nurse specialist contacts". That was across all consultants?

A. That was across all consultants, and that's why I have attempted to determine where the patients came from and that's where I picked up some came in through the Emergency Department.

Q. Then Dr. Hughes asked Kate if she would send the information to him. Did you send that on?

A. I believe I did, yeah.

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Q. "He advised he wants to be able to say resources were available but patients were not referred. He feels this is a patient's choice whether or not to avail of the support of nurse specialists". You've said your input on this. "Kate O'Neill gave an example of contact from a patient. She was never questioned when she added to MDM". Further down: "Kate O'Neill asked if the SAI is to be closed at the end of the week will be inclusive of Mr. O'Brien's response". Why did you feel the need to ask about Mr. O'Brien's response at that point?

A. I suppose we were still in a state of shock and annoyance as to where the SAIs had came to. I was conscious, as I'd said the previous week, that we hadn't been involved up to that point, and I was just asking the question has Mr. O'Brien been involved and had an opportunity to engage or provide a response, as I felt we hadn't been previously. So, it was nothing more than that.

Q. Now, you haven't seen this minute or this not verbatim note of the meeting until the Inquiry?

A. Not until the autumn or winter of last year. I suppose I didn't really know the processes of SAIs, you know, where they brought it to and who all was involved. It was a query, it was a question.

Q. You've said again: "Kate O'Neill advised it would be nice to work in an environment doing one job at a time. Reflected workload". I think you have given us details of that?

Q. In relation to other issues around the specific key worker allocation, you feel the issues that arose, for example those nine SAIs, is the potential still there for those issues to arise again?

A. I think we have eliminated that significantly. There is still improvements that I feel could be done and we'll work towards those. One of those would be more engagement with the ward-based patients, whether it could be considered or not going forward if we had sufficient resources to actually have a CNS on the ward round. You know, that provides a format for engagement with the ward staff and patients.

Q. You were involved in the lookback exercise that was carried out in reviewing?

A. Just which part of it now?

Q. At WIT-80977, you are referring to the lookback exercise in relation to the role of the Cancer Tracker and the benefits of tracking patients past their first appointment. Is that improved, in your experience? I know the Panel heard the Cancer Tracker evidence this morning, but from your experience is that system in any way better for you?

A. I think there is still improvements to be made on it. I'm not sure if they are still funded to only go to that point of first definitive treatment. But there certainly is more engagement in relation to the audit processes.

Q. Now, you've said, looking back in your statement, that you didn't think governance arrangements were fit for purpose, and. Is that something that you still feel –

A. I felt from the outset when the Mandeville Unit opened, you know, where people went for cancer treatment, there was no footprint at all for Urology within that setting. I found that strange. It removed the opportunity of meeting on the corridor or seeing the door open in an office where you could put your head in and say 'any progress with, you know for example, the advertisement for the CNSs, or any new equipment requirements. We didn't have that. They were in their corridor and we

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were in ours and the two never passed, except there you would have seen these people at the AGM or MDT. There wasn't engagement all the time. We would have worked closely with the cancer trackers and red flag team. They would have been in and out of the unit so we would have significant engagement with them.

Q. Is that the situation now; is it still that disconnect?

A. There is more to do. I thought about these just recently. We are as a team improving and striving to continue to improve. I have no doubt the cancer team is doing that and others,

'the findings indicate a disconnect between Urology MDT and Cancer Services management'

'we just haven't had the opportunity yet to come together and say what all has been achieved thus far, and collectively how much further can we go.'

Can the SLT check the connecting progress on Urology MDT and Cancer Services?

Dr Swart questioning

Q. Just last question. There was some discussion about letters being copied to patients. What's your view of that, because I was interested to see that you frequently copied your letters to patients –

A. Yes.

Q. But that wasn't commonly done?

A. Yes. It wasn't a practice that everyone done, in the same way when you were sitting in with various consultants at uro-oncology clinics, people work differently. Some people wrote down the majority of the consultation; others would have dictated that immediately after the consultation. So, people practised differently, but you had to be in the room to know what the practice was.

Q. I guess that's my point. Do you think it is important that patients do get a copy of their letter, is a more direct way of –

A. They are one of the main members of the team that's making the decision, they have to be engaged in it. Any virtual clinics that I am doing, they will get a copy of that letter.

How readily are patients in the Trust perceived by staff as being one of the main members of the care team?

Day 43

Ms McMahon questioning

Ms. Leanne McCourt

Q. Now, you were eventually appointed in March 2019 as a clinical nurse specialist, having worked two years in the unit. Even at that time, you say in your statement that you still had managerial responsibilities so that, in fact, fed into the limited time that you had for your clinical nurse specialist role?

A. Yeah. It was frustrating, so it was.

Q. Was Mr. Young appointed at the same time in 2019?

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A. No. Jason actually left the Southern Trust at that stage and he took up another post in a different Trust. So, Jason had left and then I was successful in the CNS post but still with the managerial duties that I had had previously.

Q. Now, looking back in the timeframe the Inquiry is looking at and the arguable opportunity then to appoint a CNS around 2016/2017, in hindsight is it your view that that was a missed opportunity to fill those posts?

A. Yeah, and it's frustrating because, as you have heard yesterday, we had an innovative team, we had lots of ideas we wanted to take forward, and we unfortunately weren't able to do that in the timeframes that we would have liked.

Q. You have mentioned about a concern that red flag referrals are prioritised and there is a danger that because of that, routine referrals are getting longer and longer with a concern that people are becoming more unwell, having originally been maybe allocated as routine?

A. Yeah.

Q. What's the situation with that now? Do you have any knowledge about how those people are moving along?

A. I think there's still an issue.

Q. Still a backlog?

A. Yes.

Q. But it's your evidence to the Inquiry that if there was that capacity in the CNS, that there would be greater movement along the journey for those patients?

A. Yes. It could only be a positive thing

What interim communication steps for engagement are operating with the lengthy waiting lists in the Trust?

Q. Do you have any experience or knowledge of Mr. O'Brien not recognising or preventing the involvement of clinical nurse specialists or key workers?

A. No. I always felt supported by Aidan, from first meeting him as a junior staff nurse. When you are just new into your post, you remember the people that sort of took you under their wing, took the time to explain things. Aidan would have been very much of those people.

Q. You have heard, I think, a quotation yesterday from Martina Corrigan where she said staff felt worn down by no action to address Mr. O'Brien's issues. Is that something that you recognise?

A. No, not worn down in that aspect. Maybe worn down in the volume of patients and things like that but not specifically to Aidan, no.

Q. Did you ever have any experience of challenging - which is the word that was used by Mrs. Corrigan - did you have any experience of challenging Mr. O'Brien regarding being available at clinics, or having to make your presence felt to try and be part of it?

A. I didn't feel it was an issue so I wouldn't have challenged on that, because I didn't feel it was an issue. I felt –

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Q. Just to confirm then, did you ever speak to Martina Corrigan, or Ronan Carroll indeed, about any issues regarding Mr. O'Brien?

A. Not that I recall, and I would have spoken to Martina about day-to-day issues. To the best of my knowledge, I have never spoken to Ronan Carroll. Apart from maybe attending the same meeting he was at, I have never spoken to Mr. Carroll one-to-one.

Q. Did you ever express being frightened of Mr. O'Brien?

A. Absolutely not.

Q. Did you feel you could approach him or indeed confront him if the need arose? A. Yes. Yeah.

Q. Did anyone ever come to you when you were in charge of the rota and indicate there were any problems with working with Mr. O'Brien in this role?

A. No.

Q. The quote that is attributed to you is: "Leanne McCourt doesn't feel he valued the nurse specialists. She recalled him asking her in the kitchen what the role of a nurse specialist was. He didn't understand the role of a nurse specialist". I think that you had said before you had seen this, you put in your statement at Section 21 about this incident. What you have said is to be found at WIT-85958. I will just read from that for you. So, from the top of the page: "In my experience, certain consultants would have sought more key worker input than others would. I do not know why some individual consultants adopted this approach more than others. I do recall Mr. O'Brien stating in general conversation to me 'key worker, what is this key worker role'? I do not recall the specific date or who else was in the vicinity at the time of this conversation. When he arrived to do his clinic, I had said to him that I was available as key worker for his clinic. In my opinion, his response was verbalised in the context of a condescending tone. I was taken aback and do not accurately recall my response. Consultants were aware of the importance of the key worker role as per Kate O'Neill's email from June 2017". So, there's a slight deviation in the explanation of the note.

A. Yes.

Q. The note of the SAI indicates that the problem was with the clinical nurse specialist, that Mr. O'Brien had expressed concern about that, and the note reflects that he didn't understand the role of a nurse specialist. Just in relation to that SAI meeting note, does that properly in your view capture what you meant?

A. No. I have been misquoted. I've been -- I have been misrepresented.

Q. Well, what did you say and what message were you trying to impart to Dr. Hughes?

A. So, I would have said very similar to what I said in my Section 21. Aidan would have been very particular in his use of language and words, and I think it was just the "key worker" word that he didn't like. It's not -- I don't for one minute think he didn't understand what a key worker was, or indeed what a CNS was and what my role was, he absolutely did. I believe he did value that role. It's just he could have been very specific about his use of words and language and phrases.

Q. So his query, in your evidence, was more towards the descriptor rather than function or value?

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A. The term. Yes, the actual term.

Q. You have said it was condescending; did you feel that meant to you in any way he was devaluing or showing any disrespect towards the role?

A. Not the role per se.

Q. Just the name?

A. Just the phrase, yeah. Yeah.

Clarity around language and terminology used throughout the Trust will bring better cohesiveness and messaging.

Q. I just want to ask you briefly about the nurse-led activities that you have spoken about that you have said contributed and improved patient care. One of the examples you give is prostate biopsy service. We don't need to go to this but, for the Panel's note, it is at WIT-85928. Until recently, the waiting times for these biopsies were ten to twelve weeks, resulting in patients having to be sent to the independent sector to try and move them along?

A. Yeah.

Q. Since the introduction of the nurse-led TP service, the waiting times have now reduced to two to three weeks. Is that still the case?

A. In or around. It has fallen back a wee bit with me being involved with this process but we have plans to get it back on track when I am back next week, yes.

Q. So, that's the success of a nurse-led intervention?

A. Myself and Kate, yes.

Q. Have you ever felt any resistance from any of the consultants about any of the nurse-led clinical aspects of your job?

A. No.

Q. I think you said in your statement that you felt well supported by Mr. Glackin and Mr. Haynes?

A. Yes. They mentored Kate and I through the learning of this procedure, yes.

Q. You have also said that the CNSes are now allocated to the consultants' result clinic. When did that process start?

A. That would have started when we came back from our period of redeployment in probably March '21. At the same time, the managerial duties were taken over by the manager of Outpatients. Basically, my managerial duties were taken over by Outpatients, and the manager of Outpatients was responsible for managing the other staff. That freed up the nurses to be able to be more proactive within that role. What happens now is night and day as compared to what would happened at the beginning of my tenure. So, we get the schedules through, we know when the clinics are happening. Usually because I can do the e-roster from my previous role, I have kept that on for just the CNS team. So, once we know what clinics are running, I can allocate a CNS to that clinic. What the CNS does in the morning or the afternoon of that clinic, she has the clinic list in front of her; she will screen through using ECR; she will know exactly how many patients require the key worker input; she will have all her

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information sitting, and indeed she will be proactively in the consultation with the patient, the consultant, and family.

Q. That's expected that the nurse is in that consultation for the results?

A. Yes.

Q. Is that a result of two things, the reduction in the admin duty appointment of someone to take over those duties –

A. Yes.

Q. -- and also greater resources for CNS?

A. Yes.

The success of a nurse-led intervention – a development in practice and a good news story. How can the SLT/communications department relay 'good news/constructive developments' to the Trust - boosting morale and narrative?

Q. You do mention as well in your statement about the MDMs and the quoracy issue. We have heard something about that yesterday and have and will do from other witnesses. Your experience that was if there wasn't quoracy, then at times patients discussed at regional meetings. Can you just explain that, how that came about?

A. If there wasn't a radiologist on hand and a decision was pressing or was time-sensitive and needed to be made, that patient could have been added on to the regional meeting. It's not that they -- if we'd had a radiologist, that wouldn't have needed to have happened, but that's on occasion what did happen in order for the patient to proceed down their pathway.

Q. You have said that can lead to a delay in decision-making. Was that because of the infrequency of the regional meeting or because of some other reason?

A. Because the regional meeting is for specific cases that need to be discussed there. Had we had quoracy within our MDM, some of those cases that were discussed there perhaps wouldn't need to have happened there, so it's maybe putting stress on another MDM when it was really our responsibility to have a quorate MDM to have them discussed there.

Q. In practical terms, if a radiologist was absent locally and there was one available regionally, they could use their expertise?

A. Yeah, on occasion.

Q. On occasion. And they would be informed of the patient's presentation by the consultant in charge of them?

A. Yes, yes.

Q. You have said in your statement that radiology was the one that seemed to have a greater impact by their absence than any of the others?

A. Yes, and that's because we only had one radiologist. I am not taking anything away from him, he is expert at his job, but he is one person and he can't be there at every meeting because of other commitments.

Q. The position, you say, has improved and there are now two radiologists?

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A. We now have two.

Q. Do you still attend these meetings?

A. Yes.

Q. And what's quoracy like now, in your experience?

A. It is much improved. We have a medical oncologist and a clinical oncologist most weeks as well.

What percentage of patients currently are discussed at regional meetings due to lack of MDT quoracy in the Trust?

Q. Do you feel that when you do raise concerns around that or any aspect, do you feel it should be the case that it's fed back down, if I can put it that way; that you are told, even in broad terms, of any learning from that?

A. Yes. I think it's part of the process; the process is cyclical. If it doesn't come back round and you don't know what happened, it's sort of -- it defeats the purpose, I think, because learning -- it's all about learning and being transparent and knowing what happened.

Q. Just on that point, there has been talk about the SAIs obviously yesterday. Was there any formal learning identified for the CNSes as a result of those, for example, nine SAIs?

A. I think, as I said, comparing the CNS role in terms of key worker then to now, absolutely. It's a more robust system, it's a more proactive system. There is now a person within Cancer Services that is in charge of audit, and they would send us a retrospective list at the end of every month of all the new diagnoses from that month. We appoint a CNS each month to cross-check that with the key worker activity so we can identify if indeed any patient doesn't have a key worker and rectify that.

An example of learning and action from SAIs being effective – such examples could be shared regularly throughout the Trust to evidence the value of a learning culture.

Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently?

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of pathway tracking that was alluded to in the testimonies yesterday but, to the best of my knowledge, that isn't currently in position at present.

Q. And do you think that would be a good idea?

A. Absolutely.

Note the improvement in the provision of a key worker for patients with a new diagnosis.

Has the SLT knowledge of how ready is a system to address 'whole pathway tracking'?

Q. You reflect on those cases in your witness statement at 7.28. You say: "I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done. From my perspective, I feel I could have been better informed regarding what had or had not been done about my concerns". In this regard, those were concerns that hadn't actually been raised with anyone beyond Mr. Haynes?

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A. Correct.

Q. You didn't raise them with Martina Corrigan –

A. No.

Q. -- or with anyone within your own line management in nursing?

A. Yes. And with hindsight, I think if I had to do that again, that's what would have happened.

"I am satisfied they received their definitive treatment to the prolonged referral time. However, I do feel that the two patients involved could have endured more anxiety than they ought to have done''

Important recognition of the anxiety that patients can endure on waiting lists.

Q. You speak about learning and improvement in your statement. We don't need to go to it but it's at WIT-85932. You have given some bullet points of the way in which communication and action planning could be improved. Some of these focused particularly on practical application of your skills to the system, if I can put it like that. You have said that one of the ways in which the system could be improved is to enable clinical nurse specialists to have access to a managed DARO list. Could you just explain that a little bit?

A. So, this is a list that secretaries hold for the consultants. I think the actual terminology is Discharging Awaiting Review or Outcome. These are patients waiting scans or a blood result to come back. I'm thinking more of this in terms of my nurse-led work as a safety net for that. At present, I don't have any way of monitoring, apart from me keeping it all on a spreadsheet and revisiting it every week. If I have ordered a scan for a patient, currently the radiology scans don't come back to the nurse that ordered them, they will come back to the consultant. They don't populate in my ECR automatically for sign-off. I now have it set up that my PSA bloods come back to me, so I don't have to go, and not waste time but use time to find them. They are populated on a list, a sign-off list that I can just go to, but the same doesn't happen for the scans. It's just another layer of safety that could be there and prompting me that to look for that.

Q. So you might order the scan as such but the result goes back to the clinician?

A. Yes.

Q. Would it be something that might assist if the result were to go back to both you and the clinician?

A. Yeah.

Is this an idea that the SLT agrees with, if so, what are the steps to implementation?

Q. Just in relation to the concerns overall, you say that you feel "I should have been made aware of the aforementioned governance concerns within Urology." Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

A. Absolutely, and then there's a balance to be struck.

Q. But if you had have known about issues sooner, what difference do you think it might have made?

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A. For a start, you would have had more of an awareness. Referring back to the two cases that we discussed, I think I would have handled those very differently had I had an awareness that there were issues in and around those processes.

Q. And handled differently how?

A. I would have went to my lead nurse and my Head of Service also.

Q. So, you would have escalated the issue?

A. Yes.

'Now, there's tension there between keeping someone's confidence when they are going through a process, or even their practice is being looked at, even informally, and keeping people up to date. Do you accept that, that there is a requirement?

Absolutely, and then there's a balance to be struck'

How does the SLT define this balance and then communicate it throughout the Trust?

Q. Now, I asked you before the break about learning, and I think it was my word to say there was ad hoc learning from the SAIs. I just want to indicate from your witness statement that you are a member of the Task and Finish group. You refer to this at WIT-85936 at paragraph 20.5. This was a group established in 2021 to action the outcomes of the Urology SAI recommendations by the Trust?

A. Yes.

Q. Is this a way in which learning comes back out through the formal system to the CNS, or does the learning sit within the group?

A. So, in a way it's turning the learning into an action that results hopefully in an improvement. Myself and Kate - I think it's myself and - no, myself and Patricia - are within that Task and Finish group. But as for updating the CNSes per se, no, that isn't part of the remit of that group.

Q. So when it's tasked to action the outcomes of the recommendations, how do they do that?

A. So, I have been involved with the service user group. There's going to be a survey as to what information and role they expect within their journey, and we are looking at the information that's given. Out of also this Task and Finish group, I think that is where the additional audit resource has come from in terms of us now having a list each month of the new diagnoses and being able to cross-reference those. So there has been good that has come out of it, but there's more to be done.

How robust are the plans to cascade and embed the learning from the Urology Public Inquiry throughout the Trust so that a similar statement 'there was ad hoc learning from the SAIs' will not hold true?

Mr Hanbury questioning

Q. We have seen that letters weren't automatically copied to patients from the doctors, but we get the impressions that the nurses usually did do that; is that your experience?

A. Yeah. I know within my nurse-led clinics, I would always copy the letter to the patient. A number of the consultants do this also.

Q. Is that happening more now, do you think? Not universally, possibly.

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A. I think it's the same as what it had been, yeah.

What is the SLT's line on the policy of patients automatically being copied in to letters from doctors?

Q. You have also been on this Task and Finish group. What have you personally learned from being on that?

A. There's a lot of wheels in motion.

Q. Yeah.

A. And sometimes the people on the ground don't get fed back to us as to where we are with things and what is happening.

Q. Because you mentioned a few things. Were the changes made quite quickly to start with? What was the pace? What was the feeling of that meeting; was there a sense of urgency? Or...

A. I feel people wanted stuff to happen more quickly but perhaps the resources weren't there to enable that. But there definitely was willing, whether there were resources as timely as there should have been.

Q. Whose job did you see it to unblock those resources; where did you see that?

A. I saw that happening at a higher level than me.

Q. Did they explain to you how that actually all worked –

A. No.

Q. -- or was that a mystery?

A. Mystery. It was not explained.

Q. Do you think that's right, do you think it should be a mystery?

A. I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions. Yes, I think that could be important, yeah.

Q. Did you and are you taking all of that learning back to these consultant meetings and trying to tell people what's happening? Because the nine SAI Task and Finish group, I mean it's a big deal, isn't it, and it ultimately was a big part of matters of this public inquiry. Did you see it as your role to come back and tell everyone what was going on and were people interested, or did it fizzle a bit? I just get a sense from you that it's fizzled slightly.

A. Yes, I think that would be a fair comment to make. I know I would have mentioned it within our small team in passing but certainly not formally. But some of the consultants are on that Task and Finish group as well.

'I think the more understanding of a process you can be -- the more understanding of a process you have, the more you can feed into it and make suggestions'

Taking time to explain clearly a process will reap the benefits of better engagement with it.

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Day 44

Mr Wolfe questioning

Ms Parks

"I do believe we failed to fully and robustly utilise the contractual tools of job planning at our disposal to ensure Mr. O'Brien discussed and agreed a contractual annual job plan, even if this meant pursuing facilitation and appeal mechanisms. This may have helped inform a more cohesive model of management as a repeated failure to comply with such obligations and perhaps others like appraisal may have" - and I think that should say "shone"?

A. Yes.

Q. "The light to indicate potentially a broader problem in other areas of the doctor's practice." Let me put that in context. When you are writing that, you are aware that, at least from 2016 and perhaps further back, until Mr. O'Brien walks out the door, retired in 2020, he hadn't signed off on a job plan; isn't that right?

A. That's correct.

Q. I mean, there were, as we will see in a moment, job plans that were eventually worked out through a facilitation going back earlier in his career. But that's a reflection on the period from the commencement of MHPS or around that period, right to the end of his career?

A. Mm-hmm.

Q. We will bear that reflection in mind and explore it for what it means shortly. But can you tell me from an organisational as well as an individual practitioner's perspective, what is the importance of job planning, in your view?

A. I think it's really very important. It's the key contractual document that should be a partnership approach between the consultant and the Trust to identify the supporting mechanisms that are needed to allow consultants to deliver the work. It's an opportunity for them to discuss with their clinical manager what is expected of them and what they will need to enable them to deliver that for the year ahead. So, it's very much a performance management type of tool in the sense of having those meaningful discussions to decide how is it possible to deliver the work that has been assigned, and it should also then feed into demand and capacity information so that that's driving the job planning discussions.

Q. You mentioned demand and capacity. Is job planning a tool which can address that issue?

A. I believe it has the potential to. I think that's the original intention of it in relation to it should commence with a review of what the service needs to deliver for the year ahead, with the service. That should be considered and then designed into individual or team job plans with job plan objectives to align, taking on board what supportive resources or supporting mechanisms a consultant may highlight at those meetings that are needed to deliver the service**. It allows then the service to ensure that objectives are aligned and job plans are aligned with the direction of travel that the service has to deliver and commission to.**

Currently - how streamlined is the flow from individual job planning to the objectives and direction of travel that the service must deliver?

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Q. "When/where the work is done; how much time you are expected to be available for work; what will be delivered for the employer, patients and the employee; what resources are necessary for the work to be achieved, and what flexibility there is around the above". Do they continue to be key guiding principles of what the process is about?

A. Absolutely, and I think most of those are probably replicated within the contractual documentation for consultants as that's what job planning is all about.

Q. Yes. And it sets out some hallmarks of a successful job plan.

A. Mm-hmm.

Q. And if it's undertaken in a spirit of collaboration and cooperation, completed in good time, reflective of the professionalism of being a doctor, focused on measurable outcomes that benefit patients, and consistent with the objectives of the NHS and the employing organisation in the teams and individuals with whom the urologist will work. Again, is that in keeping with what you would understand to be the requirements of a successful process?

A. Absolutely, and again it's reflected in contractual documentation.

Q. Yes. The third document that you've helpfully referred us to is a more recent document, 2019, local Trust framework for job planning guidance. WIT-89285. Again we can see your name on the front of it, you are the author. It sets out, having glanced at it, kind of practical steps that are to be undertaken as part of job planning?

A. Absolutely.

Q. Now, is the essence of a good approach that there would be a specialty meeting, Urology, that demands on the service would be recognised?

A. Mm-hmm.

Q. And articulated, and that an understanding would be reached about how that should be equitably or appropriately designated between the staff that you have available to you?

A. Yes, absolutely.

Q. And is that the approach that, broadly speaking, is adopted in the Southern Trust?

A. Yes. I am aware of many good examples of that happening where the heads of service and the operational directors -- I wouldn't be aware, I am not involved in those meetings but I do know they occur, in terms of looking at the service, what they need to deliver, what they are commissioned for. They will have discussions with the consultants around maybe what external duties they are taking on for the year ahead or what special interests they are wanting to focus on. It's about balancing all of those requirements against the needs of the service and then designing that into job plans, and more recently into team job plans which are very effective as well.

Q. I suppose, used properly, job planning, if it's actually done, will leave the employee, the clinician, with an understanding, and the manager would have an understanding, as to what's expected, and failure to deliver on what is expected will lead to questions or challenges being posed; is that fair?

A. That's fair, yes.

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Q. It provides a basis upon which inquiries can be made?

A. Absolutely.

Q. Those inquiries could potentially lead to a disciplinary route; is that fair?

A. Yeah, potentially, yes. I mean it's a contractual document so it's a contractual requirement on both parties to participate in it.

Q. Equally, in some cases the failure to deliver on objectives within a job plan might raise a wide range of other issues, the need for help or assistance?

A. Absolutely, yes.

Q. It may lead to conclusions in relation to how well the service, how well the employer is assisting the employee, supporting the employee to deliver on the plan. But it's important to have that baseline, isn't it?

A. Very important, yes

Taking time to establish a clear baseline for the contractual document between the employee and the employer is key to understanding and delivery.

Q. Why, in your view, do some situations lead to -- I will put this another way. Why, in your experience, are job plans not completed in particular settings? Are there a wide range of possible reasons to explain it?

A. I think it's -- my own view is probably I think most people see the importance of it. I think it's probably down to the increasing demand on clinical managers with -- the new consultant contract introduced job planning. It was always there historically but it's much more prominent now in the new contract. It involves a lot of those discussions. All of our consultants need a job plan, all of our SAS doctors need a job plan, so it's a significant number of medical staff across the Trust. It's just probably the increase of that requirement of work based on the clinical management team to undertake that. I suspect that probably has some influence.

Q. Your view that it's an important tool, or potentially important tool, together with something like appraisal which may allow the Trust to better understand what's going on in a clinician's practice, the challenges he or she is facing, issues that perhaps lie beneath the surface which have not yet been identified, all of those things are potentially discoverable through a good, robust job planning process?

A. Mm-hmm.

Q. The fact that this was let sit for so long and never delivered, does that perhaps reflect a failure to understand on the part of medical management the potential wins or gains that can be achieved through good job planning?

A. I think that's fair, yes.

Q. Is there any ongoing work, or any work in light of what we know happened in Mr. O'Brien's case, around job planning?

A. Yeah. There's constant work with job planning in terms of working with our local negotiating committee and providing training sessions, and lots of things to try and see how we can support clinical

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managers because it is an important task, but also ensuring that it's a doable ask for them. But yes, **we are trying to put a lot of effort into -- because job planning is also a tool to attract doctors to the Trust, and to use as a retention tool as well. So, we are looking at how job planning can be used imaginatively. It's a professional contract between consultants and their Trust, but to use it in a way that we can actually use it as a retention tool and an attraction tool as well. We are looking at it from all of those aspects.**

The importance of training to a good standard all those involved in job planning and drawing up professional contracts.

Mr Wolfe questioning

Ms. Glenny

Q. We know, and you've undoubtedly been following aspects of the Inquiry, that this patient chart issue, Mr. O'Brien taking charts home to complete dictation and storing them in his home, that had been an issue for many years. It was eventually tackled as part of MHPS. Should that issue have been nipped in the bud, whether informally, and if not resolved, formally, at an earlier time?

A. I believe so, yes.

Q. Is that the kind of issue that should be drawn to the attention of HR if the medical manager or the operational manager is concerned about it and needs direction on what steps to take?

A. Yes. We would certainly get contacts from clinical managers about all sorts of issues ranging from low level to more serious concerns, so, yes.

Q. Again, the evidence received by the Inquiry talks about issues of triage over a long period of time. By 2015, there were emergent issues around private patients and Mr. O'Brien's management of them, emergent issues around his dictation or failure to dictate following clinical encounters. You have said in your witness start - this is paragraph 17.2 - that the role of medical HR is to respond to requests and provide advice and support when concerns are supported. You say that in hindsight, it is surprising that concerns were not escalated and matters not referred to HR for advice and guidance. As the experts in the field of discipline of medical performance, your office should really have been the first port of call, shouldn't it?

A. I believe so, yes.

Q. What we also see from the evidence is that matters were addressed by managers informally. There were e-mailed escalations; there were colleagues asked to prevail upon Mr. O'Brien; there were colleagues asked to help out; he was granted extra time to respond to queries; workarounds were developed such as a default process to deal with triage and incident reports were raised. But none of that was ever drawn to your attention?

A. No.

Q. How would you explain that? Is that explicable, that issues would be troubling management for, let's call it several years, and yet nobody saw fit to elevate it on to a formal process until 2016? How is that explicable? Does that tell us that managers didn't understand? Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated? What's your best assessment?

A. Potentially a factor of all of those, I think. I mean they were aware there was a Medical HR Department, so I think that that shouldn't have -- we should have been contacted, and I don't know

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the reason why we weren't. I think there's some work we need to do in changing that culture, that you know maybe there's a feeling if you contact HR, they're going to escalate things to a formal matter whenever it's not necessarily about that. You know, there's lots of positive things that can come from an MHPS process, it's not a negative thing. There's lots of supportive measures that can be considered; there's lots of structure and framework that can be put around to support individuals to get an early resolution. I think there's maybe a fear that if you tell HR, that it's like pressing the button, a nuclear button, and things will be escalated. Maybe that's what we need to ensure is not engrained in thinking. I'd like to think that's not a case now, we are contacted very regularly by our clinical managers about issues just for advice and reassurance in terms of how they are handling things. But maybe back then, there was more fear around that all.

'Does it say something about the culture that prevailed in terms of how the shortcomings of clinicians were to be treated?'

Is there an element of fear that still exists in the Trust when it comes to dealing with the shortcomings of some clinicians?

Q. What I put to you is that there's a job of work to do, is there, culturally around understanding when MHPS is appropriate?

A. Yes, I'd agree with that.

Q. Particularly with local clinical managers to enable them to understand that an MHPS process may be necessary and may be in everyone's best interests and not to fear it?

A. Yeah. I think for me, I mean, we don't end up with lots of formal MHPS investigations, and we want to create a more restorative learning culture moving forward. I think for me the importance of establishing and addressing risk to prevent any harm, and how that has to be done robustly, cannot be understated how important that is. If that's managed well and robustly, then you can potentially then come to an agreement as to how to address issues and manage issues in a structured formal way but maybe not necessarily through, you know, formal sanctions. So there's lots of options. But it's the ability to assess and prevent any future harm and address that risk appropriately will be, I suppose, the crux and the importance of it. It's probably not something that's mentioned in great detail within MHPS currently. I'm conscious MHPS was written quite a significant number of years before the response to OSL regulations came in, and there's greater responsibilities there as well.

Q. At paragraph 40.2, if you just scroll down, you talk about the need to -- part of the learning has to be around fostering and encouraging a more open, transparent and fair culture for raising and managing all concerns as they arise. You say: "It is not appropriate to wait until one is sure there is a concern before escalating". Is that observation or reflection borne out of your sense that managers, whether on the operational or medical side, had waited too long here before putting this on a proper footing?

A. Yes.

Q. In terms of the learning and what might be done to foster the kind of culture you talk about - I mean, I am sure Rome wasn't built in a day - what kinds of work streams, what kinds of activities have taken place or could take place to help to build that kind of culture?

A. We have put together a training on managing low level concerns which we didn't have before, and we have delivered that to 70 candidates to date and another 20 to go. So, that looks about -- to ensure, it's talking about the restorative learning just culture, what that means, what that looks like in practice.

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Then also how to manage low level concerns early, and some of the options and interventions that are available, obviously promoting the fact that NHS Resolution can be contacted at any stage. There's no threshold to contact them for external advice, both by clinical managers and the practitioners themselves. It's about promoting a lot of that. It's about following up with maybe skills clinics with our clinical managers to ensure they feel well-equipped and supported to tackle difficult issues and how to go about that. Just improving some of the training and support and skills that we can provide our clinical managers to give them the necessary, I suppose, support and encouragement to take on some of those issues.

'we want to create a more restorative learning culture moving forward. I think for me the importance of establishing and addressing risk to prevent any harm, and how that has to be done robustly, cannot be understated how important that is. If that's managed well and robustly, then you can potentially then come to an agreement as to how to address issues and manage issues in a structured formal way but maybe not necessarily through, you know, formal sanctions'

Do staff at all levels in the Trust have the same understanding of 'a restorative learning culture' as the SLT?

Q. "There is a huge challenge in medical management posts, as often in my experience they cannot give up their clinical workload due to sheer work pressures and often don't want to due to deskilling that can occur if out of clinical practice for a period of time". If we go down to page 72 on this sequence, six pages further down, 90072. At 35.3, you make some practical suggestions around how medical management can be better assisted. You talk about the essential requirement of developing clinical leadership induction training. Has that now been done or is that something that's a work in progress?

A. I think it's a work in progress. Yeah, there's no national framework for clinical leadership; there's no definition anywhere what a clinical leader needs to do so there's huge variety across different Trusts in terms of job description and roles and things. I think that's something that would be beneficial because it would maybe help make it a more attractive career choice.

Q. Again, practical suggestions here. Administrative support for clinical managers; whether management role is also something that needs to be considered. Paragraph 35.4: "Ensuring enough allocated time within job plans to facilitate clinical management. It's an ongoing matter for the Trusts to deliver that", and you think it's critical. 35.5: "Continue to build skills and competencies is important to promote a proactive coaching culture where all managers and staff know they have a clear responsibility to ensure and assure themselves of patient safety". How would you reflect back on the process which you are aware of as a bystander, not directly involved, how would you reflect upon the challenges faced by the medical managers in terms of their, as we now know, limited involvement?

A. I think it would have been exceptionally challenging for them. It's very difficult when you are having to tackle an issue with a peer or with a colleague, they are very closely aligned, you know. It's so important that they have the support and skills and training to enable them to do that, to allow those issues to be addressed early and to ensure the necessary actions are taken to avoid any -- and to protect patients, and also to create good working relationships and good working environments for everyone involved.

Q. Can you give an example of the kinds of circumstances that you've seen pertaining where medical management has worked best and has flourished? What has to be in place, and have you seen it in the Trust?

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A. Yes, absolutely. I have worked with a very -- a number of Associate Medical Directors over the years. I think those that have maybe chosen it, and opted to go into it and have a passion for it, do work well, you know, where they have a strong team within -- you know, like a service-led leadership team where they work very closely aligned to their operational leads and link in for the necessary expert support around governance or HR when needed. That can work well and I have seen it work well on many occasions. I have seen many of our associate medical directors take on very challenging situations with some of their consultant colleagues and manage them effectively.

Q. Why do we have a situation where, from some witnesses who put their hands up to do a medical management role, whether it's clinical director or associate medical director, why does it appear, at least in some situations, to be the case that senior medical managers are coming in when they don't have the right amount of time available to them, haven't had training, obviously are unable to attend important meetings –

A. Mm-hmm.

Q. -- why does that continue to be a problem and one which, if I may say so, the Trust has just had to tolerate or accept?

A. I think the difficulty is medical management posts are not commissioned, they are not funded, they are not resourced. The responsibilities, I think, have extended significantly in recent years as a result of, you know, all of the different processes that are put in to manage and that they are responsible for and the demands on the service. Our workforce plans, I don't believe, have taken into account, I suppose, the fact that we need clinical managers leading and that, therefore, then takes them out of their clinical practice. I think the demands on the hospitals are so significant that that's a very challenging thing to do. But if it was properly commissioned and resourced and training associated behind it, then I think you would get individuals who are -- you know, we are seeing now adept fellows is a thing which has been established where junior doctors are taking time out of their training scheme to buddy up with a line manager and work on leadership projects, which is a really good positive step forward we wouldn't have had in the past. So that gives an introduction to management, but that probably needs to continue and have the opportunity that you are not just a consultant one day and clinical director the next, but there's actually a formal process and career path for clinical managers to follow

Is the programme of 'adept fellows' continuing in the Trust and the development of a more formal process and path for clinical managers?

Dr Swart questioning:

Q. I was going to start with that one. Just following on from that, is there a single person in the Trust who is leading any sort of, you know, big idea, innovative approach to recruitment for medical staff specifically? Where does that sit?

A. Well, it probably sits within our HR Director's remit in terms of, you know, we do have recruitment campaigns –

Q. But have you got a big strategic idea –

A. Yeah. I think it's something we are looking at.

Q. That the Board is involved in? I mean, this is a Board issue really?

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A. Of course.

Q. It is so significant. Is that there or –

A. We have it listed on our Corporate Risk Register in terms of our ability to recruit medical staff.

Q. Have you got somebody saying I am in charge of this?

A. Yes. Possibly not.

Is there a plan to have a lead in the Trust with this responsibility?

Q. Okay. You described very eloquently potential uses of job planning?

A. Mm-hmm.

Q. The challenges, which I think many Trusts face; you would not be alone in that?

A. Yes.

Q. Again, have you an agreed strategic approach to this for the future led by a senior doctor who is saying this is what we are doing?

A. I think that's what we are moving towards. We have had early discussions with our local negotiating committee that this is the area we want to focus on, and our Medical Director is fully behind that and that's the direction we are going.

Q. Have you ever used job planning as the tool you described it could be used as the basis for disciplinary action, if somebody is not fulfilling their job plan? Has that ever been done actually?

A. Not to date, no

Q. Has it ever been done the other way around, to say this consultant can't fulfil their job plan and they need support?

A. Yes. No, I think that does happen, you know, in terms of some of those areas which are very good at job planning. I think our focus is we want to get back to the importance of a job plan meeting and actually having a face-to-face meeting.

Q. Have you actually taken a consultant to say you are not fulfilling your job plan, this is a problem, you have to do something, we have to do something together?

A. Yes. No, we haven't got to that stage, no.

The importance of having a face-to-face job planning meeting.

Q. Another issue which has come through really in most of the MHPS witnesses was around a certain lack of transparency at the time that that happened. What I am talking about is nobody really knew much about the Oversight Committee; they weren't really sure what happened when matters were escalated up and senior people were talking about it. I think in your statement, you've emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing. I think the training that we have just rolled out has very much covered that in terms of making people aware of what the Oversight is, what the

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purpose of it is and what it's all about. But yeah, I think it's a journey about embedding some of that culture and some of those messages right across the organisation.

Q. You have emphasised the need for transparency, for fairness, for openness. Has that culture changed and improved in the last few years? Are you still on a journey? Is there a sort of definitive attempt to improve that, to de-mystify it, do you think?

A. I think we are on a journey, would be the fairest thing.

What measures are in place to test the current position in relation to transparency, fairness and openness? How frequently is this audited?

Q. The other thing that has come out is a sort of secrecy and mystery and all of that, but also a reluctance to manage doctors, not just not to ring HR, which you have described as perhaps due to fear of process. I am presuming you are implying that HR is trying to be less scary in that regard?

A. Yes.

Q. But there also seems to be a general reluctance for doctors to manage doctors, for managers to manage doctors. Is that something you have observed, and why do you think that is?

A. Yeah, I think it probably has been something -- I guess medical staff are -- they are so used to being autonomous workers and independent workers. But it's difficult. I mean, it's not something that I think -- I think it's a journey that we are on in terms of ensuring that they are managed in the same way as anyone else would be managed, and I think that's important.

Q. Do you think that's improving? A. Yes, I definitely do.

Note the importance of continuing this journey of consistency, transparency, fairness and equality with all staff in the Trust.

Q. You also mentioned that there are no standards for a clinical leadership but there are standards, aren't there? The GMC sets out standards. There's the Federation Medical Leadership and Management Standards; there's a range of competencies. Is the Trust attempting to bring some formality to those competencies in in its training programme, or is this also still work in progress?

A. Yeah, I think that's something that's being considered in terms of some of these development programmes for clinical management leadership structures. That has been covered in previous leadership training programmes. I think when you have a cohort of staff and changeover of medical managers, it has to be ongoing continuous thing.

Recognising that there will always be an element of staff changeover - are systems lined up and the training in place to make sure that all new staff are up to speed with the relevant standards?

Mr Wolfe questioning

Ms Glenny

Q. Yes. To try to summarise your experience over the last 10 or 15 years in performance –

A. Mm-hmm.

Q. -- in measuring performance and trying to assess what flows from it and what can be done about the difficulties and pressures faced, is it the reality that demand has outstripped, and continues to

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outstrip, the capacity to address the needs of patients in your local population across SEC as well as Cancer Services?

A. Yes, that's a fair enough reflection. It's not unique to Urology, it's actually the case for a number of the specialty areas.

Q. The Trust recognises that this places patients at risk and has communicated that to the Commissioner?

A. Yes.

When the Trust last communicated to the Commissioner that demand continues to outstrip capacity

In Urology - what was the response?

Q. You have reflected as well at paragraph 24.5 of your statement that when you raised matters through the escalation process, you didn't receive any response. Typically you were, if you like, out of the loop or kept out of the loop in what was being done or what had been done. Do you feel that more feedback to teams on the ground carrying out your kind of role would have been useful?

A. Yes. It would have been useful to know -- obviously we don't need to know everything that's going on and some of those things were confidential, but it would be -- even just to know that, you know, we are dealing with it and take our reassurance that we are dealing with it, because there was a feeling that we were continually escalating things; we were, if you like, adhering to our side of the process but we weren't really sure what was happening outside of that. So yes, it would have been nice to know that.

Note – another witness expressing the importance of 'closing the loop' when they have raised a matter through the escalation process.

Q. Can I turn finally to the SAI report and the response of the Trust to it. As you know, the overarching SAI Review looked at the cases of nine patients?

A. Mm-hmm.

Q. Some eleven recommendations were made and action planning around those recommendations was suggested; isn't that right?

A. Yes.

Q. You were one of quite a number of people appointed to the Trust's Task and Finishing group, or Task and Finish group, in order to take those recommendations forward; isn't that right?

A. Yes.

Q. That group exists under the leadership of Sarah Ward. Is she still –

A. Yes, she is still there but the Task and Finish group has now been stood down.

Q. It's been stood down. If we just look at the terms of reference for that group, WIT-82158. So the terms of reference set out succinctly at the top. "The group is charged with implementing all the recommendations and providing assurance and evidence to the Urology Oversight Group". We can see you named among the members on the right-hand side. The role of the Task and Finish group is set out there, and completion of the work will be 12 months. Has it been stood down because it's considered that the work is complete?

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A. No. The work is certainly not complete, and we are maintaining an ongoing look at implementing a lot of those changes that were recommended. I just think the larger group itself has been stood down. Certainly within Cancer and Clinical Services, as well as the specialty areas, so in particular Ms. Clayton, as Head of Service in Urology Services, is still continuing to take forward the improvement work, as is Mr. Conway within Cancer and Clinical Services.

Q. Do you have a continued role in taking matters forward?

A. Yes, yes. We do discuss all of the implementation plan at our Cancer Management meetings. We look at the improvement plan, which we have dovetailed with the recent NCAT audit that was taken of all our cancer MDTs, and tried to make sure that the recommendations from the SAI, as well as the audit that was taken of all our MDTs, has put together in one improvement plan, which we meet and discuss and are trying to move forward as best we can. There are still some inroads to be made there.

Q. Yes. Can I make for your assessment of how much progress has been made against the recommendations of the SAI? I mean, if it assists, there were eleven recommendations. There was a degree of overlap between them. I suppose the headlines might be that there was a perceived need for a comprehensive pathway audit; there was a requirement to address the issue of quoracy; there was a requirement to address the issue of tracking. It was perceived in the recommendations, or it was, more appropriately, found within the review's report that there was a disconnect between Cancer Services and the MDT itself, the MDT being largely staffed by Urology professionals who reported within that side of the service and not to Cancer Service. Amongst those kinds of issues, are you able to comment on what has been achieved and moved forward?

A. I think we have come a long way forward from where we were. I think the one surprising thing that came out of the SAIs was the lack of line of sight that we really had across all of our cancer MDTs in terms of assurance checks and around the effectiveness of our MDTs. We were very much, from a performance side, looking at our delivery of our cancer targets but when it actually came to delivery of assurances around our MDT effectiveness, we maybe weren't so much good at that. One of the main changes that have been brought in is actually to have an MDT administrator role brought into the Trust, which isn't commissioned but which the Trust has again gone at risk to bring in, which should bring some assurance around the effectiveness of our MDTs.

So, we have started off our audits around our MDT outcomes, and we have since brought in a cancer informational audit officer as well to support that.

Q. That's Mr. Quinn, is it?

A. That's Mr. Quinn.

Q. He commenced his work at the end of November?

A. Just at the end of November. We have already started monthly Urology MDT audits to assure ourselves that those audits are being taken forward appropriately. They are spot-check audits at this stage, random selected, of patients being discussed at audit. We just don't have the full resource to do all of the audit we would like to at the moment, but we are on a road to actually try and implement those kind of audits, and also roll it out across some of the other tumour sites also.

Q. If I could summarise. Where the SAI was bemoaning this disconnect between one service and another where it was saying there was a lack of support for the MDT, the response to that has been to carve out a specific role focused on those issues, and that's what Mrs. Muldrew is addressing?

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A. Yes.

Q. Where the SAI complained, or concluded, that there was virtually no audit, no monitoring of how this MDT was performing across a range of issues, the appointment of Mr. Quinn is dedicated to that concern?

A. Yes.

Q. Are there any early indications of how all of these changes are bedding down and whether you are yet in a position to say whether noticeable positive changes have arisen?

A. Well, there has been some positive change in that even from the NCAT audit that was carried out on all of the tumour sites with the Clinical Leads, the information that was clearly coming out was that there was no -- for MDT principles around how an MDT should be carried out. We are now developing an MDT principles document, which clearly sets out what's required of an MDT; things like an MDT pro forma that's to be completed to bring your patient for discussion, which brings a much better, you know, information awareness around the kind of things that were going to be discussed at MDT. It's a minimum data set to bring your patient forward for MDT. That's been developed also in partnership with the MDT leads and chairs. A communication policy as well, where there was a felt need that we needed a communication policy. So, responsibilities for each member involved in an MDT process for what they should be doing pre, during and post-MDT in terms of communication out to patients.

What stage is the development of the MDT principles document and the communication policy at?

Going forward post Inquiry, it would be very helpful to oversee the streamlining of language and terminology, values and principles in all of the Trust documents.

Q. Thank you. In terms of the key challenges that remain to be addressed arising out of the recommendations, you have highlighted already the difficulty that might affect more Trusts than the Southern Trust in dealing with the tracking issue. Is that the key challenge or the most difficult recommendation to comply with?

A. I think actually the whole thing around the audit of MDT, I'm not sure that any Trust is resourced to provide the level of audit that we would like to do. In regards of assurance around processes and systems of the MDT, and we have talked about it as a group of cancer operational managers, that it is definitely something that we would all like to do; we just haven't been resourced to do it. I know Southern Trust has gone at risk to appoint our two posts in, and we will see the benefit of all those posts in time. But it's at starting point, and we certainly would like to do much more audit than what we currently do. In particular around the key worker side of things, we also would like to audit and ensure that the key worker, in relation to those recommendations, they are actually doing what we say they are, you know, in that they are allocated, they have provided the information and those kind of things. We are not just resourced yet to do that.

Are there any interim audit measurements in place on the placement and effectiveness of the key worker role?

Day 45

Ms. McMahon questioning

Ms. Fiona Reddick

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Q. There's a couple of examples in that paragraph of what you think are poor communication. Why do you think the communication was poor?

A. I honestly can't answer. I just felt that in those couple of situations, it probably could have been better so that there was openness and transparency interlinked between, you know, the specialty and Cancer Services.

Q. Was it a case of you trying to contact people and them not getting back to you, or them trying to contact you and you not getting back; or was no one trying to contact anyone else?

A. I think in those couple of instances, it just -- you know, I had secured the funding and it just felt like a long time -- you know, I'd shared the job descriptions, and it felt quite a long time from the funding was available to the actual nurses were in post. There was poor communication as to why the reasons were for that.

Q. And was that a source of frustration to you?

A. It was, yes.

Q. Did you consider the failure to properly appoint cancer nurse specialists when the funding was available something that had an impact on patient care and safety?

A. Yes, it potentially could have.

Q. Do you think that the poor communication allowed problems to exist and persist, such as the ones that the Inquiry are looking at? Do you think the poor communication from Urology towards Cancer Services assisted in creating an environment where problems were not dealt with?

A. I suppose I have used a couple of examples here that I was aware of.

Q. Well, you were aware of the issues around Mr. O'Brien and triage from 2015, I think? Do you recall that?

A. Yes. In regard to red flag triage, yes.

Q. I know that's not one of the examples that you've referred to but if I go back to my initial question. When you saw those emails -- and I'll give the Panel the note for the emails. 2015-2016, referring to Mr. O'Brien, referring to triage, referring to referral, referring to the build-up of patients who were not coming through the system and representing a blockage to get through the care pathway. Did you think that the failure for that information to be properly communicated to you allowed problems to persist in Urology?

A. Probably, in hindsight, if it had have been more joined up communication, that everything was together, it probably would have dealt with things at a much earlier time.

Lack of clear communication adds to a confused picture, delay in understanding issues and taking the appropriate action to ensure patient safety and care.

Q. Just a couple of things in that paragraph. When you say "I highlighted on many occasions the risk to patients", over what period of time and roughly how often did you highlight it?

A. The risks would have been noted on our dashboard on a monthly basis, you know, risks like first appointments, if we had delays in various investigations along the pathway. You know, we would have

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examined the breach reports, so the reasons why patients were delayed were clearly on the breach reports and they were all, you know, those were shared widely.

Q. So the data was there –

A. Yes.

Q. -- that supported that. Did you feel a sense of professional frustration that because Urology sat outside your boundaries, you couldn't get to the bottom of some of the reasons why performance targets weren't being met?

A. Yes, it is frustrating.

Q. The second point is the quoracy is low due to low clinical oncology and radiology attendance. It had been, in October 2017, 25% attendance and it was now 11% by May 2018. You say that only five meetings were quorate throughout 2017 and it is perceived that this has decreased even further. "Therefore, more patients are not benefiting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision-making process and treatment. 3. Long waits for routine referrals. Due to increasing number of referrals, services concentrating resource on meeting red flags and urgent demand. Routine referral waiting times have increased from 52 weeks to 128 weeks, present day. Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded." The Inquiry has heard evidence that routine referrals, sitting back, not getting priority because of the red flag in urgent referrals, posed a risk to patient safety. I presume that's something that you would agree with?

A. Yes.

Q. In relation to the quoracy, you have identified there delays in decision-making processes in treatment. So, the level of oversight that perhaps is anticipated by full attendance at MDT for Cancer Services is absent if quoracy is not met and the right people aren't round the table?

A. That's right.

What are the 2022/2023 quoracy figures for MDT meetings in Urology and cancer?

Q. "I believe the previous governance arrangements relating to the Cancer MDTs were not sufficiently robust to identify the issues in Urology." "A cancer MDT administrator was appointed in January 2022. They are now leading on establishing robust governance arrangements around the cancer MDTs."

A. Yes.

Q. And that's in place. How effective are all of those posts, those additional posts, how effective are they in bolstering or reassuring you around governance?

A. Those are very effective, you know. They can run reports to give us an assurance that when decisions are made at MDT, that, you know, we can now monitor the outcomes and assure ourselves that those outcomes are actually happening.

Q. He does mention that the peer review process was stood down during Covid and, at the time of his statement, had not recommenced. Has that recommenced, do you know?

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A. Not a formal commissioning of peer review or peer review visits; that isn't happening. However, in the absence of that, I think it's good practice to continue to monitor our MDTs against the measures that are there. So, you know, our service improvement will continue to monitor our quoracy, monitor key worker role. That work will continue to happen, even though it's not properly commissioned or we do not have formal site visits.

Are the plans for peer review and peer review visits to start again?

Q. You mentioned a range of KPIs. Do you ever see those KPIs for the cancer nurse specialists or does that go as well as?

A. For the nurses in my area of responsibility, yes.

Q. What are the recurring themes from that, if you had to summarise it for us? You know, they are doing a lot of very important work; are there some recurrent issues coming up from their KPIs that you have had to take on board in terms of making improvements, for example?

A. I think one of the KPIs is regularly doing a holistic needs assessment with patients. You know, yes, when patients have a diagnosis, they want to know what's happening to me, what's my treatment planned, how long can I expect this to last, and then obviously, you know, when patients get to the end of their treatment, we, at that point, try to do another holistic needs to see, do an end of treatment summary to see what the key issues are moving forward and how we can support those patients living with and beyond their cancer diagnosis.

Q. Does that go to a Trust committee on patient experience, or how do you –

A. Yes.

Q. -- report upwards on that?

A. So, that would go to our PPI Panel within the Trust.

Note – the important value to the patient and the clinician of conducting a holistic needs assessment with the patient

Chair

Can I just be clear because it's perhaps my misunderstanding of the language used here, but it seemed to me that you talked a lot about escalation. To my mind, escalation is where you move something up to somebody more senior so that they can do something about it. Sending it back to the head of service, to my mind, is really not escalation. Is that not just sort of, well, you know, this is your problem, you need to deal with it?

A. Do you mean the head of service within the specialty?

Q. Within Urology, yes.

A. Generally, whenever I was escalating any issue, that would have gone through to the operational support lead, to the head of service and the assistant director within that area.

Q. Of Surgery and Elective Care?

A. Yeah.

Q. So, when you say escalation, it wasn't just the head of service who was expected to sort it out; by escalation you mean, in this case it would have been Martina Corrigan and her line managers?

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A. Yes.

Q. Okay. Thank you. I was obviously not clear in understanding what you meant by escalation.

A. Sorry. They have been schooled to be courteous as well and to give people their place, you know, if they are head of service and go up the chain of service as such.

Q. You don't go over their heads, you include them in it?

A. Absolutely.

Q. I understand.

A. That has always been ingrained into me, to give people their place and where they are in the chain of command.

Having raised an issue to be escalated in the correct sequence, what is the guidance on action when the issue remains on this person's desk and goes no further?

Mr. Wolfe KC questioning

Mr. Marc Williams

Q. "What we really need in the Trust is the recruitment of a radiologist with an interest in general urology, someone that can partake in the GU Service and attend and take the MDT. The only way to achieve this is to make a real attempt to recruit by putting out interesting job plans that offer more than the bare minimum, mentions of flexibility, offsite SPA, more than 1.5 SPAs, recruitment and retention premia. I remain unclear why the Trust does exactly the opposite and how it expects to recruit in the circumstances, which leaves me, as a sole practitioner, which is not safe and not recommended by the College." So you're explaining yourself in fairly strident terms to -- who is Mr. Porter?

A. He is a colleague, another radiologist.

Q. Yes. If we just scroll up to the top of that email, please. You're copying in the Assistant Director for Cancer Clinical Services, Mrs. Trouton, and Barry James. Who is he?

A. Another colleague.

Q. Yes. A. Not working now, but...

Q. Did you ever get direct feedback yourself on this point that you're making, that we need to, as an organisation, make the role more attractive, to be more proactive in our recruiting strategy?

A. No, I don't think so. I think this was something that I suggested a number of times over the years and I didn't get any feedback.

How does HR review the quality of its recruitment strategy and content of job adverts?

Q. You touched, in an email in 2017, on a particular case which had not, judging by the emails, been reported on terribly satisfactorily from your perspective. Let me bring this up and see if you can help us with a little bit of context to this. It's AOB-79923. At the top of the page we have obliterated the name of the patient, perhaps a little unhelpfully for you, but we can go back over some of the emails if you need it for context. But what you're saying here is that: "In this particular case, I think we could have done better in radiology and I am in part to blame as my review of the case for MDT was not complete enough, and I think this is unusual for me. At least the relatives were accepting of things

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after your conversation. As a slight aside, despite having three hours of prep time for the MDT, I find I am having to rush and work at a speed I am not comfortable with just to get through the cases in this time. I will be taking this under review." The fine detail of the case that was in discussion between various clinicians and yourself was, is it fair to call it an inaccurate diagnosis or inaccurate description of the precise location of the malignancy?

A. I think actually, as far as -- I remember the case now, having looked at it. As far as the MDT summary, it was absolutely correct and there was actually no error in the MDT summary, because I think it said something like we do not think this patient has metastases from prostate or bladder cancer, which was factually right. The error was that it wasn't clear on my part, or I didn't make it clear as to where the primary actually was, which was lung. The reason for that was because I had not looked at the chest part of his CT scan, which is a single event in twelve years, I think. It happens occasionally.

Q. Hmm.

A. And I don't know the reason for that, I don't know whether it was because I was rushing. I mean, I rush now, I have to rush to get through my MDT prep in three hours. I work at huge speeds. And I am also keeping it under review. I don't know whether rushing was the cause - it probably did play a part of the reason for it - or just something I forgot.

Q. Yes. And essentially that's what perhaps the Inquiry, in terms of your evidence, wishes perhaps to know something more about. Is it very much a radiology department, even today with an extra radiologist coming in to work alongside you in recent years, is it a department that has, for a long time, been under a high degree of strain?

A. I think you could say that as an understatement.

Are there others ways, apart from recruitment, that additional support can be put in place to ease the high degree of continuous strain that has been experienced in the radiology department for some years?

Q. "We should be in no doubt that the outsourcing of these examinations has caused significant quality issues and prevents the further improvement of our service to the best it can be. We are already ahead of any Trust in Northern Ireland and we could have done better. I have worked hard to get us to this position and I can do nothing more now. Ask any urologist if they are happy with the service. Managers need to rethink what is happening here. The Trust could always try and recruit." So, a number of issues are brought together there. You're unhappy with the quality of the reporting on the part of the independent sector provider, it's something that could be done better in-house, and things would be much assisted with the recruitment of an additional urologist. Is that the thrust of your response?

A. I think the way I recall is that since I came to the Southern Trust, you know, we have spent a lot of time trying to get the prostate MR service the best it could be, you know, with the assistance of the urologists; to try and make the service the best it could be for patients. Which, you know, the way that things were a changing from kind of Trust first, then MRIs later, to pre-biopsy MRI is what we'd achieved, and we were trying to move further ahead of that by progressing with fusion techniques to try and locate tumours and doing reduced numbers of biopsies in targeting tumours, and all of that fell apart as a result of the outsource, basically. That's the way I kind of saw it.

Q. Yes.

A. You know, I felt quite frustrated that all the work had been put in, to sort of lose that quality.

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Q. Dr. Gracey, addressing this, says: "The independent sector provider withdrew their services following criticism of some of the reports by Dr. Williams with the subsequent impact on report turnaround times." First of all, did the independent sector withdraw as a result of criticism directed by you or suggested by you?

A. You see, I wasn't aware of that actually until I read the bundle.

Q. Yes.

A. I've no doubt that I was, you know, critical of their reporting because there were errors, and we feed back, and, you know, I've fed back the errors. Some of the errors I regarded as, you know, fairly basic. You know, they're not just a matter of because radiology is an opinion. It's not just a matter of opinion, it's basic fundamental mistakes. I think they obviously weren't -- they didn't want to be criticised.

Q. You've reflected in your statement - I needn't bring it up on the screen but it's WIT-60286 - that you received support from urologists in relation to your expressions of concern around the standard of the independent sector work.

A. Yes, I think that's true. My memory is not very clear on that but I do remember some of the urologists not being too happy about the reports, yes.

Is the SLT happy with how the Trust monitors the quality standards of any services provided by the independent sector in the Trust?

Mr Wolfe questioning

Q. Just before we come to what the reviewers in the context of the SAI said about what was needed around quorum issues, could you bring together what you've said in evidence so far, doctor, and give us your observations overall on the impact of the quoracy issue within radiology and the MDT on yourself, for the service you worked in, and for patients? What were the real impacts of that over several years?

A. I suppose it's probably mainly the issues were just patient delays. But I mean, they're probably, you know, in a week, or the days of a week in discussion, because there won't have been that many instances where I was absence, for example, or there was no radiologist for multiple consecutive weeks, although it did happen on occasion. You know, whether those cases did have any particular impact, I can't imagine they really had much of an impact on the patient with a delay of a week more than a psychological, the anxiety of having to wait, which is never a -- you know, that's quite unpleasant, I suppose. The impact on the outcome is probably okay for, you know, a week or so. It's not going to make any difference in the outcome.

Q. Yes.

A. The other things - we've kind of hinted at them already - are decision-making. If decisions are made about cases which are primarily based on imaging, then there's a potential for error if there's no radiologist to provide a second opinion on those cases. I think they're the main issues.

Q. Yes. In terms of quoracy, are the meetings of the Urology MDT, from a radiological perspective or from a radiological input, are they now more often quorate than not?

A. Yes. Yes, they're usually quorate now. It's quite unusual for us both to be away, for example.

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Q. Yes. Stepping back into the prep time, we have heard in your evidence this afternoon that you sometimes lost prep time because of a requirement for you to come and do clinical work where there was nobody else available. Is that prep time now much more regularly protected, if not sacrosanct?

A. Yes, I think it is, yeah. I very rarely would ever lose that time now.

Q. Yes.

A. Although I have made changes to my job plan so that if, for example, it usually would be the case I'm on leave on a Wednesday afternoon, I would prepare the meeting on a Thursday instead. So, there are some other sort of safeguards that I can use if need be.

Q. If you just glance at the screen, under the heading of "Assurance" just before recommendation 5, it's back to that what you described as perhaps a gold standard, where it says here that there should be sufficient radiology input to facilitate pre-MDM quality assurance of images. Is that available or is it potentially available through your colleague to you if it was required? For example, a particularly tricky case, imaging maybe not entirely clear, or whatever the problem might be; does that quality assurance option become available to you because there's now two, even if you don't need to use it in every case?

A. Oh, yes. There would be no issue with that. If we wanted to ask a colleague a question or, in terms of the urology, the two of us wanted to go through a case together, that would be, fine, you know, that's easily done.

Q. The other issue raised here is in terms of you being available or your colleague being available for radiological input beyond first diagnosis, so if there's a need for re-discussion of a patient as disease progresses, for example. Again, is that something that you are available to contribute to?

A. Oh, yes. These patients just are put back onto the MDT so they're dealt with just in the same way.

Q. By contrast with how things were for howsoever many years - and we're going to have that checked - but let's say for the five or six years when you were single-handed, how would you characterise the improvements in terms of the capacity for radiological input to the MDT at Southern Trust?

A. I think things have significantly improved. I'm sure there is, you know, always more improvement possible.

Q. Yes. The SAI made some recommendations about how things could be done better. I suppose if you didn't appreciate that things weren't entirely optimal, then you perhaps didn't appreciate the need for improvements but I'll ask the question anyway. Have you noticed any change in the MDM environment since these issues emerged in 2020/'21? Have you noticed things being done differently? For example, is the team -- is the membership of the meeting better supported in any way, is it better organised, is the discussion any different?

A. A lot of it's similar but there seems to be more emphasis on particularly making sure the patient has a key worker. That's one thing, or a nurse who's kind of looking after that patient. That's something that I have noticed, there's been more emphasis on that. Maybe some other things but I can't really put my finger on them particularly. But there just seems to be maybe more structure and...

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Q. Yes. The Trust have carved out a new role for the person on the management side, if you like, who attends. So it's now an Angela Muldrew who is the MDT coordinator. It is said of her that her time, she's now better enabled to give more focus and more support to the needs of the MDT. Is that something you've observed from your role or do you think that's more recognisable in the hands of a urologist?

A. Yes. I think the urologists would know more.

The have been recent improvements in Urology in the Southern Trust - in meeting quoracy at MDT, the appointment of a second radiologist, the appointment of an MDT coordinator and the addition of more CNS's. These developments will have contributed to raising staff morale and improving the delivery of patient safety and care.

Q. You said that there's a recognition of the need for radiologists to do your bit, to do more than simply provide a description. Does that suggest that within the Trust, or perhaps more generally, within health care provision more generally, there is a problem with clinicians failing to read the output from such investigations in a timely fashion?

A. I think that may be the case, but I think also you have to consider that clinicians can be on leave as well. They can be off for a fortnight and there can be things that need to be dealt with. Having mechanisms to deal with that is, you know, it's important. I mean, I certainly don't think the system that we have in place is adequate in any way at the moment; e-mailing someone who could potentially not check their emails every week or who may be on week is not going to be adequate.

Q. Is there anything within the current system that allows you, the radiologist, or the tracker or any other responsible person to know that the clinician hasn't yet actioned the report?

A. Yes. So, this is what I mean by more recent changes. These are things that are being worked on. As we currently are, there is no way of knowing what's happened.

Q. So, there is a mechanism by which you can check to see administratively whether your report has gone out, you do the dictation and it's checked. Then does an administrator, a clerical person, issue that for you?

A. No. So, if the report goes automatically electronically, it just goes out, straight onto automatic, straight onto the electronic care record. There is a paper report sent as well at some point. It will be a little bit slower, obviously. That's done by the administration staff. If there's a flag put on, then that's when the administration staff would be involved as well. They would send the email to the referrer.

Q. So, as we stand in 2023, where do you think the gaps and the improvements are necessary?

A. Well, there's lots of improvements that -- I mean, there really is a lot of improvements that are possible, from using, you know, mobile devices to be able to alert consultants; you have to be sure who's covering and you have to make sure that the report goes back to someone who's actually available, not someone who's on leave; or there is a safe mechanism for someone else to check if someone else is away. There has to be an acknowledgment of reports; when you receive them that you have to acknowledge that you've received them. If there's recommendations, then someone has to check that those recommendations have been followed, or if they have not been followed, why they have not been followed. Lots of back-up, admin staff to do all these tasks of reporting and checking. So there's quite a lot of change.

What are the SLT's thoughts on these suggestions?

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Q. Is there a need for a standard read time by the referrer?

A. Well, there probably -- I mean, there probably should be. I suppose it's the only way of picking up things which you may want to know about. Although, I mean, we are using this flagging a lot more than we're used to, which will identify anything that may need action. I think referrers should check their reports, ideally daily but at least every few days, I suppose. I'm not sure, there's no agreed recommendation.

Q. "What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?" And you say: "I do not think that management take concerns seriously within the Trust and often fail to act or do not communicate that they have done so. I have previously raised, for example, in regard to the duplicity" - is that duplication –

A. Yeah.

Q. - "of investigations and that hasn't been acted upon. When one raises an issue, usually a response is not received. "35.2. Many issues I raised in regard to radiological practice through the Radiology Clinical Director and the Radiology Service Manager which are not specifically neurological are not addressed by managers and opportunities for the improvement of patient care and efficiency are lost." You give examples of SPA entitlement for service improvements, and teaching. "Such issues are raised infrequently as I do not think time raising them is not well spent." Then at 35.3 you say: "There is scope for improvement in radiological practice. Managers need to acknowledge each and every issue raised with them and state how best the issue could be dealt with, rather than appearing not to engage at all." You finish by saying, "Areas of improvement should be discussed with clinical and nonclinical managers and a plan made to make improvements to the service." Does that reflect your experience over 15 or so years, doctor, that you are articulate in raising concerns from time to time about issues affecting your own practice, your service and its impact potentially on patients, but you seem a little despondent that the culture generally doesn't seem to direct responses by to you?

A. I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to. I tend to find that, in the Southern Trust, I think there are so many big issues, major issues, that managers are probably dealing with many of these in their limited time, particular clinical managers, the limited time for managers are dealing with these things. So, things that I raise that are comparatively minor are probably just ignored, because there's no time to deal with them. I think that's probably what happens.

Q. Apart from giving you responses, can you think of any ways, any vehicles, any structures that aren't currently in place that might, with little effort and little resources, be put in place to improve things?

A. I think the problem is that we have -- the supporting professional activities, which as you probably know, is part of the job plan or things other than clinical work, of which it's kind of recognised that 1.5 is the minimum, and that's really for personal revalidation and, more recently, is supposed to include some teaching, but it doesn't include service improvement. I think the Trust is very unwilling to give

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individual consultants additional SPA time for managing a service. So, any improvements that you wanted to do a service you would do in our own time. I don't think there's been -- there hasn't been much encouragement to give consultants additional time, certainly in radiology anyway.

'I think that's summarised it really, yes. I mean, I'm kind of at the point for the last few years where I don't really raise issues any more because I don't feel it's a good use of time. I feel that I am not -- if I raise an issue, either for something that could be improved or something that's gone wrong, there's often no response to that email. That may, of course, mean that it's being dealt with in the background, and I'm sure sometimes that it is the case. *But communicating with the person who has e-mailed the manager, I would have thought, is quite important for staff morale, just to know that you've been listened to'*

What plans are in place to address lack of engagement and to boost staff morale by underlining the importance of listening and communicating clearly?

Day 46

Mr. Wolfe questioning

Dr Boyce

A.At that stage there was no corporate programme for training staff on incident reporting, risk management, because if you don't train staff on how to report an incident, you get a lot of unnecessary work later on, you know, if they grade something either catastrophic that wasn't; or vice versa, you can miss the importance. The coordinator should also have a role in terms of themeing your incidents that are coming in, and really pushing near miss reporting. We just weren't doing any near miss reporting at that stage. You want to get your near misses reporting done because that's your opportunity to fix systems before there's harm done. That wasn't happening; there just wasn't the capacity to do it.

How widespread in the Trust is training for staff on incident reporting and near miss reporting?

Q. In terms of what you say, that the governance arrangements were not fit for purpose, what was missing? In terms of activities, what was not being done which, to your trained eye, meant that it looked and felt as if it wasn't fit for purpose?

A. I suppose everything we were doing at the time was reactive. We were acting where patient harm had occurred. The serious incidents were coming through. But even with that, when those were screened -- so each division within the Acute Directorate had a screening group, so we set that up to try and get consistency of approach as well. Debbie and I got involved because obviously one division within Acute might have not something forward as an SAI whereas another would, so we set up screening groups in each. There would have been the AMD, the Associate Medical Director, the Assistant Director, and they were supported by a member of the governance team to be the consistent voice through each of the screening groups. They would have looked at the serious IR1s, the incident reports that had came in, and looked at them. We also set up as well that the governance team would have done a very brief timeline, because you can't really screen; an incident report might look innocent but actually underneath it's not. So, you had to go to the screening meetings. The Governance team, I got them to do a brief timeline and the Trudy and I worked on that so when the AMD and AD were screening, they had something more meaty to look at and understand what was happening. They would have screened that, and off that went then to become an SAI. One of the issues which we faced at that time was firstly getting Chairs which had to be from the consultant body. In the Trust by and large it was the consultant's team who led the review group. Obviously in their

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very busy workloads, there was no protected time for them to do governance as such. Once you'd secured a Chair then, there had been very little training of the consultant body in terms of how to Chair an SAI. So, towards the end of my involvement there were like standardised training courses available regionally that we could send staff on who were going to be Chairs. It meant you had a very inconsistent approach to how the SAIs were being done. There was also a real nervousness amongst some of the Chairs and panels to actually interview people. There is this reticence to actually get in. A lot, from what I had obviously previously, was being done by note review. So they would have got the notes and just instead of -- when you are doing an SAI properly - I am sort of doing them in retirement now - actually you need to talk to the people because you need to understand the situation they were in, what was happening around them when they made particular decisions and so on. Otherwise, you don't really get to the root cause. From what I observed, there was a reticence in terms of some of the staff to get in there and talk to people and interview. Again, it was time pressure, you know, that takes time. Trying to get Chairs, trying to get a consistent approach. Then getting SAI reports that maybe needed revision because they weren't really quite right in terms of they were too technical, that you couldn't have shared them with the family. The other thing we really weren't doing at that stage was the proper family engagement piece around those SAIs. You really need to meet the family at the beginning of an SAI to understand what they want to know. There is no point writing a report for a family if you don't answer their questions. Again, we hadn't the resource to really engage with the family. There was that whole side of doing dealing with the reactive piece. As I mentioned earlier, we should have been much more proactive, teeming our incidents or complaints as well, because quite often complaints are a good way to spot an emerging issue before real harm happens. Then, developing proactive things. The other thing that came under governance at that time was audit. Clinical audit had completely collapsed within Acute Services in terms of there used to be an excellent audit committee led by one of the anaesthetists, Gail Brown, which was really good. I think there was some confusion as well because quality improvement had come along and there was sort of where does audit fit, you know, and it had sort of lost support. Then, because the consultant team who were running it weren't getting the buy-in, then it just sort of petered out. That's a shame because audit is really useful in governance as your assurance piece. So, if you had done a piece of work and you've decided on your recommendations, then you should be able to use your audit capacity. So maybe your junior medical staff, or like my pharmacists or whatever, you would have directed them to audit something for you because they need to, they have to do audits as part of their job and their training. So, you use that resource if you are doing it properly to then assure yourself that a recommendation either (1) is fit for purpose but (2) continues to be followed. It was very much we weren't doing anything well. It was doing the basics but not really doing the stuff that meant long-term things were going to be safer.

Q. Of course, the concern from those kinds of shortcomings, ultimately it is in and around the safety of clinical practice –

A. Yes.

Q. -- and risk of harm to patients. Is it fair to infer from what you have said that the absence of these activities in the governance arena led you to be concerned that the Trust didn't have available to it the full picture?

A. Yes, I think so. I think that would be a fair point. I mean, I would say the lack of governance wasn't making anything more dangerous, I think it was more we could have be making it safer. Also protecting the staff because, I mean, staff are very traumatised if they are involved in an incident. If we get it

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right, they don't have to go through that. Obviously, patient safety is the key priority but it is assistance to the staff as well in terms of their experience at work.

Q. Your description just now suggests that there was no lack of appetite –

A. No.

Q. -- and no lack of knowledge –

A. No.

Q. -- in terms of how to do this properly, it was primarily a resource issue?

A. Yes. I mean, particularly -- well, just the Governance team but also the consultant body. I had seen models, and I proposed it at one point, that we could have tried to offer maybe a half PA to a number of consultants.

Q. Now, your statement doesn't suggest that you were told that there was a process in train, led by Dr. Loughran but engaging a number of both external and internal professionals in the examination of this issue. We know, the Inquiry knows, for example, that the Trust had sought advice from a urologist based in Great Britain called Mr. Fordham; a microbiologist based in GB called Dr. O'Driscoll that Mr. O'Brien was met with and Mr. Young was met with in September 2010, and that a confidential paper in relation to this was brought up to the Board in September 2010 and again in November. Was any of that drawn to your attention?

A. Not at all. I only became aware that other people already maybe knew - I don't know if they knew before me or after me - when I read the documents that had been included in the bundle that I received. Certainly Dr. Loughran, he hadn't mentioned that to me at all at the time.

Q. Indeed, a protocol appears to have been developed?

A. I see that.

Q. If we just bring that up on the screen. It's a document that I think the Inquiry has considered previously. It's TRU-251143. It sets out the steps required as part of a process to review all cases of patients currently and intermittently receiving IV fluids and antibiotics. It goes through a number of steps, and I assume you have familiarised with that. But again, not something that was drawn to your attention at the time?

A. No.

Q. You were not a junior member of staff?

A. No.

Q. You were at Assistant Director level?

A. Mm hmm.

Q. This was an issue that you had escalated?

A. Mm hmm.

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Q. It was clearly a parallel process that was taking practical steps to address. It was drawn to the attention of the Board. Can you think of any good reason why you wouldn't have been told that this is an issue that had come into the Trust separately through the Commissioner?

A. No. I mean, unless maybe I raised it and then after I raised it, because obviously I can't remember exactly when I first said. The only thing I could think of is maybe it came afterwards, but then you would have thought maybe I would have been updated in the future. It's a shame because obviously the pharmacists on the ward are a resource to keep an eye out to make sure it had stopped. I don't know why I was not updated or included at that point in terms of -- nor why Dr. Corrigan had become aware of it somehow as well.

Q. Again, the system for spotting what the Trust has called irregular prescribing, is it down to the alert pharmacist on the ward spotting the problem or is there a more sensitive way that these kinds of issues could be spotted if they were to occur again?

A. Unfortunately, at the minute it is still down to alert staff, whether it is the pharmacist or obviously the nursing staff or other medical staff. Our prescribing system in Northern Ireland based on wards and medicines administration system is paper-based, so there is no way of sitting back and having an overview. Now, I'm sure you have maybe heard already from other witnesses about Encompass that is coming. It's unfortunate. Back in 2015, I was sitting on a working group. They were going to introduce electronic prescribing and medicines administration system to all Trusts back, I think, 2015. In 2015/2016 that work was stood down because they thought at that point Encompass was going to come quite quickly and there was no point in investing in a standalone system when a bigger system was going to knock it out, you know, knock its position. So, that work was stood down. Today, we still have a paper-based system until Encompass starts in the South Eastern Trust later this year. If you have a full electronic prescribing system administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It would allow you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having alarms ringing, shall we say, that there was something unusual happening.

With the Encompass system being introduced later this year in the Trust, have training opportunities for all staff using this system been mapped out ensuring that the training is accessed before its introduction?

Q. The inquiry has heard some evidence about I suppose the difficulties faced by medical managers, those in the AMD, CD Clinical Lead cadre; busy clinical practices but also a heavy job description that goes with these managerial roles?

A. Very much so.

Q. Any particular reflections to offer on how that might be done better?

A. Again, I suppose it came back to when I put the proposal in about giving protected time for, particularly, clinical staff to focus on governance. I would still have that opinion, either that or maybe outsource some of it to - what I am doing at the moment - recently retired people who are still experienced enough that they can bring their recent knowledge to Chair SAIs and take that pressure off Trusts. But I think the Assistant Directors were slaughtered at the time, and they still are in terms

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of their workload. So things like this were a tiny -- I know they weren't -- in terms of significance, they weren't tiny but in terms of their massive workload. Also, the Assistant Directors as well would have been carrying a one-in-six on-call rota on top of their day job. In terms of the operational management of the hospital and the out-of-hours and weekend period, there wasn't such a thing as compensatory rest for that level of staff. It was massive. Even though, yes, for those poor patients, it's a huge impact, in terms of the daily workload, trying to find time to focus and keep on top of meetings and things, it was just huge for the Director and the Assistant Directors as well.

Q. Is there a sense or do you have an experience of is it left to those in operational management to give informal nudges to clinicians to get things done, and get things done better if there were shortcomings, but really it's up to the medical management, the AMD, to take more decisive action if the operational managers are not able to achieve a successful outcome, and at least exhibited through interactions between some medical managers and Mr. O'Brien, there has been a slowness about taking robust action so that things are allowed to drift. Is that part of a culture that you recognise more generally?

A. I wouldn't call it a culture as such but it is probably a symptom of how job plans and things are arranged in terms of obviously the medical staff, their focus is their patient-facing activity. Obviously the operational staff see the issues starting, and they see -- the admin team and the governance would have known that maybe a panel wasn't meeting, so they would have nudged. Actually if then there was some reason that there was a decision not to meet, they couldn't make the consultant meet or run that panel, because they weren't in any sort of line management control. So it had to go back to the medical management line if the nudges weren't working.

Q. Yes.

A. So, it was out with their scope of control to make it happen

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What are the criteria for the SLT in considering the potential for outsourcing some of the Trust's work to ease the pressure on workload?

Does the view 'I think the Assistant Directors were slaughtered at the time' hold true in the Trust currently?

Dr Swart questioning

Q. You got into this helping governance out roll particularly because of your background, I think, in the patient safety research, and governance alongside that. What was the biggest thing you learned from that research? Then, if you had been able to do something really that would have made a big

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difference in the Trust, what would that have been based on that, because it's bound to have changed your outlook considerably.

A. Hmm, that's a good question. Probably for me, the thing I learned the most was the value of near miss reporting or no harm incident. I think for me that was one of the biggest things because the number of times when you look at something serious, for example if you take the case of the -- the thing that really got me interesting was the case of Wayne Jowett, if you know it?

Q. Yes, I know it well.

A. So, that piqued my interest way back in 2000 in terms of how that could have happened. When you read into his case, he was the tenth child or adult to die as a result of that incident. The fact when you start to look into that and you get into the background to that, the number of times there have been near misses with heterocycle chemotherapy like that, where luckily someone had spotted it. To me, that was a big driver for me in all the work I did, to try and encourage staff to tell you when it nearly happened. For the staff, particularly telling you about something that nearly happened is a lot less scary than having to come forward and say someone has been harmed, so it was win-win. It was win for the staff; they felt more comfortable telling you about it. Then for the Trust, the organisation, you had that opportunity to fix it.

Q. What would you done with that, if you had been able to? Do you see that as something that could have made a difference to the culture at the Southern Health Care Trust, and what were the barriers for doing something like that?

A. I think the barriers were resource. As I say, the vast majority of incident reports we got, harm had occurred, or a level of harm. You would have needed a big resource in terms of training, encouragement and facilitation of staff. I think it would have rolled as it did, we found in pharmacy. Once staff understood what you were trying to do with near miss reporting, it wasn't scary, they could see the benefits, it then took on its own role, because certainly you'll have seen in some of my papers, we started a newsletter –

Q. Yes, I have seen that.

A. -- in the medicine safety. They used to be called cheese news, which was very -- we had a wee cheese thing on it but we changed that. Staff looked forward to getting that. Again, we were trying to be proactive, what nearly happened, and share with them, make it interesting news articles, fun, to try and pique their interest and get them to look forward to reading it every week

How can the SLT impact a shift in culture in some areas of the Trust where staff are encouraged and supported to move from a reactive approach to a learning and proactive approach to patient safety and quality care?

Day 47

Ms. McMahon questioning

Ms. Magwood

Q. Mr. O'Brien has raised issues in his witness statement, and when he gives evidence - and has done and I am sure will do - identifying the lack of resources, the staffing problems, the general concerns around capacity and demand that he, and others, would say infected Urology Services from its inception. When it was created, there was an already identified shortfalls that perhaps were never really recovered from in one way of looking at it. Are you surprised, given the extent of Mr. O'Brien's

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concerns and what you have heard in evidence in the Inquiry, that no one ever came to you for assistance around either capacity building or trying to find ways of delivering a safe service with what was available? Would you have expected to be involved in those more systemic problems and conversations around those?

A. I think I was in the sense of -- I mean you have touched on maybe coming to the day elective care centres. I think the capacity demand, you only have to listen to the news today, this is not unique to the Southern Trust, not unique to Northern Ireland. The capacity and demand is a misfit. The demand for services is well outstripping the capacity, not just in urology but within other services. Within Northern Ireland we've had 20 years of service reforms telling us what we need to do in relation to some of the transformation that needs to happen with regard to the servicing of a population of 1.8 million, as we currently do. So you don't need me to tell you potentially what I think in terms of what some of those solutions might be, but there would have been a lot of work done around trying to look at that. With specific relation to urology, the movement into a day elective care, separating essentially unscheduled care and planned care, was the direction of travel to try to make changes. But I don't necessarily believe that we had -- we had, actually - actually before I finish this sentence - we had at one point considered looking at the hospital system within the Southern Trust about how we might have looked at the splitting of our services at that point in time. But none of those types of changes would have been doable without system support from the Commissioner and wider, and I think now very much sit in a system-wide change programme. I think, to be fair to Mr. O'Brien, to be fair to everybody in the system, I think we've got to the stage now where the system is just so completely overwhelmed, and I don't believe it to be just clinicians. It is admin staff. I have heard Tracey Boyce yesterday talking about ADs, assistant directors in Acute and others, and Heads of Service, people working well above and beyond the call of duty. You only need to read staff surveys around the amount of hours. I think in the Southern Trust, the last survey we did we had 77% of staff reporting that they worked unpaid hours. It is just a system that is overwhelmed and I don't know what other way to put it than that. Certainly, the day elective care centre in respect of urology was an attempt to manage capacity and demand. Back to your question. Sorry for going on.

Q. That's helpful. Some of what you say might extend beyond our terms of reference but I would ask the Panel take your comments under note.

Q. You have answered my second point as part of that, so that's helpful, which was the issue about the loss of corporate memory when staff move around. The Panel have heard some -- as you say, the Chief Executive post was a position held by numerous people over the years. Did you think that was a particular cause of concern for you as a director?

A. Oh, it definitely was. I mean, of course it is. The senior team needs -- for me, it was about trying to redefine. You know, I changed what I did. I think I mentioned in my witness statement as well in terms of trying -- as each Chief Executive comes in or is trying to navigate their paths, their vision and how they wish to have things done, a director with the responsibility for planning and performance et cetera, I would have been working differently and trying to drive forward the vision of the Chief Executive and work closely with the Chief Executive. So, that was a challenge. It was a challenge also because it wasn't just Chief Executive changes. You'll have heard from some of the other evidence, I am sure, but we did have changes to our senior team in terms of creating a new role in the Director of Nursing, and different things that were shifting. For the matters pertaining to this Inquiry, the assistant director team and the Acute Director was a very stable team as in it hadn't changed over that period of time, but there was a lot of change and movement within it. I mention also that within the Governance team, and I think Tracey Boyce's evidence yesterday alluded to that in terms of quite a

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lot of changes in that as well. So, all of those changes do make it more difficult. There has been a lot of expertise lost and experience lost.

Q. It is also the case that some of the changes brought about by new Chief Executives can also be beneficial?

A. Oh, absolutely

The senior team in the Trust has seen significant personnel role changes in the last ten years with the potential loss of corporate memory. How is the SLT addressing the challenges in nourishing and establishing stability and consistency in senior post holding going forward?

Q. Mr. Devlin refers to reports that are sent up to the Board from the committees in his witness statement. He says that it is a fair reflection -- sorry, in evidence he said that it was a fair reflection that reports from committees aren't generally the subject of great debate or input at Board level?

A. Yes.

Q. Would that have been your experiences also?

A. It would. I think what the non-executive director members and the Chair of those committees would have brought for noting, you know, there would have been an update, maybe a verbal update on just what the last meeting had been about, et cetera. But I suppose the assumption was that's why you had the committee, the committee to do the work and to do the challenge, the discussion on behalf of the wider Trust Board. So, I would have said there wouldn't have been a lot of time spent on those at Trust Board.

Q. It seems that there was a slight shift, you have said, about the assumption in that assumption. Mr. Devlin states in his evidence: "It was not a regular occurrence for information that was discussed at committees to have any detailed conversation at the Trust Board." Then he goes on to say: "We did in probably October and November 2021 then begin to have a conversation about risk appetite and about what the process should be for escalating from committees to the Board."

A. We did.

Q. Given that was only in 2021 and given the historic nature of the issues before the Inquiry, do you think that conversation should have been happening sooner?

A. I think that's a fair comment.

Is the SLT confident that the Trust Board is now receiving and reviewing all the relevant reports and papers in accordance with the Trust's brief?

Q. I know we have shortened your statement considerably and tried to highlight the key issues that will allow the Panel to explore them with you in oral evidence. They obviously have the written evidence to supplement that. Is there anything else you would like to say or want to cover while you're here?

A. No. Other than, you know, I'm very sorry for the position that we're in and it's a source of deep regret for me for that. In terms of some of the work that's going on now to address maybe improvements, and particularly the governance link, I think some of that is going in the right direction. We described the governance report. One of the things I had started, and it's maybe just because as I'm talking now - I don't think it's in my witness statement - some things that I think is important in terms of relationships and stability within the Trust and the leadership and bringing together

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information, is, I had, as you know in my witness statement there, some responsibility around the quality improvement sort of agenda. In particular, in 2016 I had established a quality improvement steering group, which was intended at that time to do what the systems don't do yet, which is a bit more triangulation of information and insights from a number of sources. That group had been established, but it never really got full traction because of the changes in personnel, et cetera. It continued to meet. But I think there is something there in terms of learning around, aside from just data driven - which is important - data driven indicators and change and bringing information together. But the relationships particularly across the professional disciplines, that steering group we had established had the Head of Social Work, Head of Nursing, Head of Medicine, with a key indicator around enabling our workforce. One of the thing that was described, I suppose now that you have asked the question, I did hear some evidence from Marc Williams. One of the comments he made is that the organisation didn't encourage people to improve services. I would disagree with that quite strongly. I think the point of establishing the quality improvement function within the organisation was to do just that. We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted. In the first year of establishing the improvement team, Dr. Wright and I had established from the governance agendas, and in particular the complaints data, around issues around communication and, at that time, infection prevention control. We did a campaign with staff on a broad spectrum of encouraging people to do improvement projects, and we committed in support of 15 projects in that year, taking information that was coming from governance. I think that's something that could still be done more, that there could be a bit more done in that space.

'We had a model in the organisation, No Improvement Too Small. There was opportunities for people to be supported to bring forward improvements, and I think that's a good thing. It's not as connected at the moment in terms of directing the improvement works to the areas that maybe need to be targeted'

Has the SLT updated its approach to quality improvement projects?

Q. And why is it that escalation is regarded as a substitute for action. Now I don't expect you have to have the total solution to that, but do you have any reflections as to why that's the case, other than the extreme work pressure, which we have heard about and which is acknowledged and the complexity of the organisation, is there anything else, do you think, that's fundamentally responsible for the fact that a number of things don't seem to have filtered up to the right people?

A. Yes. There's probably something in the space and it's very much in the governance space, I guess, people being very clear on what their roles and responsibilities are and it's not necessarily somebody else's responsibility. So whether there is a diminution of people's understanding of what each person is responsible for and what you are certainly responsible for as a leader, I don't really have the answer to that. I do think, as you have articulated quite well, I suppose probably my own assessment and my own experience. Like I said, I would reiterate the fact that I do think it's not just as simple as saying culture, I think there is more to it than that. And I do believe there to be subcultures, but clearly it's a leadership challenge at all levels.

Q. So, in that vein, there is my impression, and I think we have heard evidence that people have concentrated very well in their areas –

A. Silos.

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Q. -- of the different committees and in their professionals areas, so you can call it silos, you can call it all sorts of things, but it doesn't seem to be integrated governance in action as far as the evidence we have heard. So what discussions have been had at Board level about how to make a more integrated approach to performance, et cetera, a reality, because it's another thing that's easy to say and difficult to do. My question is around does the Board regularly discuss this, has it discussed it, did you have any contribution to that discussion and, in that regard, what did you regard your role as a Board member in terms of facilitating the difficult discussions underneath some of these issues?

A. Okay.

Q. So that's quite a broad area.

A. There's quite a lot there, yes.

Q. It's about integrated governance and how you as a Board member can execute your responsibility for everything, it's not just within your portfolio?

A. Sure.

Q. And whether the Board in a wider sense really grasps the need for that given the breadth of the issues you are facing?

A. So if I start with thinking about the intent of the Performance Committee, for example.

Q. Yes.

A. The intent behind the Performance Committee was to consider performance in a broader optic, and not just about –

Q. The numbers?

A. -- the targets et cetera. So when we would have had a session on cancer or whatever, I mean the Board determined whatever area to drill down into in a deep dive type thing, it was an opportunity then as Board members to really get under the surface of some of those things.

Q. Did you, do you think?

A. No, I think we made a start. I think we did make a start. What I can say as a member of the senior -- here's how I measure that: As a member of the senior management team those meetings started in October 2019 and at every meeting I learned something. I think that is a measure of what I wasn't otherwise finding out some way else. So there was an opportunity for people to talk people into the other issues they were facing within their services et cetera. So I think that could be part of the solution certainly going forward.

‘but it doesn't seem to be integrated governance in action as far as the evidence we have heard’

On a scale of 0 – 10(being fully integrated) where does the SLT rate the current level of integrated governance?

A.The other area, and again under Mr. Devlin's Chief Executive accountability meetings, I think, yes, you will have had that in your witness statements as well. There was, again albeit you could say it is siloed in the sense that it is looking at specific directorates, but it was certainly aimed at, we created those dashboards to try to say well what the safety indicators, what are the quality indicators. So my team were very much around trying to enable that. As I said it is a corporate role to try to enable the optics on some of that and governance was a part of that as well, as well as other indicators that come

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from finance and HR. So it was to get a broader look at the challenges in the organisation. But, given the scale and size of it, I think there are certainly opportunities. And why I mention, perhaps, in my last comments there around the likes of, whatever it is called, quality improvement, steering group. Certainly I know when Dr. Khan was acting in the medical role, he says we could build this to become some sort of safety quality oversight group. And it didn't need to be producing just reports, it needed to be relationships, insights, putting things on the table and trying to make connections. So I think there is something more that could be done in that space. Whether that could actually be replicated at other levels given the scope and span of the organisation into particular service areas, something like that I think would be useful.

What is the view of the SLT on this comment?

What further realistic plans regarding safety and quality improvement can be moved forward into action?

Day 48

Mr. Wolfe questioning

Mrs Elliott

Katherine Robinson is reporting to Anita Carroll, "see the attached list". "This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome to some of these patients. There is a risk that something could be missed so I am escalating to you although I know that a lot of the time Mr. O'Brien knows himself what has to happen with patients. Unfortunately this was not highlighted on the Backlog Report."

We have just looked at an example of what a backlog report looks like. "The secretary assumed we knew because there has always been issues with this particular consultant's admin work from our perspective. As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality. The secretary also advised that at present Mr. O'Brien is working is some of his backlog admin report as he is off recovering."

'As learning from this the discovery, I have asked all secretaries to provide this information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality'

How regularly is the Backlog Report being monitored for adherence?

Q. "This incident demonstrated that the secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every attendance on a timely basis. I would have expected that Noleen Elliott, Mr. O'Brien's secretary, would have been following up with her consultant Mr. O'Brien to advise that he had not dictated on clinics. Also I would have expected that when she was aware of delays in dictation, she would have brought that to the attention of her service administrator, Andrea Cunningham. If this had happened, this would have been apparent on the backlog report and would be visible to myself", and those others she mentions. Do you accept that criticism, that this was an aspect of your role that you should have been performing?

A. Not really, no. As I said I looked -- I believe that that backlog report was a secretarial backlog report. I was never told that I was to highlight the backlog of a consultant on that backlog report. There was that mechanism of that 3D report that was already in the system for the service administrator to see what was outstanding.

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Do all the secretaries in the Trust have a complete understanding of the full purpose and requirement of the Backlog Report?

Day 49

Mr Wolfe questioning

Mrs Elliott

Q. Do you have visibility on the needs of the patient in a situation like this? This patient had suspicion of metastatic prostate cancer, he needed a bone scan; that didn't come to light and wasn't actioned until July or August 2020. This was obviously a period of some destabilisation within the Trust with COVID, Mr. O'Brien retired and the circumstances around that. But in general, if we can look at it perhaps, where a review isn't possible because of the capacity reasons that Mr. O'Brien is suggesting there, and you agree with that, what happens in the meantime for a patient where the scan results are saying further action is required, this patient may have cancer?

A. Well, to me that is very much up to the clinician to make the arrangements around that. That is not something a secretary would have within her remit. We certainly did not have the time to chase up every single result and see that it was actioned.

Q. If that patient had been on DARO, the service would have had visibility of the fact that results had come in from radiology; isn't that right?

A. That's right, yes.

Q. And would have had visibility that those results hadn't been actioned because the case still remained on DARO?

A. Yes. So our service administrator -- the narrative, should that person have been on DARO, how I would have validated that DARO would have been "result with Mr. O'Brien to see and action". Now, that happened on a regular basis but our service administrator never came back to say why has this not been actioned, so I'm not sure whether it would have went anywhere. All right, it would have been noted on the DARO but whether those sorts of things were ever actioned, I am not concerned -- I am not convinced that they were.

Is the monitoring of DARO a watertight system in practice?

Q. Before leaving this, can I ask you two more questions in relation to this area? When results come in, is it any part of your function to plan something, to make a quick assessment from a non-clinical perspective of how urgent a case might be?

A. Well, unless it really jumped out at you, we would have generally just read the conclusion. We certainly hadn't time to sit and read all the results. It was very, I have to say ad hoc as to what time we had to read. We are not clinicians, so not all things I suppose that were red flag or of concern were highlighted by the secretary.

Q. In terms of the cancer tracker, would you have any engagement with the cancer tracker when results came in, particularly where results suggested an unexpected course or a serious course for a patient?

A. This is just if they were a newly diagnosed cancer.

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Q. Or in Patient C's case, where there had been a history of cancer and this was a situation where there was a suspicion of metastatic disease from the primary.

A. I am not convinced, I am not sure if this patient was on a tracking system within the MDT. I can't really comment on that because I am not sure.

Q. Yes, but what I'm saying is regardless of whether the patient is on a tracking system, if you as the secretary see something untoward in the result, do you have any role - I am thinking here from the perspective of an additional safety net - to get the thing moving with the cancer tracker?

A. No, no. No role, if that's what you are saying.

Q. You had no role in that respect?

A. No. I never referred anything to the cancer tracker for MDT discussion.

Post Inquiry – will there be a refresh on the role and responsibilities for all secretaries within the Trust?

Q. Just briefly then to conclude, Mrs. Elliott. Some of your reflections contained in your witness statement refer to the extremely long waiting lists. I think you say that your main concern in urology was these extremely long lists, there was not enough capacity to deal with the workload and therefore patients suffered. You talked about how you had been, I suppose, taught coming up in the Trust, particularly in your governance roles, that we should be aiming for a gold standard, as you describe it, but that wasn't deliverable as time went on. Is there anything more you want to say about that?

A. I think there seems to be a bit of a disconnect in what governance inspired to do and what is actually happening. It is just not achievable to have that gold standard.

Q. One of your reflections as well is that management needs to engage more with the workload. Was that a disconnect as well?

A. Very much so, yes.

Q. What could they have done about it, do you think? What should they have done about it?

A. Well, I think they just started to strip away any support we had.

Q. This is on the administrative side?

A. Yes. So we started off with four, I think four audiotypists; we ended up with one, and we were just expected to work harder and harder.

Q. You have reflected in your statement at WIT-76358 that the move to the Breast Service, I suppose, has led to an improvement in your working environment and you find it to be a more effective service. What are the differences that you are observing from a position as a medical secretary in that service by contrast with the Urology Service?

A. It is basically the difference in day and night.

Q. Could you give us one example of how things work better and are better for patients because you're able to do your job as a secretary in a better way to work?

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A. Because you had more time to do it, more time to check on things. We attend the MDT meetings so you are very much aware of the cases that are discussed at MDT and you follow it up. It is just a pleasure to work in compared to urology.

It would be helpful for the SLT to continually shape an appropriate and empowering narrative around realistic expectations of the workforce as it deals with a demanding workload and stretched resources.

Q. When they are on their third or fourth time ringing up, what kinds of things did they say to you?

A. Well, a lot of it was frustration. It was frustration too on my part because there was nothing we could do. I think they accepted that, that it was out of our hands.

Q. Was there ever a time, for example, when you could liaise with some of the nurses or someone else to talk to them, because a lot of them would have had quite clinical complaints, I would think, and they would need someone to talk to. Were there any discussions about how that might be managed within urology, as far as you were aware?

A. We were never actually advised that we had the nurses there for a backup. That was never something that I was aware of, and I don't believe any of the other secretaries ever transferred to the clinical nurse specialist.

Q. What do you think; do you think that would have been helpful?

A. Well, I know now that that is expected and, yes, it would be very helpful. But at that particular time, those clinical nurse specialists were up to their eyes with work so they didn't need patient calls as well. You know, they were under-resourced as well.

What is the view of the SLT on CNS's being available to support secretaries when patients are frequent callers?

Q. Now that you are with the breast team and it feels like night and day, as you described it, what do you think is responsible for the different culture in that department? I know you feel you have more support; is there anything else that you have noticed that is different about the way that department works?

A. It works the same way but it is under less pressure.

Q. Specifically, though, you told us that in the breast team you went to the multidisciplinary team meetings. Did you feel there was less of a hierarchy in the breast team in terms of everybody recognising the importance of everybody in the team?

A. Yes, there is certainly more use with the clinical nurse specialist; they play a big part in the breast team. As I say, I attended the MDM and it means that you are very aware of outcomes.

Q. What is the situation when the patient is ringing up there?

A. Less patients ringing because they are seen within two weeks. The turnover is extremely fast.

Q. Even so, you said a few things that indicate that the relationship with management, as you call it, wasn't fantastic. Who do you regard as management? Who is management? Do you mean the service administrators and people down that end? Do you mean the senior management of the hospital?

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A. Well, the service administrators and then up to Katherine Robinson. Yes, that is who I see as my management.

Q. And that is where you feel that it wasn't very helpful. Do you think the Trust as a whole creates an atmosphere where all the staff feel valued?

A. Not particularly, no.

Q. Why do you feel that? What do you think the source of that is? I am sure they wouldn't set out to be like that.

A. I don't know how to describe or why it has went that way. I think everybody is just running about chasing their tail and nobody has time for anybody.

'Q. Do you think the Trust creates an atmosphere where all the staff feel valued?

A. Not particularly, no. I think everybody is just running about chasing their tail and nobody has time for anybody.'

Think about the importance of and how to 'be present and available' in interactions with staff amidst a busy workload.

Veryan Richards

18/7/2023

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Part 5.0 Public Inquiry – notes and reflections (day 50 - 57)

Day 50

Ms McMahon questioning

Dr Rankin

Q. Do you feel that when you were the Director of Acute Services in 2010 that there was a greater cross-fertilisation of information between the medics and the operational side so that people had a global view of issues?

A. It's very difficult for me to compare what happened in my time to somebody else's time but I do feel that we had connected systems. We had connections between the clinicians and the managers at all different levels. That was part of what I was seeking to ensure was in place. I think the openness of dialogue, which I am sure was never as good as it should or could have been, but there were never any clinical issues that were brought to my senior table that I actually didn't already know about through somebody having a conversation with me. The benefit of having the open door policy, having the senior clinicians dropping in and out, the benefit of walking the corridors, walking the wards and spending time with staff to listen. Now, not every member of staff would have opened up about things but many did. When you are walking around the hospital with a cup of tea in your hand, as I always did - it's one thing I haven't got here, is a cup of tea - a cup of tea in hand, it makes a deliberate statement, 'I want to have a chat'. I know people are busy and if you find there's something very serious to talk about, you come back and find a time to have that conversation.

Q. So visibility was a benefit in relationship building and confidence-building?

A. Very much so.

What steps can the SLT suggest to encourage all members of the senior team to become more 'visible' and for the SLT to lead by example?

Q. You do say in your statement at paragraph 28.5 that you spent "considerably more time with the Urology clinicians than the clinicians in any other specialty in acute medicine across a range of over 16 specialties across both hospitals."

A. Yes, that, in fact, is true. That's because of the Monday evening meetings. If you have a fortnightly meeting with consultants over 16 months, that is a lot of time. The meetings were all at least 90 minutes and often there was the informal conversation after the meeting, so you wouldn't really be leaving the room until 7:00. That's two hours every fortnight, so that amounts to a lot of time.

Q. You also speak to the difficulties in bringing about change in behaviours –

A. Yes.

Q. -- in order to meet targets and performance metrics. I will just read what you say at paragraph 29.5. For note, it is at WIT-15822.

Q. "The issues of changing the behaviour of the consultant team to meet the required new-to-review ration of patients, and new clinic templates in Outpatient clinics to increase the day case rate and lower the inpatient elective workload and to meet the BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was

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also unusual for the Director to have to formally write to each consultant setting out the the requirements for change tailored to each individual's practice." Just in relation to the last sentence, how often would you have had to write formally to consultants to set out the requirements again of what they needed to do?

A. I don't think I wrote to any other consultant across all the specialties. We achieved the changes that we needed to achieve, both in relation to Outpatient new-to-review ratios, but also in new pathways for patients from the Emergency Department through to specialties and vice versa. All of those changes across the many ranges of specialties and many changes to reform and modernise were achieved without final resort to a written letter to the consultant.

Q. How difficult is it from a governance perspective to deal with an individual, whether it's Mr. O'Brien or anyone in the Trust, who seeks to, or by his actions, circumvents systems in place to ensure that there's a standardised approach to clinical care, or at least their actions trigger the appropriate response?

A. It really is very difficult because some systems are electronic and automated and you can use the ability to alert when something is going to happen or has happened. I am sure we will come to some of those scenarios. Some of the other systems, when you don't have the ability to have electronic flag, they are human systems, and human systems always have the potential for failure so they can never be completely foolproof. But you expect people working in the Health Service to automatically understand about safety and to learn whenever there are processes going on which are not in the best interests of patients as seen by most of the world. So, it is difficult managing somebody who has a view that whatever they are doing is the safest thing, despite the rest of the world disagreeing with that.

Are there any current areas in the Trust where there are difficulties in bringing about behaviour change?

A. I think the journey that we were on in terms of embedding the culture of if an incident occurs, recognise it as an incident, discuss it, report, let's learn from it.

Q. Yes.

A. That learning process, and making sure that the culture was around learning from an incident as opposed to let's hide it, we don't want to know about it or own up to it, that journey of opening the culture was a journey in progress. That's a really, really important organisational journey. That's what the core thrust of the corporate review of clinical and social care governance was about. I am sure you have heard about that and seen the documents around that. That was absolutely the core of what we were seeking to do. As you well know, it takes a long time to change a system. That required all of the staff working day in, day out in the wards and Outpatients in every which part of the hospital to embrace that culture, to recognise. I mean, there were still times when a senior leader, a senior clinician would come to me and say, 'by the way, I quietly want to tell you this has been happening for a long time, nobody has been prepared to own up to it but did you know', and you go gulp, deep breath time, 'right, what do we need to do'? So that's –

'The journey of opening the culture was a journey in progress' – post Inquiry, what does 'opening the culture' require at this stage?

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Q. In that vein, a lot of people, mainly I think after your time, had said that there was a very big emphasis on performance and that data for performance was looked at very carefully, but that there wasn't much robust data to cover quality issues other than when things went wrong, and that, therefore, one didn't necessarily know, for example, if cancer peer review standards were not being met, or if people weren't following policy, or if people weren't using best Royal College guidance. Was that something you recognised in your time and did you have any views on that?

A. All that data was there. All the cancer review documents were there, again with clear action plans. All the RQIA inspections, announced and unannounced, were clear, they were always in Trust Board papers, they were in my directorate governance papers, the action plans against them were in directorate governance papers.

Q. I am talking more if you were asked what's the quality of clinical outcomes in Urology, would you have data to look at?

A. No, I wouldn't have at all. Whilst we as a Trust joined CHKS and we engaged in the process of contributing our data to CHKS, I think in my time it only got to maybe a divisional level, it didn't get to specialty level. There was a process of cascading, cleaning and assuring the data. Certainly I think there was a basket of 23 metrics that we were measured against, and we rated highly in the UK against that, but those were largely around performance and that's maybe where the perception has come from.

Q. I think that is what they said.

A. Yes.

Q. They said this is performance.

A. Yes. The audit of clinical practice and having an audit against that either locally or nationally, no, I felt that was a gap.

Is the SLT happy that there is now a high standard of robust data to cover quality standards across all the specialities? If not, as a priority, what immediate steps can be taken to address this?

Day 51

Ms. McMahon questioning

Mrs. Kingsnorth

Q. The review, what was the outworking of that in terms of how you were able to carry out your job effectively? You have mentioned the 2019 review. What improvements or did you see any improvements after that?

A. Well, there was improvements from the viewpoint that we started getting moving through those current SAIs, and then getting those finished, completed and sent to the Board and to the families. It never really sat comfortably with me getting those reports out to families because I would have built up a rapport -- in my last job, I would have built up a rapport with families, they would have known him, they would have phoned me, I would have been able to contact them and say this is where we are at with the review. With these people, I was coming cold to them, do you know what I mean. The first thing they were hearing from me was a phone call, which was really difficult for them to take in, you know. We did a review of an incident that happened maybe two/three years ago and we were only completing it in 2019.

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Good 'customer care' standards towards patients – should always be seen as part of a deliverable care package and not an optional extra in healthcare. When was the last audit of this done in the Trust? What did the results show and what actions are planned as a result?

Q. If we go to the Directorate Risk Register of July 2019 at WIT-94611. If I can read the extract from that rather than we all strain our eyes trying to find that. It says: "As of April 2018, there are 1,609 standards and guidelines identified on the Trust register. 74%, which is 1,193 of these, are applicable to Acute Services Directorate. Of these, 34%, 405, remain at a partial or non-determined level of compliance, with many identifying significant external barriers impeding the Trust's ability to comply." I think you have mentioned some of those external barriers are buy-in from GPs, and you have also mentioned, I think, the Board as well?

A. Yes.

Q. HSCB?

A. Yes, about implementing certain processes. You know, you were tried to waiting on those processes being fully implemented.

Q. From the figures provided in April 2018 to Dr. Khan's report eight months later, the figures have risen from 34% to 47%?

A. Mm-hmm.

Q. Did you ever undertake a similar sort of analysis to find out what the standards and guidelines situation was while you were the coordinator?

A. I hadn't, no, but my standards and guidelines manager did do, and she would have produced reports for me and then for my senior colleagues as well every two weeks. These would have been discussed then.

Q. Would they have been discussed in percentage terms of the total not yet implemented, or partially complied or needing reviewed?

A. Yes.

Q. The figures that I am bringing you to from 34 to 47, do these sound about right in your recollection of the amount outstanding?

A. Yes.

What are the current figures?

Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly?

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback

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through the system. It was more difficult to do that for me with such a broad remit, so that's why the guidelines team were particularly good and particularly active at following through on that.

Is the system for guidelines monitoring fit for purpose and regularly audited?

Q. In terms of staff -- I know you mentioned that the sister had meetings and there would be conversations around governance but, more widely, did you have a sense that staff across all disciplines, ancillary staff, had an awareness of their own individual responsibility around governance to alert the appropriate people if they had concerns?

A. I think the ward sisters had and the ward managers had. I would have done direct face-to-face training with them on Datixes, but –

Q. How often did you do that?

A. So that would have been done probably every few months. It would have been either me or Carly or David, the two Band 7s, that would have run that training with them.

Q. Just to clarify, Datix training every few months with staff on the ward?

A. Yes. Whilst they didn't get it every few months, they would have got it once, you were rolling out the training for staff to attend. It wasn't very well attended, you might have had maybe five or six people there at training.

Q. So was it optional?

A. It wasn't in their mandatory training, and perhaps it should have been. It is in maternity, mandatory training for midwives.

Q. Do you think that would help if it was mandatory?

A. I think it would because when I first came into post, I think there was a negativity around putting in a Datix. It nearly seemed to be that you were reporting somebody if you put in a Datix. You know, in maternity, that was the case. I had to change the attitude to staff and say, you know, hold on a minute, this is not about a person or an individual, this is about a system and process, so we need to be looking at this, Datixes are not used as oh, I am reporting somebody because they did this and, you know, putting a negative slant on it. I would have seen Datix submissions as a positive because they were recognising there was a risk there, they were escalating the risk there and we were doing something about it.

Q. Would you have ever been able to, given that you had the global view of Datixes, would you be able to identify themes –

A. Yes.

Q. -- or system weaknesses from across all your areas of responsibility?

A. Yes. Technically you can do that because we would have run reports off and said, right, okay, can you run a report and see what the themes are at the minute. The themes might have been -- at one stage we had a huge abuse to staff from relatives and patients and, you know, staff being assaulted and things like that. So that was very -- when we had produced a report on that, we realised that was quite significant, actually, people were getting battered every day in their working life. When I spoke to then the staff on the ground, so I went to the wards and I said what is this like, why am I getting so many incidents in about staff being abused, physically abused; some were beaten, some

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were hit over the head with objects. Like, it wasn't, like you know, a verbal abuse. Staff just took it in their stride. They were like oh, well, that's normal. I mean, those Datixes that came through are just really a tip of the iceberg. So that's quite worrying of how our staff were working.

Q. Was it also quite worrying of how they viewed Datix and the effectiveness of that system and the outcomes in resolving issues of concern?

A. Yes. Yes.

Q. Did it show they had little confidence in it?

A. That exactly is what you are saying. So I had to go back and say, well, do you know what we are doing, we are escalating that to your senior managers. That is going through to the Director of Acute, that is going through to the Chief Executive of how you staff are working on the ground, so it is being monitored and we are looking at it and we are trying to make it a safer place for you to work in. Because staff just thought, sure what's the point?

What is the SLT's view on Datix training being mandatory for all staff on the frontline?

Q. So if you are not on the Review Team, you are not aware of what the SAI is about; is that what you are saying?

A. No. If you are on the Review Team, you are aware of what an SAI is about, but if there are other issues with the staff member or a staff member who is involved in an SAI, you are not aware of that.

Q. So, you are aware of sort of single issues for the purpose of the SAI Review?

A. Single issues, yes.

Q. But not necessarily the background information –

A. Other issues.

Q. -- that might inform that?

A. Yes.

Q. Does that apply for the MHPS process as well?

A. So, we would never have known about an MHPS, definitely not. It wouldn't be something that would be shared at my level. It would be kept with a tight cohort of people.

Q. Does that apply even if the learning or some of the issues that arise through the MHPS have a direct impact on your role and governance and perhaps patient care? Are you not informed of anything about the outcome of an MHPS?

A. Unless there is a staff member that has been -- their contract has been terminated, I wouldn't know.

Q. Did you ever share that or mention that to anyone and say is there any way we can get beneath some of the more formal procedures that actually can highlight aspects of governance that need improved? Were they conversations that were had at any level?

A. No, because I didn't know what I didn't know at that stage, if you understand what I mean. So, it wouldn't have been on my radar to ask that question.

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Q. By the time you had left the Trust, was there any movement in thinking that that sort of issue needs to be looked at, that there perhaps is a wider benefit from a governance perspective in bringing other people inside the tent, as it were, so that learning in an anonymous context can be rolled out?

A. Not in that context. Having said that, I was aware of a Medical Director's office contacting me and saying, you know, has so-and-so -- is there any complaints or any SAIs involving this staff member? But they weren't -- you were just asked to check out if there was any incidences with that. There was no information coming back, if you know what I mean, to say look, this is what's happening in that case. It might have prompted you - that's only just before I left this started happening - that would have prompted you, oh, is there something going on? But you wouldn't have had any detail on that and you wouldn't have had any context where that's concerned, because very often the information was purely from they are revalidating, or it's for their appraisal; not necessarily that there's an investigation going on.

'Q. Do you think that there's a way of sharing information with you at your level as the coordinator, Governance Coordinator across Acute Services, that would allow you to carry out your role more effectively, assist in the protection of patients with a reduction of risk, and also anonymise sufficiently to maintain the confidentiality of the individuals involved?

A. I think so. I can see the benefits of it if you were aware there were other issues because then you are kind of joining all the dots, aren't you? You don't have all the dots to join otherwise.'

What is the current policy on sharing anonymised information and learning from MHPS/SAI's with the Governance Coordinator across Acute Services?

A. You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well because, very often, instead of looking at, well, that's a human factors issue, people still have that kind of blame 'oh, you never guess what so-and-so has just done. That needs to stop. For you to have openness and transparency and good learning coming through, you need to accept we are human, human factors, people make mistakes; this is the mitigation we put in place; this is the learning that we put in place so that the whole stigma of being involved in a serious adverse incident is removed. Because there is a stigma for staff that are involved in it, they are quite stressed about it and they think that people are pointing the finger at them. Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well.

Q. You say, if we go to paragraph 3.10, which is at WIT-92032: "Whilst I do not believe there was any ever any intention to cover up issues, I believe that some serious issues were escalated to my senior colleagues rather than to me given the confidential nature of them. The MHPS case regarding Mr. O'Brien is an example." Just to bring that point home, again people who were more senior to you on the management rank were aware of this –

A. Yes.

Q. -- and you weren't. Who did you report directly to?

A. Initially I reported directly to my line manager, who was Tracey.

Q. Tracey Boyce?

A. Tracey Boyce. Then after that was to Melanie McClements, she was my director then.

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Q. In a sense, the essence of what you are saying in those two paragraphs is that confidentiality can actually inhibit good governance?

A. To a certain extent.

Q. Does it benefit it in any way?

A. It benefits the individual's rights.

Q. But in terms of the governance?

A. From a governance perspective, I don't see the benefit in it.

'You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well'

'Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well'.

How can this narrative be reinforced throughout the Trust?

''Question: Just to be clear, in light of what we have seen from the correspondence, Mr. O'Brien was showing cooperation. Quite plainly he didn't dismiss your questions. It's been said on his behalf he is working through them. You are facing the competing pressure, twofold pressure of having to publish, and, with the benefit of some hindsight perhaps, it might have been better to wait? Answer: Yes, I think that's fair. Question: It might have been better to wait because if you had received responses from Mr. O'Brien, you would have obtained an understanding and Mr. Gilbert would have obtained an understanding of his thinking around treatments? Answer: Yes. I think some of the issues that are clearly benchmarked against international standards probably wouldn't have changed because we were benchmarking against known best practice, and I don't think those views would have changed. I think the underlying question is why some of this happened, you know, why referrals weren't made, why nurses weren't involved. I think that would have been appropriate, yeah."

Would you concur with Dr. Hughes' view that, on reflection, it might have been better to wait, and he says "Yes, I think that's fair"? Would you agree with that?

A. Absolutely. I mean, I did have a conversation with him saying I don't think it's fair for us to move on, but the pressures were being put on and we had to go ahead and publish it. But that wouldn't have been my decision to do that, and it wouldn't have been my wish to do that without Mr. O'Brien. Because if we were conducting an SAI, you do need to get that information. I think that's one of the drawbacks of SAIs, the timelines that are put on SAIs to prevent that happening.

Q. Was there an expectation that the report would be completed by January 2021, and where did that expectation arise from?

A. The Board had set that timeframe for us.

Q. Was there any reason why that timeframe was set?

A. I don't know.

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Q. "I also believe there were too many individual processes, MHPS and/or insufficient joined-up thinking. For example the details of the MHPS process were kept confidential".

We raised that point before. The first point, there are too many individual processes?

A. It's not just MHPS; there's obviously nursing and midwifery processes as well. Any health professional, allied health professional, have their own professional bodies that they would have investigations through. Also, HR have another process for other staff as well. You know, you have got your conduct or your capability processes or your disciplinary processes and things like that. They don't necessarily all marry up and feed into each other. That's what I meant by that.

Q. Have you any suggestion as to what the answer may be or are you just identifying that those individual processes perhaps be joined-up thinking, and anything that would unblock that would probably be helpful?

A. Yes.

Q. Then you say at 22.6: "We should be an organisation with an effective corporate memory so that when an adverse incident happens, that learning is not only shared through the division or area of practice but extended to all areas within the Trust. Lessons must be learned by all teams, and action plans from recommendations should be kept live and revisited at least annually to prevent reoccurrence. Too often learning from adverse incidents is shared and there is some learning for a few years, then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems reoccurring." The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate.

A. Mm-hmm.

Q. But your suggestion is that when you lose people who remember things, everyone thinks they are starting again?

A. Yes. Yeah.

'The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate'

Are there ways that corporate memory can be captured so that the narrative, the good practice, and the lessons learned can be kept present and active in the current culture and system?

Q. I know you have left but do you think that by the time you had left, learning was such from a considerable number of SAIs that have developed themes over the years, do you think the learning was such that you would be confident that someone taking over from you would have sight of information and would be more across the detail so that they could have more of a global view on governance concerns?

A. I would hope so rather than I know.

Q. Was there anything came into place that reassures you around that?

A. During my tenure -- SAIs used to be shared with the division that it occurred in, and during my tenure they were shared with all M&Ms to make sure that everybody had sight of the SAIs and the learning from that as well. With regards to the action plans, you knowhad asked that all the action plans be reviewed every year, and that they are shared with everybody frequently so that they are lived and they are in place and that they are not forgotten, because very often when an SAI happens,

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as I say, it's closed, it's finished, the action plan is agreed and it's sorted and it's parked. You can't do that in governance or in any healthcare system. So, I would hope that it's been.

Q. But rather than know?

A. But rather than know.

Q. Just a couple of clinical things. I was interested with your experience in the obstetrics and gynaecology life before the last job, and the comments you made on trigger lists and near-misses and things. Looking back with all your experience, how do you think we could use that, especially in urology but perhaps surgical disciplines?

A. Certainly I would feel in a specialty like surgery, you could have a trigger list as such that you can -- I mean, our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again. Then, from that then there's rolled out learning in theme of the week and things like that, you know, that is ongoing and is live and it keeps going. I can see how transferrable that is for Urology, looking at your near-misses. Your near-misses are a sure sign that your system is weak, and putting measures in place to see how you can prevent that happening because a near-miss one day is an actual event the next.

'Our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again.'

Can this idea of a trigger list being used as an audit tool be applied to other areas of clinical practice in the Trust?

Q. You have said that this was one of the best serious incident investigations you have been involved in. What was about it that made you say that?

A. From a family engagement. I suppose that was my big thing with SAIs, was the whole family engagement bit. The early learning being shared as well as we were going along, because that information was being drip-fed. I can see the restrictions with this SAI very clearly with the benefit of hindsight, but at the same time, I mean, we did look at a systems approach, this wasn't about finger-pointing. This was looking at our structures in place and that's why I feel that was a really good SAI. I think the intention of the staff involved in the Review Team and the commitment that was there, I mean everybody worked so hard. At the same time, that feedback to families, keeping them in the loop, keeping them informed, to me that was an example of good practice of how to do it from a family engagement point of view.

Can this approach be applied to all future SAI's in the Trust?

Q. There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.

Q. The Panel has heard evidence about the fairly recent realisation of cancer tracking to maximise being able to follow. I think, the evidence is that there's still room for improvement; that that process is not a fail-safe either. Given that, the cancer tracking issue and the CNS issue, might the findings and recommendations from the nine SAIs more helpfully have provided systemic

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suggestions around care pathways generally that might have included CNS and less emphasis on the CNS providing the answer for all of those nine patients?

A. Yes.

'Q There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.'

Is it still the case that various parts of the system are struggling to deliver successful care pathway oversight?

Day 52

Ms. McMahon questioning

Mrs. McClements

Q. Now, did Mr. Carroll give you a briefing as to what had occurred in the years prior to your taking up post that had raised governance issues?

A. Not with regard to Mr. O'Brien. He did give me a brief of the issues that were current, which were around the three sites, which was the Urology ward. There were a lot of risk issues in that ward at that time, and workforce issues, and a lot of quality indicators in terms of care. We put together a response to that with the corporate nursing team as well to try and stabilise 3 South. But that was the real emphasis for Urology in 9 June '19.

Q. So, the emphasis was on the immediate –

A. Yeah.

Q. -- issues that you were facing. Did Mrs. Corrigan ever raise the issues with you about what had preceded your tenure as regards governance?

A. No. Again, I believe that those were felt to be in hand at that point in time.

Q. Are you saying that with hindsight?

A. I am saying that with hindsight. I didn't know about them at the time, I wasn't sure of that. But as things emerged, that was my perspective, that they probably felt they were being managed.

Q. Knowing what you know now, do you think that you should have been told?

A. Absolutely.

Q. If you had have known then, what would you have done to reassure yourself about what was in place to prevent any reoccurrences or to ensure good governance?

A. I would have wanted to understand what range of intelligence there had been, not just that led to the MHPS but before that. So, I would have wanted a chronological list of all of the issues that had been raised over years or all the concerns that had been raised over years, but in particular the MHPS and the recommendations from it, and the monitoring processes and the impact of those.

As one of the learning points from this Inquiry - what measures are in place to ensure a full handover process is seen as a priority for people taking up a new post?

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Q. Now, there has been some evidence given to the Panel around the necessary confidentiality of the MHPS process and some of the perhaps barriers or challenges that puts up in relation to sharing of information, it's important for good governance.

A. Yeah.

Q. Do you have a view on the appropriateness of information not being shared to maintain confidentiality?

A. I respect confidentiality but I believe that when there are an operational team working, or there is an operational team working on issues that are referenced in that report as needing to be further addressed, and people referenced like the Assistant Director, I think they are entitled to have that information shared with them so that they can be fully informed and be part of that, and that wasn't the case. So yes, I do believe there should be a sharing with the appropriate people.

Confidentially vs intelligence and learning from the MHPS process – is there a guideline in place that addresses this? Does it need updating?

Q. Just before I move on, Patricia Kingsnorth had indicated that the staff turnover and the transient nature of staff in a Trust can cause concerns and challenges for good governance. Would that be a view that you would agree with?

A. Well, it's a view that I agree with but it's also evidence-based, so we know that where you have high turnover of people into an area, they may not be familiar with policy, with procedures; they may not be familiar with the working environment or the operating procedures; there isn't the same continuity of care for the patient. A lot of that translates into service delivery issues. There were issues with, for example, how we measure quality in the nursing care that we delivered, and there were a range of issues in poor performance that were directly linked to that high flexible agency and bank staffing. We were able to compare that with other wards where there were stable core staff and they weren't such an issue. The management styles, capability issues, there were a range of issues ongoing but very definitely linked to high turnover and workforce concerns in that ward.

How regularly is patient safety and the quality of care monitored and audited on wards that are experiencing a high turnover of staff?

A.I have no problem with inquisition or curiosity. In fact, I would be known to be of that style myself so I have no problem with that. I agree with the Chief Executive, it's right that a Medical Director is inquisitive and holds people to account. From an Acute Assistant Director perspective, I believe that the style of previous Medical Directors had been as operationally facing or involved as Dr. O'Kane would have been. They would find it difficult to get used to where does the operational bit take over and where is the responsibility of the Medical Director, and I think there was some of that behind it. I do think there are different personalities in any team and there probably was a bit of feeling annoyed and maybe a bit defensive as a result of that, but that incident in 2019 just wasn't as clearcut as described there. With regard to the model within Acute, the model in the organisation for clinical and social care governance was devolved, and still is actually because it hasn't actually flipped yet. Therefore, the information that is held within directorates from a governance perspective is the same as the information that's held in Older People and Primary Care or Mental Health Directorate and so on. It isn't in the responsibility of one person to have that information. Anne didn't even work in Urology Services, for example, she was in the medicine side of the house. That information was shared at our governance meetings, at our Acute governance meetings. The actual collective leadership structure I talk about in my statement talks about the Clinical Director

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and the Divisional Medical Director and their professional accountability line to the Medical Director. So, there are a range of mechanisms to interact and get information, and a range of fora that allow us to share that information. There would have been no evidence, and no awareness certainly from my perspective, that anybody would have withheld or made it difficult to get information.

From a governance perspective - are there currently clear pathways to allow the maximum information flow in all parts of the system?

Q. You have mentioned about there being various people in your post prior to you taking that up. There was turnover at that level, turnover at Chief Executive level. Now, obviously some individuals like Mr. Carroll and Mrs. Corrigan were there for the duration of events as they unfolded from early 2012, 2014. What impact do you think the turnover of staff at a high level like that has on good governance management?

A. Very definitely, the turnover definitely affects our governance arrangements, and the styles definitely affect our arrangements in terms of -- I mean, if I use the example of Dr. O'Kane again. When she came in, right from April '19, she was very proactively following up issues of concern from a governance perspective that perhaps could have been dealt with at an earlier stage. But she was a very proactive mover and shaker in terms of clinical and social care governance. She'd also come from Belfast Trust and had experienced a different model of clinical and social care governance, so therefore she probably saw flaws in our system which I would imagine prompted the clinical and social care governance review. I think there have been significant changes made over her tenure to date that are about trying to improve some of those vulnerabilities and some of our systems and processes. So I think some of it is about style, but definitely an impact of change in personnel at the different levels.

Have all the recommendations in the Clinical and Social Care Governance review been implemented?

Q. Just to point more widely in relation to the relationship between HSCB - SPPG as it is now - what is the nature of that relationship, and do you have any views on how that relationship might assist better governance in a Trust generally?

A. Well, in many ways it was a holding to account relationship in that the services were invested in, we were the provider of those services and we were reporting on that. But where there were issues of concern or escalations, either we were escalating to the Commissioner or issues that the Commissioner wanted to discuss with us, there wasn't really -- there wasn't really much solutions coming from commissioning side of the house. You know, you would have been guided with some novel approaches that maybe we could take or whatever, but we weren't really getting much traction, especially with regard to backlogs and waiting lists and waiting times, despite efforts to try lots of different ways to bring that about. The relationship was respectful and proactive and we could have had discussions about new investments, so that was all very healthy. Some of the discussions around what else we could do and the holding to account bit were a bit frustrating because we didn't really develop new approaches. We might have had a bit of non-current investment or a contract development with the independent sector, there was always something we were moving forward, but we weren't really turning things around despite the two-way processes.

Is this still the case?

A. But I did act on that in terms of I knew the governance review had taken place from 2019. We were waiting on the outcome of that, hoping that it would give us some sort of acknowledgement

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that there was capacity issues for the volume and scale of what we were dealing with in Acute. I did put in post a Quality Improvement Project. To me, quality and governance are very interlinked, so our Quality Improvement Project dedicated some time to the Assistant Directors to actually look at some of the gap areas they were most worried about, like action plans, and implementing recommendations post serious adverse incidents, and dealing with some incidents on the Datix system.

Q. That's one of the things that Mr. Carroll actually refers to in this paragraph, the inability to deal with action plans, the implementation of recommendations following serious adverse incidents, or to deal with the volume incidents that require active management and the complex complaints that required attention.

A. Mm-hmm.

Q. Now, what was the scale? There's quite a breadth of governance concerns around that. Did you ever get underneath what the scale of all of that work was? For example, what were the number of complex complaints that required attention; what were the SAIs; which standing; what recommendations were awaiting implementation? What was the detail behind that?

A. So, we got that detail every month. If you notice in the Acute governance papers that came, we would have got how many complaints are outstanding, how many are awaiting answer, which Assistant Director is sitting with or which Head of Service? So we would have known through the Governance Coordinator where there was glitches in the system that we needed some action. When we had a Serious Adverse Incident Review, we did have an action plan that was pooled together with the Clinical and Social Care Governance Coordinator to outline the recommendations of that review. What we were missing was has it been actioned? Has it been implemented? When was it implemented? How can you evidence it was implemented? They weren't missing it all the time but we didn't have a clean sheet in terms of we had a thorough process end to end for that action plan and implementation process. So, that was the focus of me trying to put in place, number one, the Quality Improvement Project and some of the areas around that, but, more importantly, getting funding secured for a Band 5 Governance Officer for each of the Assistant Directors, who would be their person who would work with them and hold their hand to keep a bit of momentum going within the Directorate.

Q. Those posts were filled before you left, were you?

A. Yeah.

Q. Were they two Band 5s?

A. No, there was four. There was one for each division.

Q. They actually tried to follow through on the outworkings because what this paragraph seems to suggest is the systems are effective in bringing the issues to the surface by and large –

A. Yeah.

Q. -- given that we are here, but that the actual remedial work and outworking of what's needed to make sure that doesn't happen again is the stage that has some hold-up?

A. Yes. The purposes change in learning. To bring about the change in learning needs capacity, and that's what we were missing. We had some capacity in different job roles. I mean, I think somebody said last week Clinical Governance is everybody's responsibility, and it is, but you need somebody to

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drive it, push it. We were missing a wee bit of momentum. That's why both the quality project and the Band 5s for each AD, and now in place, were to try and accept that there was a reason to be kept awake at night and we needed to do something about it.

'So, we would have known through the Governance Coordinator where there were glitches in the system that we needed some action'

With a band 5 now in place for each AD – are there any remaining 'glitches' that need addressing?

'Clinical Governance is everybody's responsibility, and it is, but you need somebody to drive it, push it.'

Q. If we could just go to the terms of reference of the review at WIT-35726. The purpose of the review, it's "Terms of Reference Southern Health and Social Care Trust Governance Review". It says: "The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on Patient Safety and that helps people learn. The objectives: The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like. It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach through the organisation**.** It will include a review of both clinical and social care governance. Specifically, the work will include gaining an understanding of the current governance structure and processes in place; meeting stakeholders to identify what works well and areas for improvement; undertaking a benchmarking exercise to identify best practice; review of existing and draft documentation, including a new governance assurance strategy. The outcome will be a written report outlining key findings from the review, and recommendations." The governance assurance strategy, did it ever come to fruition?

A. I don't believe I ever saw one.

Q. In relation to this clinical and social care governance review in September 2019, what was your understanding of the background of this particular report? Was this something that the Trust did every now and again or there was a specific reason?

A. There had been a couple of reviews in earlier years since the Trust had formed, I think it was 2012 and 2015 potentially. Again, I think it was following Dr. O'Kane joining the Trust, seeing some vulnerabilities, potentially assisting with the potential of a better model, actioned by the Leadership Centre. June Champion was the Leadership Centre author was carried out the review. She worked, in fairness, intervening teams and relevant stakeholders to make sure she put together a comprehensive report

The report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 Findings and Analysis, and are broadly categorised under the following themes: Work governance, culture of being open, controls assurance, risk management strategy, management of SAIs, complaints and legal services, health and safety, standards and guidelines, clinical audit, morbidity and mortality, learning for improvement, Datix, clinical and social care governance structures. A summary of the recommendations is provided in appendix 1."

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Q. Now, your involvement was on the SMT in trying to implement some of the recommendations. You mentioned about the operational risk versus corporate. I wouldn't call it a struggle because I am not sure that's a word you would use but was there a tension between the competing expectations or demands that perhaps ultimately led to the delay or the failure to implement these recommendations?

A. Yes**.** I think the time-lag doesn't help when there's a review happens in August '19 and, a couple of years later, or three years later, we are still moving forward with it. You then have pockets of developments to try and strengthen where we are now as opposed to the root and branch review being implemented. However, I think changes that have been made have been felt and felt positively. Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you.

Q. So, there was a degree of flexibility built in?

A. Yes. We were evolving, we were learning on our feet and it really was governance in action, how do we keep this as safe as possible with patients at the centre.

Q. Do you think it might be helpful to have a toolkit for incidents like this where there are lists of suggestions, different routes, built in flexibility, a checklist of things to make sure they are done?

A. Absolutely.

Q. Would that be something that might assist?

A. I think because of the Belfast experience and because at the end of a lookback review, one of the stages is the outcomes and the recording of the learning, I think there's a natural opportunity there to learn and to share a lot of the tools and processes that we adopted.

Q. Giving the timing of this report and the September 2018 recommendation in the MHPS about an admin review, and this clinical and social care governance review then coming after that, was there any thought given that this was a possible vehicle by which that admin review could fall under this umbrella and perhaps gain some learning from that, given the independence of June Champion and, as you say, the requirement for the MHPS recommendation to be independent?

Q. There was also learning over and above Urology Service in those. What was the position on the roll-out of those recommendations or their implementation by the time of your retirement; can you recall?

A. When I retired, there were nine out of the eleven delivered and the other two were embedded but subject to audit; we needed to evidence that they were effective. So all eleven are now implemented. I have to say that that process was extremely innovative because we had -- this wasn't about a Urology Department, this was about learning for the whole organisation in Acute Services. So, we had medicine, we had everybody sitting around that table taking responsibility because function of their MDMs, for example, was something that had read across. We had a really good process, and we had a subgroup and we had designated tasks that the different people around, say,

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job planning or audit, whatever, would work through and develop with the groups. But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work.

Alongside the learning from the SAI's, there have been several significant reviews in the Trust in the last 10 years, each with recommendations. Added to this will be the recommendations of the Urology Public Inquiry Report.

Going forward:

- what are the plans to review and bring some clarity, standardisation, and consolidation to all these recommendations?

- then to move through to systematic action and implementation?

- what is the SLT's view of developing 'a toolkit for incidents'

'Sometimes there's just a fear of change. The staff who have actually transitioned to the corporate office, I think, are feeling the benefits of that standardisation and corporate approach. Sometimes it just takes time to bring people with you'

One of the main ways of bringing people with you is to ensure there is quality and frequency of communication. Some thought needs to be given to this.

Q. You have said this previously but just to give you an opportunity to say anything else about it: "A deficit in one area of practice should provoke curiosity and require sampling of other areas of practice". We can see in the timeline there's a possibility of that thinking pre-MHPS, post-MHPS September 2019, 2016, 2017; there were signposts perhaps along the way. Do you acknowledge that that should have been the lens through which things were looked at various parts of this journey?

A. I am a great believer in always lift a stone, don't take it on face value, and I don't think we took that opportunity as an organisation early enough

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern. Also patient information and patient involvement. We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services. I think the Task and Finish work showed even when patients and relatives had been through a difficult time, they engaged with us, they trusted us to try and improve our services. I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public.

'But the bespoke bit for us was the patient involvement. For some of the families who had been through a real nightmare, to have two families coming on board who were willing to influence the future was a really good piece of work'

'We have a statutory obligation, actually, to involve patients right from design, implementation and evaluation of all of our services'

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'I think we are only scraping the bottom of what we could do for patient involvement and active development of our services with our patients and our public'

The Trust is to be congratulated on the quality to date of their PPI. There is some way to go though to achieve implementation and audit of full patient participation 'in design, implementation, and evaluation of all our services'

What are the next steps to move towards this goal of inclusion, partnership, and collaboration in all three stages?

Note – this is a more significant role and function than what is currently accepted as 'co-production'.

Q. I have tried to bring out the key points of your statement. In case I have missed anything, is there anything you would like to add or anything you would like to say or draw the Panel's attention to at this point before they ask you some questions themselves?

A. I think you have covered most of what I would like to say, thanks, but the things I would add are the missing clinical audit for me would still be a cause for concern

Does the SLT consider 'the missing clinical audit' and area of concern? If so, what are the steps to address this?

Q. Okay. Thank you. You had a comment about deep-dives, and made a comment about not all are brave enough to do it. That's an interesting choice of words. What did you mean by it?

A. Again I am back to that expression I used there about lifting the stone and seeing what else. I think you should never -- especially when you have recurrent issues, say for example like triage and delays and patients who are not being seen in as timely a way as we could offer. I think hold on a minute, we need to have a deeper look here; we need to actually sample; we need to audit some of the work. You can't just accept, and we did in many ways accept he is a really good clinician and take that as read. We should be able to evidence that in this day and age. We audit our own performance and our peers. I think we should be able to do that and I think that takes bravery.

When there are recurrent issues taking a deep-dive approach to them is important, sampling and auditing some of the work. 'Lift the stone and see what else is under it'

Can the SLT identify any current recurring issues in the Trust where this approach needs to be applied?

Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it.

A. Mm-hmm.

Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting?

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture

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standing back a wee bit, I think there's somebody thinking, no, there's a different way to do governance, I think, not just a series of tick box exercises.

How can the SLT shape the narrative post Inquiry so that this momentum can be maintained?

Q. Absolutely. Another thorny thing that's come through from a number of people, and it's on your Risk Registers at the Trust, is about standards and guidelines. Clearly a lot of bureaucratic things are involved when you try and make sure they have been read and the Department has looked at them. It would appear that there has been no systemic way of ensuring that when a standard and guideline is adopted, there's any kind of measures of whether people are actually using it. Is that correct?

A. I wouldn't say it's entirely correct. Caroline Beatty, who let the standards and guidelines work in Acute Services for many years, has now moved to corporate. She has moved to corporate because there was an acknowledgement that she had a best practice model - that was also acknowledged in June Champion's report - but that it needs to be corporate. A lot of standards and guidelines don't relate to Acute, but there's a lot that relate outside of Acute and there wasn't the same focus.

Q. But how would you know if a consultant wasn't following it?

A. The audit and the checking and the role of the change leads is critical here, for them to be able to evidence for us. I am back to the issue of clinical effectiveness and clinical audit and we need more of it.

Q. I think you would agree that we don't actually have any measures of the clinical outcomes in specialties, for many specialties. There are in some but certainly not in many surgical specialties.

A. Yeah.

Q. Has the Trust fully embraced that now, do you think? It's not very easy just to put it in if you recognise the deficit, but is there a full recognition of that?

A. I think they are on that journey. I think they are starting to think even MDM outcomes for different specialties is part of that.

Q. But MDM, it's still the same thing in that you are following a guideline?

A. Yes, but I still think there's a piece of work to get us to a watertight place.

'Clinical effectiveness and clinical audit and we need more of it. We don't actually have any measures of the clinical outcomes in specialties, for many specialties'

This is key information that is needed for quality and patient safety – can this audit process be embedded across all specialities with a timeline for action?

Q. Another thing that you talked about, I think, was the admin review. Now, having read the MHPS determination and the substance of it, it's quite clear that people have interpreted that external admin review as different things.

A. Yeah.

Q. If you'd interpreted it at the time and you'd read the statement that there were managerial failings and there needed to be external review, what kind of review would you have envisaged that to be? I know you weren't in charge of it.

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A. I think we would have looked broader at roles, remits, responsibility, governance, actions, escalations, evidence of a concern materialising into some process.

Q. Yes.

A. It would have been bigger than is there triage happening or whatever. It would have been literally a root-and-branch review of how our systems working, and have we got the right balance between operational busyness and governing our systems and ensuring the patient is safe in our care.

Q. That's I think how many people would have interpreted that. Why didn't that happen, do you think? What was responsible for that inaction?

A. I think a ball was dropped. There was a recommendation that appeared to look like it was belonging to Acute but, in actual fact, it never said it belonged to Acute. It said independent but it had Acute in the middle of it, so I think somebody thought an Acute will deal with that and it wasn't dealt with. I think also the sharing with the operational team, I know Mrs. Gishkori had it, but Ronan had no idea that there was implications for him as Assistant Director, even for, you know, some of the oversight. I think it's back to the sharing appropriately, even of what had started as confidential type processes.

Post Inquiry – it will be important to establish clear lines of communication for information flow and learning throughout the Trust. Also, to check that everyone has clearly defined roles and understands their responsibilities and accountability. Underpinning this will be the outlining of Trust values and principles and the strategic aims for the next five years.

Day 53

Mr Wolfe questioning

Mrs Gishkori

Q. Let's just look at some of the language you've used here. You're saying I want you and Colin to explore the options before anyone else gets involved. Obviously, the Oversight group were involved by that stage. Was this in a sense you trying to nip the Oversight group's approach in the bud before it developed too far?

A. Well, I wouldn't put it that way. No, I wouldn't say I was nipping it in the bud. What I wanted to do was just stall it until his own line management, his own professional line management dealt with it. I did -- I am being honest with you, I did have every confidence with Charlie McAllister because he was a straight, to the point, get the job done man. That was why I asked him to take that role on. He also didn't -- there were people that were a bit -- I'm not going to say frightened of Mr. O'Brien but felt him to be overpowering, I suppose is the best way to put it. But Charlie wouldn't have been that at all. Not at all.

Q. You say, just going through the email: "We owe this to a well-respected and competent colleague."

A. Yeah.

Q. In what sense were you meaning that? What was Mr. O'Brien owed? Why was he owed anything if he wasn't doing his job properly in the eyes of the Trust?

A. To be honest with you, that's absolutely a fair point. But the conversation always came round to the fact that he was an excellent surgeon, he set up the service, this man knew the service better

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than anybody. You know, he has, in recent years, become a bit slower but doesn't everybody when they get older; all that sort of thing. I am thinking to myself, well, he has put a life sometime of service into this particular urology, which he had and set it up together with Mr. Young, but that's another story. So I thought, do you know, I think we owe it to this man to try this first of all, because it was win-win for me with my patients thinking, well, you know, approach him nicely, get it done.

Q. Is it fair to say that when you say Richard is happy with the direction of travel, what you are referring to there is Dr. Wright indicating to you that he would require a written plan, a written indication of what you and Mr. McAllister have in mind?

A. Yes. That's what he said.

Q. Yes. He wasn't happy with the final plan; you couldn't say that because there was no final plan in place?

A. No.

Q. He was happy that you would explore this; is that a better way of putting it?

A. Yeah. Well, he wasn't happy with me at all because he said "Typical Esther", which I wasn't sure what he meant because I don't remember ever a situation. This is another thing, you know. There was a great big band -- I am going to be metaphorical talking here. There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame. It was because, I believe, they all thought that I was Mrs. Brownlee's eyes and ears; that's the bottom line. Nothing could have been further from the truth. I don't know where they got it; it must have been from her because it wasn't from me. Simon Gibson himself said in his -- that was actually what made the penny drop for me. He said "Sure, Mrs. Brownlee appointed her herself". So, he said it.

Q. Okay.

A. There was an awful lot of I was undermined really at every point. But he did have the conversation with me, he did say -- Richard did say, look, you know -- and Francis Rice was also involved, by the way, the Chief Executive.

Q. Yes, we'll come to that.

A. He says you are the operational director and, as such, we'll have to listen to you or whatever. I was very sure, honestly, that Charlie McAllister would deal with it. I really was.

Q. Just going back to your last answer in relation to bandwagon, I don't wish to - and no doubt the Chair and the Panel doesn't wish to restrict your evidence unduly - we are dealing with a very specific issue here and we need to ensure that the evidence that you give is relevant to the issues.

A. Well.

Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed?

A. An impression I formed, and information that other people gave me as well.

Q. Yes.

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A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, it was very, very plain. I was bullied to within an inch... Sorry, I am going to get through this, okay.

Q. Of course?

A. And then we'll take a break. At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands. You know, a silly thing, a really silly thing like the Trust awards, it was a good day and a light day, and all of the directors, the female directors, were up there on the stage with a wig on being the Dragon's Den, and I wasn't even asked, you know. I know that's silly but it really does... I would have come in to meetings and heard about, you know, somebody's leaving do or whatever, and I never even heard about it. I had been in post three months, in December 2016 -- sorry, going back to the meeting, I was told in the meeting, you know, by Stephen McNally, "Don't you dare ever say anything in Trust Board that we haven't discussed here", which made me panic.

Q. Again, Mrs. Gishkori, you're saying things which I have a sense are maybe not germane to the issues within the terms of reference. I'm content that you –

A. I think they are.

Q. I'm content that you broadly reflect your sense of concern that you were treated, but if you wish to descend in specific allegations about named individuals, I am probably going to have to stop you, subject to the Chair?

A. Okay, I'll not name anybody then. But, you know, when I had my interview for that job, I went -- when I had my interview for the job, I was told that I split the Panel and that my period of, what do you call it, would be a year instead of six months. You know, I would be monitored, whatever. I said right, well, okay, and how are you going to monitor me. They didn't know so they give me a list of things. But given Simon's comment in your papers that she employed me herself, I'm assuming that whenever she worked with me in prison health care, the Chair saw how I worked; probably thought it was a good idea to get me in; maybe everybody else disagreed and she was the only one, I don't know. But because she was so -- everybody says she was very friendly with Mr. O'Brien, in my mind I'm thinking, well, maybe think I am in on that too. That's the relevance of this.

Q. Yes. To summarise, you were recruited by a Panel that included Mrs. Brownlee?

A. She was the Chair.

Q. You had a history of working with her in Prison Service?

A. Not even with her. She worked for the prisons and I worked for the Trust.

Q. There was a perception, and you think an incorrect perception, that you were her favourite?

A. I don't even know a favourite. That I was giving her information.

Q. And you think that wrong, that's wrong?

A. Absolutely wrong.

Q. And you think that other people viewed you negatively as a result of that?

A. Yes.

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Q. Okay. You are right to point out - and I don't think we need go there or bring it up on the screen - but because of this backward and forward, we know that Dr. Wright tells Simon Gibson "Classic Esther", and in his evidence he explains that he was frustrated; there had been a number of occasions when decisions were changed after discussion with you. In fairness, I'll invite you to comment on that. Do you recognise that criticism?

A. No, I don't and I would like to know. I would love for him to give an example because I don't recognise it. I mean, we were all professionals and we didn't always agree. So, you know, my comments would have been me turning the thing round. I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place.

- 'There was a great big bandwagon going around the Southern Trust, Mr. Wolfe; big, massive. The title of it was Let's Blame Esther and Get Rid of Her. Lots and lots of people jumped on that bandwagon; it was big enough for everybody. The talk down in headquarters was all around me, it was great to have somebody to blame.

- Q. We know that you left the Trust, as neutrally as possible, in unhappy circumstances. What you have just said about you being blamed for everything, is that an impression that you formed?

A. An impression I formed, and information that other people gave me as well.

Q. Yes.

A. Other people, some people, felt that they should tell me too. I mean it wasn't all me thinking. You know, it was very, very plain. I was bullied to within an inch...

- At every SMT meeting, which was -- that was the corporate SMT meetings, the Chief Executive chaired it and all the executive directors were at it. They systematically, brutally, just everything I said was turned down, mocked. They whispered behind their hands.

- I was always seen as kind of a thorn in the flesh. It was commonly known, you know, all over the place

- Eamon Mackle told me they were drawing bets of how long I would last'

This narrative is now in the public domain and can be interpreted in several ways. How will the SLT address the themes that are raised in it on two fronts – for the staff in the Trust and for patients, carers, and the public interface?

Q. In the absence of any report or product that you can point to, and I have to say the Inquiry is unsighted on that, can I suggest to you that you did not, nor did the Oversight Committee, engage in any assessment of the risk to patients in terms of what had been uncovered?

A. I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly. A risk assessment at this point, sometimes you write a risk assessment to make sure you understand what risks are going to be, but at this point in time we knew exactly what the risks were.

Q. Did you? Because it wasn't until 2017, when the other clinicians in Urology sat down and began to look through the untriaged referrals, that a picture began to emerge that in excess of 20 cases, the referral into the system was wrong and triage would have led to an escalation of the referral from routine or urgent into red flag. So, it's fair to say that while you may have had the instinct that

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untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?

A. Until the consultants, which you say is January 2017. I wasn't, to be honest with you, sure of thatdate but that's when they started to do the waiting list initiatives and look at the triaging. The patients were then seen by them. Yes, you would be quite correct in saying that.

'A. 'I don't remember doing an actual risk assessment, no, nor did the Oversight Committee, I believe. But the other side of that coin is that the risks were plain to see. There was no point making out a risk assessment when we knew this thing needed to be dealt with very quickly'

Q. So, it's fair to say that while you may have had the instinct that untriaged patients could be coming to harm, no work was done to assess in any individual case the extent of any harm?'

What learning can be taken from this (and actions if needed) to ensure that the principle of assessment of the risk to patients is always paramount in clinical practice?

Q. How do we explain that, because the information was in the system that Patient 10's case was the subject of an SAI, and I don't think you were aware of that until later in the year. But you would accept that even the absence of knowledge of a particular case, it would be obvious that if you don't triage routine and urgent referrals, that lurking in that pile will be patients, perhaps many patients, who have been wrongly categorised and who have more significant disease that needs diagnosed and treated. Thinking back on things now, the failure to carry out that kind of assessment, what do you put that down to?

A. Honestly, from my point of view, it probably was you couldn't see the wood for the trees. There was just so much going on. Urology was one -- and I know this was so, so important and so serious, but there were so many other things that took up my time, that drew my attention to other things, that it was just the mania that was my job. I can only just say that. I am apologising for that. You know, it was something that was missed by me - and others, not just me - and it just wasn't good enough. But then, there should have been two of me instead of one. In fact, there probably should have been three. Not of me, you know what I mean, three people. I think one was probably enough for the Southern Trust, but three people doing -- maybe one to do medicine, one to do surgery or whatever. The job was too big. My day was filled continuously just fighting fires and just trying to keep up with the pace. Because I suppose the clerical and admin bit of it wasn't in my mind, then it wasn't done until the consultants started to look at it in 2017. Again, I apologise for it and say I'm sorry. But I was a victim of the circumstance also.

Q. What, to your mind, merited exclusion and a formal investigation? What was it?

A. Everything, all of it. My goodness, there were trends, there were patterns, there were patients who were harmed. How much more do you want me to go on? Ignoring, ignoring the system, doing things his own way. Mr. Wolfe, that's the one thing I always used to say to my team, follow the system and let the system take the pressure, not you. If you follow a system and something goes wrong, you will be fine; you follow a system or if you go off adrift and something goes wrong, you are on your own.

Q. We know that Mr. Weir, by September 2018, had produced a job plan and left it with Mr. O'Brien

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A. Yeah.

Q. -- to agree or disagree?

A. Yeah.

Q. It was never, ever finalised, it was never, ever signed off. Did you take any interest as Director of Acute Services in trying to drive that towards a conclusion?

A. With the job plan, no, I didn't, to tell you the truth. The job plans were very much the medical side of the house, the professional side. For some reason, though, I always had to sign them off at the end. I always felt uncomfortable because I didn't know what I was signing but the Director had to do it. But these were very much led by the Medical Directorate and not me.

Is it appropriate for the Director of Acute Services to sign off 'medical professional' job plans?

Q. What does it say about the systems within the Trust, the culture of the Trust, the personnel retained by the Trust, that these things weren't addressed at a lower level, as you describe it, at an earlier point in time?

A. I don't know that I am in any position to comment on the personnel that were in post at the time, what their issues were, why they couldn't do it. I know some people tried. The culture of the Southern Trust when I joined was performance, very much performance driven. There wasn't an awful lot of governance. I'm sure you are going to ask me that later anyway. So it was performance nearly or nothing. Perhaps individually wee pockets of people tried to deal with it and the culture was, well, you know, we've tried and you know, somebody moves on. There was an awful lot of movement and fluidity in terms of staff in the Southern Trust. I mean, I was one of I don't know how many directors. Eamon Mackle told me they were drawing bets of how long I would last. There was a culture of people moving a lot. That's really all I have to say. Roles and responsibilities is also, for me, massively important. As I have already told you as well, you know, the communication between me, up and down through my line and vertically and horizontally too, that was never adhered to really. If someone of my staff wanted to go to see the Chief Executive, they did. I mightn't have known, Ronan mightn't have known. There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so.

Q. Can I ask you this: Was it your sense that by the end of your time in the Acute Directorate, governance, in terms of its capacity and resourcing, was in a better place than what you found at the beginning, or was it treading water?

A. Ever so slightly. Every so -- well, we treaded water for a long time. It was ever so slightly better but, to be honest, whenever I left, anything was the last thing from my mind so I didn't even think about governance when I was going away. I was looking forward very much to working with Patricia Kingsnorth because she, to me, had exactly the same idea and I knew I could -- we could have -- and she was very proactive in Maternity. So, it was slightly better. Certainly the language that I used in my meetings about governance being important, and trying to bring on board. But, as I said to you before, you know, the culture was performance, performance, performance, and I don't know that I did very much to change that as an individual.

'The culture of the Southern Trust when I joined was performance, very much performance driven'

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How would the SLT describe the current culture?

‘There was that culture of just go and talk to whoever you like. That left people out of the loop and out of the -- didn't know then, and there was a lot of misunderstanding. That type of culture existed, very much so’

How can team working be enhanced in the Trust?

Day 54

Mr Wolfe questioning

Mrs. Gishkori

Q. Yes. If we scroll down the statement in front of us to bring us to the next point. Dr. Boyce, as you can see at 4.7, is explaining that following upon the appointment of Trudy Reid, you were not prepared to take back direct responsibility for interfacing with the Acute Governance Lead, despite it being part of your remit. Tracey Boyce was told of this verbally at a one-to-one meeting with the director, obviously you?

A. Yeah.

Q. "Therefore [she] continued to mentor and support the governance lead as they needed someone to facilitate their work. This involved meeting Trudy Reid every Tuesday morning to discuss any issues the team were having in accompanying her to brief Mrs. Gishkori on governance issues once per week."

A. Yep.

Q. By contrast, and just to lead to the question, when Mrs. McClements replaced you in mid to late 2019 –

A. Yes.

Q. -- she, according to Dr. Boyce's evidence, reassumed this interface role with the Governance Lead, and at that point Dr. Boyce was able to step back. The way it has been framed by Dr. Boyce is the kinds of duties that she was performing alongside or interfacing with the Governance Lead were the kinds of duties that you should have been taking on but you did not, by contrast with Mrs. McClements. Do you understand that and accept that?

A. No, I don't accept that. I understand it but I don't accept it.

Q. Yes. Is it the case then, just so that we understand you properly, you felt that governance in Acute was such a significant issue that you needed an AD?

A. Yes.

Q. In the absence of a formal AD, you felt the need to retain the input of Tracey Boyce?

A. Yes.

Q. Because your role was so significant, you couldn't be that interface with Trudy Reid as much as you would have liked, it needed someone of Dr. Boyce's standing to carry some of those responsibilities?

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A. It needed an assistant director, in my opinion.

Q. Yes. Dr. Boyce has suggested that -- if we just pull up her statement, TRA-05849. If we just go to line 4, please. I'm asking her why you wouldn't take on this direct interfacing role with Trudy Reid, and you have given me an account this morning of why. Dr. Boyce's perspective on it was that you were overwhelmed with the post, it was a massive post, "and also there was maybe a level of inexperience in terms of governance, leading governance in a very big, very vast ranging Directorate." She says, "I think the fact that I was there and had already been doing it sort of allowed [you] not to maybe take it back fully." The downside of it, she explains, is that it made her nervous on your behalf because obviously: "Then Esther was going into Senior Management Team, the Corporate Governance meeting and so on, without that interface so I was always nervous about how she could then represent and talk about her risks and so on." Do you recognise that there was this risk of a gap if you weren't as fully committed to the governance aspects as Tracey Boyce says you ought to have been?

A -- So yes, I was uncomfortable and I felt extremely just unsupported in terms of -- you know, if you feel supported when you are in a swimming pool with rubber rings and everything and everybody takes that away, you feel a little bit adrift.

Are there any people in current senior leadership roles who are not carrying out their full brief?

The biggest thing that was maybe just pie in the sky for me was changing the culture in relation to governance. Culture eats strategy for breakfast. If you are going to ask me what I learnt, that's the biggest thing.

Has the SLT adopted the priority of establishing a constructive and empowering cultural lens before delivering the detail of forthcoming strategy?

Is there a sense, Mrs. Gishkori, that during your time as Director of Acute, focusing on Urology now, that this was a service under stress, and the emphasis in terms of your work, and perhaps other services within Acute, was about driving performance, ensuring that your staff were driving performance because that's what the Commissioner was wanting to see, and that governance issues and the management and superintendence of governance issues played second fiddle to that?

A. Yes, I would 100% agree with you. Just to comment on the first part of your statement there in relation to Urology, I mean nobody has any idea how short. One of my consultants had to go to Belfast on a Friday to do a certain procedure, otherwise the people in Northern Ireland had to go to England. So, how was I going to keep him back from that, from patients who then had to travel to England and home again in a very poor state of health? It was regional but it was still very real for us, and it was very, very under resourced. I mean, they did everything they could, you know. They got lithotripsy going on and they tried to do extended days through theatre. It wasn't that they said to themselves -- and they always fighting me for more theatre space. Not fighting but bartering for it. But then I had to think of all the other services that would fall down if they got more space. You know, it was all of that, it was all of that. But performance was always top of the twig, and finance. We were reminded you will not appoint any more staff; you will not -- people are displaced, they have to move into this. We had to come up with savings plans all the time.

Q. Yes.

A. And it was a soul-destroying period.

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Okay. You made quite a lot of comments about culture. We have had from a variety of people that there have been problems with the silos of management and leadership. We have heard about hierarchy and problems that might cause. We have heard that everybody was working very hard to do their best throughout many parts of the Trust. What, in your view, was -- apart from just focusing on performance, I am not really talking about that, was there anything about the culture that you felt was detrimental to taking all these things forward?

A. Apart from what you've just said?

Q. Those are the things we have heard about but was there anything else missing? What was missing from your perspective, because clearly you have strong feelings about this? Everybody talks a lot of talk about strategy and culture and all these things but when you've worked in a system, sometimes you can identify some specific things that need development to go forward. What would they be?

A. I believe in terms of communication, there were silos. In terms of management that would have been above me, people didn't necessarily follow their roles and responsibilities. That was actually a trend right across, and I would say that to you. Roles and responsibilities, for me, is every bit as important as following up a procedure. I need to know what my role is but I also need to know what your role is so that we don't overlap or I don't do your job, causing conflict and concern. There was an awful lot of dissatisfaction in that. I believe it's because people didn't know what their roles and responsibilities were and they just did whatever they thought on the day.

Q. Where do you see the responsibility for fixing that as lying?

A. Well, whenever it's a culture, it's very, very, very difficult to fix. It would needed to have come corporately from the top on down. It would needed to have been -- you see, you can't make somebody do something unless they believe it's right to do. You know, me making people believe, from my very, very small part I discussed it, discussed the importance of -- and it's not even hierarchy, it is just communication lines. I didn't mind talking to whoever in the canteen or whatever, but as long as the information that needed to be passed up and down went through the proper lines.

Recognising the key role of good communication flow throughout the Trust as a tool in changing the culture.

Day 55

Mr Wolfe questioning

Mrs Burns

Q. And, in that role, what were the challenges? Was it a straightforward matter to implement these radical changes to how governance was to be done within the Trust?

A. No, it was really tricky. It was -- I mean, it was a bit like the performance era and that takes, it takes time, it takes consistency, it takes -- no, it was very difficult. Was everybody accepting of these processes? Did people want to add this on? I mean I have read in other evidence where in -- after my time in 2016/2017, they talked about giving additional PAs to consultants or 0.5 of a PA. We didn't do that at the start because we wanted to see: Can we buy you into actually this is part of your job role anyway? Now, there's a tossup between adding on a bit and paying you to do it, or you winning the hearts and minds and saying "This is part of my role anyway." I mean -- so, the whole thing just takes time to slot together, not just -- I mean, IT's not my thing, but, even that, but it was interesting reading people's statements about the use of IR1s and, you know, saying "Oh, well, I wrote the IR1"

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and it nearly felt like they came to an end-point there. No, the IR1 is to flag -- "I need to then talk with my line manager, they need to come back to me, we need to see what we're going to do about it." But they felt like they had discharged their duty just by doing it. So we hadn't got the culture there yet. It wasn't there yet**.** They hadn't the ownership.

It takes time for people to realise that governance is your business and somebody is not going to do it for you.

Is this understanding of governance widespread in the Trust today?

Q. -- the understanding of what is to be done. I mean, does that -- I mean, looking back on it, do you think these what might be described as teething problems or difficulties were just inevitable, or was there training shortcomings in how the Trust went about it?

A. I don't think -- I don't recall the detail, to be honest, of the training and the rollouts. What my -- what I recall was, we were at a time when, you know, for example, 2014, Francis was -- they were accepting the Duty of Candour and it was so broad -- we still haven't got it in Northern Ireland! So, like, we were at a zero or minus starting point, so we were, like, building our culture. And it was very similar to the challenges that you faced at the start of the performance culture. And while people said the, you know, the written IR1s, you know, went into a black hole, that was great when they could say that. When it was popping up on their e-mail that they had an IR1 notification and needed to do something with it, clearly history tells us, for example, in 2014 there was a backlog of unopened IR1s! So it didn't change the -- it takes time to change their actions and their responses. You can put in all the systems you want, but you have to build a culture where -- and I think it was just very early in those days and it was very early in Northern Ireland as well -- across the UK because Francis was only just coming out and, if you look back now -- if you look at it with a 2023 lens, it's completely different. But that was a different time and we were learning different things, so I think -- I don't think that -- I honestly can't tell you the detail that went into the rollout. I mean, certainly we were writing -- "writing" is the wrong word. We were producing 450 IR1s a month across Acute in 2014 when I look at the reports, so I don't think we had any -- we didn't have -- obviously, the quality of those and what they were reporting, you could dive into that. But I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?". And you can put in the system, but it doesn't necessarily mean that people are going to change their role and responsibility and how they view it.

‘I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?".

‘A. It demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities.’

Is the current messaging in the Trust consistent, empowering and across the board when it comes to the requirement of a clinician’s individual responsibility, accountability, and action?

Q. And recommendation 4 related to the use of timely discharge letters?

A. Yeah.

Q. And she makes the point in 3 and 4 -- this is page 10: "We are relying on people to do the right thing, which is the weakest safety net..." -- and she asks the question: "Did the team consider anything stronger in terms of making sure this didn't happen again?" So, for example, alerts for

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unread Radiology reports/ monitoring of discharge letter performance. So at least one of those aspects, the Radiology is something, as I say, you were familiar with and the Inquiry is by now familiar with the history of that through a number of incidents and with a number of patients. Are you able to assist us at all -- I know the final report was signed off in August, you weren't there, but was there any attempt in your time to correct those two issues in the context of this case?

A. No, because, as far as I was concerned, we hadn't got the right conclusions yet, and you have to get the clinicians to own the conclusions. So I can't implement things like -- I can't -- you could -- you could try and tell them to do something about unread Radiology reports, but they would have to accept that and then go and do it. Monitoring of discharge letter performance is interesting and I think the concept of how much -- these are senior people, these are senior clinicians. Telling a patient -- telling a GP how their patient is doing and what's happening with them is probably, in my book, quite basic. Do you need me to check that you are doing that? At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"? And I guess these are senior people, they're senior clinicians, this is in the best interest of that patient in front of them and -- yeah.

Q. I suppose, what you're putting your finger on is the extent to which the organisation can afford to place certain issues on trust by reference to professional obligations?

A. Yeah.

‘At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"?’

How is the SLT building this narrative into current culture?

Q. Are you able to assist the Inquiry in terms of why something that seems relatively basic but very important cannot be effectively grappled with using a system that can spot the danger and challenge in a timely fashion?

A. So I think my recollection on this one is that when Diane Corrigan pointed it out in 2011, Acute did, as they said, a broad-brush, "What are you guys doing?". And you can kind of -- I think that e-mail is 2011 where they say "The vast majority of you are doing this because this is the right thing to do and -- but there is obviously individual variation." So it comes down to I guess that issue that we talked about about how much do you audit, how much do you sit on each individual clinician's shoulder to look what they're doing at each individual juncture, and who does that of their practice to ensure that the variation is completely eradicated? You could write a protocol. Would that make the individual do the action? I don't think it would, because he had already been told. So I'm not sure what -- I actually genuinely am not sure how you eradicate individual variation. I don't know if that answers the question but it is a -- you can easily write a protocol. Can you take the -- you can take the horse to water -- can you make them drink individually? No. I guess. Could you be monitoring that? Yes. But where does that stop?

Q. And is it around this kind of line, particularly where it presents as a risk to patients and a recognised risk, that the Trust has a call to make, the employer has a call to make in terms of whether is this -- whether this is a matter for –

A. I mean, to be fair, in these cases, like you say, between SAI 1 and SAI 2, I'm aware of the swab and the other one, the review -- I mean, the swab was with the one consultant. The second one was a

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handover. The person had left, the scan went back, nobody picked it up. So those are a little different in terms of process. So, to be honest, I'm not sure I know the answer to that question -- and I'm not sure where you draw the line. Which aspects of their clinical practice do you audit and which do you not? And it comes back to skilled clinicians, experienced, doing the right thing for their patients individually. And you would imagine that if the patient was in your care, which was the case with the swab, you would look at the test. And the other one, I guess there should have been a team process to review when another man wasn't there.

Q. So, we came in to looking at those cases because I think you were telling us that incidents -- perhaps, to a lesser extent, a different -- in a different way, complaints and analysis of that –

A. Yeah.

Q. -- and then feeding that through governance meetings, was an indicator, in your time, that the –

A. Yeah.

Q. -- Trust -- the Acute Directorate was sensitive to these mechanisms and had an appetite to grapple with cases?

A. And if you say to your people, your 200 consultants "are you reviewing your scans appropriately?" and the vast majority answer comes back "Yes, we are", and you have one incident in whatever time period, although those are catastrophic and they needed addressed individually at the time, but they are not a trend. 400 a month IR1s not being reviewed is not a trend. I know that sounds quite, ehm... If you go out and you say to your experienced staff "You're doing this, aren't you?" and the vast majority come back and say "Yes" and you send a reminder and say "You need to do this because this is good patient care" –

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

Q. Do you think that this particular example is something -- I don't mean the case, I mean the process -- the failure, and you might be right that it's relatively isolated, but is that something of such significance that it just has to be got right and, therefore, it has to be monitored?

A. It could be that, in hindsight, you could say that. But if you have -- if the vast majority are coming back and saying "Yeah, we do this" and there's peer pressure and we're saying "Tell your people you really must do it" and "Your CD and your AMD says you must do it" and "It's good patient care" -- "I don't know" is the answer. There's a line somewhere and in hindsight is a wonderful thing, isn't it.

Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. You can't audit every part of their practice.

How operationally robust is the role of peer review and peer pressure in maintaining patient safety and quality standards throughout the Trust? How regularly is this audited?

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A.Performance and governance are completely tied together. They are two sides of the one coin. They have to work together. When the pressures are higher, the governance has to be better, you have to consider it more. Who gets the last bed in the ED has to be around clinical priority and has to be based on good governance.

Day 56

Mr. Wolfe questioning

Mrs Burns

Q. And there is, I suppose, a common theme or a common denominator between the two issues we've considered with you and your broad reflection, perhaps, is that both triage and the chart at home issue was not properly managed by your staff. And you might suggest that one explanation for that is that Governance was at an early stage of development and the key skills or the key instincts weren't sufficiently well honed by this point?

A. I think that's really important. I need to say that this is the most painful process I've ever had to do. My staff were excellent. They were a brilliant team. They worked really hard. They went over and above. Does that mean that you got everything right? Did it mean that they understood exactly what we were trying to sell them? Was it too early? Did they have the medical management and the medical leadership to support them in that? Was that stepping up at the same time? No, probably not. All those things were not coming together as they should. Did the staff set out to do a poor job here? No, definitely not. But we didn't get it over the line. We were too early. We hadn't grasped the concept of what the governance was.

Q. When we hear this being said candidly by you, it perhaps brings our minds back to the, I suppose, the contested evidence yesterday. We have in one corner, if you like, Tracey Boyce saying Governance wasn't fit for purpose –

A. Yeah.

Q. -- within Acute and you're, I suppose, driven to accept with these two examples of administrative process by the clinician that things were not right on his part, and, yet, the Governance people, people who were supposed to govern the system, who were aware that things weren't right, and those issues weren't grappled with satisfactorily?

A. Where I disagree with Tracey is that governance is part of your role in your day job. So, if you are a Band 3, if you are a Booking Centre manager, if you're a head of service, if you're a director, it is part of your day job. You can have administrative people in Governance sitting in an office collating reports for you -- you still have to have the challenging conversation about that report. So, you have to learn to do that. So where Tracey was saying Governance wasn't fit for purpose and it felt like she was saying there wasn't enough people -- it's not an add-on, it's an in the job/on the job role. And while they were writing the Datix, the on the job people, they just weren't following it through and addressing it, and that takes time and culture and support, and it felt -- it feels now, reflecting on that, it looks like it was too early then. To me, it's still an issue today. When I work with my teams, it's still an issue to have that challenging conversation with your consultant colleague, but we know that we have to do it and it's more instilled that it is required to be done and that's probably from all the learning that we've gained in the intervening ten years.

Is the SLT confident that training in the skill set of peer review and peer challenge is up to speed across the clinical teams in the Southern Trust?

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Q. A slightly different tack. In England in 2008 it became mandatory that patients receive copies of all their letters?

A. Yes.

Q. Now, this has not happened in Northern Ireland?

A. No.

Q. Do you have any observations as to the reluctance around that because it is a quite a good safety net?

A. It's a really good safety net and it's really interesting that you raise that because in my field now, we're in specialist palliative care - I'm the Director of Specialist Palliative Care - specialist palliative care is very much about the patient and family understanding where they're at.

Q. It is.

A. That there is, you know, active treatment to undertake and how are we going to see this through? So, we have regular debates in our governance forum about giving the patient and family the letter. My clinicians today are extremely reluctant about that.

Q. Why do you think that is?

A. Well, they tell me that it is because of some sort of protection for the patient and the family and from the clinical -- and I regularly tell them, 'If I am your patient I want to know every single detail for myself please.' So, they come from at it from, like, you know, we're protecting our patient but really, I think it's just the thought of getting used to actually saying out in black and white where you're out. They haven't just reached that point yet. And they are very good, my clinicians are very good at breaking bad news, they're very good at having those conversations but they still can't write it down.

Q. That's different from writing it, isn't it?

A. Yes, very.

This is an issue that has come up several times in the Inquiry – can the SLT clarify the guidance across the Trust on patients receiving letters after appointments recording their treatment discussions and plans?

Ms. McMahon questioning

Mrs. Martina Corrigan

Q. Now, given the way in which you found out that you would be taking it on -- and the Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that. Because, actually, the job that I applied for originally was Head of Service for Urology and ENT and, ehm, two different types of specialties, but were manageable. In 2014 I was asked to take on Head of Outpatients because there was no Head of Service for Outpatients. So, again, they needed -- it was when we were moving to HRPTS, which is our human resource system, and they needed somebody sort of as a Head of Service level. And, again, because of my background, I'd come from the Western Trust and that was my background - I would have been the

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lead in Outpatients - I was asked to take that on. So, really from 2009, in I think it was about 2012, from memory, I can't exactly remember, it became Outpatients, which was in itself quite busy because, even though I had a very, very good lead nurse, it still was five different sites that you had to sort of have an oversight of. And the problem with it was, to be fair to everybody, you still had to visit them all and make sure that everything was going well, because I like to have a presence with the staff. So that was that. And then obviously then Ophthalmology was tagged on. So I went from having two specialties to having four quite large areas to manage, along with the operational day-to-day stuff like your bed management, your ED pressures, your on-call, etc. But, yes, I do agree, to answer your question, it just seem to be -- you know, I'm just thinking back to a colleague of mine would have been Head of Service for General Surgery and then Breast was added on and then Endoscopy was added on. It was Head of Surgery and Oral Surgery, and then Breast and Endoscopy was added on to that as well.

'The Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that'

Is this a trend that is still happening? If it is, how can this be addressed?

Q. But at least from that time, you had on paper an identification that clinical risk was in your mind, would that that be fair?

A. That would be fair, yes.

Q. Given that, and your knowledge of that and your awareness of that and your operational head on, if can put it like that, was there ever a sense that you needed to speak to your medical counterparts and say, "This isn't just our problem operationally, it isn't a notes and records or a record-keeping problem, this actually has the potential for significant impact." Did anyone cross the potential divide and say, "We need your help sorting this out"?

A. From my perspective, I would have escalated and I would have had quite a number of conversations with regards to them issues with Mr. Mackle mostly so, and Mr. Young would have helped me out with sort of clinical issues that I would have felt that I wasn't able to address. To cross that, I didn't -- I don't believe I ever said -- it was quoted to me so many times by managers -- this is always an admin issue -- clinically, Mr. O'Brien is brilliant and we have no issues with it. Like, for example, Mr. O'Brien was his Clinical Director and one of his quotes is "If I had to come in, I would have had no issues coming in under Mr. O'Brien." So I think that clouded, wrongly, my judgement -- I have reflected on this -- in that I felt there may be an issue because nobody else did and that's my fault, I should have escalated it further. But it's one of those things that when I was escalating it or and thinking it and saying it in a letter and then it was removed, that it was me was thinking it was, where it really wasn't, if that makes sense? I'm probably not saying that very well.

Q. I think Vivienne Toal said something similar. She said "His excellence as a surgeon blinded us to the issues" -- I paraphrase her, but would that be a view you share?

A. Yes, yes. And I think it was everybody else sort of, you know, in and around and sort of up/out would have said that, that there was no issues clinically and it was all admin.

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Post Inquiry – one of the key messages to flag up is the importance of understanding that maintaining a consistent relationship between clinical care and administrative efficiency is central to patient safety and quality care.

Day 57

Ms. McMahon questioning

Mrs. Corrigan

Q. You understand that one of the focuses for the Panel is the governance system and processes that allow decision-making, I suppose, to be tracked back to origin. This seems to have been a fairly relatively important discussion that was going to slightly change the route by which triage was going to be approached, and certainly there's some contested evidence now around what was expected to be done. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely, because I know from the meeting with Mrs. Burns, I did put it in writing with regards to the plan with Mr. O'Brien not triaging. But I have looked back and I have never actually shared information with regards to the GP, the default of the GP prioritisation, which is now, you know, a regret. But then again, I don't think it was, you know, for me to do it because it wasn't my decision. It was a decision made by two assistant directors in discussion with a director, so I absolutely agree, we should have had minutes from that meeting, albeit even if it was an e-mail note.

'Q. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely'

Is the messaging clear throughout the Trust on the importance of documenting all decisions taken and circulating them to the relevant people?

Q. "Better inclusion of non-clinical managers with clinical managers." You say that's been improved and we can ask Mrs. O'Kane about that?

A. Yes.

Is there now a good connecting structure in operation with non-clinical managers and clinical managers in all departments? Is this being monitored and where there are issues are they being addressed?

Q. You also mention that there needs to be a clear management structure as there's no line of accountability for clinicians?

A. Yes.

Q. Would it be more that there is a line of accountability but that it wasn't actioned properly?

A. There was -- yeah, that's a fair point and I suppose listening to Mrs. Burns yesterday too, it was interested to hear that at that stage they were only all new and they weren't used to the challenge part of it. But I suppose it's something to ask the clinicians but I don't ever think they considered the clinical end as their managers. It was more to do with, you know -- like they nearly seen me not as their manager as such but as part of the team. I was the go-to person as opposed to, you know -- now, their job plans and their appraisals, etc., etc., I couldn't have become involved in and they would have

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pulled other people. I just think there's that disconnect for the clinicians, albeit the people who are in post, they don't seem to go to them.

How is the SLT addressing the ongoing need to facilitate a culture within the Trust based on respect for the different roles and responsibilities of all employees in the Trust in the delivery of quality care and patient safety?

A. Oh, absolutely. On reflection, there's a lot of things that if I had have stepped back, took the time to step back and look at, you know, for example, one of the things, and I know we're talking about governance that always sort of was like a bugbear for a couple of the Heads of Service was the SAIs were done in isolation, which is fine. The recommendations came up and the next thing you got a list of 'These are the recommendations that you need to implement.' We never got a copy of the SAI. It's a wee bit like back to the MHPS. If you're given recommendations in isolation, but the biggest problem thing for me is, and it's come from this Inquiry, when I actually sit down look and all the SAIs and read them, the recommendations could be actually mapped across. And if we'd have done that at the beginning.

Mapping the Inquiry recommendations with the recommendations of other recent reviews and SAI's will be one of the first steps post Inquiry. This will contribute to assisting the Trust in shaping a firmer foundation, develop streamlined action points as well as the important task of building confidence with the public in the delivery of good and safe patient care.

Veryan Richards

16/9/2023

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Part 6.0 Public Inquiry – notes and reflections (day 58- 63)

Day 58

Mr Wolfe questioning

Mrs Reid

Q. Under the key duties, the first key duty, perhaps, importantly, is, you were to "Take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and they are providing timely assurance and alerts to both the service director and the organisation." We get a sense of how you found the ground, so to speak, within your Section 21 statement. I suspect you are going to tell us today that your ability to provide the kind of assurance that things were operating at a sufficiently high standard of compliance was not, despite your best efforts, was not available to you because of resource issues?

A. Yes. I couldn't have provided an assurance in the organisation that all aspects of clinical and social care governance were robust within the Acute Directorate. There was a very small and limited team available, at times it was me and one other part-time person, so things in relation to audit for assurance wouldn't have been robust at the time. And there was an internal audit report that highlighted that the Audit Committee hadn't met for some time within the Acute Directorate and then that was one of the actions that I put in place to try and make the system more robust and try to provide a form of assurance to the Acute Director and, therefore, SLT.

What is the current standard of auditing across all aspects of clinical and social care governance? Where standards are low or the auditing process not taking place - what actions are planned to address this? Is this a standing item on the SLT agenda?

Q. You say in your statement that you didn't receive a handover as such?

A. No.

Q. Is it right?

A. That's correct. Dr. Boyce would have been supporting the Director at the time but there was no formal handover from a previous sort of full-time coordinator.

Q. Just in terms of the importance of a handover, Patricia Kingsnorth, when she gave evidence she said from a handover point of view, you handing over to her as you were exiting you were able to give her 45 minutes of a handover. First of all, are handovers important in your view? And the handover that you provided for Patricia Kingsnorth, was that adequate?

A. Handovers are important. And I think in retrospect 45 minutes probably wasn't enough. Although I was there on the end of the phone or if she needed any other guidance or support at the time.

The importance of setting time aside to complete a full handover

Q. And within your role, I suppose, specifically of governance. It is notable as against SAI investigations you haven't felt able to say anything in terms of strengths?

A. The challenge at the time was significant. There was a large backlog of SAI reports. They weren't able to be progressed in a timely manner. And the patient and family engagement isn't what I would have wanted for those patients and families.

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Q. Yes. You point out the core weaknesses: "Staff do not have sufficient training to make them confident with the SAI process, particularly for chairs of SAI panels and it is difficult releasing staff to attend SAI meetings." That's difficult to your staff or operational staff?

A. Operational clinical staff.

Q. Yes. Is that then pointing in the direction then of particular problems with the SAI process? Was it almost facing a situation of near collapse because of these problems or is that too strong?

A. Collapse is maybe strong but there was a significant backlog of SAIs, I think at that stage probably about 33. The small team, myself and one other at the time, it was a challenge for us to be able to support all of the chairs, help draft the timelines, help with drafting the reports, supporting the chairs and supporting the members of the panel. And again to getting the teams released to have the meetings in a timely manner and support them in writing, you know, finalising the reports, it was a huge challenge at the time.

Is there currently adequate time, training, and resource now in place for staff conducting SAI's? If not, what is the plan to address this?

Q. -- to implement actions around standards and guidelines. You talk, at paragraph 3.126 of your statement, about establishing a forum encompassing lead nurses, midwives, allied health professionals, radiography to ensure that the actions needed to implement standards and guidelines was shared and embedded with frontline staff?

A. Yes.

Q. Were those initiatives that you took forward?

A. Yes. So whenever I went into the acute governance role the worry was that the recommendations stopped at a certain level and sometimes what you find within governance is it doesn't filter down to the wards and departments. So this was our attempt to make sure that the lead nurses and midwives and AHPs were fully appraised and involved in developing the actions from the recommendations.

Q. One of the things I suppose you had a concern about, as reflected in your statement at paragraph 3.96, was that it wasn't always possible to provide assurance audit that guidelines that I suppose had been adopted by the Trust were actually being adequately implemented by frontline staff?

A. So to provide assurance you need to try and develop an audit and make sure that the audits are completed to identify that all of the actions are taking place and within the Acute Directorate there wasn't the resource to be able to sufficiently do that. For some standards and guidelines there were very robust audits but for others there weren't.

Is this forum still operating? Are resources being identified to support the auditing process to ensure that there is implementation of all the actions at ward level?

Q. I was just going to ask that. Was audit not viewed or how did things become so skewed that audit wasn't viewed as an integral part of quality improvement?

A. It should be. But the resource went to focus on quality improvement training, supporting the quality improvement as opposed to supporting the audit element of that.

Are all the elements of quality improvement being addressed in the Trust now?

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Q. Yes. When you talk about risk in this context, I suppose the risk that follows from being unable to proactively pursue governance issues, spell that out for us, what does proactivity mean in this context? Can you give us an example or two and what risk flows from the inability to pursue it?

A. So if we take some of the elements of governance. If we are looking at SAI reports, having them be able to be addressed and identify learning at an early stage and the recommendations be implemented and audited just to ensure that they were appropriately implemented is one risk. So delay in learning; delay in implementing recommendations; the inability to audit to provide assurance; to ability to provide frequent and robust training to teams in how to complete a Datix appropriately; how to identify risk; how to mitigate that risk again was another challenge and would have been a risk.

Q. Was it the case that, although you're talking the language of risk to Mrs. Gishkori, that while sympathetic, she didn't appear to be able to provide complete solutions, she talked about some initiatives that were tried, but did she appear to get it, that there was real risk here?

A. It would have been really challenging for her not to have got it because when you bring the number of outstanding SAIs, when you highlight the inability to audit to the level that we would have wanted to, it would have been really difficult for her not to have understood that risk. The challenge of providing the staff would have been a challenge from a financial perspective. But, again, how that was escalated outside and up to SLT I'm not fully aware of.

It is a key message in ensuring patient safety to listen well and pick up messages.

Q. Yes. Did you have any analytics, data analytics support? I suppose you're shaking your head. No?

A. No. Within the team we had -- Mr. Cardwell was probably our expert on the Datix system and we worked together to see if we could develop some dashboards for the wards and departments and ADs to see if they could at least see their information on a graphical fashion. Because lots of reports, as you will have seen, are lines and lines and lines of information, names and detail. And it's only when you get a really expert in data analysts that actually the information tells you the story. Because information can be presented in many ways to tell different stories. So the expertise of a data analyst is really important to get the actual facts to the people that need them in a timely manner and in a manner that actually tells a story that people can identify the risks.

Q. Ultimately it seems to come to this, you use this word which we're hearing a lot about, triangulation, "triangulation of risks was therefore challenging". You seem to put a lot of store by the need for good data access and good data analysis; why was that? Why is that?

A. Very simply, it's really challenging to identify risk when you can't see it from the different systems all aligned. So you may have a large amount of information but to identify from one system to another to another and pull that all together is really, really challenging and without being able to pull the information together you don't get the overall picture and, therefore, you can't see the overall risk. So some of the issues that had been identified, you know, with good data systems may have been easier to identify. But again it's as good as the information we put in so, therefore, making sure that your staff have the appropriate training to make sure that they know how to identify risk, how to fill in an information form so that you have got a clinician name to identify if it's a clinician or identify if it's a specific issue in relation to a medication or the sort of recording of the deteriorating patient, all of that is really, really vital to be able to really identify the risks that we have.

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Q. Do you know whether - obviously long out of the job you were doing in Acute Directorate - do you know whether the picture has changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?

A. It is still a significant challenge. The systems haven't changed that much. If you look at the demonstrations of the new Datix system that's available, you can put everything from your incidents, complaints, litigation, safeguarding, audit, recommendations, everything can go on it and be potentially triangulated and have reports coming out of that. So we don't have the most modern version of that. In relation to audit, again we need to continue to develop a system to put our audit recommendations on. And data analysts are really challenging to employ and we have a very limited team of probably one person. And again even having IT specialists who can put applications across data to, such as one of the click applications that will pull information from one or two systems into a report that is pictorial, for example, again there is a challenge with being able to resource those people within the organisation.

Has the picture changed markedly within the Trust or broadly in terms of its ability to access good data analysis for the purposes, as you say, of better being able to triangulate risk issues?

What needs to change in the immediate, mid and long term to confidently triangulate risk issues within the Trust?

Q. Another feature of some of the cases that we'll look at shortly is, I suppose, the delay from - let me not call it a delay - the passage of time between incident and final report. Obviously you have a lot of steps in the middle, you have to assemble the material, get the timeline, get the screening done and then research, interviews, analysis, drafting, maybe multiple drafts, lots of steps till you get to the final report. Some cases have taken three years to produce an outcome, again can you, in the generality, not necessarily referring to any particular case, but what is the problem there in realising the prompt delivery of an SAI outcome?

A. I suppose that's one of my sort of greatest regrets, that many of the SAIs took such a long time. It was essentially resource, resource of the governance team, myself and a small team, the number of SAIs, the complexity of some of them, the timelines, then diary management, sometimes getting a Chair. So if you start from the initial, we screen, we have to decide there is an SAI, we have to decide who the panel is, who the Chair is. There were challenges in always getting chairs, particularly if there was an external Chair required. Then organising the meetings, getting the diaries aligned. If we had to interview individuals in relation to the SAI it was getting their diaries aligned as well. So steps, small steps all along the way all slipped over time and unfortunately and regrettably the SAIs took too long.

Q. Yes. I suppose more often than not you're looking to an experienced clinician to Chair an SAI?

A. That's correct.

Q. Perhaps a clinician with other clinical and governance commitments; was that part of the problem, getting clinicians, who are no doubt to be thanked for putting his or her hand up to do the SAI when it is undoubtedly something that they maybe wouldn't necessarily have wanted to do? Is there a solution to be found? Have you thought about whether there is a better way of doing it, rather than calling ad hoc on clinicians out of the blue, perhaps, to become involved?

A. So the clinicians all have very busy clinical schedules and they did the SAIs within that diary commitment that they had. So that is why one of the governance structures looked at having some time set aside for people to be -- for chairs to have that half PA a week to help facilitate governance and SAIs. The other element was to have professional chairs, for want of a better phrase. And the

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Trust now does have some people who Chair SAI meetings, that's their -- that's what they do, they have the time and the commitment to be able to do that.

Q. Because if we start with the principle that the SAI review is taking place in order to provide learning and an opportunity to do better in the future in respect of, for example, a clinical issue or a behavioural issue or a technical issue, whatever it might be, the learning obviously has to take place in a considered environment, you don't just rush out with the conclusions right away, it has to be considered and thought about. But three years down the line or two years down the line is, would you agree, not much benefit if there is a real problem there that needs addressed?

A. They do need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So two years is too long.

'Conducting SAI's need to be timely, to identify the learning in a timely manner so that mitigations can be put in place to reduce the risk of it happening again. So two years is too long.' With the learning from this Public Inquiry on this matter – how is the SLT responding?

Q. Do you think the Trust continues to remain vulnerable to an inability to bring together different strands of information, some might call it intelligence, around the practitioners who may be putting patients at risk?

A. I think, because of the systems that we have in place at the minute, the Datix system, while it has improved, the ability to triangulate all the information is still a challenge. And again without good data analytics to help pull all the reports together, to evidence the trends, it could remain a challenge and does remain a challenge.

What immediate steps are being taken to provide good data analytics to mitigate the risk to patients?

Q. Have you any concern that clinicians would find it awkward or inconvenient to report, if you like, their colleagues into an SAI process or do you think the evidence doesn't support that?

A. I would like to think with their professional accountability that if they identified a risk that they would. From some of these it appears that on occasions that hasn't happened.

Q. Tracey Boyce has said in her evidence to the Inquiry that there was this disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team and she says from what I understood at the time they had to be kept totally separate. However, with the benefit of hindsight, she thinks that a joint approach would have been beneficial. So, for example, the SAI concerning patients, the five patients, might have been expedited rather than taking the guts of three years. A more of a joined-up approach would have led to a more efficient and perhaps a more universal learning. Do you have any view about that?

A. My understanding is that the two processes sit separately, one is in relation to the professional management of the doctor, the other is in relation to learning from a clinical incident. I think as a governance coordinator you are aware of lots of very confidential, very sort of information and it would be good to understand other processes that are going on within the Trust to help triangulate all that information and perhaps share between the two processes so that you have got a very robust rounded learning from what was happening at the time.

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Is it still the case that there as ‘a disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team’? Is there a move towards triangulation of information?

Dr Swart

Q. Last one. I mean if a member of the Trust Board came to you when you are in your governance role and said 'How can you assure me that your consultants are following up to date standards and guidelines? What assurance can you give me?', what would you have said to them?

A. I would have highlighted the challenge of the resource that we had to do it. I can't remember the exact numbers back then, but now there are over 3,000 guidance. 2,800, all of them are applicable to the acute service. They don't come with funding.

Q. But will you be able to assure him is what I am really saying?

A. No.

Okay. Thank you.

How is the SLT addressing the miss-match between no available funding and assuring your consultants are following up to date standards and guidelines?

Chair

Q. So if you could wave a magic wand and resources weren't an issue what would you like to see happen in terms, first of all, generally in governance and more specifically what do you think is the one thing that would help prevent something like this inquiry happening again?

A. I think resourcing the teams appropriately, having sufficient resource to, both - at all levels, so making sure we had the right resource to make sure that the clinical workload was doable, having the resource within the operational teams to make sure that there was managerial time to make sure that actions were taken. From a clinical governance team it's making sure that the right number of people with the right skill set, the right training, the right time were available to review the incidents, take forward the proactive work, the education, the training, the audit, the triangulation of information, having data analysts that can actually really delve into information and show it in a meaningful way and having IT systems that mean that information isn't a challenge of going to lots of different systems to try and pull it together.

This reply could be a useful summary to feed into the discussions on outlining the vision for the next chapter in the Southern Trust.

Day 59

Mr Wolfe questioning

Mr Cardwell

Q. You say, at 15.2 of your statement, that, since the inception of the Trust you consider that there could be what is described as an "element of instability" within the Acute Governance Team and you illustrate that by saying that: "Since 2012 there have been six Directorate Governance Coordinators and an extended period when there was no Directorate Governance Coordinator in place." And that was the period between Mrs. Marshall leaving her post and Mrs. Reid taking it up?

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A. Yes.

Q. Against that context and that experience, what was it that you were seeing or recognising as, I suppose, the shortfall in governance activities, not just in your own role, and you have outlined that already, but across the piece, what did you think or what did you observe as being a deficit in the governance environment?

A. Well, to me it was the collation of information between various strands of governance that would have put you in a better position to look at complete trends. Mrs. Reid had referred to it as the triangulation of information. In relation to the visibility of governance, I believe that could have been better than what it was as well.

Q. Are you in a position to say what the, I suppose, practical consequences or risks were in association with those kinds of deficits, what was the impact of this?

A. Well, the impact probably was that, you know, there was information there, it could have been used to identify specific issues. But because of the lack of resources and the ability to marry up that information, the opportunity maybe wasn't used as fully as it should have been.

Q. In your experience over that eight-year period, do you feel that the Datix system was used by the Trust to its fullest potential?

A. I would consider that the system had more potential than what was used. I would also point out that there were a number of Datix systems, in that we started off with an original Datix system which belonged to one of the Community Trusts and that was developed to meet the needs of the entire Southern Trust. We then moved from that system to what was described as the Datix new system. Some information was kept on that. Then we moved from the Datix new system to the Datix developer system which contained some information. So not all information is kept in the same place. At this point I don't know that we're using the most recent version of Datix. I think there has been upgrades but we haven't been given those just yet.

Q. Yes. So you had that level of complication associated with different versions or different types of Datix system?

A. Yes.

Q. In terms of the ability of the Trust to exploit, I suppose, the data potential, the trend building potential that this kind of repository offered - and plainly that would be important for a Trust to know where the hot spots are, where the risks are, where the problems are - was the ability or the resource available within Acute, to the best of your knowledge, to exploit that potential to its fullest?

A. No, I don't think it was. I think Datix and its management from the input of information, the quality assurance of the information that's input to the system and then getting that information back out into a meaningful report, the capacity wasn't there to deliver that.

Q. Yes. One of the problems perhaps is one you have pointed to in your statement at paragraph 8.5, you said that you would have received feedback frequently from staff who would have complained that the process of completing a Datix was cumbersome?

A. Yes.

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Q. And obviously there is an investigator's guide and I don't need to bring it up on the screen. For the panel it's WIT-99436. It certainly looks somewhat opaque and cumbersome on the face of it. What was that complaint or could you better explain that kind of feedback you were getting from users of the system and what was its implication?

A. Well, I think the feedback that I would have been receiving would have been through conversations with the likes of Ward Managers and staff at ward level. And also during the training sessions that I would have provided in relation to Datix. And the staff would have been saying that they found the system cumbersome to use. It was time limited, in that whenever they logged in to submit an incident they only had 60 minutes to complete that. But in a busy ward environment, you know, they might start off with the good intention of submitting an incident but then be called off to deal with some clinical task. And, then, by the time they got back the system would have timed them out. There was probably, maybe, not a great awareness of what the staff at ward level, what their expectations were in relation to the reporting of incidents. So whenever they come to actually log on to the form and submit, and in some particular occasions it may have asked them information which they hadn't readily at hand, and if you can understand there were certain boxes on the form that were mandatory so if they hadn't that information to hand then they couldn't get past that.

Q. Yes. The Inquiry has observed some evidence, perhaps small in number in terms of the cases, of what might be described as underreporting, a failure to complete a Datix, notwithstanding the need to do so judged by the facts of a case.

Q. There is training associated with Datix or for users of Datix, is that primarily targeted at those with investigation responsibilities?

A. There are two levels of training and they were instigated by the Directorate Governance Coordinators at certain points. There was training in relation to general governance which would have touched on the Datix system. And then there was also training in relation to someone who is investigating a Datix incident and how they work their way through that process and what elements they should consider in their investigation. That was sporadic in its nature. And in my current role now since 2019, whilst in 2019 there were a number of sessions organised but when Covid kicked in then those were put on hold. So training now is just on an ad hoc, on request basis.

Q. And it is not mandatory for Datix users?

A. It's not mandatory, no. But it's something that I feel that should be mandatory. It's an IT system that's used by the Trust and I think that that system should be supported with appropriate IT training.

Does the SLT agree that it would be appropriate for all clinical staff to have mandatory training in the most recent Datix system?

Q. Do you get a sense that - I don't want to tar everybody with the same brush - but do you have a sense that sometimes clinicians are pushing towards ruling cases out of the SAI process because harm hasn't resulted and that you have to pull them back and say well, it's not necessarily about actual harm, it's about risk?

A. Mm-hmm. Not in my experience from 2019.

Q. It's not a problem?

A. No. I don't consider it to have been a problem since then.

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Q. Yes. You make the point in your witness statement that there is, I suppose, no audit or quality assurance process in place attached to the screening exercise, do you think that that would be a useful thing?

A. Well, yes, that would be a useful tool. From the point of view of those ones that are declared a serious adverse incident, they are notified to the SPPG and they can almost do an audit and sometimes will come back to us and ask questions in relation to why is this an SAI or can I have more information in relation to that. But I suppose from the point of view of the ones that are screened out, at this time there's no process for it going back to review that decision.

Q. Do you think that resources available, that would be an important next step in maturity or maturing or the development of a good SAI screening system?

A. Well, it could be, yes, but again that would probably come down to the level of resources and who would you bring that to for a specialist opinion.

Q. Now, at the other end of an SAI we obviously have the need for learning. You have explained in your witness statement that learning should be shared at morbidity and mortality meetings within the relevant service and that's usually a recommendation of the SAI; isn't that right?

A. Yes, that's correct. Usually whenever we are looking at the recommendations for SAI reports, one of those recommendations will be that it is shared at the relevant or more than the relevant morbidity and mortality meetings for learning.

Q. Yes. One of the things that we've noted in association with a number of the SAIs is a, a number of SAIs that have emerged from urology, is the delay in moving from screening to the learning stage. The learning stage can only come, the full learning stage can only come at the conclusion of the report and some of the reports have been delayed by two, two-and-a-half, three years sometimes from the date of incident?

A. Yes.

Q. Is that delay or the risk of delay in completing an SAI process a feature of the Trust's world today?

A. I would say less so today than what it was back in 2016 to 2019. We now have in place three Band 7 Clinical Governance Managers and their role is really to move forward the SAI process. Those people weren't in post at that particular time. The main delay that we would now face would be in relation to the establishment of a team and getting a first meeting of the review team. But once we get the first meeting of the review team, we're generally inclined at that first meeting to agree a date for the second meeting and third meeting which is usually two to three weeks after the first meeting. So we find that we're getting through them a bit faster than what was previously.

Q. Mm-hmm. It's been suggested to the Inquiry that perhaps the most significant impediment to moving cases forward is the availability of the lead responsible officer on the review, who is inevitably a clinician?

A. Yes.

Q. And usually a busy, committed clinician; is that something that is just inevitable or are there ways of driving momentum and encouraging expedition that you have now recognised that perhaps weren't a feature of some of the cases we have seen?

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A. Yes. Well, I think when you're using a working clinician, that will increase the length of time, because if they have not got protected time to carry forward this SAI review, we are really depending on their clinical commitments and trying to fit this in around that. What we have been doing since 2019 is doing a lot of the preparatory work, in that we are writing the timelines, we're making the packs. So we're doing some of the groundwork for the Chairperson in advance of the first meeting. Obviously they'll still need time to prepare for the first meeting and review the information that they have available. But I find that that can quicken the process.

Is there now in place the provision of protected time for the Chairperson of an SAI panel?

Q. We asked you in your witness statement to think about a case called Patient 93. Patient 93 was a patient who had been referred into the urology service as a routine case and that there was a failure to triage that case. The suggestion in Mr. Haynes' correspondence at that time was, well, if it had been triaged it would have been upgraded to a red flag.

A. Yes.

Q. And between Mr. Haynes and a number of medical managers they discussed this case but it never made it into the SAI process, by contrast with some other triage cases of which we are aware. In fact, you have conducted some searches and you outline, at paragraph 11.2 of your statement, that, let alone it didn't reach the SAI, it didn't even get reported into the Datix?

A. Yes, that's correct. I have completed a thorough search of Datix and I can find no incident report in relation to that patient.

Q. Yes. Is that simply a frailty or a vulnerability of the system that's, if you like, to make up a word, unpoliceable; if clinicians aware of an incident that is worthy of comment decide, for whatever reason, not to commit that incident to a report into Datix, there's not much the governance team can do about it?

A. No. Well, if the governance team aren't aware of it they are not able to make sure it is directed to the correct process.

Q. I think I asked you questions about this general area earlier and was asking you to comment on whether there was, in your experience, anything resembling a culture of underreporting, if I can put it in those terms, and that's not something that you are aware of or concerned about?

A. It's not something that I am aware of. And in relation to the incident relating to Patient 102, that would indicate that there was an awareness if there is an issue that a Datix report needs to be completed.

Q. Yes. A. So I can't explain why there wasn't one completed in relation to Patient 93.

Q. We had a patient come to the Inquiry to give evidence, his name is Patient 84. You can see, if we just bring it up on the screen, PAT-000225, he directed a complaint to the Trust on 19th September 2016. Without going into all of the fine detail, this was a case where there were -- a complaint where there was a number of issues but primarily and at the heart of it it was a patient who had a stenting procedure. The stents had to be removed. The patient had been given the understanding that they would be removed by a certain date and that date moved and moved and moved until he got into some considerable medical difficulty, had to be admitted to hospital with infection, had to be re-admitted and was not, as you might expect, terribly happy with his treatment, leading to this

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complaint. And you were at that time responsible for managing or coordinating complaints and we can see, for example, PAT - well it's three pages further on at 228 - we can see that your first step, I suppose, is to send out what I take to be a pro forma kind of response which might be politely described as a holding response or an acknowledgment?

A. An acknowledgment of complaint, yes.

Q. Yes. This was one of these cases where you were unable to comply with the 20-day aspiration. A number of holding letters were issued over the following months, leading to a substantive response on 1st December. If we could have that up on the screen please, PAT-000231. That would have been signed off by Mrs. Gishkori. Now, if we scroll down through it. Just further on down, on to the next page perhaps. When this patient came to give evidence, and indeed in subsequent correspondence in response to this output, he took exception or he explained that he took exception to how his complaint had been dealt with and what was particularly sore with him was that his perception was of being made to feel guilty about complaining because - and he drew this or he was caused to feel this - because he was told that, in essence, the service is struggling to meet demands and cancer patients have to come first, if you like, and that's perhaps contained within that paragraph, commencing: "Mr. O'Brien confirms that ideally patients who have a stent inserted should have this removed and have this performed within four to six weeks later. However, the demand on the urology service is unrelenting, with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway." Just to show you how it was expressed by the patient when he came along to see us, if we go to TRA-00094. He came along at the opening week of the Inquiry and he says that, just scrolling down, he says: "Obviously, when they brought in the cancer patient stuff and, you know, while obviously I have sympathy with them life threatening conditions and things but that wasn't I suppose - you shouldn't be made to feel guilty." In other words, he took it as why are you complaining, there are people worse off than you. Did you draft the letter?

A. The information contained in the letter would have been a direct lift from the information provided by the service area. Having read that now again, I accept that the patient would be annoyed by the content of the letter and I am sorry for that. I can understand where the patient is coming from. I think the attempts to explain the pressures on the urology service have not been communicated as well as they maybe could have been.

Q. I suppose linguistically it's a difficult balancing act, you perhaps want to communicate something of an explanation as to why the treatment has been delayed?

A. Yes. Yes. And that explanation had been given to various other patients who were waiting as well.

Q. Yes. I think what you are acknowledging this morning is that, from his subjective perspective, it's understandable that he would feel annoyed?

A. Yes.

Q. And maybe there is a learning here in terms of how you convey the message?

A. Yes, exactly.

Treating each patient with dignity and respect includes attention to the quality of communication - a key component in delivering person-centred care

Q. Mm-hmm. We know, we've heard from you today about the limits to the ability of governance personnel to be proactive?

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A. Yes.

Q. And we heard from Mrs. Reid in that respect yesterday.

A. Yes.

Q. You are no longer in complaints?

A. No.

Q. But do you have any intelligence or information to share with us in terms of how well the learning to be extracted from complaints and the development of responses to, perhaps, issues that could be repeated if they are not fixed, how is that being handled? Is it being handled any better in 2023 compared to 2018?

A. I couldn't honestly comment because I don't have enough in-depth knowledge in relation to that.

Q. And again still on the complaints theme, there is a lot of emphasis on the timeliness of the complaints, I can't see a lot of emphasis on the quality of the complaint response. Did you try to assess that? Did you ask people how satisfied they were with the complaint response? Or what's your general view of that, perhaps looking back now?

A. Looking back now, it's something that could be done and should be done. But really at that particular time, given the small number of resources that we had compared with the number of complaints and MLA enquiries we weren't in a position just to do that.

Q. Mm-hmm. Again you say you cascaded, it goes for cascade down to the teams. Learning from complaints is always a very hot topic and the learning is only as good as the quality of the discussion and the actions taken.

A. Yes.

Q. Did you seek any assurances that the complaint had been discussed at the right level and did you seek any assurance about the actions taken?

A. No, that wouldn't have been part of my role. That would have been the role of the Governance Coordinator.

Q. Okay. Were you aware as to whether that happened or not? Did you have any understanding about that?

A. No, I can't say that I did.

Q. Okay. Just coming on to Datix for a minute. Clearly you've got a lot of expertise in this area. The commonest complaint, in my experience about Datix, from staff on the ground is there's no point filling in that thing because nobody ever tells me what happens. What would you say to that staff member? What did you say to members of staff who complained like that? Because I am sure you had some.

A. Yes, we would have had staff making that exact complaint about Datix.

Q. Yes.

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A. In my eyes it is the responsibility of the person who is investigating the Datix to provide feedback to the person who has reported it.

Q. Yes. So you would say that. Do you think that happened routinely?

A. No.

Q. Do you think feedback was provided?

A. No.

Q. No. And the screening meeting which we had lots of discussion about in the last couple of days, what was your impression of the degree of hierarchy at those meetings, was there deference to the most senior person, was there appropriate challenge, was there any problem with actually having open discussions? Just from at a personal perspective, how did it feel to you?

A. From a personal perspective, from 2019 onwards I considered those meetings to be very productive. The cases I considered to be discussed in an open and transparent manner. And I think that everyone has equal input to those discussions.

Q. Who would have the final say, though, if there was a difference of opinion?

A. I suppose it would be the Divisional Medical Director.

Chair: Nearly finished, just a few questions from me, Mr. Cardwell.

Q. A couple of things, well first of all if I can just ask you about Datix. It has been updated but you're not on the newest system, why is that? Is that a resource issue?

A. I would imagine so. I can't say for definite but I would imagine that is, and there would be a cost associated with that as well.

Q. The new Datix that is currently in operation, is it any less cumbersome to input the information than the previous one?

A. Not really, no.

Q. So would you accept then that in some ways it is perhaps not fit for purpose?

A. Yes, you could say that it is not fit for purpose.

Q. I mean, obviously the easier it is for people to make a report –

A. Yes.

Q. -- the more likely they are going to do it and if they are put off by a cumbersome system that requires a lot of training and that isn't particularly user friendly then it's not really going to be the most effective system, is that fair?

A. That's a fair point. But on reflection you still need to capture the key essence of what the incident is in a factual and concise manner.

Q. I accept that entirely. But if you're having to tick a box, if you're logged out after a certain period of time, then those are things that surely with the IT skills that people have nowadays could be improved?

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A. Could be rectified, yes, I agree.

Is the current Datix system user friendly? If not, what can be done to rectify this?

Q. Okay. The other thing, a comment that you made about, if someone complained about the length of time that they were on a waiting list, they were given the next available appointment?

A. Yes.

Q. Are you suggesting that the way to get moved up the waiting list is to complain?

A. No, I'm not suggesting that.

Q. Okay.

A. What I am saying is that that was a resolution or a remedy that the service was able to offer to people who complained. It wasn't that, you know it wasn't just widely known that if you make a complaint you get moved up the waiting list, and that wasn't the case.

Q. So but what -- I'm sorry, maybe I'm not being clear on it. If I write in and complain, I have been on this waiting list for months, years, whatever, what are you doing about it, I would be given an appointment within a short period of time?

A. Yes. But I accept that that doesn't look at the root cause of why there is a long wait.

Q. My point, though, is that, if people know to complain, then they can leapfrog over the waiting list, essentially?

A. Mm hmm.

Day 60

Ms McMahon questioning

Ms Thompson

Q. Is there anything in the system, either for you or for the consultants, that flag up when results have been sitting a while or waiting or if there is any delay in look at them?

A. I know the secretaries, they would, if a patient has been seen in an out-patients clinic and they are having an investigation, they are put on to the patients administration systems as what they call DARO which is discharged awaiting results. This is placed on the PAS. The secretaries would run reports then monthly and this will show if there is any outstanding results that needs to be actioned. So the secretaries could contact the consultants or even myself, if I have requested anything or if there is results available they could contact me.

Q. Now you speak about DARO at 14.3 and you say that the CNSs don't have access to the DARO functions?

A. No, that's for the secretaries would have access to that.

Q. Do you think that it would improve follow-ups if you did have access? Give us a bit of background to that, why you have said that?

A. I think it would improve my follow-up. You know, if nurses had, maybe, or Nurse Specialist had access to it we could be notified if there is results outstanding or if the result has become available. It

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would probably be around the same as what NIECR or Sectra would be and it could notify us if we have put in a request and results are available.

Is this a suggestion that could be implemented?

Q. Does the scenario now exist, if it did at all before, where you had to wait until the consultant invited you to introduce yourself to the patient or do you do that autonomously?

A. We do that autonomously. And we ensure that, when we are attending the consultant's clinic we ensure that we are present at the clinic. I wouldn't want to say we're available because we want to ensure that we are present there, that we will be in the clinic when there is a consultation with regards to a patient who has a cancer diagnosis.

Q. And is it your current experience that that works well with other consultants, they understand your role, they understand the significance of that and the patients are leaving with the relevant information following a diagnosis?

A. Yes, that works very well with the consultants.

Q. Now that's the system as it is now and you have explained that very helpfully. In August 2020, when you started, a lot of that process would have been absent, would that be fair, a lot of that certainty around allocation, around the CNS pro forma, around the marking on the NIECR, around the MDM notes being clear, the key worker being allocated, none of that existed at that time?

A. It didn't exist, no, the pro forma didn't exist at that time. CaPPS, to be honest, I feel that CaPPS really has made progress in the Southern Trust in urology since I came into post because it would have been a system that I would have used in the South Eastern Trust so I was able to bring that experience when I started in the Southern Trust. The NIECR, the progress notes wouldn't have been used either when we first started. It's only that we have been introduced to it really, we would say it was probably around the wintertime of 2020 progress notes became available on NIECR.

Q. And do you feel supported by the Trust in that succession planning? And the training that needs to be delivered so that people can segue over if anyone leaves, is the training available?

A. Yes, I do feel supported by the Trust. Now, I, myself, I am creating a document for induction for any new specialist nurse, especially if they are an expression of interest or a permanent member of staff and it's to go through the training of to be a urology CNS. So it's putting them through nurse-led clinics, it's letting them see what lower urinary tract systems assessments and they would have to need to do this and have competencies. I would like them to maybe attend different clinics, such as oncology clinic, maybe attend the Cancer Centre, attend such things as urodynamic clinic, the cystoscopy, to maybe attend the ward rounds, also maybe attend theatres. And once they have gained their competences, discuss where they would like to work, do they want to go down the cancer side or do they wan to go down the benign side. But also, it would be ideal to look at education for them, such as maybe looking at the non-medical prescribing course, looking at -- one of the new appointees is actually doing a P cert on the foundations of urology in which she will go through the likes of the prostate assessments, how to set up a nurse-led clinic and also look at flexible cystoscopies and TP biopsies.

Q. What is the buy-in with consultants in all of that? Do you work parallel with them to identify training and deliver it or is this nurse-led training?

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A. The consultants, yes, do buy in with the training. I think the consultants would value if they do do the basics first. And they would like the nurses to look at where service provision is, where there is a need for the service. Yes, they are very open and managers are very open if there is any specific training that needs, such as if they need to be sent for a flexible cystoscopy course or if they need to be sent for the non-medical prescribing, the consultants are very supportive. And also the Nurse Managers would be, there would be support from the Nurse Managers as well. There is also training at present for myself and that would be for the transurethral laser ablation. A girl had come out to assess the Urology Service and they had recommended that this would be an ideal opportunity for the Urology Nurse Specialist to be trained.

Q. What stage is that at? Is that something there has to be separate funding sought for or what way does that work?

A. There will be funding for the equipment and there will be funding for training. The company will provide training and myself and Jenny, who will be trained in this, will be sent to centres in England to be trained up and to assess for the transurethral laser ablation. We will also have consultants will assess our competencies and we will probably have sign off competencies to be able to do this procedure.

Q. But your view is that the Trust are motivated for this to go forward?

A. Yes, to bring this forward. Because this will reduce patient waiting time. If they have small bladder cancer reoccurrence, rather than be on a waiting list we can provide this nurse-led service. Also, there are maybe patients who are not fit for general anaesthetic, so we can provide the service for those group of patients.

Has the funding stream been identified for this training? Have staff been released to access the training?

Q. So if we move to the preceding page, TRU-303440. And this is an email sent to you from Patricia Kingsnorth, who we know is the Head of Governance. She sends it to you and copies Martina in and Fiona Reddick. And she says: "Hi Patricia, many thanks for agreeing to assist with the SAI process. We have a number of cases to be discussed and will measure them against the existing pathway. Can you be available to meet with the review team on Thursday, 10th September at 9:30am in the meeting room, Trust headquarters." And signs it off, "Many thanks, Patricia". So that was the start of your involvement in the process?

A. That's right.

Q. And that was the first meeting that you attended, that was your first introduction. I just want to ask you in general terms, we have looked at the notes and we have looked at the minutes and we have discussed this, in relation to your introduction at the meeting, did anyone set out your role and what was expected of you and what you brought to that particular process in relation to the make-up of the team?

A. No. I never had any information of what my role was to be with the team. I gathered that because I had experience of a urology CNS from another Trust, and a lot of experience, it was to sit on to see if there was any key worker involvements. But I was never given any task to say this is the expectation we would like you as being part of the Panel for the SAI process.

Q. When you say key worker involvement, was it indicated to you that that was the purpose for you being involved, was the key worker issue?

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A. No, I don't think it was the purpose of why I was involved. I think it was the purpose because of my experience and what I could bring to the SAI. But there was no criteria or no particular road plan was given to me.

Q. Did you have any knowledge at that meeting or after of the terms of reference of the SAI?

A. There was no terms of reference was formalised at the first meeting. But terms of reference was formalised following that first meeting. And they were written both by Patricia Kingsnorth and Dermot Hughes.

Q. Did you have any input into those terms of reference?

A. I didn't, no.

Q. Do you recall those terms of reference Doctor 1?

A. Yes, the terms of reference were referred to Doctor 1.

Q. Now you had no previous knowledge of SAIs or you had never been previously involved in any?

A. No, I had no knowledge of SAIs. I wasn't involved in any or I had never been the subject of an SAI. I never had any training either with an SAI. However, I do note that my role was just to sit on the Panel. It wasn't to be a chair or a governance part of the SAI. But no, I had no previous experience.

Q. Just so we get a feel of it. Something that we're not familiar with, but the SAI, was there a feeling that everyone was an equal member of the team and everyone brought a different lens to it or what was your feeling about it?

A. My feeling about the whole team, I wasn't given -- only my -- I felt that I didn't have a lot of input into the team. I would have liked to have maybe had more of an input. Such as with my experience and my experience of being a key worker and an experienced Urology Nurse Specialist, I felt my input would have been better if I could have liaised with families and with patients along with Dermot and Patricia Kingsnorth. Because I could have maybe found out more information, I could have spoken to the patients, I could have found out -- because the particular issue and it would tend to be that there was no key worker involvement, I could have maybe spoken to the families and maybe found out more specific information. My role really was to look at the likes of the patient administration system, the appointments process, the DARO, the protective review, but it was never anything such as, you know, being involved with the patients or the families.

Q. So it was more data-led?

A. It was more data-led.

Q. You were good for figures rather than facts of processes?

A. It was more of timelines, you know, timelines of patients' appointments and was there a key worker at that clinic and when was the patient seen, was there a letter typed for that particular episode, that was more of my involvement.

Q. Now you have been through that process as a team member, do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?

A. I think it would be useful if training was to be advised for anybody who wishes to sit on an SAI process. Also, too, it would appreciate what type of SAI is it, is it a Level 1 or 2 or 3. And also, too, what each team member brings to the SAI, such as the chair of the SAI or the governance person of the SAI.

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But I do think it would be a very useful training for anybody who wants to sit on an SAI process is to do the two-day training.

'Do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?' What is the SLT's view on mandatory training?

Q. Now in relation to your involvement in the SAIs, is there anything else you would like to add that might assist the Panel in considering whether the effectiveness of SAIs generally as a governance tool or what you think, as having been on a team, might help beyond what we have already discussed, is there anything further?

A. I feel, obviously, training is very important for the SAI. I think even informing a person what the SAI is about. Because I had no knowledge really of the SAI until I attended the day of the meeting. Now, the day before I note that Kate O'Neill and Leanne McCourt were doing a pathology Lookback Review on Mr. O'Brien and they had discussed that with us and I had mentioned to both Kate and Leanne that I was asked to be involved in an SAI and I was querying would this have been about Mr. O'Brien. They were unsure. But, obviously, when I attended that meeting on 10th September, looking at the SAIs then I realised or worked it out that it was about Mr. O'Brien. I think it is good to be notified what the SAI is about because I did find the SAIs was very, very comprehensive and very complex. A lot of it was very emotional because a couple of the patients did -- I felt was very emotional about a couple of the SAIs. And I think, too, counselling, if somebody could maybe be very upset with regards to an SAI, because a patient could have catastrophically been harmed and maybe counselling may be something to consider.

Q. Some sort of outreach around patients who have been involved in that process?

A. Sorry?

Q. Some sort of outreach in relation to patients who might have been affected by the SAI process itself?

A. Yes, for the patients been affected by the SAI process. And also staff as well, staff could value from counselling.

Q. So while maintaining the confidentiality of the SAI, when someone is asked they should be given a general flavour of what it is about, what it might entail so that you can make an informed decision as to whether you want to be part of that team?

A. Yes, I would think that. But if I was informed of what the SAI was about I would still have sat on the Panel, because those patients and relatives were looking for answers and it was something that needed to be investigated and I didn't want to delay the investigation process. And it was also to look out, to look for another Nurse Specialists because they would have had to go outside the Trust or maybe had to go across over to the mainland to look for a Nurse Specialist.

Is support offered currently to patients and staff affected by the SAI process?

Day 61

Ms McMahon questioning

Dr Mitchell

Q. You've mentioned two of the possible adverse effects of Bicalutamide 50 monotherapy being prescribed in an inappropriate way, as you say; one is potential delay and the other one is resistance.

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Is there also, given that it is not licensed in that way, is there also the potential that it is suboptimal treatment for people and that they may actually, the disease may progress more rapidly, not be effectively treated? Is this a suboptimal, ineffective treatment regime in your view?

A. So that would come back to the point of resistance. I'm not pharma related, but you would expect that a company like AstraZeneca, who were developing Bicalutamide, or known as Casodex, would have gone through a dose escalation process, looking at safety, looking at efficacy, and if they have decided that the licensed dose should be 150mg then you have to go with that research, that recommendation, rather than use a lower dose. So, the concern as a less effective treatment would still be in terms of delay or development of resistance.

Q. Did you see it as representing any potential for patient harm or risk?

A. I think because the main issue for me is delay to referral, I don't remember delay to referral in those particular cases. So, it was only when the issues of the dose prescription and the significant delay in referral came through as a discussion in 2014, that it became more important to flag it.

Q. Just to tease that out a little bit more. Just from a sort of a common sense point of view, would there be any potential that people who are not being treated appropriately for the diseases that they have are being placed on a drug regime which has not proven to be effective in the way that it needs to be for them, that that in itself is a patient safety concern?

A. Retrospectively that systemic error should have been picked up and the practise stopped at an earlier stage.

Q. And should that have been picked up by you?

A. I think I have responsibility within seeing those patients, and when we see a systemic error, then, yes, I should have taken this to a different format rather than just writing back to the GP and copying the relevant consultant.

Q. Now, I know it's a 2008 to 2014 timeframe, things have changed and governance structures have changed, but at that time, what do you think would have been an appropriate response to what you had come across at that time? What do you think you might have done, or should have done, or could have done?

A. I should have discussed it with my Clinical Director at that time.

Q. And who was that?

A. So there were a number of clinical directors at that time. I think Dr. McAleer, Dr. McAleese would have been two of the -- and Dr. Houston, would have been three of the clinical directors that were in that early phase.

Q. You've mentioned the GP letter; would the dosage of Bicalutamide 50 as a monotherapy, would that be widely known among GPs as perhaps an inappropriate drug regime on its own?

A. I don't think so. It's quite niche in terms of its use. So, I wouldn't expect a general practitioner to have picked up that 50mg as a standalone therapy was incorrect, or to have looked at the guidance on dose prescription for patients. So I don't think it was a GP's responsibility.

Q. When you didn't get any more referrals around this issue, is there a possibility that it perhaps engendered a false sense of security that the issue had been dealt with and had simply gone away?

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A. I think the answer is yes, in truth, with a busy clinical practice, and this wasn't top of the things that I was doing, and as time went on and not seeing the issue again, it simply moved to the bottom of the list, until the subsequent cases were raised.

Q. Now, if this issue was to materialise as it is now, what would you expect the governance processes, how would you expect it to operate to deal with this?

A. I think I'm a bit older, a bit wiser, I'd have a bit more of an expectation that this really needs to go further, be more direct, likely have a face-to-face discussion or phone call regarding the prescription error, seeing it as a systemic error and take it to the Clinical Director. So, I would have a different approach now as to what I did ten years ago.

Q. If we could go to WIT-96693. This should be the meeting of 17th April 2015 of the NICaN urology network and site specific group meeting. In attendance, Mr. O'Brien again, Prof. Jain, Darren Mitchell, Chris Hagan. So, this is the meeting after the one at which you said you'd mentioned the issue specifically verbally in front of others. There's an opportunity on this to correct or to record the minutes of the last meeting. Did you notice that your input, your oral input on the Bicalutamide 50 issue hadn't been recorded at that point?

A. Not at the time of the meeting. But on reflection, and pulling these documents out, then I realised that there was nothing on paper to confirm that.

Q. I suppose a wider point in relation to record keeping around governance is the absence of concerns documented. You can see that it's difficult then to follow the trail, should there be a trail?

A. Yes.

Q. And the opportunity to correct meetings is in itself a form of governance, not specific to you generally as a point in relation to NICaN and the minutes.

Q. As a mode of trying to bring about clinical change when clinical concerned have been identified, in that specific context, how effective do you think guidelines are for that purpose?

A. I think for junior trainees, for non-medical representatives at the meeting, guidelines are great. You know, the vast majority of patients fit within guidance. When I read guidance, I look to see does my practise fit within that? And if it does, then I'm pleased. If my practise is outside that, then there's a questioning as to why it doesn't fit within the standard of care guidelines. So I think guidelines are incredibly important. Was it the correct format for correcting an individual? Probably not. I should have followed more formal governance structures. But I saw it as a follow on to the e-mail. So having mentioned it in the e-mail, I think it was important to follow through with what could be looked back on and address as non standard practice.

Q. Was there anything about that period, or the processes in place, or the culture, or the way things were structured, that you considered to be a barrier to you following established governance processes?

A. I think it's my lack of knowledge of the established governance process as more than any real barrier.

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Q. And what way do you think your knowledge might have been increased around governance? How might that have fed its way into your professional practice?

A. I think, you know, the governance training we would have, I believe would have been quite limited at time of starting a consultant's post, which was six/seven years prior to the e-mail and this episode. I think there's more robust teaching now in terms of governance measures, and I think junior colleagues coming through are more aware of those structures and more likely to speak out than we would have been in the years gone by. I think if that's what you're asking, I think –

Q. I suppose do you know if there's a difference in the training or approach as you come up through the ranks as a clinician that increases your awareness and also highlights your responsibility? Is that system in place?

A. So, I think as clinical directors, people going into those posts are offered formal training in governance structures. But I didn't have that, that formal training in those structures, other than a brief two-day induction at the 2008 time.

Q. And do you think that that was perhaps at the root of your attempts to sort this out without triggering a formal process?

A. I think, yeah, if I'd more knowledge of the processes, it would have been an easier pathway to follow.

Q. You've also mentioned in your statement that the guidelines were a way of effectively encouraging good practice, because they would be audited, and you thought that that would allow then perhaps any issues to rise up to the surface.

A. Yeah.

Q. That was one of your motivations as well.

A. Yeah, retrospectively, it would have been good to audit. There are many audits it would be good to do, and particularly from an MDM perspective, you know, there are a number of things we would like to look at. I think it would have taken probably precedence in moving the service forward more than Bicalutamide 50, but actually, yes, it would have been good to take it to a year time point after the guidelines to see were they being complied with.

Q. I mean, you know, if I asked you the question "How do you know people are adhering to all the guidelines?", how would you know?

A. I think when they come for their opinion and you're seeing a trend of non adherence, that's the flag for concern.

Q. But there's no systematic look at that, you don't think?

A. No.

"How do you know people are adhering to all the guidelines?" is there now an auditing system in place that measures adherence?

Q. Because you can't have -- - you can have as many policies as you like, but it's really the way they're used and the way people feel about using them that matters. And clinical medicine is the best illustration of that, because it's so complicated.

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A. Yeah.

Q. Do you think that's changed over the last decade or do you think this is still a problem in terms of being able to give it the attention it deserves?

A. So, I still think the vast majority of patients, that within guidelines I think they're incredibly important.

Q. Mm-hmm.

A. Increasingly when I see my trainees coming through, they'll be looking at guidelines and following guidelines, and probably quicker to flag when something's outside guidelines and ask why that's happening. So I think that process is still important. I think we need to be clear in terms of where we work outside guidelines as to how we document that. And within our specialty we now have robust peer review where cases that sit outside guidelines for radiotherapy treatments will be discussed with your peers and signed off as having been peer reviewed and accepted. So having that kind of approach is helpful and supportive

Ms McMahon questioning

Mr Hagan

Q. And a lot of the things you mention are the outworking of clinical governance, the end product, coroners and medical negligence, civil claims, learning from perhaps the wrong end of the telescope. Do you consider that there is -- well, what part do you think that culture in a place has to play in both the triggering of governance and the effectiveness of any action taken?

A. I'm going to answer the -- in answering the question it's quite complicated, but in 2018/19 in Belfast, I brought in a system based around the measurement and monitoring of safety, and it was based on a document written by the Health Foundation in 2013 by Charles Vincent. And basically, it turns your organisation into a problem sensing organisation, where you ask really profound questions, like: Are you safe today? Are your systems reliable? Are you learning from past harm? Are you looking forward to see where there's going to be issues? And we've adopted that in Belfast as a way of thinking and about how we problem sense, and I think that you're right, you have to learn it from harm, but it is - it tends to be reactive. What we try to do is shift that thinking into how can we make sure we're safe today? So the out-workings of that are daily safety huddles, right the way up to executive team, ehm, weekly huddles where divisional teams come together and they review all their safety data from the previous week and look to, you know, is there any immediate learning? Is there anything that needs to be raised as a concern?

Because I think I said earlier on, at the heart of any safe system is staff feeling safe to raise concerns and be open, and be open when things go wrong, and when things do go wrong, that they will feel safe and that they won't feel that they're going to be blamed. Because we're all human, we all make mistakes, and it's important that we accept and acknowledge that we will make mistakes. But it's how we learn from it. And I think how we make our clinical governance even better is how we focus on how we learn, because that can be difficult sometimes to make sure that you put systems in place that engineer a change.

On a scale of 1 to 10 what is the SLT's estimate of where the Southern Trust is at in terms of it being 'a problem sensing organisation'? How can this approach be more fully interpreted and applied across the Trust?

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Q. Now, you spoke to Mr. O'Brien and he mentioned that he had discussed this case with a urologist in the United States of America. I don't suppose you remember the name of the urologist?

A. No, but his response stuck in my mind. Because, you know, I remember asking him and I remember him saying somebody else had raised this as an issue and he had spoken to somebody in the United States of America who said in the circumstances it was a reasonable course of action.

Q. And he didn't say who the other person was who had also perhaps shared your views, who had expressed the same view?

A. No. I mean, I think that, I suppose I felt brave challenging him and I got an explanation back which was, it was difficult to argue with.

Q. And you don't recall - you can't say whether you spoke to Mr. Young about this issue or not? You just don't recall?

A. So, undoubtedly, you know, because of the joint ward rounds, I would have expected that Mr. Young would have been aware of some of these patients. And when I did raise concerns with Mr. Young, as I've said in my statement, his response was "That's just Aidan".

Q. And what did you take that to mean when he said that?

A. It's hard to know how to interpret it. But I felt I was speaking to another consultant and raising an issue and that was the response. And, again, you look back and you think 'I'm a second year trainee, I don't know everything about urology, I'm working with senior consultants, maybe they think this is acceptable'.

The importance of addressing the cultural power imprint/imbalance in clinical teams, particularly in terms of delivering safe patient care.

Q. Was it your experience at the time, or has it been your experience since, that perhaps consultants who are more senior, who are more used to their own way of doing things, find it difficult either to be challenged or to adjust their practice to reflect advances?

A. So, I think that at the heart of safe consultant practice is good team working, and that working in a functioning team where there's a built-in peer review, essentially. I think when you work in isolation, there's a risk that you develop practice that maybe doesn't follow best practice or best guidance or, you know, keep up to date with current best thinking.

The importance of clinicians seeing themselves as an active team member where there is a built-in peer review approach operating.

Q. Just in relation to the stone issue that we mentioned just before the break as well when the ureter ruptured, I just want to bottom out if you actually did speak to anyone about that because of the patient harm involved. Did you speak to anyone senior to you or even a peer around that?

A. So, I know I discussed issues with Michael Young, and stone treatment was one of them, and the use of EHL in the ureter, you know, would have been part of that conversation, because it wasn't something that I had ever encountered before. And I know that I had discussions about purchasing a lithoclast and safer ureteric surgery.

Q. I know Mr. Young doesn't -- I think his wording is he doesn't recall you having spoken to him about any of the issues that you raise. If you're right and that you did speak to Mr. Young about the issues, some of the issues we have discussed in your evidence - and I've just used some examples to illustrate

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some of your concerns at the time - if you're right and you did express your concern to Mr. Young, given what you know now and your experience, could he or should he have considered this indisputably a clinical concern?

A. So, I think the key to managing patient safety concerns is appropriate escalation. So, I think if a trainee was raising a concern with a clinical supervisor or educational supervisor about a patient safety concern, I would expect the CS or AES to raise that with the Clinical Director of the service and then escalation as appropriate. So, to me, it comes back to the heart of how you manage clinical performance concerns and about early -- you know, if there is escalation, that it's dealt with appropriately, people in senior positions respond to that appropriately and investigate it appropriately.

Q. And in these particular examples, rather than generically, what would be best practice to happen, given the information that I've read out, the information you've provided to the Inquiry? If this were the case and you had spoken to Mr. Young, do you consider that these are cases that should trigger an approach by him to act accordingly to perhaps explore your concerns to speak to Mr. O'Brien, to speak to a colleague? Do you think these pass the threshold for necessitating some governance action?

A. So, I would have expected him to have a conversation with his Clinical Director. And, you know, these were patients who were on the ward, these were patients that he would have been aware of, you know, on the joint ward rounds. So, irrespective of whether or not he remembers me talking to him about it, he would have had sight and visibility of these patients.

Q. And also would it be right to say irrespective of whether you're right or not in your concerns, there's an obligation?

A. Absolutely.

'So, I think the key to managing patient safety concerns is appropriate escalation' Do all the staff in the Trust have a clear understanding of the appropriate escalation process? This is an important strand of practice that keeps patient safety to the forefront.

Q. Did anyone come to you and say, "Well, never mind the procedure, there's patient harm here"? Did anyone say, you know, there are a couple of different ways of looking at what happened; the patient should have been referred perhaps sooner, in particular in one of them, they had treatment plans that were perhaps suboptimal, there was resistance in their referral which delayed their treatment when they did get to Belfast, the clinician had tried to perhaps, on one view, dictate the course of action that you would take as an MDT, the patients had been told this and their expectations had been raised, but there's also the fact that people were arguably harmed?

A. Hmm.

Q. Did no one carve those out as governance concerns and say, "Well, we'll deal with the process, but my goodness, what's happening? What's happening in Craigavon?"

A. So, I think that -- I think I did the right thing and I raised it to my medical director, who then raised it to the responsible officer for Mr. O'Brien. So, the actions that you describe, whilst all correct, should have been taken by the medical director in Southern Trust, you know.

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Q. So you would expect somebody to do something about all of those issues now? If that scenario happened now, you would say "Okay, let's break this down. There's quite a few links have broken in this chain. Let's deal with the patient harm one first and then we'll work backwards to the least harmful"?

A. Yes. So I mean there's lots of issues arising. You know, I think that there's obviously an adverse, there are adverse incidents that should have been recorded as such, but there are professional issues that should have been dealt with as well.

Q. And who should have recorded it as an adverse incident?

A. So this should have been recorded, to my mind in Craigavon, because the issues were raised in Craigavon.

Q. And your way of getting that information back to Craigavon, or not just your way, but Tony Stevens' way, was to contact Paddy Loughran and inform him? That was the procedure in place. I'm just trying to understand how you would cross contact another Trust?

A. So that - it's actually a good example of communication between organisations where responsible officers have spoken to each other about a concern in respect of a doctor, and it's up to the responsible officer for the doctor to take action as appropriate, that the concerns have been raised with them, so they have been -- I think managed well in that respect in terms of raising the issues.

Q. Clearly, without any governance structure, the oversight of whether this happens again and who's responsible for keeping an eye on it or reporting it, all falls away. And as you've said, things have changed. But I just want to make the point that it's inherently an effective way of dealing with a multitude of governance concerns, from just that one example of those patients.

A. I think -- well, I'm not sure I quite agree. But I think the concerns were raised appropriately and highlighted, and I know that they were shared with Craigavon, and the responsibility of dealing with that lay within Craigavon. They were raised with Craigavon. I didn't work for Craigavon, I worked for Belfast Trust.

Q. Is it your evidence to the Inquiry that because the concerns were shared with Craigavon, the responsibility for raising them as a governance issue rests solely with Craigavon?

A. So, you asked me about the concerns about Mr. O'Brien, and Dr. Loughran was his responsible officer and the concerns were raised with them, in the same way that if concerns are raised with me as a responsible officer by a doctor, I see it as my role to deal with and manage those.

Q. So it's the -- just so I'm clear on your evidence. So it's superior clinician of the individual who's been complained about where responsibility lies for triggering, for pressing the governance button?

A. The responsible officer is the decision maker in terms of management of concerns about doctors.

Q. So, I'm maybe putting you on the spot somewhat, but would you be supportive of a hub and spoke type approach to urology, first of all, but more generally in your role as medical director?

A. So, we developed a really good model with urology where one of the urologists in Craigavon, who is an excellent pelvic cancer surgeon and kidney cancer surgeon, in a practice very close to my own,

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because we both did a lot of laparoscopic urology, so he came to Belfast to do his complex cases, we had a really good working relationship and we were quite comfortable looking after each others' patients. And that can work really well. But at the end of the day, it's about individuals wanting to work collectively in teams. And one of the biggest risks I think you have in terms of consultant practice is lone working, and the consultants that work in an isolated way, because they are the ones that carry the biggest risk. So one of the things that I've been working on in Belfast is around effective high performing teams. And the central thing about that is to avoid lone working and to get doctors working collaboratively and collectively looking after the same patients, so that you basically keep people safe, so you keep patients safe, but you keep doctors safe.

Q. And that would be a direct learning of INI?

A. Oh, absolutely. And, you know, we learned about complaints with INI, we brought in a new process how to manage complaints, in that they are now all -- any complaint about a doctor is reviewed by another clinician, where you get them to do, there's a technique called structured judgment review developed by the Royal College of Physicians, so if there is a complaint, a patient makes a complaint about their care and treatment in relation to a doctor, we do a structured judgment review to assess whether the care was satisfactory, room for improvement, or unsatisfactory. And if there's unsatisfactory then we will pick that up with the doctor.

Day 62

McMahon questioning

Professor O'Sullivan

Prof. O'Sullivan, before the break we were discussing the dosage of Bicalutamide and the 150/50 issue generally. When Darren Mitchell gave evidence yesterday, Dr. Mitchell, he had referred to the fact in his evidence, written evidence as well as oral evidence, that patients not given the correct information or on incorrect treatment regimes can be viewed as having been misled. Would you agree with that?

A. Sorry, could you rephrase that question? Sorry, I didn't quite get...

Q. Well, Dr. Mitchell was being asked about a variety of patients in relation to bladder cancer in particular...

A. Yeah.

Q. But the general point to him was, concerned whether patients, if they were on the incorrect treatment pathway, or have been treated in a way that would not be the norm, then there's a possibility, in his view, that they have been misled.

A. Yeah. Yes, that's true, yes. Yeah.

Q. I appreciate it's easy in hindsight for us to use phrases such as that when you are talking about isolated cases in your mind of three over a four-year period.

A. Yes.

Q. Can I take it from your evidence so far this morning that the idea that a patient had been misled didn't enter your head back then, or would you just not have framed it that way?

A. I was probably more focused on making sure the patient got the right treatment henceforth, and that was probably my major focus, to make sure they were hopefully offered the best advice with

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regards treating their cancer and getting them on to the correct dose of Bicalutamide and then organising their radiotherapy, was probably my major focus, rather than worrying whether they were misled or not.

Q. And I had asked you if you had spoken to anyone about it and you said "not particularly"?

A. Yeah. Yeah.

Q. Did you speak to David Stewart about it?

A. I don't recall specifically. I mean if I was talking to anybody, it would have been him, but I don't recall specifically talking to him about it.

Q. Did he ever raise this issue with you?

A. Not that I can recall.

Q. Do you think it might have been a useful approach at that time to gauge the experience of your colleagues to see if this was a wider problem?

A. Yes, I think with more experienced years behind me, that's certainly what I would do now. But those days I guess I was still finding my feet as a consultant, so I probably wasn't as well able to do that type of move.

Q. So, if I refer to it as inaction, but I'm not saying that in a critical way, just in a factual way.

A. Sure.

Q. If I can phrase my question in that way?

A. Sure.

Q. You're saying it was based on your lack of experience rather than the absence of any governance processes that would have allowed you to address it?

A. Yeah. I mean, looking back, probably I wasn't so aware of the governance processes at that stage of my career. And also I probably had, yeah, not seen it as serious enough to merit escalation at that time.

Q. And how do you become aware of governance processes as you progress through your career? Is it trial and error literally, or is it training, updating? How does that work?

A. It's all of the above. But for me, also it was gaining experience in roles not -- outside the standard consultant looking after patient role. So in medical management. So various roles over the years, MDT Chair, Lead for Radiotherapy, and then Clinical Director, you pick up a lot of skills and you meet a lot of people who have knowledge of these systems and you learn from them.

Q. And do you think that the culture within an organisation and within departments, and even within clinics, has a part to play on whether people feel comfortable raising governance issues?

A. I do. Yeah, I do. And I think looking back, you know, when I think when I arrived here from London I didn't know anybody here, I was very, you know, not quite isolated, but certainly didn't know how things worked. So that takes a while to get - not just to understand the governance structures, but also to understand exactly, as you say, the culture. Just coming in from it cold, it takes a while to understand the culture.

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Q. And the two parts of that maybe are the confidence of the person who needs to speak about something and also a listening ear or a willing recipient of that information?

A. Yes, both of those things, exactly, yeah.

Q. What would make it easier, in your view, for junior colleagues, or indeed any colleagues, to raise concerns such as this?

A. Yeah, I think first of all, it is a culture where everything gets discussed in a friendly, non-confrontational manner, and essentially just leading from the front as a more senior consultant now, I certainly would encourage open discussion in our peer chats when we're discussing patients, and we try not to have a hierarchical approach to that, but we do bring -- I have a lot of experience now, so I bring that to the table. But we really try and create a culture where junior members of staff feel empowered, and that's really just by having a friendly attitude to how we operate.

Q. And have you had to talk to colleagues over the years informally about issues maybe just that you needed clarity on or were concerned about? Have you had experience of that?

A. Sure. Certainly as Clinical Director that would be a weekly occurrence, yeah.

Q. And as Clinical Director, is that something that, in your experience, has brought about the necessary change, or have you had to then instigate formal governance processes?

A. There have been occasions where formal governance processes were required. But as I say, for the most part a more informal discussion solved a lot of things.

Q. And again from your experience as Clinical Director, when the governance processes are instigated, whichever pathway that involves...

A. Yeah.

Q. Is it your experience that the learning from the outcome of those processes is fed back?

A. Yeah. Well, I can only really talk about Belfast Trust, but that was certainly my experience when I was Clinical Director, that whenever incidents happened or learnings were found, that it was fed back in a pretty good way, I think.

The importance of senior consultants ‘leading from the front’ in developing a friendly, non-confrontational tone in open and transparent discussions. Establishing a culture of listening and empowerment of junior staff.

Q. The Bicalutamide 50mg monotherapy being prescribed for people who clinically presented as needing other clinical regimes.

A. Okay. I guess this e-mail highlighted that it was still an issue, yes.

Q. I did generalise my question earlier and said it was "widely known". What I meant was that it was known among the colleagues with who whom you worked?

A. Yes.

Q. Who would have been aware. They would have been aware that Bicalutamide 50mg monotherapy was being prescribed or had been prescribed?

A. I'm not sure how many of my colleagues were aware, but certainly myself and Dr. Mitchell would have discussed it for sure, yeah.

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Q. Was there any reflection among you or any others who you may have spoken to, who you can't recall, that given this had lasted over a ten-year period that maybe someone needed to have a look at this and perhaps see if this was a wider issue?

A. I think with regard to the 50mg, I thought this e-mail discussion was going to hopefully solve things and then the rewriting of the guidelines or the clarification of the guidelines.

Q. Well, I'll just ask it again just before we move on.

A. Yeah.

Q. This was ten years later.

A. Yes.

Q. Was there any concern in your mind that for the past decade this could have been happening? This is a clear patient risk. You've identified that e-mail does establish harm, two years. 5?

A. Yes.

Q. Was there any triggering in your mind, "Oh, that has been going on for ten years at this point"?

A. Not particularly. But in retrospect, yes. At the time probably not. But in retrospect, yes.

I think the MDTs have also improved, but we have a lot of challenges. I think the coverage of the Southern Trust with oncology is one example. That's a mixture of inadequate funding, which I think the cancer services probably are inadequately funded, and I think also we're practising based on the Campbell Report, which is well over 20 years old now. So I think that while things have improved, I do think we need a new assessment of how oncology is organised, particularly with regard to the hub and spoke model. I think that governance would be improved a lot more if we were a more, a more coherent and better funded service.

Q. Well, it's a combination of both the funding, but also the willingness to engage with new ways of thinking around governance?

A. I think organisation around that could be improved. But certainly in my 20 years here in Belfast I've seen big improvements in both identifying incidents and then learning from them.

Q. Okay. Yeah. Is it your view that compliance with NICE Guidelines should be audited regularly? Is it audited regularly?

A. Yes, and yes. I think especially when new guidance comes out about a new therapeutic intervention, yeah, we tend to have an implementation plan, part of which is auditing a year later, two years later to see are we –

Q. I think they have an audit tool quite often, don't they?

A. Yes, yeah. It's part of the implementation process.

Q. Yeah. And do you audit compliance with MDM decisions at all?

A. Personally, no. But, yes, there is an audit of MDT.

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Q. So that is a part of the culture, shall I say?

A. Yeah, very much so, yeah

Q. Do you think it should be mandatory that patients are copied in to all letters?

A. I think that's becoming the culture now. I have some issues regarding certain circumstances, especially where the patient has got very short survival who don't want to know about that.

Q. Yes.

A. So there are some challenges. But overall, yes, I think patients, and patients, with the new IT systems coming, will have full access to their health records. So I strongly support that.

Q. What do you think the barriers to that have been?

A. I think cultural and paternalistic approach to medicine over the years. "Doctor knows right".

One practical way of moving the provision of medical care on from a paternalistic approach will be to provide patients access through IT, to their medical notes and copying them in to the letters relating to their care

Mr Wolfe questioning

Mr Glackin

Q. Can I ask you some questions about the extent to which, as well as very properly complaining about the issues and seeking improvement, to what extent the urology team, supported by management, were able to engage in discussion or reflection about how things, I suppose, might be done better, more efficiently, to try to improve the lot, or are you telling me clearly that there's no blue sky thinking here, or there's appetite for blue sky thinking, but it is difficult to improve without resource?

A. So, you don't have to reinvent the wheel. Okay? Lots of these things are being done in other places very well. You may be familiar with GIRFT. It's a project that I think began in an orthopedic setting but has been extended to other specialties. We've had a recent GIRFT visit. I think on the whole GIRFT were impressed with many of the things that we were doing within the department, but they recognised the shortcomings that we have in terms of resource. We are very open to moving towards, as far as possible, day case operating for all the patients who are fit for it. We've tried to deliver that, as far as we can within the resource that we've got at the moment. We have shifted things out of theatre that used to be done in theatre, we've moved them to Outpatient Department activity. So, all of that, you know, that's not that we've suddenly seen the light, we've been doing this for the last ten years. It's just you need the resource to deliver these good ideas. And if you haven't got the resource, you're going to struggle to do it.

Q. You say in your statement, I think I've got the right reference, hopefully I've got the right reference. It's WIT-42294, 13.2, if I can see it. Yeah. Yeah. You make the point towards the very bottom that to the most extent, to a large extent, the waiting lists are a function of inadequate resource. But I think you add this other point as a contributing factor to –

A. Yeah.

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Q. -- inefficiency, that there is also an aspect of individual working styles and differing case mix. So: "If a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters, then inevitably the waiting list will grow more quickly than that of a colleague who lists chronologically."

A. Yes.

Q. Was that a problem?

A. It's still a problem. Because, you know, if you look at our current waiting list, the patients who are waiting longest are waiting for bladder outlet obstruction surgery, there is the occasional Nesbit's that's waiting. So clearly other cases have been picked ahead of them. I didn't make the comment when you put up the data of the waiting lists, by the way, but if you look at that in great detail you'll see that there are differences across the team.

Q. Yes.

A. Okay? There are people, I think in the 2016 data that you presented, who don't have patients waiting more than a year.

Q. Yes.

A. So, there is an element as to how you choose to run your practice.

Q. Yes. And the kind of forum or approach that had its first meeting last week, is that the kind of structure that could potentially bring discipline - and I don't mean discipline in the nastier sense, but organisation or build a common approach towards –

A. I think consensus is important. We need to build consensus as to how we move forward. I notice from reading Mr. Young's contributions that he shared that view. But you need the data to demonstrate to people where we are. Without it, you're just talking anecdotes.

Is there clear guidance on surgeons choosing to take cases in a chronological order? How regularly is this audited?

Q. Can I move on? We'll look at aspects of management in a short moment when we move on to look more closely at governance issues, but let me ask you about appraisal, briefly. You set out in your statement, if we could go just over the page, I think, to 32.2 - on down the page a little. So, you make the point that you're the subject of appraisal for the purposes of validation, and it's said on a number of occasions, so I get the impression that you think it important to say it repeatedly that this is not a performance related review, and in answer to other questions you make the point that consultants are outside of the performance management loop. Tell me about your thinking on that. Are you suggesting in those answers that you think it would be a good idea, in light of experiences within urology services at the Southern Trust, and perhaps elsewhere, for you and your colleagues to be subject to some form of performance management?

A. Yeah, I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.

Q. You refer to it as, I don't think I need to bring that up on the screen, it's paragraph 47.2. You seem to value the opportunity, if it had stayed like this, for a confidential reflective exercise in professional development; you see advantages or benefits in that. But what you say is that the process has now

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morphed into something akin to bean counting - my words - it's a formulaic capture of documents - your words?

A. Yes. I think bean counting is equally good as a descriptor.

Q. So, moving from the positive side of that spectrum to the negative, why was this opportunity for reflective discussion around professional development, why was that useful and what has it now become?

A. So, when I first became a consultant, the appraisal process was between two peers and was largely a discussion, and you felt that you could have a confidential discussion about the challenges that you faced, the difficulties that there were, perhaps share the successes that you'd had, all of that kind of thing. Now nobody's really interested in that. They just want to make sure that you meet all the domains that the GMC have set out, that all of those -- in our Trust they use an electronic method for capturing all of that, I think it's common across Northern Ireland, and, you know, as long as you've got a tick in every domain, that's really what it's about. You know, you can see from the spread of specialties that have been my appraiser, many of them don't have that much insight into my specialty. Maybe I don't have that much insight into theirs. So, you know, there's something of questioning the value of that conversation. They don't have the performance data, they can't possibly meaningfully interpret the performance data in the different specialty, you know. How would, for instance, an emergency medicine consultant interpret the data of a surgeon? It's difficult for them, I would think. It would be difficult for me to interpret the outcomes of their work. I don't do their job.

Q. So, if, as you imply, it is, to use another metaphor, a box ticking exercise, are there implications of that if, for example, the practitioner has some frailties or –

A. So, a point that was made to me by Robin Brown, who was at one time CD for urology quite some years ago, and more laterally has been one of the senior members of the revalidation team, he said to me "I'm not looking for all the good points in your appraisals. What I'm looking for are the little indicators that there are problems", and I think that's largely what it has become, and it may be very difficult through this appraisal process for the Trust to actually pick up where there are problems. Not too many people present warts and all in their appraisal, I would suggest.

Q. And your seeming endorsement of some form of performance management, whether integrated within the appraisal process or standing separately from that –

A. I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.

Q. Knowing what we know, and there may be a bit of a debate about what precisely we know has emerged out of urology services in the last few years, particularly arising out of the processes relating to Mr. O'Brien, do you see in that particular context a specific merit around performance management or –

A. Yes, I do. Because I think if you identify these things at an early point and they're out in the open, then it allows the team to, first of all, identify and name the issue and, secondly, then to think of ways

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that the team can address the issue together. It means a more consensual collegiate way of working, you know. So I think there are merits to that.

'I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.'

I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it.

Q. And safety of practice?

A. Absolutely.

What is the view of the SLT on this approach and suggestion?

Q. What do you think the implications are of not collecting the data and presenting it?

A. So if you don't know what your outcomes are like you don't really know if you're doing a good job, and if you don't ask the patients what their experience is then you're not going to know whether or not the patients thought you were doing a good job. So you have to collect the data to know that.

Q. You say that within the world you were operating in, and notwithstanding the health warning you put against it a second or two ago, you did feel it appropriate to carry out your own personal outcome related audits?

A. Yeah. So BAUS, which is the British Association of Urological Surgeons, ran a number of audit projects in the past. Certainly I did nephrectomy, I continue to do nephrectomy surgery and I would have contributed to the national audit, so did Mark Haynes, and we would have been able to compare our data to that of peers across the UK and Ireland, and we would have been able to compare our unit to comparator units in the same jurisdiction. So, you know, that gave us a good feel for where we were. But I caveat it with the thing that I said a moment ago; you know, we were collecting the data. So, I mean, I was pretty scrupulous about mine, I have to tell you, but, you know, it's well recognised that surgeon reported data is not as reliable as independently collected data.

Q. And again, just briefly, you say several times in your statement that audit was poorly supported within the Trust. We see some audits coming up through your patient safety meeting.

A. Yeah.

Q. Maybe some were better than others. You do say that some - and this is at paragraph 7.5 of your statement - some audits that came up were not fit for purpose, they didn't complete the full circle, the audit loop. Just explain what you mean by that?

A. So, I suppose in many departments audit would have been delegated to trainees, and trainees may have little insight into what they're actually auditing, because they're trainees and they haven't enough experience to know otherwise. So you could have a trainee undertaking an audit and not really understanding what they were doing, and there is some value in that, because if the trainee has support from an experienced practitioner then it's a learning experience for the trainee. However, the situation that we're in now is much better. We have support from the audit department, we agreed a

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programme of audit, we participate in audits across four domains, the first of which would be national audits, and they go all the way down to, like, local audits is number four. So, we now have a structured programme. We've been pushing for that for a long time. But without the support of the audit department, or the governance team, we wouldn't have been able to deliver on that. So that has been really helpful. We've had the first of those audits being presented in the past year. And on a similar vein, in the cancer services domain, we have support for audit within cancer services, which is very welcome, and it allows us to demonstrate patient safety. Because that's really what the audits are about.

Day 63

Mr Wolfe questioning

Mr Glackin

Q. Yes, of course. But in terms of what should be done around reviewing that case for learning –

A. Yeah. I mean I think what they saw demonstrates is that the number of people involved in this discussion didn't adhere to process. The process was to report this as an IR1 and allow that process to run its course. In parallel, the patient could be seen clinically and treated.

Q. Yes. One of the things that's probably overarching a lot of what we'll discuss in the course of today is the, I suppose, the appetite for challenge and the - how that feeds in to the safety culture. I pick that example. I suppose you would agree with me that it doesn't reflect well on –

A. I think there's an initial misstep of not doing the IR1. If you had done the IR1 at the very beginning you wouldn't have this issue of the round-robin discussion going on, it would have gone through the correct process.

Q. Yes. Yes. Yes. And it's not terribly different in substance from the case that you were about to review, Patient 10's case?

A. Yeah, there are similarities.

Q. Yes. I mean the big thing here was a failure to do triage simply because it was a routine referral?

A. Yeah. Yeah, that is true in this case. In Patient 10 there were more complex factors than just triage.

Q. Yes. And it wasn't just about triage, it was about the scanning?

A. Yes.

Q. And the read out from the scanning?

A. Yes.

Q. And I take that point. Okay. Just at this stage, is something like this, this misstep, your description of it, is that typical, in your view?

A. I don't know. I've only Chaired three SAIs. I don't sit on the –

Q. Sorry, the misstep in –

A. The misstep.

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Q. The misstep in failing to action it for IR1 and consider it for SAI.

A. Yeah. I don't really recall many discussions by e-mail or even in person of this kind of nature, and I don't think I was included in this e-mail trail at all. So I'm not sure whether it's common or not. I don't know.

How can the importance of reporting an incident, where appropriate, as an IR1 be understood, re-enforced and engaged with as a positive step in maintaining a safety culture throughout the Trust?

A. That I think is really relevant to this process? It mentions training and support. Prior to me undertaking those SAIs, I did not have any training. So, I recall being asked by Eamon Mackle to Chair the first, chronologically whatever the first SAI was that I did.

Q. That was –

A. I can't recall which one it was.

Q. Yeah.

A. But I sat in the office reading the e-mail and I thought "Am I really ready to do this? Do I really know how to do this?", and I batted that back to Eamon in a conversation and it was kind of - the answer wasn't "you'll be grand", but it was to that effect.

Q. Yeah. I was going to ask you about the training, and maybe that was a convenient but accidental point to stop on.

A. I've subsequently had training.

Q. Yes. You outline in your statement, 19.4 for the panel's reference, that you completed training in structured clinical record reviews in 2021.

A. Yes.

Q. As well as root cause analysis training.

A. Yes.

Q. The Inquiry is very interested in the nuts and bolts that make up the aspects of the SAI process. Training in 2021, you did your first SAI, so far as this Inquiry's concerned, in 2015?

A. Yes.

More evidence from the Inquiry about the need for proper training before taking on roles that relate to patient safety and quality care. Is this aspect now being audited?

Q. So, you are reflecting back out of your own experiences of Chairing or leading three SAIs, and more widely, is that fair?

A. Yes. So, my own experience is that they do take too long. And for the reasons I've outlined, I think that is not helpful. Because if there's quick learning needed then you're not getting that out there as it should be, you know, across the organisation. Secondly, when an SAI report comes down through the governance structure to the M&M patient safety meeting, for instance, what you get is basically a set of recommendations. It's often very difficult to contextualise those recommendations, to put them in a scenario where the people in the room understand, you know, this is what has happened and this is why we're making these recommendations. And another problem that I think with the recommendations is that I may Chair an SAI, Mr. Haynes may Chair an SAI, Mr. O'Donoghue may Chair

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an SAI - and this has happened in our department - and we all make slightly different recommendations on the same kind of core issues. I think it would be better if the SAIs are conducted by a team of people who have knowledge of what other recommendations are being made, so that there is a consistency in the recommendations. So, it is not infrequent when you are drafting the agenda for the patient safety meeting to have several SAIs coming down through the governance team, and really we don't have time to fully consider all of the recommendations and all of the nuances arising from those SAIs. So, there are other ways of sharing that information. You know, you can do case review type presentations at M&M meetings or similar learning events, and I know that that's used in other specialties. And it's probably more effective than just providing us with a summary of recommendations.

Has there been a recent review of how effective and efficient the structure is in running an SAI Review, its recommendations and cascading the learning? Have the suggestions in the witness's response in the above paragraph been considered?

Q. You managed to process Patient 128's SAI, that's the first one, Patient 10 and then Patient 90, by comparison with some of the SAIs we've looked at, relatively quickly, completed within the calendar year or thereabouts from the date the incident was reported, approximately. How do we resolve the issue of busy clinician and SAI team members –

A. Okay. So from my perspective what you need is somebody who's properly trained, first of all. You need them properly supported by the administration side. And you need time in their job plan to allow them to do this work in a timely manner. Because when the governance team came to me, they'd be looking for dates in my diary. Now, unfortunately, they may not realise this, but my diary's actually fixed for at least six weeks, because I've got operating commitments and clinic commitments, and I'm not going to be cancelling those over this kind of issue. So I'm therefore trying to fit this in at some other time. So that's already set them back four to six weeks. So you need members of staff, or perhaps independent people employed by the Trust who have time to do this work in a timely and effective manner.

Q. In terms of the learning point you make, the concern that learning just gets lost in the system and it doesn't reach those who need to hear it, and perhaps is it an additional point that the kinds of changes, whether they're changes to systems or behaviours, or whatever it might be, will quite often need time and resources; and is it part of your point that you don't see a dedicated resource focused on driving the kinds of change that might be needed arising out of an SAI report?

A. I think reflecting on our own department, when you're understaffed and struggling, it's very difficult to drive change. I'm sure there are other departments in our Trust which actually do this much better, that probably have slightly different, you know, they may be fully resourced. They may also have a different culture and they may be able to deliver this better. And I'm thinking of listening to, in particular, the way that the obstetric team dealt with their issues; they had a different approach to this. And I think that's probably something that we could learn from.

Q. Just help us with that.

A. So they would have –

Q. How did they -- what problem did they have and how did they deal with it?

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A. So obviously they're a high risk speciality. They would have lots of events that, you know, require discussion as a consequence. So they employed nurses in a governance role, they had open meetings where their consultants, their trainees, the midwives and the governance lead nurses would be present and would discuss these issues. You know? So that's a very healthy way of dealing with things. I think other specialties such as ours could learn from that.

Q. How would you assess the importance of the mortality and morbidity Forum in terms of urology services, patient safety output?

A. So, it was probably the primary place where that happened. And, you know, it was my view that it was a very important meeting, and that's why I extended the invite to all the members of the team. I think there's a very valid point about capturing morbidity. Morbidity is not as well captured as mortality. Mortality is a very easy event to note, but morbidity is more difficult to capture. And these are morbidities. And the regional M&M system that's on NIECR does not facilitate the capturing of morbidity at all. And, therefore, we are left to the discretion of individual clinicians to report morbidity items, whether they do that by listing them for discussion at a meeting, or whether they complete an IR1, or in some other way bring it to the attention of the teams and the governance structures within the Trust.

Q. And is that, I suppose, one of the major learnings or one of the major improvements that you take away from your leadership of that process?

A. Yeah.

Q. You're obviously still a member of the - or an attendee?

A. I am. Active participant is the way I would describe it. So, you know, we have had many discussions about how we try and improve the capture of morbidity. Simple ideas like keeping a morbidity book on the ward and information being recorded, an e-mail address being used to forward morbidity items so that they're captured in that way. But you are reliant on people spotting that something has happened and reporting it.

Q. To take another example, the consequences -- or, sorry, complications following post-operative processes. Is that kind of –

A. The same applies.

Q. -- clinically featured? Is there any attempt to corral those kinds of issues and get them in there somewhere?

A. So, again, that broadly falls under the context of morbidity. And unless you are specifically looking and recording complications then you're not going to capture them. So we would have discussions at the patient safety meeting outlining to trainees as they come into the unit that we - and indeed at the induction - we would outline to them that we want you to report these events, whether that be a wound infection, whether that be a patient requiring transfusion, all of these kind of things are issues that we need to look at and that we need to make sure that we're addressing appropriately and that patients are receiving appropriate care. It also comes down to things like making sure consent is taken properly, making sure VTE checks are done when patients are admitted to the hospital for procedures or on an emergency basis. There's lots of things that we have regular discussions with all of the doctors in our department about capturing that information.

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Q. I'm struck by, I suppose, the discretion point you make and the informality.

A. Yeah.

Q. It really depends upon, I suppose, the efficiency and sometimes the goodwill of people picking up on the points and recording them somewhere?

Q. Yes. I think you referred yesterday, or I referred you to the point you make that patient outcomes and the data around that is now perhaps more very recently beginning to be used, is that the kind of stuff that's –

A. Yeah. So I think there are other specialties that we can learn from. Orthopedics have had patient related outcomes for a long time, and I think that that's something that we could definitely, as a specialty, adopt and adapt to our needs. You know, the Trust could invest in very simple things like surveys of patients to ask them what has happened every time somebody comes into the hospital, you know. How was your experience? Did you have a complication? Well, the patient is going to tell you if they had a complication. So there's a very easy way of picking up morbidity, you know. There are other safety systems that other Trusts that I have worked in have used such that you cannot get to theatre if your VTE assessment is not completed. You cannot prescribe medication on the system unless you have put in the patient's weight and their VTE status. So, these are safeguards that are built into the system to allow safe practice.

Are comprehensive patient surveys been routinely used in all specialities in the Trust? If not, are there plans to introduce them, audit them and share the learning?

Q. I'm struck by some of the observations which Dr. Hughes and Mr. Gilbert made about the, I suppose the resource shortcomings of Craigavon's MDT. I'll not put it up on the screen, but just to summarise - I'll give the page reference numbers; DOH-00123, they reflect that there was no mechanism to check or track that actions were implemented. That's the actions arising out of the MDM's discussion and recommendation.

A. Yeah.

Q. They say at 00124 that it was underresourced for appropriate patient pathway tracking, that tracking only related to diagnosis and first treatment, and expressing concerns about the role, the triumvirate, and whether they worked well together, the tracker, the consultant and the secretary. At DOH-00127, they point out the limited assurance audits of patient pathways at the Craigavon MDT. Are those expressions of concern, are they concerns that you identify with and didn't need to be told that they were lacuna in how you were doing business, because you knew about the need for that kind of support from elsewhere, or do you reflect that perhaps these are exercises in resource perfection and you didn't have those resources and few people had those resources?

A. I think you've termed that very well "resource perfection". So, my reading of that was that we knew that the tracking only went to first diagnosis. We understood, we discussed that that was a problem. It would have been much better if tracking was extended beyond that and resourced beyond that. But it wasn't, because we'd already explored that. Dr. Hughes was coming from a perspective, as I understand it, that he had been a medical director in another Trust and he had also been, I think, a NICaN lead at one point in time. And he should have been very well aware that tracking in the Trusts here was only resourced to first definitive treatment. Now, he may have made different decisions in the Western Trust as to how to resource their tracking, and he may well have done that, I'm not aware,

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but I think that's where he was coming from. I've maybe lost the second point. Oh, yeah, the quality assurance about whether MDT outcomes would have been adhered to. So, at the time, as a group we would agree the MDT outcome for each individual patient. That would be spoken out loud in the room, the tracker would record that, and then the tracker would type that information into CaPPS, usually at a later time, and that would be provided to the person who Chaired the meeting to review the outcomes as they had been recorded for factual accuracy. And once that had been agreed, that would go back to the tracker to be circulated out to the whole MDT and that would then allow the CaPPS letters to be generated to the GPs and they would be posted out to the GPs. So, that's how that happened. So that was that bit of quality assurance to make sure that the outcomes were correct as discussed at the meeting. Now, it comes then to whether or not individual clinicians adhered to the outcomes when they met the patient. We now have in place, in very recent times, less than the last 12 months, support available within cancer services whereby we run a random audit of whether or not outcomes have been adhered to. That information is brought back to the MDT and shared with the MDT. I also receive that report as the lead clinician, and if there are cases that don't appear to match what the outcome was, then those cases are addressed on an individual basis.

Has the effectiveness of the tracking system recently been audited in all specialities in the Trust? Do steps need to be taken to improve the system?

Q. We know, if we pull up the stats for last year, WIT-24251, for the first half of last year. And counting these meetings up in the darkness of last night, I think I got to 21 meetings across those first five months of the year. And it would appear, if my trembling finger count is correct, that there were 12 meetings, looking down the red, which weren't quorate, as recently as 2022. I understand that there has been improvement in recruitment of a radiologist?

A. Yes. So, there is an issue about how quoracy is counted, okay? And I'll explain that in a moment. But we now have the situation where we have two radiologists, and that has helped a lot. We are also in the position where we have a single clinical oncologist linking in from Belfast, and her attendance is probably in the order of high 70s to 80%. We have two medical oncologists, one who usually physically attends the meeting and the second person links in by video. So, those aspects have improved. However, when you count quoracy, you have to count all the core members. And if one of those core members is absent, you're not quorate that week. So, as you can see from the top line there, on that particular week there was no clinical oncologist. So, technically we are not quorate. **Quoracy** has never really been an issue for pathology, urology, clinical nurse specialists, and the tracker, the coordinator. So really the quoracy issues lie in radiology and oncology.

Q. And, of course, one always will anticipate that there will be a meeting here and there where one of those disciplines can't attend.

A. Yeah.

Q. And you've explained the setback that that causes in terms of some cases. Because, as you say, you don't necessarily need an oncology discussion around every case, or for that matter a radiology discussion around every case?

A. That's correct.

Q. But I'm just trying to assist the panel to gauge where we're at now in 2023.

A. We're in a stronger position, but we are reliant on a single clinical oncologist. And if that person is sick, or that person takes leave, then we don't have their valuable input

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Quoracy is an issue that has come to the fore several times in the Inquiry. Is there any further guidance that the SLT can give on the challenges of meeting the quoracy standard?

Q. I'm sure the Inquiry is interested in, I suppose, the nature of the governance relationship between these two centres. In essence it's one patient, and while they're going to different facilities, they probably think, right, globally this is my care package, so they will want, I suspect, to be assured that if things go wrong on either side of those centres that it's being well managed so that you are alerted in Craigavon if Belfast thinks things are not as they should be and vice versa. Is that a relationship - is the relationship one that works in that way?

A. I don't think that there is enough sharing of information across the cancer network here. I think that -- I can't recall what's been provided on a unit basis from the centre data demonstrating timelines and pathways. I can't recall that for either bladder cancer or prostate cancer. We've had a recent exercise whereby all of those units providing kidney surgery have participated in a project. So I have participated in that at Craigavon on behalf of our Trust, and my colleagues in Belfast and Altnagelvin have participated as well, and I think the Ulster. So that's the kind of work that we need to do. So, I think it's somewhat frustrating to hear things being thrown back at the units when, indeed, the communication coming the other way from the centre could be better.

Are there current plans in place to continue to develop collaborative relationships and roll out continuity of care pathways across different centres?

Q. I mean, do you have a sense, as the lead of the MDM, that while systems are always vulnerable to human error, that safety nets, if I can describe them as that, are as robust as they need be, or do you have any lingering concerns that keep you awake at night in this context?

A. At this period of time in 2018, we didn't have resource to properly audit and quality assure what was happening, and we had flagged that up as a concern. We now do have that resource. So as I spoke about earlier today, we run a check on random cases every month to ensure that outcomes are actioned.

Is there regular monitoring and awareness across the Trust on how effectively its 'safety nets' are functioning? How quickly is there a response when vulnerability is flagged up? Has this been recently audited?

Veryan Richards

26/10/2023

Received from SHSCT on 26/02/2024. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Young, Michael Mr <[redacted]>
Sent: 30 March 2010 17:34
To: Trouton, Heather; O'Brien, Aidan
Cc: Mackle, Mr E
Subject: RE: Triage

March 25th is my longest letter !!!!
MY

From: Trouton, Heather
Sent: 25 March 2010 17:14
To: Young, Michael Mr; O'Brien, Aidan
Cc: Mackle, Mr E
Subject: Triage

Michael and Aidan

I really appreciate that you both have been extremely busy in recent weeks and we are grateful for the effort that you have all put in to meet the access standards by the end of March.

However it has been brought to my attention that there are still 60 patient letters that urgently need to be triaged.

Can I request that you give this matter your urgent attention as there may be patient who require an urgent appointment.

Many thanks

Heather.

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Stinson, Emma M

From: Rankin, Gillian <[redacted]t>
Sent: 09 September 2010 11:57
To: Stinson, Emma M
Subject: FW: Urology Referrals that are breaching
Attachments: image001.gif

Importance: High

From: Corrigan, Martina
Sent: Thursday, September 09, 2010 11:56:35 AM
To: Rankin, Gillian
Subject: FW: Urology Referrals that are breaching
Importance: High
Auto forwarded by a Rule

Dr Rankin,

As discussed earlier re: triage of Red Flags and the email I sent to Mr O'Brien.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Craigavon Area Hospital

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Corrigan, Martina
Sent: 02 September 2010 10:58
To: McCorry, Monica
Subject: FW: Urology Referrals that are breaching
Importance: High

Hi Monica,

As discussed, can you check has Mr O'Brien triaged letters as listed below?

Can you let me know and if these have not been triaged can you highlight again to Aidan for me?

Many thanks

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Dabbous, Marie
Sent: 27 August 2010 13:28
To: Corrigan, Martina
Cc: Montgomery, Angela
Subject: FW: Urology Referrals that are breaching

Hi Martina

See below the details of Urology Referrals that are breaching.

Marie

From: Dabbous, Marie
Sent: 27 August 2010 11:07
To: Montgomery, Angela
Subject: Urology Referrals that are breaching

Hi Angela

Here is a list of referral totals as requested:

Haematuria

O'Brien

18.6.10 Referral Date

Personal Information redacted by the USI

Haematuria

O'Brien

22.6.10

Personal Information redacted by the USI

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Urology Triage

Update Monday 4 April 2011

There were a total of 129 letters for triage from Mr O'Brien's office – longest date was 1 February 2011 and these were a mixture of GP and other Consultant referral letters.

On Friday 1 April - Mr Young triaged 14 letters to allow for patients to be sent for ICATS clinics week beginning 4 April.

On Friday 1 April – Mr Akhtar triaged 53 letters which included 3 red flags sent up from Mandeville. From these three 2 were downgraded.

9 were upgraded to red flag and these have been left with Mandeville for appointments at Mr Akhtar's additional clinics next week. Longest wait in this is 3 February.

13 patients to GPWSI (including 1 of the downgraded red flag)
1 patient to stone service
8 patients to LUTS
1 patient was for an urgent appointment at consultant clinic
18 patients for routine consultant clinic (including 1 of the downgraded patients)
2 need to be brought into the ward
1 needs to be discussed at MDT

There are 62 letters still to be triaged by Mr O'Brien –

30 dated February (longest wait is 1 February)
32 dated March (dated from 1 March onwards)

The above figures include internal referrals – consultant to consultant

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Stinson, Emma M

From: Young, Michael
Sent: 15 December 2021 09:49
To: Stinson, Emma M
Subject: FW: Personal Information redacted by USI

Section 21

From: Young, Michael
Sent: 22 December 2015 18:35
To: Corrigan, Martina
Subject: RE: Personal Information redacted by USI

This is a r/v case not necessarily a new referal

From: Corrigan, Martina
Sent: 30 November 2015 07:47
To: Young, Michael
Subject: FW: Personal Information redacted by USI
Importance: High

Michael,

Please see attached. I have got 8 more of these similar emails this morning asking for my action. I am only forwarding this to you as an example
and I will really need help at getting this resolved as there are currently 277 not triaged letters from when AOB has been oncall dating back to October 2014!!

I have told the booking centre to continue booking these patients in as their date comes up but just to say that these are letters that have no indication to the booking centre which waiting list they should be on.

I have no doubt that Aidan does look at these whilst he is oncall but it would just appear that he doesn't return them with instructions to the booking centre.

I have no choice but to escalate this to Heather as the longest is going back 58 weeks!

Happy to discuss

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Cunningham, Andrea
Sent: 27 November 2015 12:27
To: Corrigan, Martina

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

30th December 2016

Dr Aidan O'Brien
Personal Information redacted by the USI

Dear Mr O'Brien

Formal notification of exclusion and investigation under Maintaining High Professional Standards (MHPS)

I am writing to confirm our discussions from our recent meeting and inform you of the Southern Trusts intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practice.

This investigation should be seen in the context of the letter written to you on 23rd March (copy attached as Appendix 4), in which a number of concerns were raised and a plan was sought from you to address these concerns. No plan was provided and similar concerns have been raised again.

The Terms of Reference of this investigation are attached as Appendix 1 and will focus on 4 areas, as detailed below:

Area 1 – Untriaged letters

As of 22nd December, you had 318 untriaged outpatient referral letters, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks. It would appear from an ongoing Serious Adverse Incident (SAI) investigation that a number of patients may have had an adverse clinical outcome caused by this lengthy delay in triaging outpatient referrals.

Area 2 – Patients notes at home

It has been identified that, as at 23rd December, there are 365 notes directly tracked to you on PAS (Appendix 2), and there is continuing concern that a proportion of these notes may be at your home address and may have been there for some time. There is a concern that the urological clinical management plan for these patients is unclear, and may be delayed. There is also concern that when patients have attended other specialties within the Trust for care or treatment, their notes have not been available to assist with their consultation.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

One immediate action that I confirmed at our meeting is the expectation of the Trust that all hospital notes at your house are returned to Martina Corrigan, Head of Service for Urology, within 72 hours of the date on this letter.

There are to be no exceptions to this.

Once these charts are returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretary's office, in line with Trust procedures.

Issue three – Unreported outcomes from clinics

It has been reported that, as at 15th December, you had a backlog of 61 undictated clinics going back to November 2014 (Appendix 3). This means that a significant number of patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Issue four – Non-compliance of Trust policy in relation to management of private patients being seen within NHS services

A case has been raised which may indicate that you may have offered an advantage to an NHS patient awaiting an inpatient procedure who had previously attended you in a private outpatient capacity, to the disadvantage of other patients awaiting an inpatient procedure, by not listing patients in chronological order.

These issues were considered by the Southern Trusts Oversight Committee on 22nd December. Given the seriousness of these issues, the Oversight Group further considered if exclusion or any restrictions of practice should be placed upon you during the course of the investigation.

It was agreed by the Oversight Committee that there was the potential that your administrative practices may have led to patients coming to harm. If this was the case, should you return to work, the potential that your administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude you for the duration of a formal investigation under the MHPS guidelines. In line with NCAS and DHSSPS guidelines, this decision was discussed and endorsed by NCAS on 23rd December.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Southern Health and Social Care Trust

I very much appreciate that investigations can be particularly stressful and I therefore wish to advise you that the services of Carecall (0808 800 0002) are open to you throughout the course of the investigation to provide help and support.

Under MHPS, it is intended that the Investigation Team will conclude their investigation by 31st January; however, you will be kept informed if this is not achievable.

Yours sincerely

Dr Richard Wright
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

During the initial 4 week period following immediate exclusion of Mr O'Brien, investigations continued within the Acute Services Directorate to determine the scale of the concerns regarding Mr O'Brien's administrative practices, to inform the scope of the investigation under MHPS Framework and the Terms of Reference for the investigation.

A meeting was held with Mr O'Brien, who was accompanied by his son, on Tuesday 24 January 2017 at which an update was provided in terms of the preliminary investigation. Mr O'Brien was updated in respect of the initial 3 concerns notified to him on 30 December and was notified of a fourth issue of concern identified during the preliminary investigation.

The update position as at 24 January was:

- that, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals. All referrals require to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. This work is being undertaken by 4 Trust Consultants and the review is not yet complete.
- that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics over a period of at least 18 months. Again this review is still on-going.
- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing. Work is continuing to validate this list of missing notes.

The fourth issue of concern identified during the initial scoping exercise relates to Mr O'Brien's private patients. A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients. Further investigations are on-going.

Prior to the meeting with Mr O'Brien, a further update had been requested by the Case Investigator. This information was not available for discussion at the meeting with Mr O'Brien. On review of the update received following this request, early initial review of the un-triaged patients suggest that a number of patients required upgrading to red flag status, a number of others required upgrading from routine to urgent.

3.0 Statement of Case – Mr A O'Brien

Mr O'Brien was provided with an opportunity at the meeting on 24 January to state his case to Case Investigator. Mr O'Brien advised that he will make a written submission as part of the investigation in due course.

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

Angela Kerr

From: O'Brien, Aidan [redacted]
Sent: 16 March 2014 17:03
To: Kothandaraman Suresh; Corrigan, Martina
Cc: (Aidan [redacted]; (my [redacted]; Glackin, Anthony; Young, Michael; Suresh, Ram; Tony Glackin (aglackin [redacted]
Subject: RE: Triage of Red Flags

Dear All,

I would like to avail of this opportunity to share my views regarding the triage of Red Flag referrals.
In doing so, I entirely appreciate that I can justifiably be criticised for tardiness in triage of referrals which are not Red Flag.

- I am surprised that there has been a problem with delay in triage of Red Flags. Even I, the greatest sinner in triage, have not, to the knowledge, delayed triage of Red Flag referrals. I have returned Red Flag referrals to Office of Cancer Services, at the latest, the day after the referrals have been delivered to me. On occasion, I have delivered the triaged Red Flag referrals to the Office myself. In fact, the last tranche of Red Flag referrals which I triaged about 2 weeks ago, I did so in the Office of Cancer Services before they had even been delivered for triage.
- I am not the only one to note that some referrals, which have not been made as Red Flag, have been delivered to consultants as Red Flags after someone in Central Appointments Office has determined that they be so. This is usually done on recognition of some apparent key words in the letters of referral, such as 'Haematuria'. I think that this is not necessarily a bad thing. In fact, quite the contrary. However, whilst it may be a very good practice to have such referrals brought to our early attention (flagged up), it should not mean that they should remain Red Flags. However, I kind of have a reluctance to downgrade Red Flags, unless that it is untenable that they be so.
- I do believe that some Red Flag referrals cannot, and should not, be triaged in 30 seconds while someone waits to have it handed back. When that happens, they are triaged to inappropriate destinations. Let me give you an example. A patient was referred recently for assessment of persistent, intermittent, visible haematuria. Only because I noted that he came from [redacted] I decided to check it out. On doing so, including talking to patient by telephone, I learned that he has been [redacted] and is entirely dependent on ambulance transport. I therefore arranged for him to have CT Urography done in South West Acute Hospital. This was reassuringly normal. However, shock and horror, I retained the letter of referral until I had the report available, and so that I could determine the next, most appropriate move. I have arranged for him to come to CAH by ambulance for flexible cystoscopy to complete investigate. I have done all of this without 'seeing' the patient to date, though I have had two very pleasant conversations with him by telephone. No doubt, quick turnaround would have ticked the box, delivered him to Haematuria Clinic, which he would not have been able to attend.
- Lastly, I so welcome Kothandaraman's understated view that we should perhaps reduce our clinical commitments, particularly when being on call, to provide time to triage! Of course, we have paid lip service to so doing for years. I can think of several other, even more important, obligations can are expected to be done on a wing or a prayer, or not done at all. I feel insistent that we have time to triage and to do so in a manner which is optimal for all patients. I believe that this should have been done long ago. If we do not succeed in doing so, on the appointment of two more consultants, then we never will. They need to register the virtual clinic is a chimera. Just do it, have the cases registered (such as 2 consultations, by telephone, in the case above) and tell however needs to know, such as Commissioners, this is how we do it,

Sin é,

Aidan.
From: Kothandaraman Suresh [redacted]
Sent: 13 March 2014 21:42
To: Corrigan, Martina
Cc: (Aidar [redacted] (my [redacted]; Glackin, Anthony; Young, Michael; O'Brien, Aidan; Suresh, Ram; Tony Glackin (aglackin [redacted]
Subject: Re: Triage of Red Flags

Dear all,
I do go to the office every day, particularly while on call, esp to triage the referrals. But, I have been able to do this only after 5or6 p.m, ie after finishing my clinical commitments. I think, we may have to cut down our clinical activities during the on call week, so that we can clear the desk in a timely fashion and will be able to assess the emergency admissions.

Received from Tughans OBO Mr Aidan O'Brien on 29/04/2022. Annotated by the Urology Services Inquiry.

RESPONSE TO REPORT OF FORMAL INVESTIGATION

I am writing this report in response to the report of formal investigation from Dr Neta Chada. My response is structured in parallel to the Dr Chada's report. In responding to the report, I have considered to set the reasons for the investigation in an historical context. Thereafter, I have commented upon the investigative process and the report itself. Lastly, I respond directly to the five terms of reference.

Historical Context

Igraduated in Medicine from the Queen's University of Belfast in 1978. After basic, postgraduatea surgical training in Northern Ireland, including a year as Demonstrator in Anatomy, and duringa which time I had spent some time in every surgical specialty, except for Urology, I applied for aa post as a Registrar in Urology at Belfast City Hospital in 1984. During my tenure in that post froma August 1984, I became increasingly impressed with Urology as a surgical specialty for a number ofa reasons: the greater ability to apply objective diagnostic tools to assessment of urinary tracta pathology, such as renography and urodynamic studies; the rapidly increasing role of endoscopica and minimally invasive surgery, and most importantly at that time, the varied spectrum ofa malignancies of the urinary tract. I became increasingly interested in new diagnostic tools in thea assessment of bladder carcinoma, such as nuclear image analysis and DNA flow cytometry.a

As DNA flow cytometry was unavailable in Northern Ireland at that time, I applied for and was appointed to the post of Registrar in Urology at St. James' Hospital, Dublin in July 1985, followed by a Research Fellowship at the Meath Hospital, Dublin, in 1986. I was appointed a Senior Registrar in 1988, and completed Higher Surgical Training in Urology on 30 June 1991. During that training, I was particularly aware that it pertained exclusively to adult Urology. As a consequence, I applied for and was appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol, taking up that post on 01 September 1991.

In May 1991, I received a phone call from Mr. Ivan Stirling, (now retired) Consultant Vascular Surgeon at Craigavon Area Hospital, to advise that Mr. W. Graham, Consultant Surgeon at Craigavon Area Hospital, was due to retire on 30 June 1991. He was a general surgeon who had developed an interest in urological surgery. Mr. Stirling advised me that there had been some discussion among colleagues as to whether he should be replaced by a general surgeon or by a urologist, and sought my view. I immediately advised that he should be replaced by a general surgeon and by a urologist. Some days later, I was invited to meet with him, his consultant colleagues and with the Chief Executive, Mr. John Templeton, over lunch. It was during that meeting that they appreciated that I had a two month hiatus prior to taking up the post in Bristol. I was asked whether I would spend some time during that two month period as a Locum Consultant at Craigavon Area Hospital, as Mr. Graham had 77 patients on his waiting list for elective admission for prostatic resection (TURP). After a one week break, I came to Craigavon Area Hospital, performing 77 TURPs, and a left ureteric reimplantation for ureteric stenosis, in seven weeks.

On Wednesday 28 August 1991, I was invited once again to meet with the Chief Executive and the remaining three Consultant General Surgeons, Mr. John O'Neill, Mr. Osmond Mulligan and Mr.

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Ivan Stirling. I was earnestly requested to remain as a Locum Consultant Urologist with the intent that I would be appointed to a substantive post when approval was granted. However, as I passionately believed in the importance of a period of training in Paediatric Urological Training, I declined. However, the Chief Executive then advised me that obtaining approval would require a long battle, and which he was not prepared to embark upon, without my promise to apply for the post, if successful. I pledged to apply for the post, without fully understanding how it could possibly require such a battle to gain approval.

The only specialist urological service in Northern Ireland at that time was provided by the Department of Urology at Belfast City Hospital, led by five consultant urologists. I did anticipate that there would be strong resistance from that Department to the appointment of a Consultant Urological Surgeon, and indeed there was. I did not anticipate at all that the greater battle would be with the Director of Public Health at the South Health and Social Services Board, and who did not believe that there would be enough work for one consultant, and at a time when Northern Ireland had the least adequate urological services in the 34 EBU countries and in the 42 OECD countries!

In any case, the struggle was successful, the battle was won. I was appointed by competitive interview on 11 June 1992, and took up post 26 years ago, on Monday 06 July 1992. Mr. Graham had indeed been replaced by a urologist and by a general surgeon, Mr. Eamon Mackle, who had taken up post earlier in 1992.

On taking up post, I was provided with four inpatient beds in Ward 2 South, one inpatient operating session per week, one outpatient clinic per week, and the assistance of half a Registrar, Mr. Shamim Khan, who was then embarking upon the third year of a four year work visa in the UK. It was only after some time that I came to appreciate the reason for struggle to gain approval for the appointment in the first place, followed by such minimal provision of capacity on appointment. It was because in the minds of the majority of clinicians and managers, 'Urology' was spelt 'TURP'. However, during that first year, I had introduced ureteroscopic lithotripsy to Northern Ireland, performed the first and only radical prostatectomies in Northern Ireland, and on 15 December 1992, performed the first radical cystectomy and orthotopic bladder replacement in Ireland, and one of the first to be performed on a female in the UK. By 31 March 1993, the end of that first financial year, over 850 referrals had been received.

The first four years were most difficult, until the appointment of a second consultant urologist in 1996. During that four year period, I provided a continuous, 24/7, emergency urological service, except for one week when colleagues at Belfast City Hospital agreed to provide emergency cover while I attended the Annual Meeting of the American Urological Association. I did take off either two or three separate weeks from elective work each year, made possible by the continued assistance of Mr. Shamim Khan, who ensured that elective work continued, while I provided a continuous emergency service. I had also succeeded on obtaining Home Office approval for Mr. Shamim Khan to remain in the UK for one further year, from August 1994 until July 1995, as our Department's first Clinical Research Fellow.

That appointment was a necessity at that time as it had otherwise become impossible for a single consultant urologist to provide an adequate service to meet the increasing urological needs of the population of the then Southern Health and Social Services Board. By then I had secured four

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inpatient operating sessions per week, and occupied 20 to 30 inpatient beds in Ward 2 South. We had begun to have outreach clinics in Armagh and Banbridge. We had urodynamic and flexible cystoscopy sessions, while still providing a continuous emergency service. It was also only made possible by the founding of CURE (Craigavon Urological Research and Education) by Mrs. Roberta Brownlee and myself in 1994. That enabled CURE to fund all of the costs of research while the Trust agreed to provide the salary of the Fellow as he provided clinical sessions in addition to undertaking research. Mr. Khan's research enabled him to be appointed a Senior Registrar in Dublin in 1995. He was appointed a Consultant Urological Surgeon at Guy's Hospital, London, in July 1999, was awarded an OBE in 2007, and was appointed Professor of Urology at King's College School of Medicine in 2017. Mrs. Brownlee progressed on several fronts, not least becoming Chair of the Southern Health and Social Care Trust Board in March 2011.

During subsequent years and much hard work, including numerous collections, charity lunches and Gala Dinners with guest speakers, including Lord Eames, Lord Trimble and Sir Kenneth Bloomfield, CURE had raised approximately £250,000, used to fund research by some five trainees, leading to their higher degrees. Our Ward Manager, Mrs. Eileen O'Hagan, since deceased, was a founding member of the British Association of Urological Nursing (BAUN). CURE still jointly sponsors with BAUN its annual keynote lecture given by an eminent international speaker, the Eileen O'Hagan Memorial Lecture. Through its collaboration with the Faculty of Health Sciences of the University of Ulster, CURE promoted the joint appointment of Mr. Jerome Marley as Lecturer Practitioner in Urological Nursing in 1998. Since then, through on site and distance learning, numerous urological nurses from around the world have been able to study academically accredited, urological nursing modules as part of their primary and higher nursing degrees. Mr. Marley was a founding member of the European Association of Urological Nurses in Brussels in 2000. In 2006, we launched the International Journal of Urological Nursing, with Mr. Jerome Marley as its first Editor in Chief. The Journal is the official organ of all national associations of urological nursing throughout the world, apart from the Society of Urological Nurses of America, which has its own Journal. I have to confess that it has been one of my proudest days was when I presented to Mr. John Templeton the first edition of the Journal on his last day as Chief Executive of Craigavon Area Hospital Group Trust.

The second Consultant Urologist, Mr. Wahid Baluch regrettably left his post at Craigavon Area Hospital in 1998, but was replaced by the appointment of Mr. Michael Young, who took up post in May 1998. By then, I had secured the approval of the Trust, with the support of the Southern Health and Social Services Board, for the establishment of first (and still only) on site, extracorporeal shock wave lithotripter (ESWL). During 1997, I had visited a number of leading on site ESWL centres in Belgium and Germany, and concluded that we should have the multipurpose Dornier Lithotripter in a setting adjacent to theatres, with anaesthetic facilities if required, but one also amenable to ambulatory access. With some resistance from other interests, I secured the current location of the Stone Treatment Centre which had been vacated by CSSD. On his appointment, I charged Mr. Young with the task of designing its interior. On his appointment, I had my first holiday with my family, outside of Northern Ireland, Personal Information, since appointment in 1992.

The Urological Department at Craigavon Area Hospital had been remarkably successful in its first decade, and was widely recognised throughout Northern Ireland for being so. However, that success was achieved at the cost of much personal sacrifice for me and for my family, and also particularly for Mrs. Eileen O'Hagan, our Ward Manager, and whose death at the age of Personal Information

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in 2001 was, in hindsight, perhaps a harbinger of more difficult times to come. It is often said that everyone can be done without. I would add that not everyone can be done without as well. There is no doubt that the success of our Department led to some envious resentment, the Chief Executive having received complaints and delegations alleging favouritism. I believe that charge led to a long delay in further, desperately needed development of the service. It was after a commissioned, external review of urological services by Professor Sam Mc Clinton of Aberdeen that the Trust could be impressed of the dire need for further, urgent development.
Mr. Mehmood Akhtar was appointed to a third Consultant Urologist post in July 2007, facilitating the introduction of laparoscopic renal surgery. However, in 2008, we were devastated to be advised that we had lost our single inpatient department in Ward 2 South, our patients being dispersed throughout three general surgical wards. Even though our inpatients were later concentrated in one ward, Ward 3 South, it remains my contention that inpatient care has never been of the high standard it had been previously. Then, in September 2010, radical pelvic surgery for bladder and prostatic carcinoma was centralised to Belfast City Hospital. I was strongly opposed to this centralisation, in the belief that patients would suffer and die as a consequence. I submitted a written proposal that radical prostatectomy continue to be performed in both Derry and Belfast, while radical cystectomy would continue to be performed in Craigavon and Belfast. Of course, the proposal was dismissed. Meanwhile, I believe that two patients died of bladder cancer due to their not having radical cystectomies performed when they could have been, and radical prostatectomies have not been performed at all anywhere in Northern Ireland for several years. Moreover, the loss of radical pelvic surgery at Craigavon Area Hospital contributed to the departure of Mr. Akhtar in April 2012.

Mr. Akhtar had established and chaired a weekly Urology MDM in April 2010. On his departure two years later, I was appointed Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of the Urology MDM, in April 2012. Concurrently, my colleague, Mr. Michael Young, and I became increasingly concerned by ever increasingly long, waiting lists for elective admission for surgery, with the consequential risks of death and morbidity for those patients. We therefore embarked upon extended operating days, Mr. Young operating until 7 pm each Tuesday and my operating until 8 pm each Wednesday. After arriving home at 9 pm, and having the meal of the day, I would then typically spend three to four hours previewing the 30 to 50 cases to be discussed at MDM which I chaired the following day, finishing at 02.00 to 03.00 am. After each MDM, all clinical summaries were corrected and amended if required, and all outcomes were reviewed and signed off, with Mrs. Vicky Graham, Cancer Tracker and Coordinator, finishing by 7 pm each Thursday evening. So doing enabled formatted letters to be generated from CaPPS and sent by post to each patient's GP each Friday morning. No time was allocated in job planning for extended operating sessions, or for the previewing or reviewing patients discussed at MDM which I chaired each week.

In late 2012, I was requested by consultant colleagues and by the secretariat of NICaN to consider taking on the role of Lead Clinician of NICaN's Clinical Reference Group in Urology. I agreed to do so, if no one else offered to do so. Regrettably, no one did do so. I was appointed to that post in January 2013. Being Lead Clinician of the Southern Trust's Urology MDT and Chair of its MDM in addition to being Lead Clinician of the Regional Clinical Reference Group was a heavy burden and consumed much time and energy, particularly during the two years leading up to National Peer Review of Urological Cancer Services, both by the Southern Trust and Regionally, in June 2015. I wrote the required Operational Policy for the Southern Trust's Urology MDT, holding monthly

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meetings with multidisciplinary colleagues to discuss and seek consensus for its many parts. I commissioned ongoing audits of histopathological diagnosis of prostatic carcinoma. I addressed deficiencies in input by radiology and oncology, which compromised MDM quoracy, and which still does. More successfully, I received a weekly update of those patients who were at risk of breaching cancer target timelines, undertaking to review and/or operate on these patients myself, with the result that not one patient had breached a target timeline during the previous six months by the time the Southern Trust was peer reviewed in June 2015.
It is worthy of note that there were some failures in preparedness for Peer Review. Firstly, I had sought the agreement of my consultant colleagues to advanced triage of red flag referrals to facilitate and expedite their assessment, diagnosis and management with the required timelines. It was not possible to obtain that agreement as my colleagues asserted that there was not enough time, while being urologist of the week, to do so. Similarly, they declined to provide to the Cancer Tracker a clinical summary of each patient to be discussed as is required, insisting instead that they would ask the Tracker to list patients for discussion at MDM, providing a copy of a letter dictated to a GP or other referrer, the Tracker having to compose a clinical summary for CaPPS, and which is contrary to the regulations. Once again, they declined to do so because of time constraints. Lastly, I failed to obtain the agreement of my colleagues to compile a management plan for each patient, a copy to be given to each patient and a copy to be included in the chart. This too has been a requirement of the National Cancer Plan. I do have to agree that this requirement was, and remains, entirely unrealistic, as there was simply not enough time to do so, and certainly not enough time when my colleagues had already asserted that there was not enough time to undertake advanced triage or to provide clinical summaries.

Concurrently, I was responsible for ensuring that Northern Ireland's Regional Uroiogical Cancer Services were prepared for National Peer Review by June 2015. This proved to be a significantly more complex process than preparing the Southern Trust for review. This entailed not only the Operational Policy for Regional MDM, it involved the composition of Clinical Management Guidelines for all aspects of referral pathways, investigations, diagnoses, management and review for all of the urological cancers. It entailed compliance with NICE and EAU Guidelines. It particularly included the identification of aspects of the patient pathways that could not be compliant with NICE or EAU Guidelines, either throughout Northern Ireland as a whole, or in areas within Northern Ireland. It included the commissioning of Operational Policies from Urological Surgeons, Clinical and Medical Oncologists, Pathologists, Radiologists, Clinical Nurse Specialists, Palliative Care Specialists and Nurse Practitioners. I believe that my work over a period of two years led to a successful Peer Review of Northern Ireland's Urological Cancer Services. During that time, I was also requested to join the National Peer Review Panel, being a member of the panel which reviewed the North West Urology MDT in June 2015.

Having completed the three year tenure as Lead Clinician of NICaN's Clinical Reference Group for Urology, I stepped down from that post in January 2016. I remained as Lead Clinician of the Southern Trust's Urology MDT until 31 December 2016, having completed National Peer Review updates in September 2015 and again in September 2016. With some substantial success, I addressed the chronic lack of input by Clinical Oncology to our MDM, and with much less success, the chronic inadequacy of radiological input to MDM, even though I met with the Medical Director for the first time in April 2016 to discuss the concerns of the MDT regarding this particular issue. Both these issues continue to pose an existential threat to the continuation of a Southern Trust Urology MDM.

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The burden of the roles of Lead Clinician of the Southern Trust's Urology MDT, Chair of the Southern Trust's Urology MDM, Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology from 2012 to 2016, and preparing both the Southern Trust and the Region for National Peer Review in June 2015 was considerable, particularly in terms of the time and energy required, both of which were additional to continuation of the usual and preceding, clinical commitments.

Since the departure of Mr. Akhtar in April 2012, the compliment of Consultant Urologists at Craigavon Area Hospital had increased to six. However, the operating capacity allocated to the Urological Service had not been correspondingly increased. Irrespective of the number of consultant urologists, and irrespective of operating capacity, the number of referrals continued to increase annually. One obvious consequence was that increased numbers of urologists were unable to provide operative management to increased numbers of patients referred, resulting in increasing numbers of patients waiting for ever longer periods of time for admission for surgery. The cohort of patients who suffered most severely were those acutely admitted in the first place. As there was no consultant staff available to operate on these patients when required, and no theatre capacity to facilitate their surgery, these patients were attended to after elective surgery had terminated, and by staff who had already completed an elective day, and in a manner which only temporised the acute condition, those patients then being discharged to a waiting list for readmission for definitive surgery, and at risk of acute readmission due to acute morbidity as a consequence.

After a long gestation period, the 'Urologist of the Week' was introduced in 2014. I have no doubt in asserting that the reason for the delayed introduction was the belief on the part of one or two of my colleagues that the Trust would not agree to funding its introduction as there would not be enough work to sustain it, and the reason for that belief was the failure to appreciate the distinction between 'Urologist of the Week' and 'Urologist on Call'. The latter would just have required the Consultant Urologist to be available when required and called upon by a Registrar. As a consequence, it was even proposed that we would have time to conduct an afternoon clinic each day when Urologist of the Week. It was as a consequence that it was agreed that we would be able to conduct triage when Urologist of the Week.

Even though I too agreed with the conduct of triage while being Urologist of the Week, I soon came to realise that there simply was not enough time to do so effectively and optimally whilst also delivering optimal, definitive and timely management to those patients who had been acutely admitted. I could not do so in addition to spending three to five hours conducting inpatient ward rounds with the registrar, assessing patients in the Emergency Department, advising regarding the management of acutely admitted patients elsewhere in Craigavon Area Hospital, Daisy Hill and South West Acute Hospitals, in addition to performing zero to six operations each day. It has been my belief and understanding that the primary purpose of Urologist of the Week is to optimally care for those patients acutely admitted to the above three hospitals due to urological pathology. To do this, the Urologist of the Week is required to undertake the duties described above and these are time consuming and it is therefore not possible to accommodate triage in addition to those duties without compromising the standard of care provided as Urologist of the Week, or compromising the standard of triage, or both.

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In order for my colleagues to accommodate triage, it has been necessary for them to reduce the work done as Urologist of the week. For example, some do not come in to the hospital at all over the weekend. Some colleagues may not conduct a ward round during a particular day or days, letting the Registrar "get on with it." It has also recently been reported to me and other colleagues that one consultant did not do one ward round during an entire week on call. I have also observed some colleagues undertaking triage whilst the registrar "got on with it" in theatre. It has been the case that patients did not have their definitive operative management following their acute admissions, being discharged by the Urologist of the Week, only to be readmitted at a later date, suffering complication as a consequence. In outlining the above examples, it is not my intention to be critical of my colleagues but rather I am setting these out to explain that the demands of triage and the demands of the Urologist of the Week are not compatible and it has been my experience that having triage included in the workload of Urologist of the Week has compromised patient management and was therefore unsafe.

It is stated in the investigation report that I had argued for advanced triage to be employed as the method of triage by the department. It is important to point out that the reason why I believe this to be necessary is because the waiting times for first appointment for routine and urgent referrals are so lengthy that to allow that time to elapse without having directed some further investigations can lead to a compromised outcome. An example best illustrates the issue. Personal is a 63 year old man who was routinely referred in December 2017 with symptoms indicative of bladder outlet obstruction. He did not have any Red Flag symptoms such as haematuria. He had normal renal function and a normal serum PSA level. Urinary microscopy and culture were both normal. I triaged that referral and concluded that it should remain categorised as Routine. However, in addition, I wrote to the patient to advise that I would request an ultrasound scan of his urinary tract. I also wrote to the GP requesting that he prescribe Tamsulosin for the patient. When ultrasound scanning was performed at Daisy Hill Hospital in January 2018, it did indeed confirm that the patient had an enlarged prostate gland probably causative of of bladder outlet obstruction. However, it also indicated that he probably had a bladder tumour. That impression was then further assessed and confirmed by flexible cystoscopy. The patient has since had multifocal, high grade, transitional cell carcinoma with carcinoma in situ resected. He is currently undergoing intravesical BCG therapy.

If I had not taken the time to request ultrasound scanning, writing to the GP and the patient in the process, and acting upon the report, this man may not have received an appointment until 2019. I have absolutely no doubt that only one of my colleagues may have requested a scan. The probability would have been that he would have still been awaiting a routine appointment. However, it probably would have taken me a minimum of 15 minutes to review his details on NIECR, request the scan and write to both GP and patient. We currently receive approximately 160 referrals per week. Even if triage time per patient were a mean of half the time spent on the referral of Personal, that represents 20 hours of work while Urologist of the Week. Yet, to date, there has been no predictable sessional PA time allocated to triage in any of our Job Plans. Moreover, in my comments relating to the SAI report concerning Patient 10, in January 2017, I requested the Trust to address the issue of triage, determining who, when and in what manner it should be done. To date, there has been no response.

The year of 2016 proved to be difficult for several reasons. I had become increasing concerned by the morbidity, and risk of mortality, suffered by patients awaiting admission for surgery. I had

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shared my concerns with colleagues and with the Head of Service on many occasions, at Departmental meetings during that year, as I had done during many years previously. I was so often advised that the waiting lists were a Trust issue, if only! It had been my experience that the Trust was either unaware of the waiting lists or times, and of the disparity between specialties, or were aware, but it was not an issue. For several years, I had not taken any leave for any reason on an operating day, or on any day when operating sessions were made available to me, when my colleagues did take leave. I continued with this practice during 2016 in an endeavour to mitigate so far as was possible the risk of harm to patients. I did so even though I was suffering increasingly from Personal information redacted by the USI. In addition, I had undertaken to Personal information redacted by t for as long as possible to enable me to provide backup support to Mr. Suresh, for whom we had been requested to provide such support when he was Urologist of the Week, and which some of my colleagues had declined to do. It was when Mr. Suresh confirmed to me that he was returning to a Consultant post in England in October 2016 that I decided that I should Personal Information redacted by the USI on 17 November 2016. Personal Information redacted by the USI [redacted]

The Investigation

I received a telephone call from the Medical Director's office, also on Wednesday 28 December 2016, to advise that the Medical Director wished to meet with me the following Tuesday, 03 January 2017 at 11.00 am. I advised that I would be unable to do so as I had a Day Surgical operating list that morning. However, I advised that I was happy to speak with him by telephone before then. I then was advised that the Medical Director was of the view that he required to meet with me in person, and offered to do so on Friday 30 December 2018. I enquired whether he was aware that I was on Personal Informati leave. I was advised that he did. I telephoned later to request an agenda, which was provided by email. Otherwise, I would have attended, unaccompanied, recovering from infection, while on Personal Informati leave.

The meeting was both shocking and devastating for both me and for my wife who accompanied me. It initiated the worst month in my life with serious consequences for my health. It initiated a period of trauma which still persists. Inter alia, I was advised of my immediate exclusion in accordance with the Southern Trust Guidelines for handling Concerns about Doctors and Dentists' Performance (September 2010) and Maintaining High Professional Standards in the Modern HPSS (November 2005). The exclusion was subsequently confirmed by the Medical Director in writing on 06 January 2017, when it was also confirmed that Dr. Khan had been appointed Case Manager, and Mr. Weir had been appointed Case Investigator. I was not advised of the appointment of a non - Executive member.

Cognisant of the stipulation in the Southern Trust Guidelines that the Investigation had to be completed within four weeks of the date of exclusion, and not having received any communication from the Case Investigator, I contacted Mr. Weir by telephone on 16 January 2017, when he advised me that he was equally cognisant of the significance of the four week period, but was alarmed to be advised by him that a meeting had been scheduled for him to meet with the HR Representative, appointed to assist him in the Investigation, on Thursday 26 January 2017, the

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penultimate day of the four week period, and that no meeting with me was scheduled to take place until after that date.
On 17 January 2017, I wrote to the Medical Director to express my concerns regarding the conduct of the Investigation to date. I requested to be advised of the identity of the non – Executive member. I requested Minutes of the Meeting of the 30 December 2016. I requested to be advised of details of when I would meet with the Case Investigator. Lastly, I requested to be advised in more detail of the reasons and justifications for the immediate exclusion imposed on 30 December 2016, so that I could prepare to offer alternatives to exclusion when I would meet with the Case Investigator. (Appendix 1: Letter of 17 January 2017).

I received a Note of the Meeting of 30 December 2016 from and approved by the Medical Director, dated 18 January 2017.

I then received a telephone call from Mr. Weir on 19 January 2017 to advise that a meeting had been scheduled for Tuesday 24 January 2017 to discuss alternatives to immediate exclusion. I did not receive any detailed reasons or justifications for immediate exclusion from the Medical Director prior to the meeting. I returned a telephone call on 19 January 2017 to clarify whether the meeting of Tuesday 24 January 2017 required me to state my case. I was assured by Mr. Weir that it was not. I subsequently received a letter from Mr. Weir, dated 20 January 2016 (sic), advising of the time and venue of the meeting of Tuesday 24 January 2017, advising that he meeting would provide me with an opportunity to state my case and to propose alternatives to exclusion.

I then received a letter from Mr. Weir, dated 23 January 2017, requesting my knowledge of the hospital charts of 13 patients and which had been tracked out to me, and which had not been included in the charts that had been returned from my home. I provided a detailed account of each patient, including those who had never been a patient of the hospital at any time, or had never been a urological patient, or had been discharged from urological review 15 to 20 years previously. One patient whose chart was tracked out to me and whose chart was missing, I operated on six months later, in July 2017, her chart made available for her admission by Medical Records in the usual fashion.

I met with Mr. Weir and with Ms. Hynds, the HR Representative, accompanied by my son, Personal Information on 24 January 2017. In addition to the three issues of concern already identified, I was advised of a fourth arising from a review of TURP patients, identifying nine patients who had been seen privately as outpatients, then had their procedure within the NHS, their waiting times being significantly less than for other patients.

The Oversight Group met on Thursday 26 January 2017, concluding that immediate exclusion be lifted with effect from Friday 27 January 2017, subject to advice from Occupational Health regarding fitness to return to work, and to agreed conditions relating to work practices. I was advised of that decision by Dr. Khan, by telephone, later that day. I received written confirmation of that decision, dated 06 February 2017. The conditions relating to my return to work were detailed at a further meeting with Dr. Khan and Ms. Hynds on Thursday 09 February 2017, and I returned to work in a phased manner later that month, as advised by Occupational Health.

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

On 06 February 2017, I received by email from Ms. Hynds, the Note of the Meeting of 24 January 2017 with Mr. Weir.

On 07 February 2018, I met with Mr. Wilkinson, non – Executive Director, to raise a number of Concerns Regarding the Investigation Process, (Appendix 2). The Case manager replied to those concerns by letter on 24 February 2017, (Appendix 3).

On 14 February 2017, I wrote to the Medical Director, detailing a number of errors and omissions in the Note of the Meeting of 30 December 2016, requesting that amendments be made, (Appendix 4).

On 01 March 2017, I received from Ms. Hynds an acknowledgement of the letter to the Medical Director, advising that she would arrange for an amended Note to be sent to me, taking into consideration my comments.

On 06 March 2017, a list of Questions to be Asked were provided to Mr. Wilkinson, non – Executive Director (Appendix 5).

On 16 March 2017, I was provided with the List of Witnesses to date (seven persons) and the Terms of Reference. The Terms of Reference should have been provided when it was decided to have a Formal Investigation, in accordance with NCAS Guidelines.

On 28 March 2017, I submitted to Ms. Hynds a list of Amendments to be made to the Note of the Meeting of 24 January 2017, requesting that she return a copy of the amended Note.
I received no response.

On 30 March 2017, the Medical Director replied to the Questions to be Asked, and which had been submitted on 06 March 2017 (Appendix 6). In response to Question 13, the Medical Director asserted that an initial verification of the issues by the Clinical Manager was not required, as the information was being collated by Mr. Carroll and Mrs. Hogan (sic).

On 19 April 2017, I sent to Ms. Hynds an email to remind her that I still awaited an amended Note of the Meeting of 30 December 2016.
I received no response.

On 14 June 2017, I received a letter from Dr. Chada, the Case Investigator, inviting me to meet with her on Wednesday 28 June 2017. Due to my having scheduled operating that day, and my son's unavailability to accompany me, I made myself available on Saturday 01 July 2017. However, that date did not suit Dr. Chada, and the meeting was eventually rescheduled for 03 August 2017 to avoid cancellation of scheduled clinical commitments and to facilitate Dr. Chada's leave, as outlined in email correspondence (Appendix 7).

On 29 July 2017, I was provided with a list of 61 outpatient clinics which the Case Investigator had been advised had not been dictated (Appendix 8).

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

On 30 July 2017, I wrote to D. Khan, Case Manager, detailing my concerns regarding the Investigation to date (Appendix 9).
I did not receive a response.

On 31 July 2018, I submitted to Ms. Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group in December 2016, a copy of the correspondence / communication with NCAS in December 2016, an amended copy of the Note of the Meeting of 30 December 2016 (previously requested), an amended copy of the Note of the Meeting on 24 January 2017 (previously requested), a copy of the Trust's Policy and Procedure regarding Triage (previously requested) and a list of the Witnesses and their Statements (Appendix 10).
I did not receive a response until 28 September 2017 when I was provided with a list of Witnesses and their Statements. I was not provided with any of the other requested documentation.

On 03 August 2017, I met with Dr. Chada and Ms. Hynds, accompanied by my son, who wished to advise that we would have considered it reasonable to expect that the Witness Statements would have been provided prior to the Meeting, to enable me to address and respond to them, but he was advised initially that he was not permitted to speak.

On 03 August 2017, I also submitted to Dr. Chada and Ms. Hynds, detailed documentation of all additional inpatient and day case operating during the years 2012 to 2016, and all additional outpatient clinics during 2012 to 2016, in addition to all additional time spent in the roles of Lead Clinician of Urology MDT and of Chair of Urology MDM from 2012 to 2016, (Appendix 11).
None of this documentation has been included in the Report of the Investigation.

At the meeting of 03 August 2017, I was provided with a list of 11 patients who had attended privately, had been added to the waiting list and had been admitted after a short time frame. I was surprised to find that another two TURP patients had been added to the list, as I was certain that only nine patients had been admitted for TURP during 2016, having previously attended privately. Upon review, it was evident that the new list provided on 03 August 2017 contained only three patients who had TURP performed during 2016, the remaining eight patients having other diagnostic or surgical procedures performed. I then reviewed all 46 patients who had TURP performed during 2016. This figure included the 9 patients who had previously attended privately and 37 who had not. The mean time on waiting list for the nine patients who had attended privately was 202 days whilst the mean time for the remaining 37 patients was 219 days. In fact, 5 (56%) of those who attended privately had waited more than 100 days while 14 (38%) of the remaining 37 patients had done so.

On 06 November 2017, I met for the second time with Dr. Chada and with Ms. Hynds to discuss the issue of the private patients. I submitted a detailed account of the management of each of the eleven patients. I also shared my conviction that an analysis of all the TURP patients of 2016 had not complied with the anecdotal allegation that those who had attended privately, had had their surgery performed after a significantly shorter period of time, and that this finding had laid those compiling the information for the Case Investigator to find patients who had had other procedures performed following prior private consultation, and who better fitted the allegation. Regrettably, I

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have not since had the opportunity to undertake a similar comparative analysis for those patients and their procedures.

On 06 November 2017, I also provided a spreadsheet addressing the issue of Term of Reference 3, (Appendix 12). This clearly established that not all of the patients who had attended 51 clinics had not letters dictated, and not 61 clinics as the Case investigator had been advised by those collating the information. The total number of patients who had attended those 51 clinics had been 450 patients. Moreover, 261 patients had had letters dictated. These 261 patients were those who were more clinically urgent. This left a total of 189 patients who had not had letters dictated, and not 668 as had been advised by those who had informed the Case Investigator, and whose data the Medical Director found no need to validate. This detailed information submitted on 06 November 2017 was not included in the Report of the Investigation.

On 02 April 2018, I submitted an email to Ms. Hynds, attaching my comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2017, and my comments relating to the Statements of Witnesses, (Appendix 13). It was the earliest date that I could do so. Mindful that I had been advised that Dr. Chada had intended to begin writing the Report on 30 March 2018. I also reminded her that I still awaited amended Notes of the Meetings of 30 December 2016 and of 24 January 2018. I particularly requested that she would clarify whether it was intended to provide amended Notes, and if so, when I might expect to receive them.
I did not receive an acknowledgement or a response.

On 10 June 2018, I sent an email to Ms. Hynds, requesting an update on progress of the Investigation, and responses to the requests submitted previously, (Appendix 14). Having received her response, I determined that I would not enter into further communication. I was also most concerned to find that my comments relating to Witness Statements and to proposed Respondent Statements, submitted on 02 April 2018, may not have been duly considered in the Report which was not submitted to the Case Manager until 12 June 2018.

Investigation Report

The first comment regarding the Investigation Report is that it is entitled 'Investigation Report under the Maintaining High Professional Standards Framework'. There has been no reference whatsoever to the Southern Trust's Policy and Procedure for Handling Concerns about Doctors' and Dentists' Performance (September 2010). I have submitted my views previously concerning this issue. The Southern Trust's Policy and Procedure was obliged of it in response to the Maintaining High Professional Standards Framework. It is the Term and Condition of Employment.

In Section 1, the report states that the team work a 'Consultant of the Week On-call' model, with the consultant of the week responsible for triage of all referrals during their period on-call. I believe that this is, by definition, and crucially, incorrect, and not just a matter of semantics. The model is a 'Consultant of the Week'. As I have already described, I believe the presence or absence of 'on-call' in the perceptions of participants has been critical to the feasibility of triage.

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In Section 4, it is stated that Mr. Mackle and Mrs. Trouton met with Mr. O'Brien on 23 March 2016. This is incorrect, as it were Mr. Mackle and Mrs. Martina Corrigan who met with Mr. O'Brien. More importantly, it is stated that Mr. O'Brien was provided with a letter detailing concerns, and asking him to respond with an immediate plan to address the concerns. This is absolutely untrue. As stated previously, Mr. O'Brien asked what he was to do in response, the answer to which was a shrugged silence.

In Section 4, referring to the period April to October 2016, the Report states that considerations were ongoing about how best to manage the concerns raised with Mr. O'Brien and it was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. In addition to failing to identify those who had done the consideration and determination, the Report does not include the allegation in a Witness Statement that those who were prepared to help in a supportive manner, had been instructed not to do so.

In Section 4, referring to the Meeting of 30 December 2018, the report states that Mr. O'Brien was placed on a 4 week immediate exclusion 'in line with the MHPS Framework to allow for further preliminary enquiries to be undertaken. This is of course incorrect as the instrument for doing so was the Southern Trust's Policy and Procedure for Handling Concerns about Doctors' and Dentists' Performance.

In Section 4, referring to 03 January 2017, it states that Mr. O'Brien met with Mrs. Martina Corrigan to return all case notes and all undicated outcomes. Mr. O'Brien had in fact returned all case notes on 02 January 2017 and met with Mrs. Corrigan on 09 January 2017 to return clinic outcomes.

In Section 6, the Report states that a large number of un-triaged referrals were subsequently located in an office drawer in Mr. O'Brien's office, by Mrs. Corrigan. In his review of those un-triaged referrals later upgrade to Red Flag status, Dr. Julian Johnston had been advised that the large number had been discovered there by Mrs. Corrigan. In fact, Mr. O'Brien had advised Mrs. Corrigan of their exact location.

In Section 6, Page 19, the Report listed eight patients to exemplify patients who had attended as outpatients without letters having been dictated:d

1.d Personal Information redacted by the USI: Patient seen 6 times and no letters on file for any attendances.d

Personal was a six year old girl when she attended for the first time on 18 August 2015.dI provided a hand written letter that day to the GP, detailing the diagnosed and prescribingd Cephalexin, Oxybutynin and Desmopressin. I reviewed her on 18 January 2016 when Id again provided a hand written letter to the GP requesting increases of dosage in herd medication and advising of intended review. I reviewed her on 14 March 2016 when Id dictated a letter to the GP advising of her arranged admission on 06 April 2016 ford hydrostatic dilatation of her bladder. I did not provide a letter following her review in Julyd 2016 but did do so following her virtual review on 16 October 2017. A letter was dictatedd following her last review on 20 November 2017, (Appendix 15).d

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Personal had three outpatient consultations for which no individual letters had been dictated, and two of which hand written letters had been provided to the GP.

2.a Personal Information redacted by the USI: Letter done when patient was a private patient, no other letters on file.a

Personal was admitted for flexible cystoscopy and bladder biopsy on 04 September 2015.a Discharge letter is on file. I subsequently advised the GP and the patient of the benigna nature of the biopsy.a

3.a Personal Information redacted by the USI: Patient seen 14 times but no letters on file – not on a review lista

Personal is deceased. Last episode in 1998. No record of patient having been a urological patient.a

4.a Personal Information redacted by the USI: Patient seen on 19 September 2016, letter dictated on 28 February 2017.a

As abovea

5.a Personal Information redacted by the USI: Patient attended on 19 June 2016 but note in chart says DNA (discharge toa GP), this has not been done.a

Personal did not attend on 19 September 2016 and no further appointments were arranged fora hima

6.a Personal Information redacted by the USI: Patient seen 11 April 2016, letter dictated on 22 February 2017a

As above.a

7.a Personal Information redacted by the USI: No urological entries in Chart or on PASa

Has never been a urological patienta

8.a Personal Information redacted by the USI: No urology entries in Chart or on PASa

Has never been a urological patienta

In Section 8, page 31, the Report states that Mr. o'Brien's preference was that advanced triage should be done for red flag referrals only. This is untrue. As stated previously, I believe that it is even more important that advanced triage be conducted for urgent and routine referrals, if possible, in view of the waiting times for first appointments.

In Section 8, page 32, the Report states that Mr. Mackle reported that Mr. O'Brien had previously raised a complaint of bullying against Mr. Mackle in or around 2012. This is completely unture. Instead, I submitted a formal written grievance against Mr. Mackle when I discovered that he had

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unilaterally advised Payroll to halve agreed, remunerative payments for additional clinical work. The grievance was upheld. I suspended further action as his [redacted]

In Section 8, page 36, the Report states that Mr. O'Brien acknowledged that there were 66 undictated clinic and no dictated outcomes for these. This is untrue. As stated above, the number of clinic incompletely dictated was 51, and the number of patients affected was 189. Even though this information had been submitted to the Case Investigator on 06 November 2017, the Report still includes the wrong information, and claims that I had agreed with it.

In Section 9, Page 45, the Report states that Mr. O'Brien has worked rigidly to the action plan out in place and has met all of requirements of the action plan on an on-going basis. However, this has been at considerable cost. IAs I have continued to find it impossible to complete triageewhile Urologist of the Week, I have had to take an Annual Leave Day on the Friday following completion of the Week to enable me to complete the week's triage. That has also resulted in a reduction in the number of cancer review clinics, normally conducted on Fridays.

Lastly, The Report states that Mr. O'Brien displayed some lack of insight and reflection into the potential seriousness of the above issues. This I would completely dispute this contention. I believe that this impression has been gained due to my disbelief at the lack of insight on the part of the Trust into the harm and risk of harm suffered by patients already on the longest waiting list. It has also been disappointing to read the Report, after 18 months of investigation, concluding that Iedid not agree with triage anyway.e

Terms of Reference

1. Triage

I do accept that I was not undertaking triage of non-red-flag referrals. I have been clear since the outset of this investigation that I was not doing so because I found it impossible to do so. The background to that is explained above in detail.

I agree that triage is a vitally important process to ensure that patent management is initiated effectively and to ensure that patients are correctly categorised. It is my belief that some time with triage is necessary if the Consultant Urologist is to bring the value of his/her specialist expertise to the process and this means that triage becomes time consuming. I believe that it would be beneficial for the department to allocate sufficient time for the Consultants to complete triage effectively. I have raised this issue as part of my response to the SAI and I hope that the Trust will address the issue as soon as possible.

The investigation report states that the issue of concern relates to the fact that I failed to properly highlight to the Trust that I was not undertaking this aspect of the role. I accept that there are steps that I could have taken to more clearly state that I was not undertaking triage of routine or urgent referrals. I regret not having done so. That said, it is relevant to point out that senior management were aware of the fact that I was not completing Triage of non-red-flag referrals. This is demonstrated by the fact that everyone acknowledges that I repeatedly raised the fact that I found it impossible to complete triage, that they knew that triage was not being done and in fact a process was introduced to deal with the fact that it was not being done through the

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For a period in 2013/14, instances when charts were not available were recorded on the Southern Trusts Adverse Incident Reporting (IR) system: there were 61 consultations where charts were not available. In speaking to the Health Records Manager, Mr O'Brien is currently continuing this practice although this is not now recorded on the IR system.

Mr O'Brien was spoken to about this issue in 2012 by Dr Rankin, and twice in 2014 by Mrs Burns, the Directors of Acute Services at the time, seeking a change in behaviour, although none of these meetings were formally recorded.

Issue four – Recording outcomes of consultations and inpatient discharges

Whilst there has been no formal audit of this issue, concern has been raised by his urological colleagues that Mr O'Brien may not always record his actions or decisions regarding a patient following a period of inpatient care or outpatient consultation. This may cause subsequent investigations or follow up not to take place or be delayed.

Summary of concerns

This screening report has identified a range of concerns which may be counter to the ***General Medical Councils Good Medical Practice*** guidance of 2013, specifically paragraphs 15 (b), 19 and 20:

15. ***You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:***

- *a. Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
- *b.* ***Promptly provide or arrange suitable advice, investigations or treatment where necessary***
- *c. Refer a patient to another practitioner when this serves the patient's needs.*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. ***You should make records at the same time as the events you are recording or as soon as possible afterwards.***

20. ***You must keep records*** *that contain personal information about patients, colleagues or others securely, and* ***in line with any data protection requirements.***

Conclusion

This report recognises that previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm.

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

I am not persuaded by the justifications provided by Mr O'Brien for why the 9 private patients highlighted above were seen in the timeframes outlined. I would conclude that these patients seen privately by Mr O'Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over HSC patient's with the same clinical priority.

Mr O'Brien's explanation for patient Patient 124 was that he undertook surgery for this patient, Personal information redacted by the USI in an additional theatre session and therefore no HSC patient was affected. If an additional session was available in Theatre, patients from the waiting list should have been seen in chronological order.

Term Of Reference 5

To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

It was confirmed by a range of witnesses that they were aware of the difficulties in respect of Mr O'Brien's administrative practices.

Senior managers indicated they were aware of issues with regards to triage but not the extent of the issues. There had been attempts to raise this before 2016 with Mr O'Brien and in response, things would have improved for a while but then reverted again. I believe managers must have known there were significant ongoing issues of concern, given that a default system was put in place in 2015. However it was noted the default system meant this issue was no longer escalated to senior managers as the default system meant the triage was allocated as per the GP's impression. It was noted senior managers agreed with Mr Young that he would undertake Mr O'Brien's triage for 6-8 months whilst Mr O'Brien chaired a regional group. Clinics were also shortened to allow more admin time, extra PAs were paid for, admin time and no day surgery was scheduled after a SWAH clinic. It was indicated MDM letters which were always dictated were very long and detailed, and if theatres were unused Mr O'Brien would ask to increase his theatre time, i.e. additional time for his admin was being used in other ways.

Senior managers were aware Mr O'Brien took clinic notes to his home after the SWAH clinics and there were delays in notes being brought back. However, there is not a robust system in place for determining how many charts are tracked out to one consultant, nor how long the notes were gone for; as such managers were not aware of the extent of the problem.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Young, Michael
Sent: 15 December 2021 09:50
To: Stinson, Emma M
Subject: FW: Personal Information redacted by the USI

Section 21

From: Young, Michael
Sent: 24 August 2016 21:14
To: Corrigan, Martina
Subject: RE: Personal Information redacted by the USI

I think an office conversation is about to happen before CW gets to him

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From: Corrigan, Martina
Sent: 24 August 2016 13:45
To: Young, Michael
Subject: RE: Personal Information redacted by the USI

Yes he does email but doesn't respond – all of the other consultants are in the same boat as you – frustrated! – I have pulled notes as well from time to time when I am worried about something in patients letter, but most time this doesn't help as nothing or minimal information in the notes. Direct questions are asked but rarely get a response.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Young, Michael
Sent: 23 August 2016 11:12
To: Corrigan, Martina
Subject: RE: Personal Information redacted by the USI

Does he do email?
I was triage last night and had 2-3 letters with this exact issue. = pt seen but no letter but pt saying they were told something. Frankly I have told the booking office to give letter to AOB as I have enough issues of my own. But would getting the notes and seeing what was written be beneficial? In that way the direct question can be asked of AOB. Ie Aidan do you want this pt put on the waiting list for …..?

From: Corrigan, Martina
Sent: 20 August 2016 09:28
To: Young, Michael
Subject: Re: Personal Information redacted by the USI

Problem is Aidan does see all of these letters but we never get a response. It worries me because as I said a get about 5 to 6 a week that are sent to Aidan and copied into me. Majority of times nothing is actioned

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

and since they have been escalated and I am sitting with them if something happens to patient then I'm responsible to.

I sent this as one example and I was looking your guidance on how best to address the non-response of them.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Young, Michael
Sent: Friday, 19 August 2016 22:36
To: Corrigan, Martina
Subject: RE: Personal Information redacted by the USI

This man has a stent in situ and last xray showed a residual stone

Has AOB seen letter
Has Noleen asked when his date is to be
Otherwise you could ask when op is planned directly – which is best way and phrase as we do for the red flag patients

MY

From: Corrigan, Martina
Sent: 19 August 2016 10:11
To: Young, Michael
Subject: FW: Personal Information redacted by the USI
Importance: High

Can you help/advise?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Coleman, Alana
Sent: 19 August 2016 08:26
To: O'Brien, Aidan; Corrigan, Martina; Elliott, Noleen
Cc: Heaney, Linda; Cunningham, Andrea
Subject: Personal Information redacted by the USI
Importance: High

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Morning all,

Patient currently on WL with Mr O'Brien for ROS and RT Lithotripsy. Please advise if we need to review this patient or expedite procedure?

Thanks
Alana

Registration and Booking Clerk
Referral and Booking Centre
Ramone Building
CAH

Tracking Code: Personal Information redacted by the USI
Tel : Personal Information redacted by the USI

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t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Cunningham, Andrea
Sent: 19 December 2016 13:09
To: Robinson, Katherine
Subject: FW: Backlog report - no clinic outcomes
Importance: High

Update as discussed.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by USI
T: Personal Information redacted by USI

From: Elliott, Noleen
Sent: 15 December 2016 14:04
To: Cunningham, Andrea
Subject: Backlog report - no clinic outcomes

Andrea,

Please find attached list of clinics with no outcomes completed as per 15th December 2016.

Noleen

Mrs Noleen Elliott
Mr O'Brien's Secretary
Level 2
CRAIGAVON AREA HOSPITAL
Tel No: Personal Information redacted by USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

DATE	CLINIC	CLINIC CODE
24/11/2014	SWAH	EUROAOB
22/12/2014	SWAH	EUROAOB
12/01/2015	SWAH	EUROAOB
23/02/2015	SWAH	EUROAOB
09/03/2015	SWAH	EUROAOB
13/04/2015	SWAH	EUROAOB
11/05/2015	SWAH	EUROAOB
22/06/2015	SWAH	EUROAOB
06/07/2015	SWAH	EUROAOB
28/09/2015	SWAH	EUROAOB
19/10/2015	SWAH	EUROAOB
02/11/2015	ARMAGH CLINIC	AAOBU1
06/11/2015	URODYNAMICS CLINIC	CAOBUDS
24/11/2015	NEW CLINIC	CAOBTDU
30/11/2015	SWAH	EUROAOB
04/12/2015	URODYNAMICS CLINIC	CAOBUDS
07/12/2015	ARMAGH CLINIC	AAOBU1
22/12/2015	NEW CLINIC	CAOBTDU
08/01/2016	UROONCOLOGY CLINIC	CAOBUO
11/01/2016	SWAH	EUROAOB
15/01/2016	UROONCOLOGY CLINIC	CAOBUO
08/02/2016	SWAH	EUROAOB
07/03/2016	SWAH	EUROAOB
21/03/2016	ARMAGH CLINIC	AAOBU1
01/04/2016	UROONCOLOGY CLINIC	CAOBUO
04/04/2016	REVIEW CLINIC - CAH	CAOBTDUR
08/04/2016	UROONCOLOGY CLINIC	CAOBUO
15/04/2016	UROONCOLOGY CLINIC	CAOBUO
18/04/2016	ARMAGH CLINIC	AAOBU1
19/04/2016	NEW CLINIC	CAOBTDU
22/04/2016	UROONCOLOGY CLINIC	CAOBUO
22/04/2016	URODYNAMICS CLINIC	CAOBUDS
29/04/2016	UROONCOLOGY CLINIC	CAOBUO
29/04/2016	URODYNAMICS CLINIC	CAOBUDS
03/05/2016	REVIEW CLINIC - CAH	CAOBTDUR
06/05/2016	URODYNAMICS CLINIC	CAOBUDS
23/05/2016	REVIEW CLINIC - CAH	CAOBTDUR
27/05/2016	UROONCOLOGY CLINIC	CAOBUO
27/05/2016	URODYNAMICS CLINIC	CAOBUDS
03/06/2016	URODYNAMICS CLINIC	CAOBUDS
10/06/2016	UROONCOLOGY CLINIC	CAOBUO
13/06/2016	ARMAGH CLINIC	AAOBU1
20/06/2016	SWAH	EUROAOB
04/07/2016	REVIEW CLINIC - CAH	CAOBTDUR
22/07/2016	UROONCOLOGY CLINIC	CAOBUO
26/07/2016	NEW CLINIC	CAOBTDU
09/08/2016	NEW CLINIC	CAOBTDU
12/08/2016	UROONCOLOGY CLINIC	CAOBUO
19/08/2016	UROONCOLOGY CLINIC	CAOBUO

19/08/2016	URODYNAMICS CLINIC	CAOBUDS
22/08/2016	SWAH	EUROAOB
19/09/2016	SWAH	EUROAOB
07/10/2016	URODYNAMICS CLINIC	CAOBUDS
11/10/2016	NEW CLINIC	CAOBTDU
14/10/2016	URODYNAMICS CLINIC	CABOUDS
14/10/2016	UROONCOLOGY CLINIC	CAOBUO
21/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	UROONCOLOGY CLINIC	CAOBUO
04/11/2016	URODYNAMICS CLINIC	CAOBUDS
04/11/2016	UROONCOLOGY CLINIC	CAOBUO

Anaesthetics & Surgery
Personal Information redacted by USI

From: Haynes, Mark
Sent: 23 December 2016 10:39
To: Carroll, Ronan
Subject: Management of PP's / non chronological listing

Morning Ronan

I mentioned in discussion the management of PP's by Mr O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events I feel this practice should also be looked into.

Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 5th September privately (given the headed paper the letter is on) and placed on his NHS theatre list on weds 21st September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

Do you think this should be fed into the overall investigation?

Mark

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Hynds, Siobhan

From: Young, Michael [redacted]
Sent: 26 November 2015 12:03
To: Haynes, Mark; Corrigan, Martina
Subject: RE: Queue jumpers

I had spoken before to the person in question re this issue in general and the justification of urgency – and I agree since the waiting list for some things are so long eg urodynamics.
Will have to speak again then

MY

From: Haynes, Mark
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private pa

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This item has been archived by HP Consolidated Archive. View Restore

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Southern Health and Social Care Trust

Quality Care - for you, with you

A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

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1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: paying.patients@southerntrust.hscni.net or http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

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- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

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4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

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- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

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1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

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Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 14 September 2017 09:02
To: Hynds, Siobhan
Cc: Chada, Neta
Subject: RE: MHPS Investigation - Request for Information
Attachments: Update AOB all surgery 2016 5 May 2017.xlsx; clinically should they have been sooner.docx; Scan from YSoft SafeQ (5.27 MB); Scan from YSoft SafeQ (5.54 MB)

Importance: High

Siobhan,

The process undertaken was that Ronan had requested Wendy Clayton, Operational Lead to request a report to be run on all Mr O'Brien's surgery during 2016. See attached.

Any patients that had a short wait time between being added to the waiting list and been operated on had their record checked on NIECR to see if they had a private patient letter, i.e. [redacted]. Out of this list there were 11 patients, for which all the letters were printed off.

I then asked Mr Young if he could look at these letters and gauge from his clinical opinion should they have been as soon as they had been or should they have been added to the NHS waiting list to wait and be picked chronologically.

Mr Young agreed and he took away the letters and using NIECR (i.e. checking lab results, imaging and any other diagnostics available), made his decision on whether in his opinion they were sooner than they should have been. (letters attached with Mr Young's comments which he went through with me and advised which he felt was reasonable or not)

Regards

Martina

From: Hynds, Siobhan
Sent: 13 September 2017 09:30
To: Corrigan, Martina
Cc: Chada, Neta
Subject: MHPS Investigation - Request for Information
Importance: High

Martina

Could you please clarify for Dr Chada the process undertaken to assess the clinical priority of the TURP private patients. Who assessed the clinical priority and what was this based upon.

Can you also please provide me with a copy of the information pertaining to each private patient assessed.

Could I please have this information as a matter of urgency. If you have any queries please come back to me.

Many thanks

Siobhan

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry

Patients seen privately by Mr O'Brien and added to waiting list and came in for procedure within a short timeframe.

Casenote	Consultant Name	Date on Waiting List	Date Operation	Days between Added to WL to Operation Date	Is there a clinical reason why they should have waited such a short time
Patient 114	O'Brien A Mr	22/02/2016	22/03/2016	29	No
Patient 115	O'Brien A Mr	25/04/2016	04/05/2016	9	Reasonable – Red Flag
Patient 116	O'Brien A Mr	11/04/2016	15/04/2016	4	No
Patient 117	O'Brien A Mr	01/04/2016	27/04/2016	26	No
Patient 118	O'Brien A Mr	08/07/2016	09/08/2016	32	No
Patient 119	O'Brien A Mr	29/07/2016	21/09/2016	54	No
Patient 120	O'Brien A Mr	04/12/2015	24/02/2016	82	Reasonable
Patient 121	O'Brien A Mr	11/07/2016	17/08/2016	37	No
Patient 122	O'Brien A Mr	08/10/16	02/11/16	25	No
Patient 123	O'Brien A Mr	31/10/16	04/11/16	5	No
Patient 124	O'Brien A Mr	16/02/2016	24/02/2016	8	No

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina
Sent: 28 April 2016 16:25
To: Carroll, Ronan
Subject: FW: Confidential letter to AOB - updated March 2016
Attachments: Confidential letter to AOB - updated March 2016.docx; Actions from AMD and Mr Suresh Meeting; Actions from AMD and Urology Consultant Meeting

Ronan,

Conscious that we are currently without an AMD and a CD in our division and there were a few issues that were been taken forward by Eamon and I want to make sure that they are not forgotten about. The Medical Director is aware of these.

Attached is joint letter from Eamon and Heather to Aidan. Eamon and I met with him and on 30 March 2016 and discussed the issues and gave him the letter, we were to get a response in 4 weeks (nothing as of yet).

There is also an on-going issue with Personal Information redacted by USI and I will update you about this when we next see each other, again Eamon and I have been taking this forward and I attach some emails regarding this, again now that we have no AMD and CD, this still needs to be actioned, because yet again he is oncall this week and no formal cover.

There is also the issue of Job Plans. Mark Haynes has firstly been trying to get his job plan put on Zicardian since he started 2 yrs ago (11 May 2014). It has now been put on and he is waiting for sign-off and there was to be a meeting with Eamon to get this signed off. He is constantly asking me about it as he needs it sorted – again not sure how to progress?

Happy to discuss further but wanted to make sure so that you are aware of these.

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

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Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Corrigan, Martina
Sent: 17 August 2016 17:07
To: Wright, Richard
Subject: RE: confidential

Hi Richard,

See updated position below:

1. Untriaged outpatient referral letters

There are currently 174 untriaged letters dating back to May 2016

2. Current Review Backlog up to 31 July 2016

Total in Review backlog = 679

2014	243
2015	244
2016	180

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Wright, Richard
Sent: 09 August 2016 09:21
To: Corrigan, Martina
Subject: confidential

Hi Martina. Did we ever make progress with regard to the issues raised re Urology which Eamon had been dealing with? Regards Richard

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

Oversight Group Meeting

Tuesday, 13th September 2016 @ 10:00am in
The Chief Executive's Office, Trust Headquarters, Craigavon Area Hospital

NOTES & ACTION POINTS

Present: Dr Richard Wright
Mrs Vivienne Toal
Mrs Esther Gishkori

In attendance: Mr Simon Gibson
Mr Malcolm Clegg

Medical MHPS Cases, Doctors in Difficulty, GMC & NIMDTA Issues

Irrelevant information redacted by the USI

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

AOB:

The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Gibson, Simon

From: Gibson, Simon
Sent: 13 September 2016 14:12
To: Gishkori, Esther; Toal, Vivienne; Clegg, Malcolm; Wright, Richard
Cc: Stinson, Emma M; White, Laura; Mallagh-Cassells, Heather
Subject: CONFIDENTIAL - Letter to AO'B - first draft
Attachments: Letter to AOB - 1st draft 13-9-16.docx

Dear all

Draft of letter for comments back please.

Esther – I phoned Martina with regard to what is a realistic yet challenging target with regard to the outpatient review backlog. Her view was 229 in the month of October (19 additional clinics) would not be achievable, and we don't want to set him a target we know he can't reach, and then penalise him. So, we have gone with 70 per month, every month, until end of December. Operationally, this is your call, but just wanted you to be aware of the thought processes behind the target chosen

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Southern Health and Social Care Trust

Draft letter

21st September 2016

Dear Mr O'Brien

Formal notification of investigation under Maintaining High Professional Standards (MHPS)

I am writing to inform you of the Southern Trusts intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practice. At this stage, we will be taking an informal approach as outlined within MHPS, but following the outcome of this we may proceed with a formal investigation.

This investigation should be seen in the context of the letter written to you on 23rd March (copy attached), in which a number of concerns were raised and a plan was sought from you to address these concerns. No plan was provided and the same concerns still exist.

This informal approach will consider four areas of your practice, and be time bound as indicated below.

Area 1 – Untriaged letters

In August 2016, you had 174 untriaged outpatient referral letters, dating back 18 weeks. It is the expectation of the Trust that by the time you commence your next Urologist of the Week session, on 21st October, this backlog is eliminated. Furthermore, it is the expectation of the Trust that at the end of your week as Urologist of the Week, you are completing the triage of outpatient referral letters within the Trust standard of 72 hours.

Area 2 - Outpatient review backlog

As at 31st August 2016, you had 658 patients on your outpatient review backlog, including 229 going back to 2014. It is the expectation of the Trust that this 2014 backlog is reduced to zero by the end of the calendar year, with a reduction of a minimum of 70 patients per month.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry

Personal Information redacted by USI

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther <Personal Information redacted by USI> wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.
>
> I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.
>
> Happy to discuss any time and I will of course brief the oversight committee of any progress we make.
>
> Many thanks
> Best
> Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust

Received from SHSCT on 21/12/2021. Annotated by the Urology Services Inquiry.

Toal, Vivienne

From: Gishkori, Esther [redacted]
Sent: 16 September 2016 13:37
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Vivienne,
I spoke with Richard this morning.
He is happy with the direction of travel and I will be asking the AMD and CD to record their plans and actions.
Mr O'Brien isn't back On Call for 6 weeks, however work will begin immediately to address the back log.
I have promised Richard a written plan of how we will be proceeding and have asked for a period of 3 months to address.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: Toal, Vivienne
Sent: 16 September 2016 08:57
To: Wright, Richard; Gishkori, Esther
Subject: RE: meeting re Mr O'Brien.

Esther – I am conscious you go off on leave today; how do you wish to handle Richard's request below?

Vivienne

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

Received from SHSCT on 10/12/2021. Annotated by the Urology Services Inquiry.

From: Boyce, Tracey
Sent: 09 November 2016 15:39
To: Gishkori, Esther
Cc: Stinson, Emma M
Subject: FW: Emailing: sc of partial SAI
Attachments: sc of partial SAI.pdf

Importance: High
Sensitivity: Confidential

Hi Esther
I had my weekly update with the governance leads today and they shared a draft of an SAI that is nearing completion as they are concerned about its implications - I have attached the first page to give you the gist. I think we may need to discuss this one with Richard as the cause seems to be directly attributable to one of the consultants (AOB)?

.sically this lady's GP sent in a referral in relation to an incidental finding on a CT in relation to her kidneys - it came in as routine.
The urologist consultant of the week collected that week's letters to do triage, as per the urology arrangements but from what the investigation team has found out that letter was never seen again and no instruction were received re triage appointment booking.

Apparently this had happened before with this consultant so the booking team's way of dealing with these type of 'lost letters' was to book them a routine appointment (because letters were lost before they had started keeping copies to work from). As a result there was a 16 month delay in diagnosing this ladies renal carcinoma. The triage consultant is meant to look at the CT as part of triage process but the SAI team found that it hadn't been looked at. The urologist on the SAI team has said if it had been reviewed at triage it would have been immediately obvious it was a tumour. (there was also an issue in relation to the reporting of a subsequent MRI back in 2014 that meant the GP or breast team did not pick up that it was potentially a red-flag or urgent referral was needed)

Although this was an SAI about a single case it has come to light that the other 7 urology referral letters received that week are also missing - as an initial action I have asked Trudy and Connie to try and track them via PAS to check they have been seen and pull their notes if necessary. I haven't asked the question yet whether we know if any ure of that consultants weeks triage letters have been lost - but it is probably something we need to discuss.

I am conscious that I haven't spoken to Ronan about this yet as AOB's AD - but I wanted to get your take on it before I shared it with anyone else.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.