Urology Services Inquiry

Oral Hearing

Day 44 – Thursday, 18th May 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON THURSDAY, 18TH DAY OF MAY, 2023 AS FOLLOWS:

CHAIR: Morning, everyone.

MR. WOLFE KC: Morning, Chair, morning, Panel. Your witness this morning is Ms. Zoe Parks and I understand she intends to take the oath. 10:01

THE WITNESS: Yes.

MS. ZOE PARKS, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS: 10:01

1 Q. MR. WOLFE KC: Now, Ms. Parks, in advance of today you've kindly furnished us with a statement and then an addendum statement to tidy up some additional matters. Let's get those up on the screen, please. The first document is dated 17th November 2022. It's your first 10:01 witness statement. WIT-90030. You will recognise that as your first page. You can see at the top right-hand corner, a reference to the fact that we received an addendum statement from you, which we will turn to presently. If we go to the last page of this statement 10:02 at 90081, and you can see your signature at the bottom?

A. Yes.

2 Q. And the customary question is do you wish to adopt that statement as part of your evidence today?

A. Yes, please. 10:02

3 Q. Thank you. Then your addendum statement. It's to be found at WIT-94910. This primarily deals with the issue of Mr. O'Brien's intended return to work post-retirement, an issue you hadn't dealt with in your

first statement?

A. That's right.

4 Q. We'll look at that towards the end of your evidence. If we just go to the last page, please, at 913 in this sequence. Again, your signature. Do you wish to adopt that statement as part of your evidence? 10:03

A. Yes, please.

5 Q. Thank you. Now, as we can see from your statements, you came into what was the Craigavon Hospital Group Trust immediately after qualifying from university? 10:03

A. Yes. More or less, yeah. It was within a year or two of finishing my degree, yes.

6 Q. And you took up a job there in January 2003 in the Human Resources Department. After a project officer's post, you took up a job as medical staffing manager from 2nd February 2004; isn't that right? 10:04

A. Yes, is that right.

7 Q. That's essentially the same job you have remained in ever since?

A. More or less. It's changed obviously with the evolvement to the Southern Trust and the role has grown, but yes, the same job. 10:04

8 Q. Yes. Your main duties similarly include providing advice, support and guidance to all medical staff and managers in relation to HR matters, such as recruitment and selection, employee relations and contractual issues. Is that a fair summary? 10:04

A. That's correct.

9 Q. Just so that the Inquiry can understand where this post

sits, yours is a specific medical-facing HR role; is that right?

A. Yes. So we have a part of HR that looks after the medical and dental staffing, so we look after all of the HR-related issues concerning the medical and dental staff in the Southern Trust.

10 Q. So, HR is obviously broader and bigger than medical and dental, so you would have other of your colleagues dealing with the other general HR issues?

A. Yes, that's correct. 10:05

11 Q. Yes. Is it all under the leadership now of -- oh, I've forgotten her name?

A. Vivienne.

12 Q. Vivienne Toal, that's right. Is she ultimately your line manager within the structure? 10:05

A. She is not my line manager but she is our director, yes.

13 Q. Who do you report to?

A. So then, when Vivienne started there was a new deputy director posted that was created. Siobhán Hynds, so 10:06 she would be my direct manager.

14 Q. Thank you. We can see from your statement, particularly at paragraph 7.7, that you have been involved in the development and updating of various HR guidance policies and procedures relating to medical 10:06 staffing over the years; isn't that right?

A. That's right.

15 Q. To pick up on a number of examples, we will look briefly this morning at your contribution to an update

to the guidelines for handling concerns about doctors; isn't that right?

A. That's correct.

16 Q. That was 2017?

A. Yes. 10:06

17 Q. And that's a companion piece to the MHPS framework?

A. It is, yes.

18 Q. We will also look at, later this morning, a document dealing with the reengagement of doctors post-retirement. Again, your fingerprints, if I may say so, are on that issue, that was something you developed in 2020; isn't that right? 10:07

A. That's correct, yes.

19 Q. That's to take but two examples. There are many others set out in your statement. 10:07

A. Mm-hmm.

20 Q. The first substantive issue I wish to address with you this morning is the issue of job planning.

A. Okay.

21 Q. Let me pull up something that you've said as perhaps an important reflection in the context of what you understand to have been the issues in relation to Mr. O'Brien. 10:07

A. Mm-hmm.

22 Q. We will look at that specific issue -- look at that specific reflection and then move through job planning more generally as a concept, and then come back to look at particular job planning issues around Mr. O'Brien, and we will ask for your observations in relation to 10:07

all of that.

If we could have up on the screen, please, WIT-90079. You can see at 40.3, this reflection here comes at the end of a long series of reflections about how the case, 10:08
if you like, of Mr. O'Brien could have been better handled, and that's something we will come to later this morning. But ultimately you come to this important reflection, and you say:

10:08

"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 10:09
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. 10:09

23 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 10:09
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.

24 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.

25 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.

26 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. 10:12 10:12

27 Q. Now, you've helpfully - and I should preface this remark by saying we don't have the time this morning to delve into the detail of this - but you have helpfully set out for us some key job planning documents. If we can just run through them on the screen just to illustrate them. WIT-19840. That is a 2009 document, Local Trust Framework on Job Planning For Medical Managers. That was developed within the Southern Trust; is that right? 10:12 10:13

A. It was, yes.

28 Q. Is that a product of your work?

A. Yes. I was involved with that, yes, along with the associate medical directors.

29 Q. We have job planning for consultants, which is a BAUS document, that is 2016, which you have referred us to. WIT-83181. If we just open this one, but briefly. I'm going to ask you ultimately to help us to better understand and to distill for us how you go about job 10:13

planning to serve the objectives that you have just outlined.

A. Mm-hmm.

30 Q. If we just look at 2.1 of this document. Sorry I don't have a reference but if we just go through it. Yes, thank you. Just before we do this, this is a 2016 document; does its advice or guidance remain pertinent today? 10:14

A. As far as I understand, yes, I think it's still available. 10:14

31 Q. Yes. You've set out some of this already in your answers, that job plans are an annual agreement or they should be --

A. That's right.

32 Q. -- between the employer and the consultants setting out the work that is done for the Trust reflecting a balance between operative outpatients and emergency care, depending on the setting, I suppose? 10:14

A. Mm-hmm.

33 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". 10:14 10:15

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.

34 Q. Yes. And it sets out some hallmarks of a successful job plan.

A. Mm-hmm.

35 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.

36 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.

37 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.

38 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? 10:17

A. Yes, absolutely.

39 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 10:17 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 10:18 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 10:18 are very effective as well.

40 Q. Yes. Tell me about team job planning. We saw in some of the documents you appended to your statement that that, I think in 2009, became an issue raised, I think was it by Dr. Rankin who wanted to have some work done 10:18 in relation to that? Have you been able to include team as well as individual objectives into the job planning process?

A. So, team job planning is not contractual so we can't

enforce team job planning, but it's certainly something we would encourage and where we are trying to aim to. We do have a number of good practice examples within the Trust, and we are writing those up as case studies to share with others specialties on how that is managed, where a team have come together to consider their specialty and then have designed team job plans. I mean, it allows more flexibility within the team and cross-cover and lots of different benefits to both Trust and the consultants when they are signing up to deliver a set number of activities for the Trust, which is then fed in as objectives. 10:19 10:19

41 Q. Could I ask you just to rewind on that for the uninitiated. What is team planning, team job planning, as contrasted with perhaps the more traditional individualised approach? 10:19

CHAIR: Ms. Parks, could you please slow down a little? We don't have a stenographer present in the chamber today. I am guilty of anyone as speaking very quickly but if you could just slow down a little bit, please. Thank you. 10:20

THE WITNESS: No problem.

MR. WOLFE KC: It's probably my fault as well.

42 Q. I was asking you just to help us better understand the conceptual basis for the team approach, and contrast it, if it's helpful, with the more traditional individualised approach to job planning. What's the merits of a team-based approach? 10:20

A. I think it probably promotes more openness and

transparency amongst the team as to what everyone is doing. It allows them to work better as a team, to align themselves with the service. It's, you know, a very open, transparent, fair approach in terms of everything is out on the table in terms of what has been allocated in job plans. I think it just allows that flexibility to be discussed about how they can work as a team, you know, between certain days. It's just that more enhanced level of job planning where they can consider those things as a team, as opposed to having individual discussions with their clinical manager about their individual job plan. 10:20 10:21

43 Q. We have talked as well this morning about the importance of job planning in perhaps helping to address demand capacity issues. 10:21

A. Mm-hmm.

44 Q. Is it possible to see those two things as having a relationship with each other if there is a service such as urology facing significant demand capacity pressures with a limited and, as we have seen in evidence to date, a less than optimal consultant body servicing that need? Is that particular environment or particular context in which root job planning, team job planning is helpful or potentially helpful? 10:21

A. I certainly think the specialty review meeting to consider the demands on the service and the capacity of the number of consultants you have, it highlights if there's a huge gap in terms of when you consider all of the programmed activities that you can have within the 10:22

consultants aligned to the service, then it allows the clinical managers and their operational management team to make the necessary business cases for more consultants if there's a very obvious gap between the two, or it allows the consultants to discuss how better they maybe can use their programmed activities. I know some specialties have chosen to reduce the programmed activities to support the appointment of a new consultant. It gives you those options to have some of those discussions. 10:22 10:23

45 Q. Does team job planning also assist in getting to grips with any quality issues that might exist within a service?

A. I think job planning in general would allow for that in terms of identifying what the expectations are and building those into job plan objectives, because you will always have variation between consultants, not everyone operates on the same way. It allows you to best match those and deal with those. I think it allows you then just to build that into -- and it's obviously having discussions as to best use the resources you have to address some of those quality measures you need to factor in. 10:23 10:23

46 Q. How successful do you think the Trust has been in using job planning to deal with demand and capacity issues? 10:24

A. I think I would have to be honest and say it has been challenging. I don't think we are alone in that regard. I mean, I think there's been many an audit report, both nationally and locally, looking at this

issue. So, I think it has been challenging. We have -- I mean, we started in 2009 with the Chief Executive chairing monthly meetings on job planning for probably five years or more. I think they ran from 2009 right to the end of 2014. Subsequently, it was chaired by the medical director and HR director, with all of the divisional medical directors and CDs coming to those meetings to discuss job planning. So, there was a lot of focus and effort in terms of the importance of it. 10:24

It's not without its challenges. It is a very challenging process to continue to do this on an annual basis, and the resources required to do it effectively and well are significant. We were the first Trust in Northern Ireland then to try and get a system that would support them in terms of using an electronic system for job planning, which brings benefits but obviously is not easy for everyone to use as well initially, so we've had a journey with that as well. We have moved to a new system now that brings better benefits in the sense that it's now accessible by more of our operational managers, and so it's giving that oversight to all of those operational managers who need to understand what is in job plans to match against their service plans as well with their clinical managers in those meetings. So, it's been a journey and I think there's been lots of guidance. We have worked closely with our local negotiating committee and we've agreed our guidance with the local negotiating 10:24 10:25 10:25

committee. I have run training, and we have training videos up on our job planning hub, of how job planning should be delivered. We continue to support our clinical managers as best as we can to do it in the way it's designed to do. 10:26

47 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? 10:26

A. That's fair, yes.

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

A. Absolutely.

49 Q. Those inquiries could potentially lead to a disciplinary route; is that fair? 10:27

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

50 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? 10:27

A. Absolutely, yes.

51 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? 10:27

A. Very important, yes.

52 Q. You have said in a number of places within your statement that there wouldn't have been a signed-off job plan for every consultant in Urology, and indeed wider afield; the annual process isn't always completed? 10:28

A. That's fair, yes. That's true.

53 Q. Just before I ask why that might be, why is an annual process viewed as important? Clearly such a process will place some pressures on those who are required to carry it out, notably the Clinical Director usually; 10:28 isn't that right?

A. That's right, yes.

54 Q. Has there been any thinking about planning on a three-year basis or a two-year basis? Why is there a requirement for a one-year approach? 10:29

A. Well, it's contractual, but it also offers the opportunity to have a discussion with their line manager on an annual basis. We have acknowledged that if the services haven't changed and both parties are willing parties, then the job plan can be rolled over 10:29 from the previous year to the next year if nothing needs to change. So, it just gives that opportunity for either party to bring something to the table that maybe needs to be discussed for the year ahead. But there is the opportunity, and there is opportunities 10:29 where they don't have to have a lengthy meeting if nothing has changed and the job plan just stays as it was before.

55 Q. The recognised failure which you have identified of job

planning not being completed across the board, how widespread is that within the Trust?

A. I think it's been a challenge over the number of years since the new consultant contract has been introduced. I think a lot of effort has gone into try and encourage more engagement. We certainly saw through our system, and I can, I suppose, only go our system, because there will be lots of systems happening about job plans. We did have 90% of our job plans signed off in 2021-2022 year; we did have prospective plans in place. But we're obviously just back to a new job planning year because it goes from April to March every year. So, every time the system will automatically put it into the next round and it has to be discussed and agreed again. It's a continuous process. 10:30

56 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 10:31

requirement of work based on the clinical management team to undertake that. I suspect that probably has some influence.

57 Q. In Mr. O'Brien's case, you, as I have said at the start, were probably aware that for a period of at least four years, there wasn't a signed-off job plan. Mr. Haynes wrote in respect of this in 2019. If we just bring his e-mail up, please, it's WIT-55764. He's highlighting to the then Medical Director, Maria O'Kane, and Simon Gibson in the Medical Director's office, and you are copied in, that: 10:32 10:32

"Mr. O'Brien does not have a signed-off job plan. discussion has occurred and the job plan has been awaiting doctor agreement since November 2018. Mr. Haynes is second sign off, so he would not be requested to sign it off until he and his Clinical Director signed it". 10:33

So, have you any sense as to why Mr. O'Brien didn't sign off on his job plan? 10:33

A. I don't know, the honest answer to that, in terms of what his rationale for that job plan was. But I mean, if it was anything in relation to his previous, it may well be because he didn't feel I had given him enough time to undertake the duties. But yeah, it's just unfortunate that neither party then maybe pushed it on to a facilitation to try to get to the bottom of those reasons and get some sort of an agreement reached. 10:33

58 Q. Isn't that what you allude to in the quotation I read from your statement at the start, there are contractual tools available --

A. Yes.

59 Q. -- in order to press this to a conclusion? 10:34

A. Yes, that's correct.

60 Q. And either party can take it to facilitation to bring the matter to an end?

A. Yes. Ideally, you obviously want the job plan not to be enforced and to be agreed as a partnership, but if 10:34 that's not possible, then either party can refer the matter to the Medical Director or facilitation.

61 Q. Why would this have been tolerated, do you think? Why would this issue have been allowed to sit and sit and sit for a number of years without the alarm button 10:34 being pressed?

A. I think that's a difficult one for me. I think it should have been escalated sooner. What I can say is, I mean, it has been -- it's not unique to Urology, it is evident across the Trust in terms of... So, it's 10:35 understanding where there's actual issues as opposed to just that the job plan is there and hasn't maybe changed and just hasn't gone through the motions of maybe getting it signed off again.

62 Q. Your view that it's an important tool, or potentially 10:35 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.

63 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? 10:36

A. I think that's fair, yes. 10:36

64 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 10:36 10:37 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 10:37 it as a retention tool and an attraction tool as well. We are looking at it from all of those aspects.

65 Q. Just to explain to me a little further, how is it useful to address a retention issue?

A. So, it gives opportunities for consultants to discuss with their clinical manager if there's an area of special interest they want to take on. Or similarly if a consultant is maybe considering leaving the Trust because they want to get extra experience. We have had 10:37
examples of Trusts then being able to negotiate sessions in another Trust, for example, in one of the bigger hospitals to get a bit of special interest. So, rather than losing them all together from the service, we are able to retain them in the service but maybe 10:38
allow a day out. So, all of those factors can be considered to ensure that we are using job planning to its fullest potential to allow for those opportunities to be taken on board. It has all of those opportunities as well, if there's full and open 10:38
discussions with managers, to address what is the needs of the individual and then how that matches against the needs of the service.

66 Q. Let me take this issue back specifically to a number of scenarios around Mr. O'Brien. 10:38

A. Mm-hmm.

67 Q. I take it that you were, I suppose, speculating to some extent as to why he didn't sign off in 2018 or 2019, and you suggested maybe he was dissatisfied with the time allowed. I mean, that appears to have been 10:38
a feature of at least two instances or incidents around job planning during his career with the Trust.

If I could take you back to 2004. That was the year

you'd recently taken up a job in HR in the Craigavon Trust?

A. Mm-hmm.

68 Q. A new consultant contract had been devised and was being implemented. As you explain in your statement, for example at paragraph 1.2, consultants had, as a preface to this process, to complete a diary card to show their activity, and we can see Mr. O'Brien's diary card -- 10:39

A. Mm-hmm. 10:39

69 Q. -- as an addition to the back of your statement. You've said in your statement at WIT-90030 - just take a look down at paragraph 2, I think. Yes - that looking back on those diary cards and the correspondence that came with them, that Mr. O'Brien was saying that the service which he was working in has been in crisis for years and that there was a gross overburden of clinical work. 10:40

Thinking back to that, you were medical staffing officer at the time, you were early career; that does indicate, doesn't it, on Mr. O'Brien's part, that, in the context of this new consultant contract, he, and perhaps his colleague Mr. Young at that time, were facing real struggles in their work in the delivery of urology services? 10:40 10:41

A. Yes.

70 Q. Can you think of anything that was done on the part of HR to better investigate that or to address it?

A. Well, I recall it being highlighted at the highest level in the organisation. The Chief Executive was aware of this and the Medical Director was very much aware. We had an external facilitator that came down from Belfast Trust who met with him as well to discuss the job plan.

71 Q. It was Dr. Gaskin?

A. That's right, yes. Obviously then the implementation of the contract was a retrospective process at that point in time because it was going to be backdated, so it was probably then a little bit more troublesome in terms of working through that because you are working through work already completed. So, I do recall that the urologists were awarded the highest PAs in the whole Trust in terms of recognition of the work they were undertaking at that time.

72 Q. Yes. They were seeking 17 PAs and I think at one point Mr. O'Brien pitched for 17.5. But in the context of an ex gratia award of £30,000, he accepted, at the point of facilitation without requiring facilitation to take place, he accepted a PA award of 15.5; isn't that right?

A. He did actually go to facilitation - Dr. Joe Gaston was the facilitator - but he didn't go to appeal. So yes, before the appeal he accepted the 15.5 programmed activities.

73 Q. Dr. Gaston. If we just pull up WIT-90102. It's recorded that:

"During the review of the diary card, it became apparent that Mr. O'Brien spent a considerable amount of time on patient administration. This was significantly above the average for his colleagues and the other general surgeons. Although no adjustment was made, it was felt that this should be addressed in the future".

Just dwelling on that, Mr. O'Brien, of course, wasn't a general surgeon? 10:43

A. No.

74 Q. The comparison here, the appropriate comparison I suppose, should only have been with Mr. Young; is that fair?

A. That's fair, yes. 10:44

75 Q. Mr. Young was also awarded 15.5 PAs?

A. Yes, I believe so.

76 Q. What it says there about no adjustment being made but it was felt that this should be addressed in the future, I interpret that as a reference to 10:44 Mr. O'Brien's administrative workload or how he approached his administrative workload?

A. I think what that refers to is the fact that when Dr. Gaston was providing facilitation, he was looking at the work that had already been completed. 10:44

77 Q. Yes.

A. So it was a retrospective review in terms of giving an award of PAs. So he was making the point that whilst he couldn't do anything to change what had gone before,

it was something that should be considered into the future.

78 Q. Yes. Was any initiative taken to the best of your knowledge by the Trust, or by HR specifically, in relation to the issue of administrative workload? 10:45
Clearly Mr. O'Brien had his perspective and perhaps the Trust had a different perspective. Whatever the views might have been, can you recall any initiative taken to focus on that issue?

A. I just remember it was passed back to the relevant 10:45
operational and the management teams but I'm sorry, I don't know exactly what was -- how it was taken forward.

79 Q. Because I think you will recognise this, that as matters moved forward, administration on the part of 10:46
Mr. O'Brien, his delivery of administrative tasks and, if I may say so, his failure or his inability to deliver on those administrative tasks was to be a key factor of consideration in the MHPS process; isn't that right? 10:46

A. That's right.

80 Q. We can see the seed for that quite a long way back --

A. Mm-hmm.

81 Q. -- in his career within the Trust. Just before leaving that, just the issue of the ex gratia payment, were you 10:46
unaware that such a payment had been made at the time?

A. I was aware, I didn't know any details around it. I think from memory now there was correspondence further back with -- between Mr. O'Brien about what

this was about. But at the time it was directly a Chief Executive issue with him. I was involved because I was involved in formulating the final offer letters for consultants on the back of the consultant contracts, so I was aware of it from that perspective but I didn't know the context behind it at all at that stage.

82 Q. Do you recognise now that it was paid to him pursuant to an application made on the basis of the extra work required of him in the early years of the service? 10:47

A. That's my understanding. There was an earlier letter that he had written quite some time before around working on his own or without a registrar, or something along those lines, and I think it was something in connection with all of that. 10:48

83 Q. Mm-hmm. But to put it in its proper context, it was a recognition that he was carrying out a heavy burden of work --

A. Yes.

84 Q. -- in the delivery of urology services? 10:48

A. That's my understanding.

85 Q. The 15.5 PAs that were awarded following facilitation with Dr. Gaston were to be significantly reduced by the time of the next facilitation in 2012; isn't that right? 10:48

A. That's correct.

86 Q. You have commented in your witness statement at WIT-90034, paragraph 1.13, how he was offered 12.75 PAs with effect from 1st October 2011, to revert to 12 PAs

from 1st March 2012. Your colleague, Martin Clegg, oversaw this process from a HR process?

A. That's correct.

87 Q. The reduction in PAs through that process, does that suggest that the requirements of the job had reduced? 10:49

A. I'm not a 100% sure I have all the details in front of me in terms of when they moved to that. I know they got funding in 2012 for the five consultant models, so there may well have been more consultants joining the team. I wasn't involved with the facilitation so I'm 10:49 not sure that featured as part of it. Certainly there would have been an expectation that what work was being delivered was put into a job plan and that's what you are asked to deliver. There's probably lots of services where there's expectation to go over and above 10:50 that, but it's the contractual commitment that we want to agree that that's what you are required to do. So, I don't know anything further than that.

88 Q. You are aware that Mr. O'Brien accepted the outcome of facilitation resignedly and not, if you like, with 10:50 a good heart?

A. Mm-hmm.

89 Q. What I mean by that description is reflected in the correspondence he sent after the process was completed. If we go to WIT-90292, you can see he wrote to 10:51 Mr. Clegg. The last paragraph reflects his concerns. He says he now feels:

"... compelled to accept the amended job plan from

1st October 2011. Even know I neither agree with it or find it acceptable, I have endeavoured to ensure that management is fully aware of the time which I believe is required to undertake clinical duties and responsibilities included in the job plan to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure I only spend that time allocated whilst believing that it will be inadequate". 10:51 10:52

That is clearly firing a warning across to the Trust about the doability of the work that was required of him; isn't that right?

A. It appears. Yes, absolutely.

90 Q. Mr. Mackle wrote upon receipt of that. Could you just look at that at WIT-90291. You can see Mr. Clegg is copied into that. He is dealing with Mr. O'Brien's response to facilitation. There has been some correspondence already and the Trust's position is reduced to: 10:52 10:53

"This will undoubtedly require you, Mr. O'Brien, to change your current working practices and administration methods. The Trust will provide any advance and support it can to assist you with this". 10:53

Mr. Mackle arranged a meeting, it seems. He says that the meeting was cancelled by Mr. O'Brien, and he writes into the conclusion of his letter an assumption that:

"If you are not in contact with us, then we will proceed on the basis that you do not require any support to adjust your working practices".

Now, can you recall was that the subject of discussion with you at any point?

A. I don't remember this. I can't say for sure but I don't remember it at the time being discussed. Obviously I have looked at it subsequently to coming here but I don't recall being involved at the time. I may well have been but I don't think I was copied into those emails so --

91 Q. Mm-hmm.

A. -- I don't remember it.

92 Q. What we do know is that by December 2016, there are all sorts of administration-type issues associated with Mr. O'Brien's clinical practice which are so alarming for the Trust, the Trust would say it necessitated an MHPS process.

A. Mm-hmm.

93 Q. But what we can see is that from 2006/2007, at the time of the original facilitation with Dr. Gaston, 2012 facilitation with Dr. Murphy with Mr. Mackle's awareness and Mr. Clegg's awareness of a challenge from Mr. O'Brien as to the viability of his job plan, and doesn't it appear to have encouraged the Trust to come up with a plan to address that challenge? Is that a fair analysis?

A. Yes, I think that's fair.
94 Q. If that had been drawn to your attention, what would you have been saying? What would you have been thinking in terms of the options to address this?
A. I mean I can't say for sure but obviously thinking back now, I mean, I would have had a very close working relationship with both the Medical Director -- and I know as far back as 2012 we would have used NCAS, at least on five or six occasions, to undertake a detailed action plan. So it sounds to me like that's what was needed here in relation to identifying it early and getting in there with a performance action plan to ensure that it was set out in that formalised manner. We successfully used those on a number of occasions as far back as 2011/20 12, so I can only assume that that might have been something we could have considered at that time. 10:56 10:56 10:56
95 Q. You do draw attention in your statement to an event or an incident or a series of incidents in 2013, where two specialist registrars working within Urology were found to be working in excess of 60 hours per week? 10:57
A. Mm-hmm.
96 Q. This was obviously not compliant with the Working Time Regulations that were in place, and arrangements had to be made with general surgery to provide cover to address that problem? 10:57
A. That's right.
97 Q. This is paragraph 1.20 of your witness statement; we don't need to bring it up to the screen. What I want

to ask you is this: Was there an appreciation that Urology, and those who worked within the Service, were finding it very challenging to deliver what was required of them, or was Urology regarded as, I suppose, no different to other challenging services?

A. I think at that time surgical services in general were a challenge. We had the Board Liaison Group available to us back then. There was our regional group that was chaired by a medical director and had a medical project officer on it, which would have been a junior -- a senior junior doctor taking time out of practice to work on the Board Liaison Group.

CHAIR: Ms. Parks, if I can just ask you to take it a little more slowly. Thank you.

A. And they moved around Trusts to give advice on rotas. We worked very closely with them in relation to Urology. They would have come down and met with us and discussed what options were available. It was a body that then followed up with the Medical Director at the time to see what was happening. We could apply for funding from the Board Liaison Group. Unfortunately, Board Liaison Group, it doesn't -- I think it last met in 2014 so it's not a feature any longer, which is unfortunate. But they were very helpful in terms of addressing those sorts of things. They did come down and help us with Urology and we then got a new working pattern in place that was compliant for Urology.

We only had two training numbers in Urology, so we were

also relying on recruiting research fellows or clinical fellows to work on that rota. So, it was a challenge in terms of those factors but certainly it was very much -- I think I remember it was on the Risk Register with the Medical Director and HR Director at that time until we got the new working pattern in place and resolved for them.

98 Q. I want to turn briefly to look at the issue of how Mr. O'Brien was managed and the extent to which HR knew of any difficulties in management relations. You have set out in your statement - if we just bring it up briefly - at WIT-90036, and at the bottom of the page, 1.19 -- just keep it on the screen and I will do my best to summarise. On 30th January, Dr. Rankin directed you to a complaint that had come in from Mr. O'Brien in respect of a financial issue? 10:59 11:00 11:00

A. Mm-hmm.

99 Q. He had made a claim for some extra-contractual work and he hadn't been paid all that he believed he was entitled to receive. Do you remember that? 11:01

A. I do remember that, yes.

100 Q. If we could briefly open his letter that you would have looked at at the time, WIT-90380. That's him writing on 30th January. Essentially he is saying that the payments he was due to receive for Friday working had been halved? 11:01

A. Mm-hmm.

101 Q. You looked at that issue; isn't that right?

A. That's correct.

102 Q. And you spoke to Mr. Mackle and Mrs. Trouton in respect of it?
A. That's correct.
103 Q. As a product of your investigations, you were able to establish that Mr. Mackle had authorised the reduction -- 11:02
A. Mm-hmm.
104 Q. -- in the claim made by Mr. O'Brien. He had done that because he had interpreted the situation as arising out of an understanding that some of this work would have been covered by Mr. O'Brien's normal programmed activities? 11:02
A. I believe that's the case, yes.
105 Q. But he accepted that he had not gone through the appropriate process in making the deduction, and he agreed that he should relent and Mr. O'Brien should receive the full payment as claimed? 11:03
A. That's correct.
106 Q. Is that an appropriate summary? Is there anything incorrect in terms of what I have said -- 11:03
A. No.
107 Q. -- just to get through this?
A. That's all correct.
108 Q. I'm obliged, thank you. You were then able to write. I think we can see that at WIT-90379. You were able to write to the salaries department, or the pay department, I suppose? 11:03
A. Mm-hmm.
109 Q. And you explain there what had happened.

"These claims were changed by the Associate Medical Director, Mr. Mackle. Spoken to Mr. Mackle and Mrs. Trouton and it seems there's some misunderstanding about what had been agreed against his job plan. However, they agreed to concede as changes shouldn't have taken place without prior discussion with Mr. O'Brien".

Did you regard this issue as clearly a financial one?

A. I did, yes. 11:04

110 Q. There was no suggestion in how it was communicated to you as being an issue to do with harassment or bullying or anything like that?

A. No, there wasn't.

111 Q. Now, this was early 2012, and clearly the matter was resolved, as you've described. At or about that time, Mr. Mackle became aware of an allegation or a complaint that he was being -- it was said of him, he was told, that he had been harassing Mr. O'Brien. I just want to show you what Mr. Mackle has said about that. It's WIT-11769. At paragraph 92 of his statement, he says: 11:04 11:05

"Although I am unsure of the exact date in 2012", he was informed that the Chair of the Trust, Mrs. Roberta Brownlee: "Reported to senior management that Aidan O'Brien had made a complaint to her that I", that is Mr. Mackle, "had been bullying and harassing him". 11:05

He was called into an office on the administration

floor of the hospital to be informed of the accusation. He was advised that he needed to be very careful where he was concerned from then on. He recalls being absolutely gutted by the accusation and left and went down a corridor to Mrs. Corrigan's office. 11:06

"Mrs. Corrigan immediately asked what was wrong and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said that 11:06 I told her at the time it was Helen Walker, Assistant Director of the HR. I now have a memory of same but can't be 100% sure that it is correct. I recall having a conversation with Dr. Rankin, who advised that for my sake, I should step back from overseeing Urology and I 11:06 was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by Head of Service or the Assistant Director. As a result I instructed Robin Brown to act 11:07 on all governance issues regarding Urology, and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson" --

He was the Medical Director; is that correct? 11:07

A. That's right.

112 Q. -- "I advised of the issue and the change in governance structure in Urology. There was no formal investigation of the complaints, and I checked with Zoe

Parks, Head of Medical HR, and she says that there's no record on my file of the accusation".

Is that last bit correct, that he did at some point check with you? 11:07

A. Yes, yes, he did.

113 Q. And before I ask you about that, and I want to set Mr. O'Brien's recollections or an aspect of his recollections aside, what Mr. Mackle has recorded there. If we go to AOB-56083. This is a transcript of 11:08 a meeting that took place between Mr. O'Brien and his son Michael O'Brien with a gentleman called John Wilkinson, who is a Trust Board member --

A. Mm-hmm.

114 Q. -- and was the Trust Board member appointed to oversee, 11:08 if you like, the MHPS investigation. It dates from the spring of 2017. Mr. Michael O'Brien, at the top of the page. The context here is a discussion around the March 2016 meeting between Mr. Mackle and Mr. O'Brien at which a letter was handed over and Mr. O'Brien was 11:09 asked to provide a plan to address concerns about his practice. Michael O'Brien says:

"There is also another issue with regard to this March 2016 meeting and that is that, whilst I don't want to 11:09 personalise the issue, Mr. Mackle should not have been involved at all because my father had had a form of grievance against Mr. Mackle".

Now, that grievance was effectively -- was stayed effectively, I should say.

Mr. O'Brien says:

11:09

"I suspended it on condition that I could initiate it again at any time in the future, which I haven't done. And you know one can only speculate as to whether this letter would have followed up with some kind of informal attempt to resolve the issues had it been someone other than Eamon but in a sense that's secondary to the fact that there was no informal process".

11:09

Just scrolling down the page so we can see the bottom of the page. Mr. Michael O'Brien, towards the bottom, says:

11:10

"It had also been agreed at the time or around the time the grievances were being issued, that he would have no dealings with him", - that's Mackle would have no dealings with Mr. O'Brien - "again".

11:10

Mr. O'Brien then comes in and says:

11:10

"Yes, I sought and obtained an assurance from Dr. Rankin and from Eamon Mackle himself, particularly from Dr. Rankin, that I would have no more dealings or meetings with him because I was on the point of

breakdown as a consequence of his treatment over a period of years".

Just over the page, I think, just to finish this:

"Was this agreement before this letter" - that's the March 2016 letter was issued - "absolutely years before, yes".

So, some issues arising out of all of that, Ms. Parks. First of all, as Medical Human Resources, were you aware of any of this?

A. No awareness at all.

115 Q. Specifically were you aware of any complaint, formal or informal, whispered, behind the scenes or however it might be described, that Mr. Mackle had or was alleged to have been bullying or harassing Mr. O'Brien?

A. No, I wasn't aware.

116 Q. Again, specifically were you told that there had been, if you like, a change in managerial arrangements in that the Associate Medical Director, Mr. Mackle, would and should stand back because of advice given by someone in HR from directly engaging with Mr. O'Brien on any issue?

A. No, I wasn't aware.

117 Q. It does appear, marrying the two accounts together, that something of that nature has happened?

A. Honestly, I have no recollection. Not to my awareness. I'm not aware of anything.

118 Q. Yes. Plainly, if something like that had happened --
A. Mm-hmm.
119 Q. -- Medical HR should have been engaged on the issue; is that fair?
A. Definitely, yes. 11:13
120 Q. As you've said earlier, you were dealing with, in 2012, what you regarded as a purely financial issue?
A. That's right.
121 Q. Mr. O'Brien, in that transcript, has said that essentially the grievance was stayed and he had 11:13
advised - he doesn't say who he advised - but he spoke to the ability to be able to reignite or reinitiate that grievance at any point in the future. Is that your understanding of how it was brought to an end?
A. No. Reading back over his email now, I can see those 11:13
words were used, but at the time I didn't even view it as a grievance because it didn't get to a grievance panel. It was a matter that was brought to attention and it was quickly resolved, so it didn't actually need to go anywhere further than that. That was my 11:14
understanding. And certainly in my interactions with Mr. O'Brien when advising him of the outcome, I was led to believe he was content with that. I mean, obviously if anyone has a grievance to raise, they can raise it at any time in the future about any issue but there 11:14
wouldn't be a practice of holding a grievance on stay like that. That wouldn't be a normal practice.
122 Q. It's fair to say, isn't it, as well that allegations of harassment, if they are raised, should be investigated?

A. Investigated, absolutely.

123 Q. It would also be fair to say, would it, that a chairperson of the Trust Board shouldn't be making representations on behalf of a clinician of this nature unless there had been some agreement with that clinician to do so? 11:15

A. Sorry, I don't follow you there.

124 Q. It's suggested in what Mr. Mackle describes --

A. Oh, yes.

125 Q. -- that Mrs. Brownlee, chairperson of the Board, had made these representations, alleging harassment on the part of Mackle against O'Brien. That is not an appropriate approach, is it? 11:15

A. No, it's not.

126 Q. In terms of medical management, we have seen, through the evidence received by the Inquiry, that over a period of several years of this, obviously leading to the events of '16 and '17 and the initiation of the MHPS process, that there were issues in relation to Mr. O'Brien's practice that were causing the Trust concern, and specifically Mr. Mackle concern? 11:15 11:16

A. Mm-hmm.

127 Q. He had engaged with Mr. O'Brien on a range of issues, including triage, keeping notes at home. He dealt with Mr. O'Brien in the context of an intravenous antibiotic issue, a benign cystectomy issue. There was debates about the ward for urology patients between Mr. Mackle and Mr. O'Brien. There was an engagement between them on the issue of his job plan, as we have seen. 11:16

A. Mm-hmm.
128 Q. Taking Mr. Mackle out of his role as Associate Medical Director, if that's the way it happened, would have left a less than optimal management arrangement where it was most needed. Is that a fair thing to say? 11:17
A. I think that's fair, yes.
129 Q. You were the HR input into an investigation conducted alongside Mr. Brown in relation to Mr. O'Brien's admitted disposal of some extracts or sections from a patient's chart, his disposal of those into a waste 11:18 bin?
A. Mm-hmm.
130 Q. That investigation took place, I think, in 2011; isn't that right?
A. I think so, yes. 11:18
131 Q. You have said in your witness statement -- if we pull up WIT-90034. You have said - if we scroll down, please - that it was understood by you and Mr. Brown that this was an isolated incident and resulted in an informal warning. You go on in your witness 11:19 statement - if we go on down to WIT-90067 - at paragraph 28.1, that you are concerned to read in the context of the public inquiry that there were ongoing issues with the management of patient charts with Mr. O'Brien storing a large volume of these at home, so 11:19 an issue that is somewhat different in nature to disposing of some part of a patient's record in a bin?
A. Mm-hmm.
132 Q. But your concern is that it's generally of the same

nature or same kind of concern, the confidentiality aspect, perhaps, of patients' records. Is that the way you were looking at it when you discovered this?

A. Yes, yes.

133 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. 11:20 11:21

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. 11:21

134 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. 11:21

135 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 11:22

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. 11:23

136 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; 11:23 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.

137 Q. How would you explain that? Is that explicable, that 11:24 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 11:25 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. 11:25

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. 11:25 11:26 11:26

138 Q. Was your office regularly the source of advice to services within the Trust in relation to medical performance or is that something that is only later developed and matured in recent years? 11:26

A. I would say certainly it's an area that has grown. Probably traditionally years ago they would have gone

directly to the Medical Director and had a conversation. I think over the years we have had a much closer working relationship with the Medical Director. We have developed more formal mechanisms through our monthly meetings and things to have discussions around. I think that in itself has generated then outside of those meetings, those clinical managers would contact us much more regularly just for day-to-day advice on how to handle things. 11:27

139 Q. Yes. Of course there was, as we saw earlier, an opportunity for HR, from another angle back in 2012 at the time of facilitation, to have involved itself in addressing what Mr. O'Brien was saying were his needs in relation to his job plan, and that crossroads moment, perhaps, or fork in the road moment, perhaps, wasn't grasped by HR when it was there in front of them. Nobody saw fit, as you have suggested this morning, to think of developing, in conjunction perhaps with NCAS, an action plan? 11:27 11:28

A. Yeah. I think that's unfortunate. 11:28

140 Q. Yes. I mean, given the issues that were to come into play as part of MHPS, I mean, looking back at that, they were administrative-type issues directly linked into the clinical practice of Mr. O'Brien. The MHPS issues, they were potentially the issues that could have been looked at at the point in 2012 when he was clearly saying I haven't got enough hours here in my job plan to deliver? 11:28

A. Mm-hmm, yes.

141 Q. You were on maternity leave, as I understand it, in 2016 when Mr. Mackle and Mrs. Corrigan sat down with Mr. O'Brien on what it made clear to the Inquiry was the first - I use the word "formal" advisedly - but the first sit-down we're dealing with these issues with you now and here is a plan, a request for a plan? 11:29

A. Mm-hmm.

142 Q. You were off at that time?

A. That's right, yes.

143 Q. So I will use "formal" in that context, and I know that's not a terribly helpful word in that context because it wasn't the start of a formal process, as such. 11:29

A. Mm-hmm.

144 Q. But you have said in your statement - this is paragraph 38.2 - you believe that it would have been helpful for management to have sought specialist HR advice at that point in time. What could HR advice have brought to the piece that you think, with the obvious benefit of hindsight, might have enabled things to proceed better? 11:29 11:30

A. For me, the critical factor in managing concerns is that initial scoping of the concern and really taking a deep dive at that process to understand what was going on. I think that's the role of the clinical manager to assess the risk of what is facing them in front of them, and understand from a bird's-eye view, take a look, a wider look, to see what's going on so that the risk to patients can be tackled at that point, because obviously that's what it says, if you have 11:30

a concern about a practitioner's practice, the first thing you ascertain is what you are dealing with and establish the level of risk associated and then put immediate plans in place to address that risk.

11:31

I think that would have been for me what should have happened at that point, if not prior to that but certainly at that point, in terms of getting a really good idea of exactly what was going on and then ensure there was a robust plan in place to address that. 11:31
I know certainly, because we had been working with Dr. Simpson as Medical Director, we had been through, as I said previously, at least five or so action plans, which would have included consultant action plans. So, something like that would have been something I think 11:31
we would have been considering, as opposed to letting it drift on.

145 Q. If your office had been approached in March, the key reflection you are offering is that you would have been well-placed to advise on how this process should start, 11:32
if a process is to be started. You would have suggested a need for a clear understanding of what the problems are, and that would have necessitated what you have called a deep dive?

A. Yes, I think, yes. 11:32

146 Q. Within your statement, you go on and deliver a number of key reflections about what might have been done better --

A. Mm-hmm.

147 Q. -- over the period of -- particularly before the investigation starts, and you reflect a number of specific practical as well as cultural shortcomings. I think if we take a short break now, we will take up with those just after. 11:33

CHAIR: A quarter to 12.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone. 11:52

148 Q. MR. WOLFE KC: Now, just before the break, Ms. Parks, you were outlining your view of what you would have done if HR had been consulted in March 2016. I readily appreciate you weren't at work at that time and you wouldn't have been in a position to provide advice for 11:53 that reason, in any event.

If we turn to an important part of your witness statement, which I know the Panel will consider with interest. It's WIT-90075. At the bottom of the page 11:53 from paragraph 38, running, I think, all the way through to paragraph 40, you set out some key learnings from your understanding - undoubtedly with the benefit of some hindsight and as a bystander as such - but some key reflections of what you think could have been done 11:54 better in association with the investigation, or indeed the beginnings to the investigation, into Mr. O'Brien's practice. If we scroll down to the next page, please, you say at 38.3, and this is sort of repeating what you

have said just before the break:

"It is incumbent upon a clinical manager to take a deeper dive and scope to establish the full nature of concern". 11:55

You borrow from the MHPS framework the need to take into account the importance of the continued safety of the patient or the member of the public, and, for that reason, try to get to grips with every aspect of the 11:55 problem?

A. Certainly, yes.

149 Q. You say - scrolling on down at 39.1 - that, on your understanding of what had happened, there was a need to establish the facts but it is not clear to you what 11:55 action was taken following the meeting in March. You don't believe that it was appropriate, given the significant concerns, to ask for an immediate plan. You think the threshold for an investigation had been met and that's the area that should have been the 11:56 focus. Is that fair?

A. I think what I mean by that is when you establish a concern, either you decide that you can handle and manage it informally, but if you don't have all the information and you need more information, then the 11:56 means to do that is through a formal investigation to get to the crux of it. But I think, yeah, that proper scoping at the outset would have facilitated the right path to follow. Whether an action plan could have been

put in to address it or whether more formal method would have been necessary, probably would have depended upon that extent, the full extent of that scoping being completed, and drawing all of the issues out at that stage, if possible. 11:57

150 Q. Mm-hmm. Leaving aside this case, perhaps, the specifics of this case and bring it up to the more general, you talk about scoping quite a bit in your statement?

A. Mm-hmm. 11:57

151 Q. You talk about the need to make inquiries and to triangulate. We will go on in a minute perhaps to look at the paragraph, but at paragraph 40.2, you say that governance systems need to be strengthened to permit the triangulation of data for clinical managers. 11:57

In the scoping context, bearing in mind your experience of using MHPS, what, from a HR perspective, is possible when performing scoping?

A. I think you are looking at all aspects of the practitioner's practice. You are looking at all of the information that's available to you in terms of all of the various different information systems that the Trust has, appraisal, job planning, you know, complaints; all of those information systems. As a clinical manager, you are trying to establish the level of risk, so you need to consult as much information as you can and look at what information you have in front of you to help you to determine that 11:58 11:58

risk. There's probably not an awful lot mentioned in MHPS about how that process is undertaken. I know we have subsequently worked up some guidance on helping clinical managers because it is a difficult decision to use their professional judgment, but to possibly utilise some of the tools around forming a judgment, call around the level of risk and what action is needed. 11:58

152 Q. I am just going to slow you up.

A. Sorry. 11:59

153 Q. This is possibly important stuff. What was investigated here, if I may say so in the specific case, what was in relatively plain sight, issues that had been known about for years. Does your answer suggest when you have issues of concern that are in plain sight, that you are entitled, and indeed must, follow your nose a little further and see what else there might be of concern in a practitioner's practice that may not just be as obvious? 11:59

A. I think that's the responsibility, yes, of a manager who is looking after staff, if something comes to their attention, that they establish is that all they need to know about, so they do look a bit further just to get their facts and get the root cause established. 11:59

154 Q. Does this involve -- and you put a great onus on the immediate clinical manager, which I suppose can you just define that for us? Is that the Clinical Lead or is it the Clinical Director, or could it be either depending on the circumstances? 12:00

A. It could be either but in management terms, I suppose, it's the clinical manager who has the clinical management responsibility for the staff.

155 Q. Yes. That's the Clinical Director, generally?

A. Yes. 12:00

156 Q. I mean, would such a scoping exercise possibly involve speaking to people, speaking to colleagues who might know things that they haven't revealed or said before?

A. I think, yes. I mean, at this stage they are just trying to get a sense of what's going on, so they need 12:00 to make some inquiries to determine that.

157 Q. But it's on the basis, I suppose, of an established concern?

A. Yes.

158 Q. I suppose from an employee perspective, it might be 12:01 frowned upon if an employer went poking its nose where there was no grounds for suspicion; is that fair?

A. Yeah, it's not a -- it's not a, you know, I suppose a whole-out investigation, going fishing for something. It's just making some inquiries as a manager, do I have 12:01 all the facts in front of me.

159 Q. If we scroll. You say at 39.2 -- this is again a point about a robust review being undertaken as part of preliminary inquiries. Just scrolling down to the top of that page, yes. You place the onus on the immediate 12:01 line manager, as you describe it. It's important that the task of conducting this screening exercise, that preliminary inquiries rests with that immediate line manager to avoid what you describe as any possible

disconnect.

What does that phrase convey?

A. I think it's important that it's the immediate line manager, they are closest to the practitioner, closest to the service and to the patient and they understand the local systems that are in operation within that area, so they are the most likely person to understand how to complete that screening appropriately and thoroughly, and they understand what information will mean in their area. I think it's important that it's the clinical manager to undertake that for those reasons, so that they, you know, have a good understanding of what to look for and what the information is telling them. 12:02

160 Q. I think you go on at 39.4, if we just scroll down, to express your puzzlement that an assistant director in the Medical Director's office was the person charged with responsibility of carrying out a screening exercise? 12:03

A. Mm-hmm.

161 Q. That's an inappropriate role for such a person, in your view?

A. Yeah, it wouldn't be usual. That wouldn't be normally how it's managed. 12:03

162 Q. Yes. Yet that was how it was set up or established by a medical director, Dr. Wright, who has told the Inquiry that he has significant experience in the conduct of MHPS processes, and it was a role given to

Mr. Gibson which Mrs. Toal, albeit after the work had been done, would have known about, and she's an experienced HR professional.

Does this suggest, the fact that Mr. Gibson conducted this role, suggest either that the requirements of MHPS were not well understood or that people with responsibility within the Trust felt that there was an à la carte approach available to them when working through an MHPS process? 12:04

A. Yeah, I think you are probably right. For me, the MHPS processes don't replace the normal line management and don't supercede those at any stage, or shouldn't. They are essentially a HR process at the core for managing concerns. But ongoing line management has to continue throughout that whole process and it's a continuous process, so they certainly shouldn't be lifted out as a separate process. That's my view in terms of just that the ongoing line management has to -- it's a continuous process that should sit out right through that. There's designated roles within MHPS to manage a HR process of established concerns but that should continue throughout that. 12:04 12:05 12:05

163 Q. Yes. While it's quite clear from the guidance which is produced, and indeed within MHPS, that the role does belong to the line manager -- 12:05

A. Mm-hmm.

164 Q. -- it may be the case, however, in particular circumstances that the process could be compounded if

the immediate line manager is too close or disinterested or fails to engage on the issues. The Inquiry has heard evidence that, while a decision was taken by Oversight committee to follow a particular process which had the MHPS label on it in September 2016, to the exclusion of the immediate line manager, when this issue was raised with the immediate line manager, that's the Clinical Director Mr. Weir, and with the Associate Medical Director, Dr. McAllister, that there was on the evidence so far - and I don't prejudge where the case takes us - but there was, expressed through some of the evidence we have heard a decision to step away from MHPS and the process that the Oversight Committee had determined. Some of the explanations for that might be - and certainly it was expressed in emails by Mrs. Gishkori - and I paraphrase here, that these issues don't need to go in that direction; Mr. O'Brien has delivered for the Trust in the past, he's an experienced man and we feel that we can - the local management - feel we can take this in another way. 12:06 12:07 12:07 12:08

What I put to you is that there's a job of work to do, is there, culturally around understanding when MHPS is appropriate? 12:08

A. Yes, I'd agree with that.

165 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. 12:09

166 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". 12:10

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.

167 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? 12:10

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. 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. 12:11 12:11 12:12

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 12:12

and encouragement to take on some of those issues.

168 Q. Thank you for that. Scroll down a little. I thought it was paragraph 40.2, but you did use the phrase "Governance systems need to be strengthened to triangulate data for Clinical Managers". 12:12

Have you a sense of how that can be done? What needs to be done within the Trust's governance processes, or what perhaps has been done since this, to make the task of the clinical manager easier when doing the kind of 12:13 screening or robust inquiries that your reflections suggest are necessary?

A. It's maybe a little bit unfair for me to state that. In my statement and with retrospect, I suppose for my thinking I'm not aware of what those systems all look 12:13 like essentially, but I feel if there's any benefit in terms of technology or analytical tools or triangulation. I think it's a huge area in terms of trying to ensure when a clinical manager is making a decision, that the available information streams are 12:13 there to allow them. So, it's about ensuring that they are fully informed about -- so we will ensure they are fully informed about where consultants are with job plans or where they are at with appraisals, you know, so that they have all the information to hand. But I 12:14 am sure there's other information in terms of Datix, patient complaints. I am sure the governance team are working in relation to that in terms of just making sure that it's easy to triangulate information.

169 Q. Mm-hmm. Some work has been done in light of the experience of the Trust. They have been working through this particular, Mr. O'Brien's process, to try and improve matters; is that fair?

A. Yes. I think so, yes. We are all learning. 12:14

170 Q. We have heard from a number of managers, Mrs. Corrigan, Mrs. Trouton, Mr. Carroll on the operational side. They have told us variously that they really hadn't heard of MHPS at all until this process started. Mrs. Corrigan, in particular in her witness statement, 12:15 WIT-39881, said:

"I can confirm that after the concerns were raised regarding Mr. O'Brien, I became aware that MHPS Framework existed, and this awareness was mainly 12:15 through conversations with, in particular, Mrs. Hynds and Mr. Gibson. However, I can confirm I was never provided with a copy of the framework and I have never read or received training with regard to it".

12:15

I know that training is now in place and I will look at that with you in just a moment. Can you explain how, from your HR perspective, awareness of the MHPS framework wasn't built into management awareness, management training, before all of this happened? 12:16

A. I think it should have been. Certainly, probably the focus was down the clinical management line, and that's unfortunate. It should have covered all operational management as well because it would need to have been

aware that it was there.

171 Q. You have indicated in your statement -- and just bring it up on to the screen. I think it's a document the Inquiry has seen before when Mrs. Toal was giving evidence. WIT-90655. This is the training plan. 12:16
I think you are the author of it --

A. Mm-hmm.

172 Q. -- which was developed last year and is being rolled out this year, I think; is that right?

A. Yes, that's right. 12:16

173 Q. The Inquiry will know -- we don't need to look at this. You have addressed the issue perhaps that Mrs. Corrigan spoke about, in that training is now being provided to Boards, Board members?

A. Yes. 12:17

174 Q. Case Managers?

A. Mm-hmm.

175 Q. Investigators, Clinical Directors, Clinical Leads and Operational Assistant Directors; isn't that right?

A. And Heads of Service, yes. 12:17

176 Q. Yes. You also took up the role, after returning from maternity leave in 2017, of working up new Trust guidance to sit as a companion piece to MHPS, and new guidance, I think, was published towards the end of 2017. If we just briefly look at that, it's TRU-21031. 12:17
Yes. That's the document with contributions from some others that you put together?

A. Yes.

177 Q. Just in the interests of time, could you just distill

for us the key changes that you made to this guidance originally published in 2010 by the Trust. Is it fair to say that you had concerns around how the Oversight Group was being used?

A. Yes.

178 Q. Concerns around the role of the local or lead manager, and concerns around how informal approaches could be used?

A. Yes, that's correct. Those were the two key things that we had learned out of a number of cases coming forward, that the informal approach is not really mentioned at all within MHPS. So, we wanted to make sure that was a bit clearer for clinical managers.

Then the role of the Oversight, we wanted to ensure that it was very clear that that wasn't a decision-making role, that the decision-making in the context of formal investigation obviously sits with the Case Manager, but they are there to provide a sounding board and advice. It was just to clarify some of those things that we were finding. The Case Managers were maybe relying on the Oversight for decisions, so we needed to ensure that that was corrected.

179 Q. Thank you. You have also spoken in your statement about what you described as the complexity of MHPS and how it has the potential to mislead those who have less experience of using it leading to a lack of confidence, you say, around handling concerns efficiently and compliantly with MHPS?

12:19
12:19
12:19
12:19
12:20

A. Mm-hmm.

180 Q. Just in that context, you have said in your statement that the Trust has been given authority recently to appoint a Band 7 MHPS Case Manager?

A. No. What I mean is a HR manager within my team to support, because probably any of the cases would have been myself taking them forward. So, it's an additional resource to work in my team so that we have more people trained up in the handling so we can work alongside our clinical managers when we are managing a case. 12:20 12:21

181 Q. Okay. Is the idea that the appointment of someone like that taking a specific interest in MHPS will enable a smoother process to help advise the clinical managers on how to conduct MHPS, to de-mystify it, perhaps? 12:21

A. Yes. I think it's additional capacity that we can ensure that the training is rolled out and continues to be rolled out; that there's more assistance with the reporting that goes with it. So all of the -- just making sure we have got a bit more capacity to actually ensure that's fully embedded appropriately. 12:21

182 Q. If we go back to your statement at WIT-90073. At paragraph 35.7, just scrolling down:

"There are factors within MHPS framework that need greater clarity such as clear definitions of all the roles referred to in the document". 12:22

You go on here to express concern that the framework

doesn't provide the clear practical steps or sufficient clarity around the steps that a clinical manager needs to perform?

A. Mm-hmm.

183 Q. You say that another issue is that it's unclear whether a case manager can take soundings before reaching a decision; that is have conversations, as we discussed earlier? 12:22

A. Mm-hmm.

184 Q. And you do think it's appropriate? 12:23

A. Yes, absolutely.

185 Q. You point out that there's no adequate definition of the word "concern", which is, as you have explained, the trigger --

A. Mm-hmm. 12:23

186 Q. -- for moving forward?

A. Yes.

187 Q. Professional misconduct is not defined; intractable problems isn't defined; various things like that. You also say that it's not clear how far confidentiality within the process extends? 12:23

A. Mm-hmm.

188 Q. Could I just have your final thoughts on that. In terms of MHPS, is it fair to say that you think it wasn't well used in this case? 12:23

A. I think that's fair.

189 Q. Are you now confident that the Trust is in a better place in terms of its ability to use it compliantly --

A. Yes.

190 Q. -- going forward?
A. Yes.
191 Q. Just another feature of the improvements before we leave it altogether. It says within the guidelines that you have published in 2017 that there's a obligation at the end of an MHPS process for a medical director and the - is it the head of service - to report to SMT for learning purposes about the experiences of the particular process that was undertaken; that wasn't well-used in the past? 12:24
A. No. It's something we have added as like a shared learning, you know, for the Case Manager to summarise in terms of shared learning that can go back and be fed back to the director and the service; that they may want to pick up on issues that maybe came out of an investigation, maybe not necessarily resulting -- linked to that individual that's being subject to the MHPS, but that would warrant some benefit of being looked and shared widely across the service or across the Trust as appropriate. So, each of our clinical case managers would be asked to reflect on that at the end of a case, at the Oversight meeting, to discuss what needs to be fed back into the organisation, and then that's captured on the reports that we send to the governance committees. 12:25
192 Q. Now, we touched on it indirectly but you have some observations to make about the lot of the medical manager and the challenges that are faced in that role.
A. Mm-hmm.

193 Q. You say at paragraph 41.2 of your statement that, "Consideration needs to be given to how medical management role can work better and how it can be better supported".

12:26

If we pull up WIT-90066. At 26.2, just in the last few lines there, you are setting out the contextual problems faced within this particular investigation because of the changing in management roles; Dr. McAllister taking on a second role --

12:26

A. Yes.

194 Q. -- at that time. You say, I think more generally:

"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".

12:27

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.

12:27

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.

195 Q. Again, practical suggestions here. Administrative support for clinical managers; whether management role is also something that needs to be considered. Paragraph 35.4: 12:28

"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. 12:29

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". 12:29

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? 12:29

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 12:30
taken to avoid any -- and to protect patients, and also to create good working relationships and good working environments for everyone involved.

196 Q. Can you give an example of the kinds of circumstances that you've seen pertaining where medical management 12:30
has worked best and has flourished? What has to be in place, and have you seen it in the Trust?

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 12:30
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 12:31
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. 12:31

197 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. 12:32

198 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 12:32 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 12:32 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. 12:33 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 12:33 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. 12:33

199 Q. Do you recognise the problem that I described, that the Southern Trust has had experience of appointing medical managers who, despite perhaps their best endeavours, are not able to deliver the level of commitment that the job self-evidently requires, but yet they continue 12:34 to be appointed to these roles, the roles are extended over time? Is it simply a case of there's not enough people putting their hands up to do it and the Trust has to, I suppose, accept what they can get, or do you not recognise the concern I paint? 12:34

A. No, I do recognise the concern you paint. I mean, I think it is a challenge and I think it's a challenge for all those reasons I have said in terms of the ability to release; probably more so in the surgical specialties which are known as craft specialties where 12:35 you struggle to get -- somebody has to make that choice that they want to leave their clinical practice somewhat behind and take on a management role. Or else there will be an element of deskilling; that's maybe less so in other specialties. It is difficult for 12:35 those to take on that role, understanding that they then are moving into a management role which is a very different skill set to clinical role.

200 Q. If there is one, is there a current big idea or big

project being pursued within the Trust around medical management? What is the state of play in terms of some of the practical suggestions that you have put in your statement as being good ideas for improving the lot of the medical manager? 12:36

A. I am probably not the best person. I know the medical management structure sits under the Medical Director's office and I know they have done a significant amount of work. Dr. O'Kane did that, and I think our current Medical Director is following that on and looking at the structure of clinical management. I think they might be better placed than me to sort of explain what that looks like, but I do know they are looking at that fairly... 12:36

201 Q. Can I ask you then some questions in relation to Mr. O'Brien's retirement -- 12:36

A. Yes.

202 Q. -- and the concern that he wished to be re-engaged, and the circumstances and the reasons why that didn't happen. You deal with aspects of this in your supplementary statement, which we have received recently. If we could put that on the screen, please, WIT-94910. Just back to paragraph 1, please. You take as your starting point 2018 and 2019 and increasing numbers of consultants indicating they were considering early retirement, something you think is to do with the taxation policy -- 12:36 12:37

A. Yes.

203 Q. -- of the Exchequer at that time. Within that context,

you were also starting to receive more queries from consultants around retire-and-return options. You explain in paragraph 2 that, I think towards sometime in 2019, you were engaged in a conversation with the BMA and this issue came up, and you learned that the Western Trust had done some work around this and had developed a set of guidance, and that guidance was provided to you? 12:38

A. That's correct.

204 Q. Paragraph 3. You had some engagement early in 2020 with Mrs. Toal? 12:38

A. Mm-hmm.

205 Q. You wanted to discuss that guidance document you had obtained from the Western Trust. Scrolling down. On down, please. Mrs. Toal responded, and the upshot of it was that this work could be taken forward and should be taken forward? 12:39

A. That's right.

206 Q. We can see at WIT-94915 that by July 2020, a final document, guidance document, had been developed. That wasn't in place at the point in time when Mr. O'Brien retired; is that right? 12:39

A. We didn't have a formal document, no.

207 Q. Could I just refer to one aspect of the document. It's the next page, sorry, 916. Just scroll to the bottom of the page. A process of reengagement is described. It says: 12:40

"The Service Director may conclude that there's no

alternative but to ask the clinician if he or she is willing to be re-engaged following their retirement. This conversation must take place while the clinician remains in the employment of the Trust and arrangements put in place prior to retirement date. But before to proceeding to re-engage a retired clinician, the Service Director should, in conjunction with a senior HR manager responsible for Medical HR, consider the following: That there are no outstanding or unresolved concerns regarding the clinician's overall performance and conduct, and that the clinician is medically fit to perform the role having demonstrated an acceptable level attendance subject to DDA requirements". 12:40 12:41

A. Mm-hmm. 12:41

208 Q. So that's the piece. I will come back to that piece as we look through the timeline here. Can I go back to your statement in this respect in WIT-94911, and take up paragraph 5, please. You recall that Mr. O'Brien contacted your colleague, Mr. Clegg, in February, to indicate that he was considering retirement. He requested the relevant application forms. You say he understands, having spoken to Mr. Clegg recently, that during the conversation there was a brief discussion on whether he could return to work post-retirement. Mr. Clegg advised this would not be an automatic, it would have to be discussed and approved by the Associate Medical Director. You say HR had no further involvement in these discussions at that time. 12:42 12:42

Now, if we look at TRU-01744. This is Martina Corrigan, 13th April 2020. She is attaching Mr. O'Brien's notice of retirement and she is asking for advice, "Is there anything further that I need to do with this, please?" You are one of the recipients of this, along with Mr. Clegg.

So, is it fair to say that you knew from at least April time that Mr. O'Brien wished to retire at the end of June and then return in August? 12:43

A. I wasn't aware that he wanted to return. I knew that he was planning to retire and had asked for the application forms.

209 Q. Mm-hmm. But did his application forms not demonstrate that he did wish to return? 12:44

A. Not that I'm aware. They don't come initially to me, these are forms that go off to the pension office to get the pension calculated. It wouldn't have indicated on that, to the best of my knowledge, no. 12:44

210 Q. Yes. Then if we could look at TRU-258960. Just the bottom of the page, please. This is two days later. This is Mr. Clegg advising Mr. Carroll, Mr. Haynes, Mr. Young.

12:44

"Mr. O'Brien's application for benefits is all in hand. He will be processed as a leaver on 30th June. I just need to know if it has been agreed for him to return to work following retirement and, if so, from what date,

as we will need to reinstate him to the payroll?"

A. Mm-hmm.

211 Q. Certainly Mr. Clegg had an awareness, as a result of receiving Mr. O'Brien's notice of retirement into the HR office, presumably through Mrs. Corrigan's correspondence -- 12:45

A. Yes.

212 Q. -- that this was what Mr. O'Brien was proposing?

A. Yes.

213 Q. Just if we scroll up the page, please. Ronan Carroll asked "If we are taking Aidan back? "Yes". Mark Haynes, only copying Ronan and Martina in, not, it appears, Mr. Clegg, has said: 12:45

"Needs more discussion than can be had at present. In short yes but with strings attached and these strings need to be clear and accepted before he is offered anything". 12:46

Now, it's fair to say that at that point in time, you were well aware, and indeed Mr. Clegg was well aware, that there were processes unfinished in connection with Mr. O'Brien's performance and/or conduct, the MHPS; there had been a referral to GMC at that point? 12:46

A. That's right. 12:46

214 Q. The MHPS leading to a grievance but with a potential for disciplinary; all those processes were still at large with the grievance?

A. Mm-hmm.

215 Q. Then just working our way along the timeline. There was a conversation between Mr. Haynes and Mr. O'Brien in the presence of Mr. Carroll. I think it was a telephone conversation on 8th June. Mr. O'Brien recorded the conversation but we know, broadly, that he was told that a decision had been made that he could not return. Did you know that that conversation was going to take place? 12:47

A. Between Mr. Haynes and Mr. O'Brien?

216 Q. Yes. 12:47

A. I don't recall. I mean, I know Mr. Haynes contacted me to ask for my advice and obviously I advised him in the way we always advise, that it's not an automatic right to passage to return. Obviously consultant decides when they want to retire, there's no retirement age, they make a choice when they decide to go. If they are wanting to return, the advice we always give is they have to seek to discuss that with their Assistant Medical Director and Director of Service because very often consultants -- and it wasn't common in the past, it was more common, as I said, because of the taxation issues, but sometimes they want to come back maybe on a lesser job plan, maybe not doing on-call. There's lots of different factors that have to be considered. It wouldn't have been automatic because there might be trainees coming through and we were able to recruit and it's not a hard-to-fill post. In other areas like Urology, it obviously is. So, it's a discussion that has to be had. I would have given Mr. Haynes the 12:48 12:48 12:48

advice in accordance with our guidance at that time. I don't believe I was aware when or how or what was discussed during the conversation.

217 Q. Yes. But there was a conversation, as I say, on 8th June? 12:49

A. Okay.

218 Q. If we go to TRU-163341, you have sent an email on 9th June --

A. Mm-hmm.

219 Q. -- to Mr. Haynes. You've explained in your witness statement at paragraph 6 - I don't need to bring it up - Mark Haynes asked you to provide him with a form of words, essentially, to allow him to respond to Mr. O'Brien, who wanted to have his explanation in writing? 12:49

A. Mm-hmm.

220 Q. Is it fair to call this a script --

A. Yes, it would be fair.

221 Q. -- that you provided to Mr. Haynes to send?

A. Yeah. I remember he asked me specifically could I put a form of words together. 12:49

222 Q. So, in terms of the decision to not permit Mr. O'Brien to return, you have known, or at least Mr. Clegg has known --

A. Yes. 12:50

223 Q. -- from three or four months previously that there's an interest in returning?

A. Mm-hmm.

224 Q. This is now 9th June. Why has it taken to 9th June to

advise Mr. O'Brien that the reason why he can't come back is something you've always known about, that the MHPS and GMC processes have not yet been concluded? Why couldn't he have been told that back in April?

A. He should have been, is my view. He should have been told earlier, he would have been able to be aware of that at the earliest possible opportunity. I don't know the reason why there was a delay or whether they were considering it at any point. I am not sure of that. 12:51

225 Q. Mm-hmm. You talk about speaking to Mr. Haynes about this issue. Did you mean to suggest that you had spoken to him in advance of this email to set out the policy to him?

A. He phoned me and asked me could I put a form of words in an email to him. 12:51

226 Q. Yes.

A. And that's exactly what he asked for, and then that was a quick phone call to say, look, I need a form of words in accordance with -- that I can respond; can you put a form of words together. Obviously I used our guidance as our guiding principles for how we would do that and e-mailed that back to him. 12:52

227 Q. Yes. Back in April, he's thinking Mr. O'Brien could return but with strings attached. We saw that email? 12:52

A. Mm-hmm.

228 Q. And on 8th June he is having this conversation with Mr. O'Brien to say no, you can't return?

A. Mm-hmm.

229 Q. Is it your evidence that during that period, nobody in HR engaged on that issue with Mr. Haynes?
A. No, the way -- I mean, normally what happens when a consultant indicates that they are going and is there an option, we very much say, look, that's for you -- because they are ending their permanent contract with us, they have given their notice, they are working their notice and if they are wanting to negotiate to go into a new contract, then that's very much left to them to go and discuss with their director and AMD and we will generally get advised by one or either parties that that has been agreed and this is the job plan that has been agreed for and this is the length of time that the new contract has been agreed for. It's not something we would proactively -- because, you know, they have given us notice that their permanent contract is ending, and until we are informed that an agreement has been reached with the director and AMD that a new contract can be formed, we wouldn't. I suppose we would leave that to the service to have those discussions. 12:52 12:53 12:53 12:53
230 Q. I am conscious that the guideline that we looked at earlier didn't become live, if you like, until July. If we just bring that up on the screen, please, again. It's WIT-94916. It says, just reminding ourselves, that under the process of reengagement: 12:53

"Before proceeding to re-engage, the Service Directors should, in conjunction with senior HR manager, consider

the following".

Mr. Clegg, and perhaps yourself in April, knowing that there were reasons why, looking at this policy, he shouldn't be returning, are you saying that despite this policy - I realise it didn't come into effect in July - that you didn't and Mr. Clegg didn't see fit to provide the advice that there are concerns about Mr. O'Brien's practice so that a return isn't really an option? 12:54 12:55

A. I think probably the purpose of having that in the guidance is to ensure that managers check, you know, for anything. I think the concerns were well-known within the Director and the Associate Medical Director. So, the checking mechanism, I suppose, in that situation was probably not necessary because they were fully aware of what those concerns were. I think that's the purpose of that there. 12:55

But the decision would be under our advice, which is the advice I give, but the decision is theirs in terms of whether that's something considering the facts, but we would be giving our advice around that. 12:55

231 Q. I already understand while general advice was given. Ultimately this was a decision for Mr. Haynes and he had a discretion, notwithstanding his awareness of continuing issues yet to be resolved with Mr. O'Brien, but he had a discretion whether to return him or not? 12:56

A. I think it's the Associate Medical Director and the

Service Director and the Medical Director would have to be informed as well, given his responsibility as Responsible Officer.

232 Q. Thank you very much. I have no further questions for the witness. 12:56

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIR: Thank you very much. Thank you. I am going to turn to my colleagues first of all to see if they have some questions for you. Mr. Hanbury. 12:56

MR. HANBURY: Just a couple of questions from me. Firstly on job planning, you kindly described -- it's retrospective, so if you are doing it later after appeal, from a PA's point of view, you are sort of going back after a year and that puts the appeal mechanism under a bit of pressure, I suppose, to search. Is there any way of sort of forcing the process so it's done in advance or a timely way in your experience? How do you bring a reluctant consultant to the table to discuss it? 12:57 12:57

A. Yeah. That has been -- I mean that was certainly an experience in the early days, it was more retrospective. I think we have definitely improved to move towards prospective job planning. I think we have still a way to go to have it in place on or before 1st April every year. Your point in terms of how do we encourage it or, you know, provide that to happen more 12:57

frequently, I think it's about that cycle and aligning the cycle with appraisal and job planning, and appraisal comes first and feeds into the job planning and it's trying to ensure those cycles are aligned with each other to facilitate that and allow that planning to take place on a prospective basis. I think it's certainly something we have definitely moved greater towards that, and we continue to do what we can to try and encourage that. 12:58

233 Q. There was some comment about software being very difficult. Has that eased now; is there a new better system? 12:58

A. Yeah, we have just moved to -- we had a software company since 2012 and we just moved to a new provider, which its tag line is "power and simplicity", so it's meant to be more simple. It was designed by a consultant anaesthetist. It also allows us to add clinical managers so that they are very much involved in that loop. We are hoping -- it's just been rolled out from February this year. We are hoping that that will make the system easier for them to use. But it's obviously teething problems when you implement a new system, oh we will have to work through those, but that's the intention behind it. 12:58 12:59

234 Q. Thanks. Just moving on to the charts at home, Mr. O'Brien was sort of keeping notes and charts at home, and your comment about had you been aware of that, you might have sort of given some more robust advice. What would that have been if you had, say, 12:59

just heard that as an isolated problem?

A. I think it's about the patterns that were maybe evolving. Obviously I had been experienced in dealing with the binned notes. If there was then a recurring pattern, you know, you would have wanted to get to the 12:59
bottom of why it was happening and establish was there systemic issues behind that or, you know, was it -- and had he been told not to do it. It was about engaging with the practitioner early to understand what was going on, and try and ensure that that doesn't happen 13:00
and that they understand why that can't happen from a patient point of view, from data protection, and put the necessary measures in place. So, just to try and get a bit more information as to why that was happening and see what we can do to stop it. Hopefully, that 13:00
early intervention would avoid that but if you have somebody doing it against what they have been told to do, then obviously yes, taking them forward through appropriate HR disciplinary process if needs be.

235 Q. Thank you. You mentioned briefly recruitment. We are 13:00
aware that Urology here was a hard-to-recruit service. Is there any influence you have on that? You mentioned job planning as a tool to try and keep people that --

A. Yes.

236 Q. Would you have any comments about recruitment as 13:00
a general feature?

A. I would say it's a significant challenge for us. There's a number of factors at play in relation to that, from my reading of it. Generally in Urology,

when we got commission funding and we advertise, we are able to appoint. Unfortunately we did lose a number of our consultant colleagues along the way; two of them went to England and two went to the City, I believe.

13:01

England, you know, we have a difficulty with England in comparison to Northern Ireland because we no longer have a Clinical Excellence Award scheme in Northern Ireland. That was ceased in 2009. Back in 2009, I think we had maybe nearly 50% of our consultants held 13:01
some sort of a Clinical Excellence Award. That system in Northern Ireland ceased back in 2009 and in England it recommenced again. England and Wales recommenced around 2012, I think, 2013. That allows consultants to -- it gives them something to work towards in terms of 13:01
that award. Local awards, you know, anywhere between one and nine awards, 3,000, or national awards between 30 and 70,000, and our consultants haven't had the opportunity apply for that. That could have a bearing on attracting consultants; our consultants going to 13:02
England. We know we lost some to England and some to the City. The difficulty, I think, we have in terms of competing with some of the bigger hospitals in Northern Ireland is a lot of our consultants, and I know this is a generalisation, live and work in around Belfast. If 13:02
they are coming to the Southern Trust, then if they are on-call, they generally have to live in, and if they are in Belfast, they are sometimes on bigger rotas, they are maybe not as frequently on-call, they can

maybe live at home when they are on-call. So, there's lots of challenges we have around that. We are trying to do what we can, albeit sometimes we feel like there's some things you can't change.

13:02

We know we can't really recruit from the south of Ireland. I am sure you are aware they have introduced a new contract there within the last number of months which has starting salaries twice, nearly three times what the starting in Northern Ireland are. That's 13:02 a huge challenge for us.

We do employ whatever techniques we can in relation to recruitment, you know, and advertising far and wide. Looking and asking our clinical managers, yes, to look 13:03 at our job plans to see how can we make them more attractive, how can we ensure -- you know, when Dr. O'Kane started, she made sure all of our new consultants got extra SPA in their job plans to allow them to come in, get up to speed, undertake their 13:03 mandatory training. All of that was built into their job plans to facilitate that. So, there's lots of things we are trying to think outside the box of things we can change, but obviously operating within that challenging environment in terms of being able to 13:03 attract consultants.

Another big pull factor for them is the number of middle or SAS grade doctors that they have underneath

them. Obviously in bigger hospitals they will have probably more. We had two training numbers in Urology and then we are trying to recruit clinical fellows or research fellows. That's difficult because if they are on call, then they are generally first on call if they have an inexperienced doctor underneath them. We struggle to recruit through training schemes as well for some of the comparisons with England and the new contract that they have where junior doctors in England, which was introduced in 2016. In Northern Ireland, we are not on that contact, we are back on the 2002 contract. So that has a differential in terms of the starting salaries for juniors because a lot of our national -- our recruitment in Northern Ireland, our training schemes are national recruitment schemes, so we're recruiting from the national recruitment. I think less than 50% or 50% of them are national. If they are appointed to Northern Ireland, then their starting salaries are not necessarily always comparable. That's a challenge for us. 13:04 13:04 13:04

There's issues. Health Education England fund relocation packages for junior doctors in England but we are not eligible for those expenses in Northern Ireland. So, I think I have highlighted there's huge challenges that we can't fix but we are trying to do what we can to fix them. We are looking at international recruitment. We have set up -- and when we get a new Deputy Medical Director, myself and her 13:05

set up the Southern Academy in the Southern Trust which is focused on international doctors and providing stimulation training for them, enhanced induction, things that we can try and encourage them to come to the Southern Trust to get some of those enhanced, and have been working with some of our international doctors and a group of really experienced and interested doctors to try and develop that for us and help that along. So, we are doing lots of things but, as I said, there's some things we just can't control, unfortunately. 13:05 13:05

237 Q. Thanks very much. No more questions.

DR. SWART: 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? 13:06

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

238 Q. But have you got a big strategic idea --

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

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

A. Of course. 13:06

240 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.

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

A. Yes. Possibly not.
242 Q. Okay. You described very eloquently potential uses of job planning?
A. Mm-hmm.
243 Q. The challenges, which I think many Trusts face; you would not be alone in that? 13:06
A. Yes.
244 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? 13:07
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. 13:07
245 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. 13:07
246 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. 13:07
247 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.

248 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? 13:08

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.

249 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? 13:09

A. Yes.

250 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. 13:09 13:10

251 Q. Do you think that's improving?

A. Yes, I definitely do.

252 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? 13:10 13:10

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. 13:10

253 Q. It does, yes. You have got your retire/return policy. Are you using that a lot these days?

A. More so than what we did in the past, but a lot of time when someone chooses to retire, they don't want to return. So we are not using it that often but there would be some occasions. 13:11

254 Q. And has it been beneficial to have an actual policy?

A. Yes.

DR. SWART: Thank you very much.

CHAIR: You will be relieved I have nothing further I want to ask you, Ms. Parks. Thank you very much. Your evidence has been helpful to us. It's now ten past one, let's say a quarter past two. 13:11

THE INQUIRY ADJOURNED FOR LUNCH 13:11

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Chair, good afternoon, Panel. Good afternoon, Sharon Glenny, who is your witness this afternoon, Chair. She proposes to take the oath, I believe. 14:17

SHARON GLENNY, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS: 14:17

255 Q. MR. WOLFE KC: I understand you are a bit nervous, Ms. Glenny?

A. Yes.

256 Q. There's nothing to be worried about and we will take it as slowly as you can. If the Chair frowns at you, it means you are speaking too fast. If she frowns at me, I will tell you off. Okay. 14:17

CHAIR: If you want a break at any time, just let us know. 14:18

257 Q. MR. WOLFE KC: The first thing we need to look at your witness statements. The first witness statement you have given to the Inquiry is at WIT-81720. You will recognise that as the first page. We have put a little note at the top to indicate that there's a second witness statement that has come in from you as an addendum. Let's go to the last page of this one, 81795, and you have signed that electronically. Would you like to adopt that witness statement as part of 14:18

your evidence?

A. Yes, please.

258 Q. Thank you. Then your addendum statement, WIT-94966. That's the first page of it. Can we just scroll down because I think we were advised yesterday - just stop there - we were advised yesterday that there was a typographical error in this? 14:19

A. Yes.

259 Q. When the statement came to us, I think this is how it... Yes, I understand. So you moved or -- 14:19

A. I stayed where I was.

260 Q. Okay, that's a better way to put it. As is explained there, your responsibility for Integrated Women's Health Maternity Services has moved to somebody else?

A. Temporarily, yes. Just from April '23 there. 14:19

261 Q. And it's April '23, as it says in the last line, and not April '22 which is highlighted in pink. April '22 was a typographical error. So, that tidies that up.

If we go to the last page then, it's page 71 of this sequence, five pages down. Again, that's your signature? 14:19

A. Yes, it is.

262 Q. Do you wish to adopt that statement as part of your evidence? 14:20

A. Yes, please.

263 Q. Thank you. Now, you joined the Trust in October 2006 as a temporary project manager; isn't that correct?

A. Yes, although I did join the Trust in 1990 originally,

but from the time that I have been filling in there, for the Inquiry purposes, that was my role then.

264 Q. Yes. We are not terribly interested in your temporary project manager's role.

A. No. 14:20

265 Q. We are, however, interested in the two posts that you have held since that time. Both of them were Operational Support Lead posts; isn't that right?

A. Mm-hmm.

266 Q. You took up an Operational Support Lead post in Surgery and Elective Care on 15th July 2007? 14:20

A. That's right.

267 Q. You stayed in that post until 31st March 2016; isn't that right?

A. That's correct. 14:21

268 Q. That's when - and the Inquiry has heard evidence about this already - Mrs. Gishkori, who was the Director of Acute Services, decided that Assistant Directors and their Operational Support Leads would move?

A. Move. 14:21

269 Q. So you went from SEC, from Surgery and Elective Care, to Clinical Cancer Services; isn't that right?

A. That's right, and Integrated Women's Maternity Health. The two together, yeah.

270 Q. Yes. And you have remained in that post ever since? 14:21

A. That's correct.

271 Q. Subject to the change that we talked about earlier --

A. Yes.

272 Q. -- just relatively recently; isn't that right?

A. Yes.
273 Q. Your report in the first of those posts, in SEC, was to Simon Gibson until September 2009, and thereafter your Assistant Director to whom you reported was Heather Trouton? 14:22
A. Up until 2016, yes.
274 Q. That's right?
A. Yeah.
275 Q. Then when you moved across to Cancer Services and Integrated Women's Health, it was, on the cancer side, 14:22
Barry Conway?
A. It was Heather initially until 2018 and then Barry Conway from 2018.
276 Q. Yes. I suppose in both of those jobs, obviously different settings but your main duties and 14:22
responsibilities were the monitoring, as you have described, of the operational functions associated with the performance of elective care pathways, and supporting the Heads of Service and the Assistant Director? 14:22
A. That's right.
277 Q. As you have said in paragraph 11 of your statement - if you can just maybe bring it up, WIT-81748, at 11.1A - "Monitoring of performance was against expected levels of activity". Is that right? Is it right to describe 14:23
those expected levels of activity as the departmental standards or access targets?
A. Yes. So, I suppose there was two things. There was really the levels of activity that you were expected to

deliver, as well as the waiting times that you were expected to deliver.

278 Q. Yes. So, it was numbers and times?

A. Yes.

279 Q. You have explained that there. Just briefly some buzz words there. You had to take into account or you were monitoring trajectories. What's that in this context? 14:23

A. So, throughout both the posts, I suppose the way we monitor activity has changed over time. Initially, the drive or focus was delivering waiting times, so when the Integrated Elective Access Policy came in, it was more about delivering what the standards were in the Integrated Elective Access Policy. So, our nine weeks for Outpatients, 13 weeks for in and days, and nine weeks for diagnostics were pertinent to me at that time. 14:24 14:24

It then kind of moved more into levels of activity as well, as the waiting times. That was where our service and budget agreements came in. So, that was the agreed level that we had with our commissioners set for each of our specialty areas to deliver each year. That, then, kind of moved then into more trajectories. So, if we thought we weren't able to deliver a level of activity, then we had to traject what we were able to do for each of those specialty areas for that specific year. We moved to service delivery plans as in, you know, that was the expected level. It may not have been your commissioned level but it was an expected 14:24 14:25

level that we had to deliver within the year. More recently then since Covid times, it's all been about rebuild plans and trying to get services back online and moving back to our pre-Covid levels of activity.

280 Q. Yes. Thank you, that's very clear. The mainstay of your role -- that's maybe unfair, a key task for you, possibly every day, was the production or the contribution to the production of performance report and dashboards; isn't that right? 14:25

A. Yes. 14:25

281 Q. We can see all that material attached to your witness statement. They were important documents for keeping the business area --

A. Mm-hmm.

282 Q. -- where you worked well-informed of what was going on on a day-to-day, week-to-week, month-to-month basis, so that everybody understood how well the service was performing against the standards that you have talked about; isn't that right? 14:26

A. That's correct. It also would have led to the looking of trends and things, you know, where we were starting to fall behind on areas, looking at referrals into the service, trying to sort of place where pressures were starting to take its toll on the service, and looking towards trying to come up with reasonable ways of trying to meet those challenges in conversations with the Heads of Service and the clinical teams. 14:26

283 Q. And also in conversation with the Commissioner; is that right?

A. Yes, yes. We would have met with them. It may not have been me personally but I certainly would have been provided information to the senior management team in relation to those challenges and pressures --

284 Q. Yes. 14:27

A. -- around the delivery of those targets.

285 Q. Mm-hmm. I am going to ask you some questions about delivery because I think it's important for this Inquiry to understand the context in which clinicians worked into which patients obviously had to fit to 14:27 receive treatment, and the pressures of the context. You are obviously in a good position to know what was going on; you were extracting the data and producing the results. So, I want to ask you about how that information was used, what was the response to the 14:28 pressures that was being felt. Obviously if you can't address any of the issues, you just tell me.

A. Mm-hmm.

286 Q. One of the things you say, if we put it up, WIT-81726. You say at 4.3A, if we just scroll down, that you were 14:28 responsible for monitoring the day-to-day operational functions associated with performance via management of patient target lists and waiting lists management processes. Primary target lists, is that the same as patient tracking lists? 14:28

A. Well, there is slight variation. A patient tracking list is probably more in relation to our Cancer Services post. Primary target lists are those patients where you are trying to achieve your nine-week target,

your 13-week target, and they would have been very focused on the list of patients to get your service to that point by a certain month in time.

287 Q. Okay. So, particular kinds of patients --

A. Yes. 14:29

288 Q. -- are expected -- well, the Trust is expected to deliver its service in accordance with those targets?

A. Yes.

289 Q. If we go down to 5.2.1. I will give you the page reference number, WIT-81729. If we just scroll down a 14:29 little, you talk about exploring opportunities for nonrecurrent funding bids in order to increase capacity with the service. That's something that you monitored?

A. Yes. So I would have played quite a key role in the development of plans around the funding aspects of 14:30 yearly money that was coming down from SPPTU Department of Health in making those bids and what we felt was a reasonable amount of waiting list initiative work that we could complete within each of those services, or what we thought we could secure out in the 14:30 independent sectors by ways of additional capacity.

290 Q. Okay, yes.

A. Those would have been done in relation to the Heads of Service then to build up a plan.

291 Q. Yes. Thinking about Urology in particular, I suspect 14:30 is there a certain element of what you can do with nonrecurrent funding that is in a sense inflexible? You only have a certain number of personnel who can do clinics or diagnostics or theatre work; you only have

certain access to theatre time?

A. Mm-hmm.

292 Q. In what sense was nonrecurrent funding useful when some of your capacity constraints are inflexible and can't be changed? 14:31

A. So, there certainly was limitation to what you could do with nonrecurrent funding. The ideal thing would obviously be to have recurrent funding into your service that you could recruit through, and if there was a recruitment pool out there to bring resources in 14:31 against. The noncurrent funding in Urology in particular during my tenure in SEC, we did explore options of trying to use much more independent sector usage, and we did use some services across the border as well with bringing in additional Outpatient elective 14:32 capacity.

In terms of what we could do with our existing resources, there's only a certain amount of sessions that those consultants were permitted to deliver, and 14:32 there were rules around the volumes that they were permitted to deliver. We also were constrained by the accommodation, theatre capacity, and access into theatres. Certainly within Urology, the consultants certainly did try their best to work around what was 14:32 available to them in terms of evenings and weekend sessions and what they could do. So, we tried to make as much use of what we could, and take as much of the allocation down as what we could to deliver as much

service as we could to our patients.

293 Q. Yes. We will go on shortly to look at some of the waits and the numbers of patients on those waits; one feeding, no doubt, into the other?

A. Yes. 14:33

294 Q. But is it fair to say that noncurrent funding in the context of Urology, while undoubtedly welcome, was not really making a significant dent into the demand that was out there for the Trust services?

A. It would be fair to say it was a sticking plaster over what was a larger problem. 14:33

295 Q. Yes. If we go to WIT-81742, we will start to explore some of the scale of that problem. At 10.3, just down the page, you set out some of the waiting time targets that you have alluded to already. Outpatients should, in theory, receive a first referral appointment nine weeks after the Trust receives the referral? 14:34

A. Mm-hmm.

296 Q. Elective inpatient or day cases should be progressed 13 weeks after the patient is added to the waiting list. So they'd come in for their Outpatients appointment, they may require some diagnostics and then they might then be added to the waiting list. It's at that point the clock starts to run; is that right? 14:34

A. That's right. So, from the date the patient is added to the waiting list or the decision that a patient requires elective surgery, the clock is ticking from that point really and it's 13 weeks to have the surgery. 14:35

297 Q. Yes. Then we looked at some of this yesterday, there's the cancer targets, specific target for breast, 98% should receive their first definitive treatment if they have come through the 31-day. That's consultant-to-consultant referral -- 14:35

A. Yes.

298 Q. -- the 31-day target. Then the 62-day target, the Trust would expect or be expected, according to this target, to deliver 95% of the patients through to first definitive treatment by the 62nd day? 14:35

A. That's right.

299 Q. Yes. You then, at 10.4, explain where the service sat by April 2016 when you moved into the cancer post, having been an SEC?

A. Mm-hmm. 14:36

300 Q. So, the specific SEC target, 74 for an outpatient, 74 weeks for an outpatient appointment when, in fact, the patient should be seen in accordance with the target --

A. It was nine weeks for first appointment.

301 Q. -- nine weeks for first appointment? 14:36

A. Yeah.

302 Q. The 120 weeks was the standing average then for inpatient or day case procedures?

A. So, those would have been the longest waiting patients on the waiting lists at that point when I was handing 14:37 over. Although the IEAP states nine weeks for outpatients and 13 for elective, there would have been interim targets that would have been sent through from the Department of Health to say you are now going to

work an interim of 26 weeks or an interim of 52 weeks, but the actual targets of the IEAP never actually changed.

303 Q. Yes. So, the Department, not to be impolite, is moving the goalposts with interim targets? 14:37

A. Well, I think they were recognising that there was demands that the services weren't able to meet. So, they were unrealistic targets within the IEAP at that time but those were the targets that were being held within the IEAP. 14:37

304 Q. Yes. What was the cause of the inability or the failure to meet those targets?

A. In my view, there was a huge demand and capacity deficit within Urology Services specifically. In fact, it was across a number of the specialty areas that 14:38 I worked in at that time. The referrals to the service were increasing at an ever-increasing rate. They still only had the number of consultants in post that they had more or less started out with. I think there was two when I initially started working in Urology, it 14:38 moved to three. I am not sure how many there was actually at the point when I was moving, but there hasn't been a whole lot of change in the number of consultant posts during that time. Certainly there was huge pressures on the Urology Service to deliver those 14:38 targets.

305 Q. So, the inability to meet the targets was not due to under-performance on the part of clinicians or those working within the service, it was due to an inability

on the part of the Trust to meet the demand with sufficient capacity?

A. I think yes, in one -- yes, in one respect, there was. I think there had been a number of meetings with HSCB to raise concerns about capacity issues in the service. 14:39
Certainly there would have been performance meetings with HSCB throughout my tenures where the Assistant Directors would have been attending and putting forward concerns about the demands coming in. There was certainly no downturn in any of the activity during my 14:39
tenures. The activity was still great for what the service was providing, there was just too much demand coming in.

306 Q. You continued obviously to monitor and track the demand and your service's capacity to meet that demand, and 14:40
you have produced figures. What is the purpose of monitoring performance in that sense when it's quite clearly not a service that can deliver? Is it just to keep the message alive, to ensure everybody understands what's out there? What is the goal of it? 14:40

A. I suppose at that time it was twofold. It was, yes, keeping an emphasis on the fact that the service was under a lot of pressure, but we also used the information to look at innovative ways to try and move the service in a different direction, drilling down 14:40
into the demand to see, you know, even into more treatment-type areas, particularly when we were brought in the ICAT service at that time, trying to look at what more innovative ways could we do this; is there

more specialist nurse services that we could bring in; GP with special interest areas; other ways that we could try and meet that demand knowing that there was difficulties with recruiting consultants at that time.

307 Q. When the commissioners advised of the impossibility of meeting the targets that they had set, did you go to these meetings or was it fed back to you in terms of what they were saying? 14:41

A. I didn't attend those meetings. I certainly would have provided some of the preparatory work for those meetings, and it would have been fed back to me. There might have been more work required to set the scene for some of those meetings. But it would have been more at our Assistant Director level that would have been attending those meetings and putting forward cases. Certainly Martina Corrigan, Head of Service, might have been at some of those meetings, as well as some of the clinical teams I know did attend meetings with HSCB around changes to models and looking at one-stop clinics and things like that in the past as well. 14:41 14:42 14:42

308 Q. You provide a table at paragraph 10.6 of your statement. This addresses the issue of Outpatient referrals; isn't that right?

A. Yes.

309 Q. I know from your addendum statement, which I don't need to bring up on the screen, it should be self-evident here, but there's an error in this table and it involves flipping the columns about, if I can put it that way? 14:42

A. The columns, the two middle columns.
310 Q. So let me explain. The yearly commissioned Urology new outpatient activity should be 3,588 for each of the years; isn't that right?
A. That's correct. 14:43
311 Q. So on that left-hand column next to the fiscal year column, that should contain a steady 3,588 of commissioned activity each year?
A. That's correct.
312 Q. The other column, for example, 5,121, is the new Outpatient referrals received? 14:43
A. That's the actual activity, so that's actually what the team delivered.
313 Q. Right. And then it's a simple subtraction sum --
A. Yes. 14:44
314 Q. -- to show the gap between what was delivered and what was commissioned; is that right?
A. Yes. So, you can see throughout that, all of the years, that the service actually outputted much more than what they were commissioned to deliver in an effort to see those referrals. 14:44
315 Q. How was that achieved?
A. A lot of the clinics would have been overbooked. You know, we did have the ICAT service there at that time too, and they were seeing a lot more patients as well. 14:44 So, there was a lot of work done just within the teams themselves to see that level of activity.
316 Q. Can I just be absolutely clear --
A. Yes, I see it's actually referrals. Sorry, it's

referrals.

317 Q. Yes. So 5,121 isn't the activity?

A. It's the referrals.

318 Q. Right. Okay. In other words, in that year, you weren't able to care for 1,533 people -- 14:45

A. That's right.

319 Q. -- or at least that was the gap?

A. Yes.

320 Q. So, were you not able, in any of those years, to go beyond the commissioned level? 14:45

A. Sorry, I actually don't think I have the activity information on my Section 21 there, so I just don't recall.

321 Q. Okay. Let's just rewind a little because I think you went off on a -- 14:46

A. I did.

322 Q. -- false trajectory there, through no fault of your own.

So, the Commissioner was paying each year for 3,588; is 14:46 that right?

A. Yes.

323 Q. What came into the Trust as new referrals was 5,121?

A. That's right.

324 Q. And that's the gap? 14:46

A. That's the gap.

325 Q. Okay. Do we know whether the activity was able to make up that gap or was there always a shortfall?

A. No. The activity was never able to make up the gap,

there would always have been a shortfall. We certainly would have been putting in our nonrecurring plans to try and address some of that gap, but it never would have addressed all of the gap.

326 Q. The fact that the commissioning on recurring funding stagnated at that figure throughout each of those years, stayed stationary, does that suggest that the Trust received no positive response from the Commissioner to concerns that might have been articulated about its inability to address the number of referrals coming in? 14:47 14:47

A. Normally, if there had been any business cases, or IPTs as we would call them, that had been done and accepted by the Commissioner, the outpatient activity levels would have increased, you know, so the referrals that you were commissioned to deliver would have increased. It wouldn't appear that we were given any further funding for those years. It remained the same. 14:48

327 Q. If we scroll down to 10.7 of your statement, you explain the impact of this. You say: 14:48

"This had an impact on the waiting times for first appointment and the number of patients waiting beyond IEAP targets. Issues around capacity challenges, including Urology capacity challenges, are discussed at monthly Head of Service performance meetings with the Assistant Director present. Notes of those meetings were taken and would have been submitted for evidence already to the Inquiry. These issues are also 14:48

discussed at the monthly acute SMT when performance risks are presented by the Head of Performance".

You explain who was attending those meetings.

Can I ask you this: Obviously if you are not commissioned to deliver, there's going to be a struggle, unless nonrecurrent funding comes in, to address the needs of your local population; people are going to be on waiting lists for periods of time. Did the Trust engage in any attempt to assess the risk posed to patients waiting for long periods before their first Outpatient consultation? 14:49

A. There was a risk raised on, I think it was the Corporate Risk Register, in relation to outpatient, inpatient, day case waits, which was more general, it wasn't just specific to Urology. But it certainly would have been raised on the Corporate Risk Register regarding concerns with delays of treatment to patients. 14:49 14:50

328 Q. The risk is perhaps obvious, it's a question of whether anything was done about it. Was there any attempt to go beyond the general recognition of a risk? If a patient is not seen in accordance with the target, then self-evidently it's a risk to their health. Was there any effort to delve down beneath that to see what kinds of risks there were and whether any mitigations could be put in place to address them? 14:50

A. There would have been conversations through HSCB for

those performance meetings regarding patients waiting, and if there was any appetite for referrals between Trusts, and things like that, to try and get patients seen. I know not just for Urology but for other specialty areas, the other Trusts have been involved in trying to see patients to bring -- to equalise waits across the region rather than one Trust setting out as compared to the other. 14:51

But again, it's my understanding that most Trusts within the region in relation to urology have capacity and demand issues, so it was felt that there was probably very little could be done in the way of moving patients around between Trusts. It certainly was attempted. 14:51

329 Q. Other options like prescribing or doing preemptive investigations; would they have been options that were considered?

A. From a point of view of analysing review backlogs and things like that, there would have been an ongoing review of patients on waiting lists, which the consultants had been involved with, as well as Urology Nurse Specialists; going through patients on waiting lists, checking to see if they had been seen since the time they have been added to the waiting list; what had happened to their care; if there was any information update that they could give to the consultants in order to try and move patients along the system. That work had been ongoing for a number of years. 14:52 14:52

330 Q. If we look then at WIT-81742. Scroll down to 10.3, please. So, it's to be recalled that departmental waiting lists for first referral appointment are nine weeks and then elective patients 13 weeks. At 10.4, then, we can see what the state of play actually was. 14:53
At the point of you handing over to Wendy Clayton in April of 2016, the waiting times for an Outpatient appointment were sitting at 74 weeks, and 120 weeks for inpatient day case elective procedure.

14:53

Now, there is a table sitting just below that at 10.8. This shows across the period of time up to relatively recently the state of play for inpatients. We can see that for -- well, it's across a number of sectors but just focusing on inpatient, for the year that you left 14:54
and moved across to cancer, the longest wait was 201 weeks. I think you had earlier said it was 120?

A. Yes. That particular -- the 201 weeks at that time, this was a report provided by the information -- or sorry, the performance team. That was an outlier on 14:54
their report which just needed validated. The position I gave in the earlier one was the true reflection.

331 Q. Yes. There were 505 patients on that list?

A. Mm-hmm.

332 Q. As we can see from the data, the position doesn't get 14:55
any better as years pass. In fact, it gets a whole lot worse. The waits are now sitting at over 400 weeks; that's almost eight years?

A. Yes.

333 Q. Again, was the Trust engaged in any specific audit of the risks faced by patients in that kind of situation?
A. I haven't really been working with Urology Services from 2016. I know there has been a number of meetings around Urology Services that Mrs. Corrigan, and now Ms. Clayton, will have been involved with since that time, certainly in terms of trying to build up the service and how they would go forward with the service. But I'm not close enough to the information to be able to give you a proper answer on that. 14:55 14:56
334 Q. Yes, yes. We will move to your more familiar territory, your more recent territory in cancer in just a moment. I think you said earlier that in terms of clinical output, there was no decrease in the level of activity? 14:56
A. No, and certainly it was my experience that they did meet their level of activity required on the SAVA?
335 Q. Yes.
A. Yeah.
336 Q. Do you have any sense of the impact on clinicians of working in a context such as this where there is this pressure of demand, an expectation, perhaps, that you would go the extra mile in trying to provide additionality so that matters don't get any worse? Do you have any sense of that or were you, if you like, siloed from -- 14:56 14:57
A. Because I obviously would have had -- I did attend some of the department meetings up until I moved tenures, just to give positions on where we were with waiting

times and to discuss what we could do in terms of the in-house additionality and things like that. There would have been a sense among the team - all of the team, not just the clinicians - so this would have been the secretarial staff, the nurse specialists, in fact everybody involved with the team - Martina Corrigan herself included - you know, that they were trying their best as they could, but the demands coming in were just so large that they weren't able to meet everything that was being asked for them. They did work as much as they could cohesively together to try bringing in additional capacity inasmuch as they could, and they certainly done as much waiting list work as they could to see as many patients above and beyond the expected level of activity. So, yes, I suppose there was a sense of frustration that they were doing all that they could but these demands were still ever-increasing. 14:57 14:57 14:58 14:58 14:59

337 Q. Let's move to the situation in cancer. You have helpfully provided a comparative performance table at WIT-81745. The next page, I think. Yes. Am I correct, looking at the 62-day performance table, does this show that the number referred to the Urology Service with suspected cancer and who had their first definitive treatment within 62 days was consistently lower than compared with the other Cancer Services within the Trust?

A. Yes, that's correct.

338 Q. While there was a neck and neck situation in 2016/2017

comparing Urology with the Trust's other Cancer Services, there is a widening gap as time moves on; isn't that right?

A. That's correct.

339 Q. Did you have an understanding of how that occurred? Is it simply a case of Urology being under-resourced to meet the demand? 14:59

A. Yes. Comparatively, the overall referrals into the Urology Service had increased and, likewise, the red flag referrals also had increased across all of those years. Certainly from a cancer perspective, you know, we would have been meeting on a bimonthly basis with HSCB, now SPPG, where I would be aware that this is no different than what it was across the rest of the Trusts within the region as well, where the Urology performance was, unfortunately, becoming much lower than what it was with the regional performance. 15:00 15:00

340 Q. If we just scroll down, I think you suggest in the next paragraph that -- you say:

"It is recognised that at times" - this is halfway down this page - "that minimal action could be taken due to ongoing capacity and demand difficulties within specific sites including Urology". 15:00 15:01

You explain the capacity demands and difficulties across the entire cancer pathway in Urology. Scrolling down, you do suggest that there were some workarounds possible, some mitigations possible?

A. Mm-hmm.
341 Q. So, those four items you are suggesting as being steps that were taken, perhaps on occasion, to try to address the pressure. But again, looking at those figures, they don't appear to be putting much of a dent in the demand for the service? 15:01
A. That's correct.
342 Q. Again, would that message that these patients are at risk because they are not being seen within the target timeframe, would that have been communicated to the Commissioner? 15:02
A. Yes. The Commissioner would have had sight of all of those waits. Certainly in advance of us meeting with them bimonthly, they would have been providing a presentation to us from the information that they were analysing, which would have compared how we were sitting as a cancer service, down to tumour site level against the region and against other Trusts. So, they would have been aware. 15:02
343 Q. I think if we go down to WIT-81759. At paragraph B there, you refer to these bimonthly meetings with the Commissioner? 15:03
A. Yes.
344 Q. You were attending those?
A. I didn't initially but then I did, yes. 15:03
345 Q. Yes. At these meetings, cancer performance is reviewed across all tumour sites and those representing SPPG, formerly the HSCB, are identified. Is that an opportunity at that meeting to discuss risks?

A. Yes. When we would have, as a Trust, seen the presentation that had been prepared, what normally what happened was would have been Cancer Service would have met with all of the acute areas to discuss the information within the presentation. The Head of Service would have had an opportunity to bring any issues that they had to that meeting. Indeed, they attended the bimonthly cancer meetings as well and would have been raising their concerns around their inability to meet the cancer targets and the concerns that had within the clinical team. 15:04 15:04

346 Q. How is that articulated? Is it articulated in terms of people will die here if we don't get this sorted out, or is it much less personalised? Is it you just need to find resource for us? How is it spoken? 15:05

A. It would have been much less personalised because it would have been all eight tumour sites being discussed. So it wouldn't have been -- Urology was one tumour site amongst eight being discussed on most occasions. Obviously, if you had serious concerns within one particular area, you would have been raising that and articulating that. But Urology was always one of those areas that was discussed at those SPPG meetings. 15:05

347 Q. You have said that no notes were taken at these notes?

A. There was no notes taken. They were more -- it was like an action came from those meetings. Sometimes it was just an email after the meeting to say these are the actions that each person is taking as part of that. More recently, it was a table that came out to say the 15:05

action that had to be taken forward. It wasn't an actual written note of the meeting.

348 Q. If no formal record is being made, maybe a follow-up email, what does that say about how seriously these issues are being regarded, or what does it say about the nature of the meeting? 15:06

A. Well, from Cancer Service point of view, we took the meetings very seriously and we would have been relaying -- we would have provided information to them in advance of the meetings to let them know some of the areas that we would have been keen to discuss with them and try and find a way forward with them in meeting some of those demands, so... I am not sure how I can respond on the part of HSCB. 15:06

349 Q. Yes, you answer the question as you best see fit. We know, for example - we will come on maybe later and look at it - that the Trust's requirements for extra trackers was, after a period of time, recognised by the commissioner and additional, initially nonrecurrent and then some recurrent, money has come through. On the whole, we can see from the statistics that not an awful lot has changed in terms of compliance with the targets. If anything, things have gradually got worse so that the target is rendered almost meaningless such as the non-compliance with it? 15:06 15:07

A. Mm-hmm.

350 Q. What, if anything, was coming out of these meetings on a practical level to try and arrest the problem?

A. I suppose in more recent times since we had Covid,

I know they have been looking at regional diagnostic centres to try and fast-track patients through services; regional elective centres. All this kind of information would have been relating into those kind of discussions. Also, the equalisation of waiting lists across tumour site areas, those kind of discussions. So, I suppose there were bigger discussions that were beyond me and I wouldn't have been involved in those discussions. My main purpose of being there at those particular meetings was to convey how we were performing as a Trust, at those meetings. I suppose the Head of Service and the Assistant Directors were trying to get their points across around the challenges and the pressures that they were feeling within their particular service. 15:08

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

A. Mm-hmm.

352 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? 15:09

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. 15:09

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

A. Yes.

354 Q. What we have seen, or what you have seen, over a period of years is a failure, some would call it, or an inability, others might call it, to provide the structures and the resources to get to grips with the demand, and it's left to clinicians and those who assist and support clinicians to do their level best, and sometimes going beyond what is perhaps healthy, to try to meet that demand as best they can but knowing that, at the end of the day, there's going to be an awful lot of people still waiting to get their service? 15:10 15:10

A. Yes.

355 Q. WIT-81775, if we just scroll down to that. Paragraph 26.5, please. You have said, in terms of the consultant body, that: 15:11

"As the scheduling of elective patients for urology took place in a team schedule meeting with all of the consultants taking part in it and sharing the patients across consultant theatre lists for chronological management of patients in urgency order, I didn't have any concerns". 15:11

Is that intended to convey that all surgeons in Urology had an equal share of the elective burden? 15:11

A. The way the Urology team worked was one week in the month, there would have been a rota meeting - it was normally the first Thursday of the month - where they sort of set up for the month what each consultant was

going to be doing, so you had -- at the end of that meeting you knew what each consultant was going to be scheduled for throughout the month. The following Thursday, they would have had meetings where I would have been providing a list of patients that needed to 15:12
be scheduled to meet the targets or that we were trying to concentrate on, depending on what the clinical discussion was at the time. During those meetings, there would have been discussions around who was taking what patients. Obviously the consultants who were 15:12
there had had an idea of the patients that they were talking about, the complexities, the co-morbidities of those patients and whether they were suitable to share amongst other consultants or not share amongst other consultants. We would have come away from those 15:13
meetings with a plan for the majority of those patients and how they were going to be scheduled. That happened a lot during my tenure. It didn't happen all of the time but it happened a lot when we were trying to achieve certain targets or work towards certain groups 15:13
of patients being scheduled. For example, we were trying to target our resources at our urgent SEC patients, or our red flag patients, I would come along with those lists to try and help with the objective of getting those patients scheduled. 15:13

356 Q. Is this referring to a period in time when you were in the Surgery and Elective Care?

A. In surgery, so up until 2016.

357 Q. Yes. Could I just ask your comments on a particular

table. It is at WIT-81869. Can we highlight the top table, please? We can see the names of the various consultants identified. If we look at Mr. O'Brien's inpatient numbers. So we can see his name, it's the second name down and it's the third intended management DCIP -- sorry, it's the second intended management. It's IP. He has 213 patients across that 13-week block. Other consultants have significantly fewer inpatient numbers. Mr. Young, for example, at the bottom of the page, has 82, and I think he's Mr. O'Brien's nearest comparator. 15:14 15:15

Can you explain to us how does one clinician seemingly have many more inpatients to address as compared to his consultant colleagues? 15:15

A. I can't explain it, really. From a point of view of it could have been that Mr. O'Brien was seeing more patients at Outpatients or, you know, he just didn't have as much access to theatre as what Mr. Young did, although I don't recall that being the case. So, he just seemed to have much larger waiting lists than anybody else. 15:15

Some of the other consultants on that list at that time would have been new into the Trust, so there would have been a sharing around of patients when those consultants would be coming in. On the whole, the consultants would have sat on Mr. O'Brien's list until those consultants agreed to take them, to schedule 15:15

them. So, he would have held a waiting list until they moved around.

358 Q. Okay, thank you. I want to move on now to look at some other discrete issues. Can I ask you about triage, relatively briefly. 15:16

A. Mm-hmm.

359 Q. We have heard on Tuesday from your colleague, Vicki Graham, who explained how she either asked for referrals to be escalated because triage hadn't come back or, when she took over the coordinator role, she 15:16 was cast in the role of escalating herself. You have said at WIT-81722 that during your tenure in SEC, there was an apparent issue with untriaged letters within Urology, particularly with Mr. O'Brien. That's not to say there weren't issues in other specialties, and you 15:17 have set that out fairly in your statement, for example at paragraph 24.3.

From your job's perspective in looking after performance, and we will maybe look at one or two 15:17 examples just now, why were you becoming involved in escalations around unreturned referrals?

A. So, there is a target within the IEAP where triage should be turned around within 72 hours. If they fell short of the 72 hours, part of the process was that it 15:18 would be escalated up through the OSLs and Heads of Service for them to try and find a resolution to get the patient triaged. My role, I suppose, in that was to make sure the Head of Service was aware that there

was actually an issue with the triage. I would have forwarded on all of those escalations. The way that we worked at that time, and still do, is that all of our offices are on the same floor - in fact, my office was across the way from Mrs. Corrigan's - and I would have regularly went in and said to her, you know, there seems to be a problem here with the triage again with Mr. O'Brien. She would have, you know, said for me to just leave it with her and she would be sorting it out with him, or taking the necessary actions to take it forward with him. So, yes, whilst -- and there did seem to be a lot of it, unfortunately, with Mr. O'Brien. 15:18 15:19

360 Q. We can see - and I don't think we need to open it up, I think you will remember it perfectly well without having to take the time to go to the screen - that perhaps your first noted issue on the issue of triage was back to 2008 -- 15:19

A. Yes.

361 Q. -- when yourself and Mr. Gibson engaged in an email conversation about the problem with Mr. O'Brien's triage, as it was perceived. You had a particular understanding of the detail and the lengths to which Mr. O'Brien would go when performing triage, and it was labour-intensive? 15:19 15:20

A. It was.

362 Q. And it was time-consuming?

A. Mm-hmm.

363 Q. By 2013, five years later, and even beyond that - but

I want to ask you about a particular intervention by you in 2013 - the issue was seemingly still the same?

A. Mm-hmm.

364 Q. Was it something that really everybody in your world, in your area of work, knew about and knew to expect, that we are not necessarily going to get triage back as quickly as the target requires? 15:20

A. It wasn't that you wanted to expect it; it was happening, unfortunately. I suppose you still were always hopeful that somewhere along the line, you know, you would start to get those referrals back within the time scales. Unfortunately, it just didn't happen. We were following the process, we were adhering to the escalation around those triages but just, unfortunately, the behaviour hadn't changed. 15:21 15:21

365 Q. You eloquently described your role as the person who escalates?

A. Mm-hmm.

366 Q. Not the person who has to do anything to address the triage issue beyond that? 15:21

A. Mm-hmm.

367 Q. You bring it to the attention generally of the Head of Service, Mrs. Corrigan, and you leave it to her good offices to try to resolve?

A. Yes. 15:21

368 Q. But it was your targets that were being comprised by the failure of the triage process; is that fair?

A. Well, yes, the targets were being compromised but also we were very mindful that there were patients in the

back of that you were trying to get an outcome for, to try and move on to clinics so you could actually get the patients seen. Because whilst you were waiting for those patients to be triaged, they weren't on any waiting list, they were just still sitting on a primary target list with nothing really happening with them. So, you wanted to get them moved onto the correct waiting list to get them seen in the correct part of the service where they would get the care that they needed. 15:22

369 Q. With that concern behind you, was there never any opportunity for you to say, listen, Urology Service, we need this sorted out once and for all, this is just too bad, it's affecting our patients and placing them at risk? 15:22

A. I suppose my sort of line was, you know, up to the Head of Service to let them know, and they were taking forward any of the changes that needed to be taken with the service themselves. I also had a direct link in with the Assistant Director as well, so I would have worked very closely with the Assistant Director through all those times. It would have been something I would have been raising back with her as well, and him. 15:23

370 Q. If we look at WIT-81999. If we start at the bottom of the page, please. Leanne Brown, she is in RBC? 15:23

A. Yes, Referral and Booking Centre.

371 Q. She is writing on 19th November to Andrea Cunningham; who was she?

A. She was the service administrator in Urology at the

time.

372 Q. Yes. That was a normal escalation process?

A. Yes.

373 Q. She is saying:

15:24

"Below is a list of untriaged Urology referrals. Can you please arrange for these to be triaged and returned as soon as possible".

What lies behind this email is some 47 pages of well spaced out names. What the number is, I didn't count, but it's a significant number of patients. If we scroll up the page, you are then copied in six days later. You are being told that this list of untriaged Urology referrals was e-mailed to secretaries on 11th November. Would that suggest that was the start of the triage process? 15:24

A. Yes. So that would have been the initial forwarding on to the secretaries to liaise with the consultants to get them triaged. 15:24

374 Q. Yes. They should have been back within a maximum of three days?

A. Three days.

375 Q. Yes. Then if we scroll up the page, please, you are writing to Martina Corrigan. You are saying: 15:25

"I know this has already been escalated to you but do you think we are at the point where we need to permit the Referral and Booking Centre to send for these

patients despite not being triaged? It may mean we have some consultant clinics with lots of andrology rolling patients, but rather than lose any more reasonableness of offer, do we need to consider this?"

15:25

This was essentially saying let's take the patients forward without triage because triage hasn't come back in time?

A. Yeah. So, back at that time obviously the waiting lists weren't as long, patients were being seen quicker than what they are now, for certain, and you were trying to make sure that those clinics that had available resources were being utilised to maximum capacity. You needed your triage of your referrals to happen in order to get them onto the appropriate waiting lists for patients to be seen.

15:25

15:26

376 Q. Yes. You have described this in your statement, I think at paragraph 28.2, as intended as a short-term work around and as a mitigation of risk?

A. Yes.

15:26

377 Q. The risk being what?

A. The risk being that the longer the patient waits, the more root space you have for something untoward to the patient. Our aim was let's get the patient seen; it may not be at the right type of urology type clinic but at least the patient is getting seen and a management plan starting with the patient.

15:26

378 Q. You must have been at the end of your tether to come up with something as seemingly different or radical as

this?

A. Yes. Well, I can sense my frustration within the email.

379 Q. We know that, I hesitate to call it the same approach, but we know that something similar became the decisive action of the Urology Service within the year. We have called it the default triage approach. You have mentioned it in your statement, I think. If we go to WIT-81776. Let me just go back a page, please. Yes, so if we stop there. You say at 26.3: 15:27 15:28

"In order to mitigate risk, a decision was taken by Martina Corrigan, Head of Service for Urology, to accept the GP priority code to avoid unnecessary delays to patients receiving appointments, and to permit the Referral and Booking Centre", it should say, "to appoint patients to the relevant clinics". 15:28

The idea that you were putting forward in November 2013 appears to have, if not immediately, shortly thereafter, taken hold within the service. You have suggested that it was Martina Corrigan. I know that you have corrected that -- 15:28

A. Mm-hmm.

380 Q. -- in your addendum statement. Could you just explain that? 15:29

A. Yes. So, Martina and I would have obviously worked very closely together. It would have been Martina who told me about it. I can't say that she actually was

the one made the decision. I am not actually sure who made the decision but I was told by Martina that a decision had been made to accept the GP priority code to avoid those delays.

381 Q. Yes. For the avoidance of any unfairness to Mrs. Corrigan, if we just look at what she said to the MHPS process in relation to that. If you go to TRU-00746, and at paragraph 13, please. She says that: 15:29

"It was agreed by Debbie Burns, Heather, Anita, Katherine and I that the attempts to get the triage done didn't work so we needed a way of ensuring that patients were at least on a list so that they were not disadvantaged chronologically, because by being on this list then we were assured that they were always allocated an appointment when it was their turn. By adding these patients to the waiting list, it looked as if they had been triaged, so it wasn't escalated to me any more". 15:30 15:30

So, I suppose therein lies two things. First of all, are you happy to accept that it wasn't necessarily Martina Corrigan's decision but the product of the input of a number of people, on her account? 15:31

A. Mm-hmm. Yes, happy with that. 15:31

382 Q. The second point she is making towards the end there is that it looked as if patients were being triaged, but that is clearly the downside of this arrangement which you suggested in your email and which clearly was

ultimately implemented. It's one thing to use it to get the patient into the system to avoid any delay, get them their place chronologically within the appropriate waiting list or at the appropriate service, but if this isn't escalated, if the triage issue isn't pursued with the clinician, there are clearly risks attendant to that. Do you see that? 15:32

A. Yes. I suppose my initial email at that time back in 2013 was more to deal with that immediate 'let's get these patients attended to' rather than it becoming a replacement of the triage process. I don't think at any point I would ever have foreseen that it would replace triage. It would have been my thoughts that the triage still should have happened. So yes, you were moving forward with getting the patients seen but you still ultimately would have liked the patients to have been triaged in the background, so that if there was a change and the triage had maybe upgraded a letter or the patient needed to be seen more urgently, that you would have had an opportunity to bring that patient forward. 15:32 15:33 15:33

383 Q. You have reflected in your statement, if we go to WIT-81789 - just at the bottom of the page, please - that:

15:33

"On reflection, the learning is that Mr. O'Brien does not appear to have been held to account for his processes around untriaged referral letters and this practice was able to continue", as you have referenced

at the continuing escalations.

Are you able to put your finger on why you feel Mr. O'Brien was not effectively challenged?

A. Well, I didn't obviously know everything that was going on in the background at that time but, I suppose, from what I know now and what's been in my witness bundle and things like that, I do know that some measures were put around trying to address those situations with Mr. O'Brien, and that maybe behaviours changed for a short period of time and then, unfortunately, those behaviours, they seemed to come back into play again, and it took a while then for those to be acted upon again. 15:34 15:34

384 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? 15:34 15:35

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, 15:35

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.

From my point of view, Urology wasn't the only service I was working in at that time, I was working in a lot of services. So, when I was escalating things on, you were almost moving on to the next thing because that was the challenges of the role. Once you had moved it on, you were like, okay, somebody else knows about that now. You might have popped into the office and said "I have sent you that and you need to look at that email", and you knew that person was dealing with it. That's where you left it because you charged it over to somebody else to deal with. So, you didn't necessarily chase it up, just with the operational challenges of being in our kind of roles. 15:36 15:36 15:36

385 Q. Yes. Chair, I probably have another 45 minutes to an hour. Would it be convenient to take a short break rather than go all the way through? 15:36

CHAIR: We will take maybe ten minutes.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe. 15:48

MR. WOLFE KC: Thank you.

386 Q. If we could have up on the screen, please, WIT-81770. If we go down the page to 24.6. Just a discrete issue I want to explore with you concerning dictation and

backlog reports, and the system that was in place during your time in SEC to monitor that area of work involving administrative and clerical staff.

The Inquiry's concern is that in late 2015, leading into an investigation into Mr. O'Brien's practice, a concern arose that he wasn't dictating on clinical encounters as quickly or as effectively as was expected by the Trust at that time. My questions are designed to explore with you what system you had in place -- 15:49

A. Mm-hmm.

387 Q. -- that might have assisted in that respect. As you say just here at 24.6, you had responsibility for administrative and clerical staff within the division until 31st May 2013, and that included Urology. After 15:50 that, responsibility for secretarial and audiotyping moved to Katherine Robinson; isn't that correct?

A. Yes.

388 Q. If we go down the page then to 24.7, you say:

15:50

"In relation to delays with dictated triage information, I do not recall this ever being raised as an issue with me by the secretarial staff".

You use the phrase "dictated triage information". Was 15:50 there ever a wider concern raised with you about delays or failures to dictate other types of clinical encounter?

A. So, the Backlog Report that I have attached in with

this statement there, it actually encompasses all dictations, so it wouldn't have been just triage. It would have been dictation of any nature really within Urology at that time. I don't recall any issues being raised with me regarding dictation specifically to do with Mr. O'Brien.

389 Q. Yes. Let's just look at the kind of backlog risks matrix report that you had in place to track how your typing resource was performing. I will ask you what the purpose of this document is when we just have had a look at it. If we go to WIT-82317. If you look down the left-hand margin, we are going to look at Urology but we want to see the headings at the top as well. Maybe I will just start by asking you what is this document and what was its purpose? 15:51 15:51 15:52

A. So, there had been an admin and clerical review initiated back in 2010. In fact, all members of admin and clerical were involved in that review. Part of that review, and obviously with us as managers involved in that review as well, we wanted to be more aware of what was happening within secretaries' offices, what were the issues that they were having to deal with, where were the bottlenecks with their work and what they were trying to deal with. Back at this time, we didn't have the infrastructure that we now have in terms of systems with digital dictation and things like that. So, this was an attempt by the admin managers at that time to get a better handle on what was happening with issues around workload and secretaries, with 15:52 15:53

secretaries and in secretaries' offices.

The purpose of this particular report was that each secretary would complete it and send it back to their service administrator, identifying numbers, volumes, 15:53
dates, with their workload in that, the numbers of charts that they had to type and the number of charts that they had sitting in their office that required dictation. I suppose the expectation would have been at that stage if they knew of charts that were sitting 15:54
within their consultants' offices also that would have been included.

Most secretaries at that time were in very close proximity to their consultants and, in fact, a lot of 15:54
consultants actually used the secretaries' offices to store their charts for dictation and things like that. So, that was the purpose of it. Just getting back --

390 Q. Just to cut across you slightly. So, if there was a bottleneck in place A, you could reallocate the work 15:54
or one of the managers could reallocate the work to --

A. Yes, so the service administrators and I would have had a look at this together. We would have looked to see which particular area has a difficulty on this week. We had a number of audiotypists within the division at 15:54
that time, and we would have allocated those audiotypists to where we felt the greatest need was.

The report was also discussed back at the Head of

Service meetings, and this would have been shared with the Head of Services. If there was any particular concern in relation to the consultants with their dictation, that would have been evident from the columns actually identified there in yellow on the reports, and they would have been aware of that to take that back to have a conversation with the clinician.

391 Q. Yes. This is obviously a random month in June -- or week in June 2012. We can see the top line in the box that James has helpfully pulled up for me, Mr. Young's secretary was Paulette Dignam. Going all the way across to the yellow, he had 155 charts awaiting dictation? 15:55

A. Yes.

392 Q. By contrast below that, Mr. O'Brien, whose secretary is Monica McCorry, had zero? 15:55

A. Yes.

393 Q. The next column to the left of that assumedly is charts that have been dictated but have yet to be typed?

A. Yes, that's correct. 15:56

394 Q. And Mr. O'Brien's secretary had typed 162, or there was 162 pieces of work outstanding --

A. Yes.

395 Q. -- for typing. And Mr. Young, 113. This was pre-digital dictation days? 15:56

A. It was.

396 Q. Again, is my assumption correct when I say the populating of the information or the data into this depended upon the compliance or the cooperation, the

accuracy, of the secretary who is returning it?

A. It would, yes. The secretary was completing this and sending it in and we were taking at face value what the secretary was telling us.

397 Q. Yes. But at least there was provision, at least the question was being asked are there charts awaiting dictation? 15:57

A. Yes.

398 Q. Yes. One thing we will perhaps explore with other witnesses is whether that system by which you are able to record charts awaiting dictation, whether it was removed subsequently. I want to just ask you if you can help us on that. If we go to TRU-255967. Just scroll down, please. We can see that this is an email Katherine Robinson is sending to Anita Carroll. It is 20th December 2016. It's in the lead-up to a meeting that would decide that Mr. O'Brien should be subject to a formal investigation under MHPS. Information is being gathered about various alleged shortcomings with Mr. O'Brien's practice, and one of the issues that comes to the fore is the question of dictation. I will read the first paragraph; a list is attached to it. 15:57 15:58 15:58

"This is the list of clinics that Mr. O'Brien has not dictated on and hence no outcome for some of these patients. There is a risk that something could be missed so I am escalating to you although I know a lot of the time Mr. O'Brien knows himself what is to happen with patients. Unfortunately, this was not highlighted 15:58

on the Backlog Report. The secretary assumed we knew because there has always been issues with this particular consultant's admin work from our perspective".

When she says "unfortunately, this was not highlighted on the Backlog Report", I take her to be saying that the failure to dictate on what was a lengthy list of patients is not something that was recorded at that time -- 15:59

A. Mm-hmm.

399 Q. -- it had ceased to be recorded perhaps at some point after you had left that part of the service, or at least after you had handed the administrative responsibilities over to Mrs. Robinson. Can you help us on that? 15:59

A. I am not sure what her report actually looked like. I know certainly at the time --

400 Q. Just scroll down. I think it's behind this email. No, it might be above it. Can you go right up? No. Okay, sorry. 16:00

A. I'm not sure what the report itself actually looked like and what her columns on the report were. Certainly, even on the report that I have given as evidence, there was a column to the right for risk. So, if a secretary had some concern that we hadn't covered off in any of the columns that we were asking about, there was opportunity for them to fill that in and let us know of anything that they were concerned 16:00

about. They could, of course, have come to us at any time and let us know if there was something they were worried about or concerned about if they didn't want to be filling it in on a report, and we would have listened to them and taken that forward. So, I can understand her saying, you know, that they would have expected the secretary to highlight it rather than waiting for a formal report to come around and collect the information.

401 Q. Yes. Thank you for that. Can I move then to just a number of discrete questions around cancer tracking. 16:01

A. Mm-hmm.

402 Q. The Inquiry heard substantial evidence from, again, your colleague, Vicki Graham, on Tuesday, so we don't need to go into the fine detail about it. Just one or two issues. If we go to WIT-81762, and if we go down to 22.7, please. What you have said here is that: 16:01

"Importantly, it has been [your] view over a number of years that the cancer tracking team were inadequately staffed and inadequately funded by HSCB, the SPPG, to fully track the volume of patients on cancer pathways". 16:01

The implications of that for the service were what?

A. So, if we are not fully funded and fully resourced to track patients on cancer pathways, we are obviously working against ourselves in trying to track our patients along our pathways. The ultimate aim is that every patient who is on a cancer pathway will be 16:02

tracked at least once in that week to ensure, you know, exactly where they are in the pathway, what's happened to their care since the last time you looked at them, and that you are able to give an update on those patients on the CaPPS system. 16:02

When I came into post or moved over to Cancer Services in 2016, we were only funded for 3.9 cancer trackers. We did have 6.6 in post at that time, so the Trust had already gone ahead and funded some at risk. But even 16:03 at that, we still weren't at the level that we needed to track the patients on the 31- and 62-day pathways.

403 Q. Just to help you on this answer, if you go down to 22.9. You have explained that in January 2019, you raised a concern with your line manager, Mr. Conway, in 16:03 respect of that?

A. Yes.

404 Q. Isn't it fair to say that that came after the HSCB conducted a study themselves which recognised across a number of Trusts that there was a shortfall in 16:03 tracking?

A. Yes, and I would have been involved in providing some of the information for that piece of work that was done. They were taking the tracking levels that were completed for 2017 and analysing that to see what was 16:03 the required level of staff required to fully track the patients on the 31- and 62-day pathways. At that stage it was felt that we needed 8.6 full-time equivalents to do that, based on the 2017 figures. At that stage we

were asked to submit a business case, or an IPT, to put forward for one additional tracker, bringing up our funded resource to 4.9, so we still were short of what we required in terms of tracking. However, the Trust did go at risk in bringing what we actually needed to track the 31- and 62-day pathways at that stage.

405 Q. Putting at risk again, just so the public understands, you didn't have recurrent budget for this?

A. That's correct.

406 Q. Did you have any budget for it when you go at risk? 16:04

A. At times, no, you might not have a nonrecurrent funding stream for that either. The Trust obviously sees a risk to patient care and they will decide to go a financial risk to the Trust to actually appoint those people and bring them into post. 16:05

407 Q. Yes. You have reported more recently in your addendum statement, I suppose some good news --

A. Yes.

408 Q. -- around tracking, if that's not too exaggerated too much. Maybe we will just go to it; WIT-94967. You say at paragraph 4 that there's been fresh allocations of money? 16:05

A. Yes.

409 Q. Is some of it recurrent and some of it nonrecurrent?

A. Yes. The exercise that was carried out in 2018 was repeated, and that was done for all Trusts. At that stage, it was seen that the Southern Trust required 14.03 full-time equivalent tracking staff to complete the 31- and 62-day pathways. We were asked then to 16:06

submit another IPT to bring up our tracking resource by another three, so we now are funded for 11.6. Because we had already gone ahead and put those staff in post, they came back and gave us nonrecurrent funding then for the remainder. So, we actually do have the required number of staff in that we need to track the 31- and 62-day pathways.

410 Q. Yes. I suppose I am now thinking about the SAI recommendation which was for tracking through the whole patient pathway. This funding, just to be clear, only allows you to continue to track to first definitive treatment; is that right? 16:06 16:07

A. That's correct.

411 Q. Yes. I think if we go back to your original statement at 81763. Wrong page. Just go back one page. You say at 22.7: 16:07

"As with all other Trusts in the region, we currently track patients to first definitive treatment only on cancer pathways. That is if a patient required longer treatment and cancer support, no Trust is funded to support this level of tracking". 16:07

A. That's correct.

412 Q. It's perhaps convenient to deal with it here but I'm going to come to look at the reforms that are on-stream and your role in the Task and Finishing group in just a minute or so. 16:08

A. Yeah.

413 Q. But while we are looking at the issue of tracking, how

is the Trust proposing to address, if at all, the recommendations of the SAI reviewers in respect of tracking beyond first definitive treatment? Do you have an answer to that?

A. Well, I know from having discussions with my Assistant Director, Mr. Conway, that there has been discussions ongoing with the commissioners around the issue of tracking. At this stage there is no resource to move beyond first definitive treatment. There is work going on in the background try and understand what that would look like. We would need to know what that model is; how we are going to take that forward as a region. I suppose since I have been involved in the Task and Finish group as well, I have been raising it up through our own cancer operation links, which is where the cancer managers come together once a month and have discussions. And there's no Trust that I am aware of at the minute who is tracking fully beyond a 62-day pathway. 16:08 16:09 16:09

The CaPPS system itself is not set up to track beyond first definitive treatment either, so the whole system, the information system that's around there to support the tracking of patients isn't there, the infrastructure wouldn't be there to allow us to do it. 16:09 16:09

We know that one of the Trusts do set notifications for patients, so beyond first definitive treatment they maybe set an alert if a patient is being discussed at

MDT and something was to happen. We have since adopted that and we now do that for all our pathways. That's something additional that we do that we are not commissioned for.

414 Q. Yes, okay. Maybe we will touch on aspects of that in just a moment when we reach the SAI report. Briefly, just before we get there, during your time in Cancer Services you have been aware of the problem that the Urology MDT has experienced in achieving regular attendance by Oncology and by Radiology at the weekly MDMs? 16:10 16:10

A. Mm-hmm.

415 Q. We can see an example of that that I think you had some input on in September 2016. WIT-89477. It is the case, isn't it, that you were fairly aware of quorate problems, particularly around Radiology but perhaps because the radiologist came from your own Trust, the oncologists were supplied from Belfast; isn't that right? 16:12

A. Yes. So, Radiology also sits within Cancer and Clinical Services. We do have weekly meetings with the Radiology team, and if I was aware of issues around difficulties with Radiology attendance, I certainly would have been putting them forward for discussion at the Radiology meetings. I know that I have been copied into a few emails where there was issues around quoracy of Radiology as well. 16:12 16:12

416 Q. How would you diagnose the problem around Radiology, in particular in terms of being unable to secure the

attendance of the sole radiologist as regularly as was required by the MDTs?

A. When I came into post in 2016, we were ten consultant radiologists short within our Radiology team. There's been a significant improvement in that, in that we are now down to two radiologists short within the team. I think one of the challenges from 2016 has been actually securing a radiologist who had interest in urology and was able to attend the MDT. We have been fortunate now that we have that person in post, and he has been attending the MDTs from, I think it's May 2012. Since that time, we have had much better quoracy with our MDTs in respect of Radiology. I think this year in particular, for the calendar year 2023, there's only one that hasn't had a radiologist present. So, 18 out of the 19 have had a radiologist present. 16:13 16:13 16:14

417 Q. The example I was going to draw to your attention from 2016 - and I apologise, I can't locate the reference - but it was of a female patient whose discussion at MDT had to be deferred on, I think, three occasions -- 16:14

A. Mm-hmm.

418 Q. -- because of the absence of Radiology. It required radiological input at the meeting before a decision could be arrived at. That's the impact in a particular case of the absence of that resource. 16:14

The issue was a long-running sore. The absence of Oncology from the meetings was arguably worse --

A. It was.

419 Q. -- in terms of percentage terms?
A. Mm-hmm.
420 Q. Were those issues issues that the Commissioner was made aware of, and did you receive any assistance from the Commissioner or is that not the Commissioner's role? 16:15
A. The Oncology absence, I suppose, was higher than my level in that I know that Mrs. Reddick, who is the Head of Service for Cancer, was involved in IPTs and business cases revolving an Oncology and stabilisation plan, given that the regional resource was so small, 16:15 and looking at other areas where we could move to maybe more nurse practitioner ways of delivering cancer care and treatments and things like that. I would have seen those business cases and IPTs more from putting in resources and things from an admin point of view. But 16:16 yes, the Commissioner was fully aware of that, and that would have been escalated back through our bimonthly cancer meetings with the SPPG as well.
421 Q. Can I turn finally to the SAI report and the response of the Trust to it. As you know, the overarching SAI 16:16 Review looked at the cases of nine patients?
A. Mm-hmm.
422 Q. Some eleven recommendations were made and action planning around those recommendations was suggested; isn't that right? 16:16
A. Yes.
423 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.

424 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. 16:17

425 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.

16:17

"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. 16:17

Has it been stood down because it's considered that the work is complete? 16:18

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 16:18

within Cancer and Clinical Services.

426 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. 16:19 16:19

427 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. 16:19 16:20 16:20

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. 16:21 16:21

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. 16:21

428 Q. Okay. Is that Mrs. Muldrew?

A. That's Angela Muldrew, yes.

429 Q. Just so I understand that, she has got the job title of MDT -- I thought I had it written down. What's her job title? 16:22

A. She is the Cancer MDT Administrator and Projects Officer, so it would have projects specifically within cancer area. 16:22

430 Q. Yes. Does she still have a tracking role as did at the MDT coordinator before her in terms of monitoring tracking?

A. It was felt, because a lot of the issues were raised

were in relation to cancer tracking and things around cancer tracking, that it would be advantageous to have the cancer trackers reporting to Angela, given that she was going to be the MDT administrator. She does now regularly meet with the cancer trackers, discuss areas with the cancer trackers. So, it sat quite well with her role.

16:22

431 Q. What makes her role more impressive or more sympathetic to the needs of the MDT as compared with what went before, which was the MDT coordinator sitting and preparing for the meetings as well as having a tracking role? What has changed? Is it simply a name change or is it much more than that?

16:23

A. No. The cancer tracker and MDT coordinator is still there. The cancer tracker still provides all of the support to the tracking of the patients as well as the MDT preparation. Angela's role is more around the effectiveness and assurance of processes that are there in behind the scenes. 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.

16:23

16:24

432 Q. That's Mr. Quinn, is it?

A. That's Mr. Quinn.

433 Q. He commenced his work at the end of November?

16:24

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.

434 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? 16:24 16:25

A. Yes.

435 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? 16:25

A. Yes.

436 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? 16:26

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; 16:26

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. 16:27 16:27

Mrs. Muldrew has also been involved with trying to take forward information on CaPPS, on changing CaPPS so that we can start to record if a key worker has been allocated to patients. We are still in the early stages of that as well in that now we can record and say yes, they have been allocated. We also would like to take it a step further and further enhance the module within CaPPS for Cancer Nurse Specialists so that they can actually fill it in themselves and record that they have been allocated who they are and what information has been provided to the patient as part of that key worker interaction and consultation. 16:27 16:28 16:28

437 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. 16:29
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 16:29
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.

16:29

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 16:29
and those kind of things. We are not just resourced yet to do that.

438 Q. Yes. You mentioned at the very start when we were looking at your addendum statement how your responsibilities towards the maternity and women's 16:30
health side of your role have been temporarily removed from you?

A. Yes.

439 Q. Somebody has been employed to do that part of what was

previously in your job description; isn't that right?
A. Yes.
440 Q. Why is that? Is that to allow you to respond in some way or a more focused way to the issues raised by the recommendations of the SAI, or is it some other reason? 16:30
A. Yes, that is one of the reasons. I suppose there's recognition that the role that I'm in is actually quite a large role. It is a large role, it covers a number of areas, not just cancer; we have a large profile of work. That was one of the reasons. 16:31

The second reason was that Mr. Conway did feel that in light of all of the improvement work that we were trying to bring into Cancer Services, it would be good to have me focused on that for a period of time to help 16:31 move this forward as quickly as we can and get these things in. So yes, it's twofold.
441 Q. But you think it's indicative of the commitment of the Trust to try to address these matters?
A. It is, yes. 16:31
442 Q. Okay. I think that's all I have for you, you will be glad to know. If I could just give the Panel the reference I was struggling to find for the three deferrals for the cancer patient. It's WIT-89947. We don't need to bring it up. 16:31

Thank you.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIR: Thank you, Ms. Glenny. I am going to ask Mr. Hanbury if he has some questions for you. 16:32

MR. HANBURY: Thank you very much for your evidence. Just a few things which hopefully should be straightforward. The very long Outpatient waiting times, was there ever an initiative from the clinicians or anybody else to maybe not see everybody or have 16:32 a discussion about groups of patients or a recognition that they can only perhaps see red flags, the urgents and others maybe not? I mean, did that ever come over?

A. Yes. In fact, probably since Covid all the clinicians really are seeing are red flag patients and 16:32 time-critical urgent patients. So, really during triage, they are identifying the reasons for referral. If it's not clear that it's a red flag which we are able to code as a red flag and that it is urgent, if it's somebody who must be seen within a certain time 16:33 period, that will be recorded on the Outpatient waiting list to say that they must be seen. So, they are doing an element of that.

443 Q. The very routine, say someone requesting a vasectomy, for example, has a higher-up decision maybe not to see 16:33 that group of patients?

A. The routine patients, unfortunately, are not being seen, as I understand it, currently. Very few of them would be seen, if at all.

444 Q. It must have been very depressing bringing your 62-day figures to the regional performance review. When you discussed that - I accept other departments had these problems - were there any solutions generated from that forum? 16:33

A. Not always. I suppose they would have been looking to us to see if we had any ideas of how things could be improved or innovated. There would have been obviously the NICaN regional groups as well where discussions would have been ongoing amongst the clinical team. We 16:34 would have been hearing feedback through those meetings as well as to some of the ideas or information that they had. I just think there was very little that could be done in the way. You know, everybody was trying to do as much as they possibly could. 16:34

445 Q. You mentioned as a throwaway line, regional diagnostic centres; is that a thing now?

A. It is --

446 Q. What's the state on that?

A. It has just opened recently. At the moment it is just 16:34 seeing patients on a vague symptom pathway. They are patients who don't necessarily meet the red flag criteria but a GP is concerned about those patients and has a gut instinct more or less that there's something sinister happening, and they can refer into those 16:35 diagnostic centres. The view is that diagnostic centres, because they will have imaging behind them, that we will be able to use those imaging facilities to start to see some of our longer waiting patients on the

imaging waiting lists, which will ultimately help our red flag pathways.

447 Q. That's not specifically Urology, that can be --

A. Oh, no, it can be anything.

448 Q. Lots of things, more generic. Okay, thank you. 16:35

Moving on to waiting list management, you mentioned the once a month Thursday meetings, and who is going to do what in the next, and all consultants having different arrangements? 16:35

A. Yes.

449 Q. Is there a role for more of a centralised waiting list office type set-up, or what's your view on that?

A. Yes. Whilst I was in SEC, I actually was tasked with setting up what we call the scheduling team, so it was 16:35 on the premise of trying to have a centralised waiting list office. There were a number of specialties who came on board with that at the time. Unfortunately, Urology wasn't one of them at that time. I know it is something that the current Head of Service, 16:36 Ms. Clayton, is thinking about trying to involve with for certain particular maybe procedures like your flexible cystoscopies, day cases, things like that that would be more able to be scheduled in that way. It is being considered at the moment. 16:36

450 Q. The main theatre cases are still done independently by the individual urologists?

A. Yes. The ones where they feel they need to be involved with, or for co-morbidities or where they have been

involved in long period of time, yeah.

451 Q. Thank you. A couple more. The full pathway training. You mentioned a module on the CaPPS system involved the CNSes. What about another module for the final definitive treatment; is that a possibility? Is it a system that can lend self to additional -- 16:37

A. I am going to put my hands up and say I am not sure, because I don't sit on the CaPPS user group so I am not sure of the limitations of the system. I do know that the CNS module is one that they have talked about. I think it's actually there, it's more a matter of trying to get it into use. 16:37

I don't know if there's modules that move it beyond first definitive treatment, I don't think there's anything there on the system at the moment but I don't know enough about the system to say that for sure. 16:37

452 Q. Thank you. MDM. You have said the situation is better in the Radiology grade. What about Oncology, is there an improvement there? 16:37

A. Oncology is slightly better. There's not as many patients or there's not as many MDMs that haven't been attended as with Oncology as what there had been in previous years. It does still happen because it is still a regional service and they still are having significant recruitment issues within Oncology. So it's still, unfortunately, a problem. 16:38

453 Q. So, approximately what proportion of not --

A. I think there was six during the last 18 where there

was no oncologist available.

454 Q. So, roughly three-quarters -- which is great improvement?

A. A great improvement on what we had.

455 Q. Thank you. Just one very short one. We saw one or two cases where MDM safety nets have unexpected positive pathology for cancer diagnosis have slipped through the net. Maybe that's not your role, but do you think that has been tightened up; is there a better system now? 16:38

A. Yes, sorry, I forgot about that one. We do now have a pathology checklist in place. That was something following one of the recommendations that we had explored and looked into. We now have a weekly pathology checklist that comes down from the region. Then, Mrs. Muldrew compares that against the CaPPS system then to see if there's any patients that are not registered on CaPPS. That's brought forward to the cancer tracker and the MDT lead, if need be. 16:38 16:39

456 Q. Thank you. Very helpful.

DR. SWART: Just a few things, you will be pleased to know. I just want to take you back to the Health and Social Care Board. You have attended those meetings, if I understand it correctly? 16:39

A. Yes. For the cancer meetings, yes.

457 Q. And you presented a lot of data generally to the meetings over the whole waiting list portfolio as well? 16:39

A. Yes. So for those meetings, we would have had to prepare breach reports for patients who were breaching. So, I would have had conversations in advance of those

meetings with members of the HSCB to discuss those breach reports, talked about capacity issues, what the challenges were, and give slide updates then on the performance to the meeting.

458 Q. In those meetings, was there ever any focus on anything other than performance? Did they talk about, for example, the consequences of all those breaches for patients in any form? 16:40

A. There would have been discussions about, yes, consequences from the point of view of them trying to look at maybe bigger pictures in or around what they could do within HSCB to try and help that. 16:40

459 Q. I am talking about, you know, examples of patients who had waited a long time and had come to grief, or patient stories, or any discussions to say what has happened to the patients who have waited, say, 120 days for their cancer treatment. Did they ask you about anything like that is what I'm after? 16:40

A. Yes. In preparation for those meetings, we have been asked to provide the breach reports for every patient who had breached. 16:40

460 Q. Did they ask you to assess the harm to the patient?

A. No. We probably weren't asked to, but everything would have been in the breach report to describe what happened in that patient's treatment and care. 16:41

461 Q. At these cancer meetings, did they ever ask about the quality of services in the context of are you meeting Peer Review standards or anything of that nature, or was it purely numbers?

A. I don't recall any discussion around Peer Review standards.

462 Q. Any other qualitative things brought up in those meetings, or was it really just about targets?

A. Really, it was a performance meeting. 16:41

463 Q. Yes. You have described your role in the Task and Finish group, and there's clearly a lot of work that's ongoing. If I had to ask you what conversations do you have now at your cancer meetings that you didn't used to have before all of this, what would those 16:41 conversations be like now that are significantly different and you are perhaps a bit proud of?

A. So, we have actually changed the format of how we meet. Yes, we do still have our cancer performance meeting, a monthly cancer performance meeting, where we meet 16:42 with all of the specialty areas and they are all invited. We do go through all the performance reports. We do also then talk about things that are happening with each of the service areas, what in particular is causing challenges to each of the services, any issues 16:42 they may have, which we log as a cancer team. We now share that up through the senior management lines and give them line of sight on what the issues are.

As a cancer team ourselves, we now meet every Thursday, 16:42 and one meeting will be about performance, and one meeting, the next week, will be about things that's happening within our areas, our improvement work, what we are doing. We will go away with our actions. We

look at things like our incidents or anything that has been brought to light in that last time. So yes, as a service, I suppose we are more -- we are looking at ourselves much more inwardly in how we are delivering our services.

464 Q. Does that feel better?

A. Yes, it does.

465 Q. Would that be the thing you are most proud of after the Task and Finish, or is there something else that you would highlight as being a fantastic thing? 16:43

A. I think all the improvement work that's been put in since, because it was a difficult read to read the report and to know the effects that it had had on patients. So, to come away after it and take a step back and sort of reflect on some of the things, and what we could do here to try and improve those things and actually see those improvements now happening, and happening in a relatively short period of time as well since we have all became aware of it, I think that's something to be proud of. 16:44

CHAIR: You will be glad to know I don't have any questions for you, Ms. Glenny. I think we will end on that note and thank you very much for coming along to us. It's a quarter to five. Then next Tuesday, ladies and gentlemen, and 10:00, I think. 16:44

THE INQUIRY WAS THEN ADJOURNED TO TUESDAY, 16TH MAY 2023 AT 10:00 A.M.