Urology Services Inquiry

Oral Hearing

Day 50 – Wednesday, 7th June 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.

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THE INQUIRY RESUMED ON WEDNESDAY, 7TH DAY OF JUNE, 2023 AS FOLLOWS:

CHAIR: Morning, everyone.

MS. McMAHON: Good morning. The witness this morning is Dr. Gillian Rankin, a former Director of Acute Services with the Trust. She is going to take the oath. 10:00

GILLIAN RANKIN, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:00

1 Q. MS. McMAHON: Dr. Rankin, my name is Laura McMahon, I am junior counsel for the Inquiry. Thank you for coming along to give evidence today. You have already given evidence in the form of your written reply to the Section 21 notices, and if I could just take you to those and ask you to confirm that that's your evidence in written form. 10:01

The first one is at WIT-15779, and that's Notice 8 of 2022. That's signed at WIT-15935. Do you recognise that as your signature? 10:01

A. I do.

2 Q. It's dated 14th June 2022. Do you wish to adopt that as your evidence? 10:01

A. Yes, I do. Thank you.

3 Q. We then received an addendum statement which can be found at WIT-96714, and the signature can be found at WIT-96721. That's dated 1st June 2023. Do you

recognise that as your signature?
A. I do.
Q. And do you wish to adopt that as your evidence?
A. Yes, I do. Thank you.
Q. Thank you. We will look at the second statement shortly. You have added some further information you have recalled in relation to one of the issues we are going to discuss, and we'll come to that. 10:02

Now, you have provided a lot of information in your Section 21 and I suppose that's our fault, we asked you for a lot of information so thank you for providing all the detail that you did. By this stage, the Inquiry has heard evidence from a range of witnesses, some touching on aspects of your evidence. The focus of today will be some key aspects of your statement that are relevant to the governance issues for the Inquiry's terms of reference during your tenure as Director of Acute Services. Really, in global terms, the focus will be on the issues that arose during your tenure, how you became aware of them, how the governance systems operated to make you aware or not, what you then did and what subsequently flowed from that. We will take each item separately. 10:02 10:03

Just at the outset, I know that you have retired and you say that you got the documentation that you relied on in the preparation of your statement from the Trust?
A. That's correct. 10:03

6 Q. And all the documents were provided to you by them?
A. That's correct.
7 Q. Now, you have set out just briefly your background, if I can just touch upon that. You studied medicine at Queens; then you had various junior hospital jobs in Belfast; then you did your GP traineeship, achieving your MRCGP. After that, you moved into various medical and social healthcare management roles, leading ultimately to your appointment as the Interim Director of Acute Services on 1st December 2009? 10:03 10:04
A. Yes.
8 Q. Until February 2011, in the Southern Health and Social Care Trust. Then you were made full-time Director of Acute Services on 1st March 2011 to 31st March 2013. After that, you then left the Trust, moved to part-time consultancy in the NHS in England, and then subsequently worked part-time with the PHA and HSCB in a role through 2013 to 2016, and that included undertaking regional medical workforce planning? 10:04
A. That's correct. 10:04
9 Q. And then you retired in August 2019?
A. I did, yes.
10 Q. The job description, which we don't need to go to, for the Director of Acute Services is at WIT-15949. I would like to just read some extracts from that to set the boundaries of your responsibility at that time. The job description says: 10:05

"The Director of Acute Services will be responsible for

the development and delivery of safe, high quality emergency and elective hospital care within the Southern Trust. She will lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. She will provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, the post holder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives. The Director is responsible to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the successful delivery of agreed patient safety programmes, and the reporting of appropriate indicators to provide assurance to the Chief Executive and Trust Board."

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You also are to ensure high standards of governance "including the effective assessment and management of risk."

And you must "ensure that robust performance management arrangements are developed and implemented within the Directorate".

You say at paragraph 5.2 in your statement that you consider that the job description was an accurate

description of the duties of your post?

A. Yes.

11 Q. Just to give the Panel the context of other players at the time, if I can put it like that, there has been some changes in personnel over the years. During your time as Director of Acute Services, the Chief Executive was Mrs. Mairéad McAlinden? 10:06

A. That's correct.

12 Q. The Medical Director was Dr. Patrick Loughran, and then Dr. John Simpson? 10:07

A. That's correct.

13 Q. The Director of Performance and Reform was Mrs. Paula Clarke. The Director of HR was Kieran Donaghy. The Director of Nursing was Frances Rice. At that time the Assistant Director of Surgery and Elective Care was Heather Trouton? 10:07

A. Correct.

14 Q. And Ronan Carroll was Anaesthetics, Theatres & Intensive Care Radiology?

A. Yes. 10:07

15 Q. The AMO -- is that the AMD as well, are they interchangeable?

A. AMD.

16 Q. AMD, was Dr. Eamon Mackle -- sorry, Mr. Eamon Mackle, for Surgery and Elective Care, and Dr. Charles McAllister for Anaesthetics and Intensive Care. Now, the Clinical Directors For General Surgery and Urology were Mrs. Samantha Sloane, then Mr. Sam Hall and then Robin Brown? 10:07

A. That's correct.

17 Q. Throughout all of the time, the Head of Surgery for Urology and ENT was Martina Corrigan?

A. That's correct.

18 Q. Have I left anyone out? 10:08

A. I don't think so.

19 Q. Now, you have set out in your statement the general landscape for governance while you were the director. I just want to take you through some of those roles and processes you had in place before we move on, as they 10:08 will hopefully help explain how things actually were brought to your attention. I promise you you will be talking more than me subsequent to this, but if we set out the landscape, we will be on fair ground.

10:08

We don't need to go to this but at WIT-15830 at paragraph 32.1 of your statement, it says:

"The Director of Acute Services was operationally responsible for the day-to-day safety of patient care 10:09 and the quality of service, and this role was accountable to the Chief Executive."

If I can just ask you in relation to the Chief Executive at the time, what was your interaction with 10:09 Mrs. McAlinden, formally and informally? What were your lines of communication?

A. Formally I would have had regular one-to-one meetings with her, to which both of us brought issues for

discussion. I was formally appraised by the Chief Executive, of course, and that had a regular review throughout the 12 months relating to the performance indicators which had been set for the year.

Informally, I would have had contact with the Chief Executive, with Mairéad, almost daily, either face-to-face when we were both at a meeting or when I was in headquarters and wanted just to have a quick conversation with her. Or we phoned and caught up on the activities of the day, often at the end of the working day, which was often 7:00, 7:30 in the evening. So, it would have been an unusual day when I didn't have a degree of contact with Mairéad.

20 Q. In relation to your assistant, Heather Trouton, Martina Corrigan, can you give us a flavour of what your lines of communication and lines of interaction with them were both formally and informally as well?

A. Okay. The beauty of Craigavon hospital is that the offices where most of the managers are located are at the front of the hospital on the first floor, just above the main entrance to the hospital. So, most of the direct staff that I was working with, all of my Assistant Directors and many of the Heads of Service were in the next door office or around the corner. So, a lot of the communication was people coming to my office, me going to their office, some of it of course had to be by e-mail, and during one-to-one meetings or performance meetings when the whole system needs to be

10:09 10:10 10:10 10:10 10:11

present those were face-to-face more formal meetings. But a lot of the ongoing contact was face-to-face, informally, in the corridors around the hospital and along that corridor.

10:11

Because the suite of offices was situated at the front of the hospital, it was very easy for clinicians to call in on their way out or their way in in the morning, or their way out to the car park.

CHAIR: Sorry, I need to interrupt you but you do speak rather quickly. Although we don't have a stenographer present in the chamber, they are trying to get a note of all that you say. If I could ask you just to slow down a little bit, please. 10:11

A. I will do my best. Thank you. It meant that the clinicians often would have popped their head around the door of my office on their way out to have a quick conversation, to discuss an issue, to pass on some information or to seek some information. My policy was always to have an open door, a physically open door to my office and to my secretary's office. Everybody knew my secretary and knew that Emma would know exactly where I was. If I wasn't physically in the office, I could be contacted, and obviously could be contacted any time 24/7, seven days a week, 24/7 by e-mail. 10:11 10:12 10:12

21 Q. So the geographical close proximity, in your view did that assist good governance?

A. Absolutely. Absolutely assisted in governance. There was a lot of soft intelligence was in discussion.

That's often the way hospital systems work. You have the formal processes but you have also the conversations that happen through the wards and talking to nurses and talking to a range of staff, some of whom you don't necessarily met in formal meetings but you make it your business to be out walking in the hospitals, in both hospitals. I mean, I have to mention Daisy Hill, of course, here because I would have tried to spend some time every week in Daisy Hill Hospital, and the present -- I didn't have an office there but I would have arranged meetings and would have sometimes done formal meetings within the Directorate from Daisy Hill and videoed into my staff who were in Craigavon that day. So, we tried to make sure that there was one of the senior team in Daisy Hill on most days. 10:13 10:13 10:13

22 Q. You have set out at WIT-15832 - we don't need to go to that, I am going to summarise it - at paragraph 33.3, some of the systems you put in place to provide oversight of clinical and social care governance in the acute services when you started? 10:13

A. Yes.

23 Q. We will start at February 2010 and work through. Just before we do that, you had just started the role. Was it your view -- did you take an overview of what the governance structures were like in place and felt that you needed to bring about change, or is it usual for a new director to come in and develop their own systems of governance to ensure they are aware of all issues? 10:14

A. No, it wouldn't be usual to start afresh without understanding the existing systems because if they were fit for purpose, you would continue and develop those. What I inherited appeared to be a once-weekly meeting with the Assistant Directors. It was a one-hour 10:14
meeting on a Friday afternoon and it covered governance, performance, finance, HR, in an hour. I felt that Friday afternoon is not the right time of the week to have a senior leadership meeting. It
doesn't give you time to address things promptly 10:15
because you are coming towards the end of the working week, so the timing of that meeting was not good. I felt that to be able to cover all of the issues in sufficient depth and understanding, I couldn't cover them all within an hour. 10:15

So, I set up various -- three sets of meetings. One was a meeting with the Assistant Directors and the associated finance, HR staff from the Medical Director's office, where they were bringing information 10:15
on our complaints reports, on our risk registers and our IR1 reportings. That was a weekly meeting on a Tuesday afternoon. That was an in-depth meeting. We rotated that. One week it was governance, a detailed look at all of the wide range of issues under 10:16
governance, such as Patient Safety alerts, such as NC pods, such as learning letters, our risk registers, the recent monthly report on IR1s, complaints, any SAIs and their draft reports; looking at progress against actual

plans. That was one meeting. A second meeting in the month was on performance and another meeting was on finance and the fourth one was probably on HR.

Now, to echo that then with the senior clinicians, I started in April 2010 an acute clinical governance meeting. There had been no forum to which the senior clinical and management staff came together to discuss governance. Our first meeting, I think, was 16th April 2010. It was set at a Friday morning at 8:00 a.m., at a time when all the senior clinicians could be present. Again, we had a very similar agenda to the meeting that I had with the Assistant Directors. The whole range of safety issues were brought to the table, and it was an opportunity for anyone present to raise issues but also provide their views on the range of issues that we were discussing. 10:16 10:16 10:17

The third meeting that I set in place at that stage, which didn't exist, was a weekly performance meeting on a Tuesday morning at 9:00, where I expected all of the Heads of Service, and Katherine Robinson as Head of the Referral and Booking Centre and the Assistant Directors to be present. We met in a small room, there were often two people to a seat. It was an hour long meeting. It was a fast and furious meeting, provided and supported by the data. Another key person at the meeting was an Assistant Director from Performance and Reform, who brought the data that was up-to-date to the 10:17 10:17

previous day, to the Monday. We used that, those reports, from both the Assistant Director from Performance and Reform and from Katherine Robinson in the Referral and Booking Centre then to monitor how the system was doing against a whole range of metrics. That had not been in place before and I don't think the system had really used the data that was available to it to inform how we need to work, going forward.

24 Q. We have heard from Katherine Robinson about her intensity of preparation for those meetings and the effectiveness of them from her perspective, I will put it in neutral terms. One of the things that was clear from Mrs. Robinson was that the focus at that time was ensuring the data was collated almost concurrently so that those meetings were as up to date as possible? 10:18

A. Absolutely. Absolutely.

25 Q. I presume that was the aim for you, to know exactly what was happening across your division?

A. That was exactly the aim, to understand how each service was performing against the range of metrics, whether that was triage, whether that was the waits for Outpatient clinics, for first appointment, whether that was for review appointments, and to look at the inpatient waiting times and the day case waiting times. Those were the broad range of metrics that we looked at and to understand, projecting forward within the next months, three months, where we were likely to be within the waiting times, given we had the integrated elective and access protocol which had clear time standards 10:19

against each of those parameters which we were expected to meet.

26 Q. Were you confident at that time that -- we have looked at metrics and the way in which data can seem very one-dimensional but, when you go underneath it, there's perhaps a bit of a story that needs to be told. Were you confident in relation to the data that you were receiving that you were understanding of any outstanding issues that were perhaps interfering with performance metrics? 10:19 10:20

A. Well, that, in fact, was the benefit of having the face-to-face meeting and everybody in the room. If I had just been looking at a cold report, I wouldn't have understood necessarily the reasons underlying some of the issues that the data was telling us. By having the Head of Service for each of the specialties across all of medicine, surgery, obs and gynae around the table, and Katherine Robinson, we were able to delve into some of those issues. Sometimes they were significant and had to be taken off the table, and we would have had a separate meeting about those to understand what was happening and to try and get things back on track. It was a matter of bringing together all of that intelligence so that we could understand what was happening and then to take the appropriate action to deal with it. 10:20 10:20 10:20

27 Q. It may have been in preparation for this introduction of different ways of looking at governance but you also, in February 2010, sent an email to the ADs?

A. Mm-hmm.

28 Q. Asking them to set out the divisional processes to record IR1s.

A. Mm-hmm.

29 Q. "Identify SAIs, share IR1s and SAIs with clinicians and managers, identify and record actions and lessons learned, share information with the staff involved, i.e. complete the feedback loop, please send to my office by 24th February 2010". 10:21

Was that because you weren't that long in the post; was that you trying to get a feel for systems in place, or had there been something that prompted that?

A. No, I don't think anything had prompted that other than an awareness that things were not as I felt they should be. I was really asking the ADs, two of whom were new into post, to really look at their systems. As we were designing the overall Directorate system, that was to be echoed within each division and then within the Head of Service. So, there was a cascade in both directions. 10:21 10:22

There was a real thrust at that stage in the Trust that IR1s, we perhaps didn't have a culture that every incident was recorded on an IR1. So therefore, if it wasn't recorded it was only a very small group of people knew about it. Therefore, there wasn't necessarily learning from it and certainly the whole 10:22

system didn't learn from it.

One of the things we were very keen to do was to gain people's confidence in completing IR1s. Unfortunately at that stage, they had to be written and then sent to the Medical Director's office to be put on the system. But the whole thrust was to get IR1s to get completed, to get them visible, to have the local system where the IR1 was generated, to look at that and to understand what the learning was, and then to cascade that back up the system so you had information going in both directions. Very difficult to really get that motoring, but that was certainly the thrust of what we were seeking to do. 10:22 10:22

So, my email to the ADs at that stage was saying, look, you know how we are now managing ourselves at the top of the directorate, please now put in your systems with the same regularity, using the same information but a deeper dive, and get this working really well, get this energised in your system and I want to hear how you are doing it, because if you didn't ask for the feedback, you wouldn't necessarily get the feedback. 10:23 10:23

30 Q. It was that feedback and your identification of perhaps some vulnerabilities in the system, or some improvements that might be made, that then led to the setting up to the two new governance meetings that you have discussed, the monthly acute clinical governance meeting on a Friday, and the acute governance meetings

which took place monthly?

A. Yes.

31 Q. With the ADs?

A. Yes.

32 Q. Was it also an attempt by you to try and standardise the approach to governance feedback, as you say, both up and down the systems so that everyone understood what should trigger an IR1, what it should contain, what is an SAI, and confidence-build staff to engage with those processes? 10:23 10:24

A. It was absolutely. If you think of the Southern Trust - this was late 2009, early 2010 - the Southern Trust had only been a single organisational entity from April 2007. Prior to that, it was four Trusts, two acute hospital Trusts and two community Trusts, and there was still a lot of standardisation needed. So, a lot of processes were about finding new ways of doing them, engaging people in determining those processes but actually then bedding down, implementing and accruing the learning from those systems. 10:24 10:24

33 Q. What was the response from the ADs and the Heads of Service in relation to these new changes and these new systems of looking at how things were working? Did you meet any resistance, or were people keen to embrace new ways of working? 10:25

A. I think there was a mixture of reactions. Some felt that the old system was fine, and took a little bit more time and energy required to actually address the new way of going. Others very, very comfortable going

on that journey and welcomed it. As with any system, you will find the earlier adopters and those that come along a little bit later, and you've just got to work with the whole system to get it all there.

34 Q. Part of your role, you were also involved in various committees in the Trust Board, the Governance Committee of the Trust Board throughout your tenure? 10:25

A. Yes.

35 Q. Your role was to provide assurances by reporting back issues. How often were those meetings held with Trust Board? 10:25

A. My recall is that they were quarterly.

36 Q. Was it your experience that they were meetings at which you could report any issue and speak freely about any concern around governance, patient safety risk, any matter that was on your mind? 10:26

A. Yes. The meeting was supported by reports and papers which went out before the meeting. So those were discussed, obviously, but there would always have been an opportunity to raise an issue that had perhaps arisen in the week since the reports had gone out or the papers had gone out. So yes, they were long meetings, they were three to four hours long. Of course, each directorate was setting out their own report. The span of the range of services that are governed by a Trust in Northern Ireland includes not only acute health but community health, social care, all the social care problems, the disability problems. So yes, it's a very wide range of services. 10:26 10:26

37 Q. There's a sense that it could be a lot of papers presented unless you could filter down the issues that needed being brought to the Board's attention, at least the Governance Committee's attention primarily?

A. I am sorry, I don't quite understand what you are asking. 10:27

38 Q. You had the exercise, your discretion as Director, as to what made it into the report?

A. Yes. There certainly is an element of that. There perhaps would have been discussion at the senior management team, the senior management team governance meeting, as to which particular issues from each directorate needed to go into the report. The Director obviously had the discretion to add more in but there's a risk if you overload with too much, you lose sight of the key issues. So there's always a balance to be struck in terms of what goes into all of the reports. 10:27 10:27

39 Q. And the SMT governance is a way in which you hear from the Medical Director as well as to two issues arising?

A. Yes. 10:28

40 Q. And the Director of Performance and Reform --

A. That's correct.

41 Q. -- at that point as well?

A. Yes.

42 Q. Now, the Acute Clinical Governance Group; I think you were Chair of that group? 10:28

A. I was, yes.

43 Q. That was another way in which you could find out information from various members of staff from the

acute governance or acute services --

A. Yes, that's correct.

44 Q. -- on issues that were outstanding. Again, there were monthly reports. You also in those meetings received quality checking assurances from the ADs and the AMD. What does that involve, if they are giving you assurances around their particular areas of responsibility? 10:28

A. Well, that would have been the reports that were being brought to the meeting. It may have been assurances around actions coming out of RCAs; it may have been assurances actions around medicines governance, which we omitted to mention five minutes ago, another really important report on that agenda which Dr. Boyce would have brought to the table. So it would have been -- it's a face-to-face assurance as well as the data that is sitting on the page, and you've really got to do both. 10:29 10:29

45 Q. We will come to some examples when you sought assurance from, for example, Mr. Carroll on some of the issues arising. You will be able to give the Panel examples of the correspondence seeking that. 10:29

A. Okay.

46 Q. Just in relation to the line management of raising governance issues, and we don't need to go to it but I am referring to your statement at WIT-15855. I just want to read this paragraph. 10:30

"With the exception of the Serious Adverse Incident,

the governance process was taken through the line management process of managers and clinicians in CD and AMD roles. Therefore, the Head of Service and Clinical Director took appropriate action if they deemed the risk to be moderate to serious. They raised this with the AD and AMD, who in turn raised it with myself as Director. The data on the risk would then be further detailed and discussed at the service monthly meeting led by the Head of Service and the divisional monthly meeting led by the AD and/or both the acute services monthly governance meetings with the AMDs and ADs." 10:30 10:30

It doesn't seem there's any shortage of opportunity to discuss the issues?

A. No. 10:31

47 Q. One of the issues that has potentially arisen is the failure of people to inform each other whether they are on the clinical side or the operational side of potential issues or real issues, the issue of delegation or escalation and that perhaps being seen as being sufficient in circumstances. 10:31

Do you feel that when you were the Director of Acute Services that there was a greater cross-fertilisation of information between the medics and the operational side so that people had a global view of issues? 10:31

A. It's very difficult for me to compare what happened in my time to somebody else's time but I do feel that we had connected systems. We had connections between the

clinicians and the managers at all different levels. That was part of what I was seeking to ensure was in place. I think the openness of dialogue, which I am sure was never as good as it should or could have been, but there were never any clinical issues that were brought to my senior table that I actually didn't already know about through somebody having a conversation with me. The benefit of having the open door policy, having the senior clinicians dropping in and out, the benefit of walking the corridors, walking the wards and spending time with staff to listen. Now, not every member of staff would have opened up about things but many did. When you are walking around the hospital with a cup of tea in your hand, as I always did - it's one thing I haven't got here, is a cup of tea - a cup of tea in hand, it makes a deliberate statement, 'I want to have a chat'. I know people are busy and if you find there's something very serious to talk about, you come back and find a time to have that conversation. 10:32 10:32 10:32 10:33

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

A. Very much so.

49 Q. You were involved with the Urology Review in 2010?

A. Yes. 10:33

50 Q. That was another meeting that you chaired weekly or fortnightly with the Urology consultants at that time and the AMD, the ADs, the Heads of Service, senior staff from Performance and Reform, and HR and Finance?

A. That's correct.
51 Q. This was a process by which the development and agreement around the implementation plan was brought about over a period, you say, of around 16 months?
A. Yes, yeah. 10:33
52 Q. You also represented the Trust along with Mr. Young, who is one of the consultant urologists, and the Director of Performance and Reform on the Regional Implementation Project Group set up by the then-director of the HSCB? 10:34
A. That's correct.
53 Q. In relation to the Urology Review, that was almost simultaneous, I think, with your appointment; the same sort of era?
A. That's correct. Yes, it was. 10:34
54 Q. Would it be fair to say that you were responsible for, as Director, in your role taking the reins of implementing the change that was envisaged by the Review?
A. That's correct. It had been started by my predecessor 10:34 and I followed it on. The Monday evening meetings, Monday five o'clock meetings, were fortnightly. They were open meetings always to the three consultant urologists, the Assistant Director, the Head of Service and, as you have indicated, other staff from other 10:34 disciplines. The meetings were very clear in terms of what they were seeking to do. I always created an agenda for every meeting, every meeting that I chaired across the Trust. If there were 12 meetings in the

day, there were 12 agendas had been sent out prior to the meeting.

The regional review was very clear in terms of what it was seeking to do for Urology in Northern Ireland. All three units were expected to meet the same demands of certain metrics they had set out. So that was our challenge, to take our Urology Service through each of those different parameters and to get agreement before we could then set out our implementation plan for discussion and approval with the Health and Social Care Board. 10:35 10:35

55 Q. Now, you say in your statement - again we don't need to go to this - just for note, it's WIT-15811 at paragraph 16.6: 10:36

"The main issues were a combination of a lack of sufficient resources and a less than optimal use of the existing resources. The discussions with the Urology Service improved the use of resources in many ways, but during my tenure the service was still on a trajectory of improvement in this regard." 10:36

Is that in terms of the implementation aims, or was that your understanding of the provision of Urology generally? 10:36

A. No, that was in relation to the implementation. We had to work very, very hard to get agreement on the range of metrics, things like admission on the day of

surgery. There had been a longstanding -- as with many surgical specialties, patients would be admitted the day before, and we were now moving to a scenario that unless there was a medical reason for the patient to be pre-admitted the day before for assessment for further tests, most patients would now be being admitted on the day of surgery. That was quite a significant change. 10:37

The issues in relation to the number of procedures which we were undertaking as inpatients that we needed to change to day cases, that was a very significant change that had to be made over this time. There were quite a lot of changes that we were taking the urologists through that perhaps had been around before the regional review but the changes had not been made. 10:37

The thinking about the management of Outpatient clinics and the amount of time that a new patient should warrant within a clinic setting, and a review patient and the new-to-review ratio. What is interesting, the new-to-review ratio had been an issue for the Health and Social Care Board prior to the implementation of the regional review. Prior to 2007, 2008 when there was this structural change within Northern Ireland, we had four commissioning boards. Most people took the view that was three too many and we moved to a single commissioning board. The single commissioning board had to embark upon a process of standardising across Northern Ireland to prevent the inequity of post-code 10:37 10:38

lottery and post-code access. One of the things they had done was to look at all of the specialties within the acute sector, and to look at national guidance on what new-to-review ratios there would be within Outpatient clinics. So, there would have been guidance from the Royal College of Physicians, or from BAUS in relation to urology, or from the Royal College of Surgeons. The board adopted national guidance in relation to each specialty and we were required then to implement that. 10:38

So, I had brought the Clinical Lead for all of the specialties into those meetings with the board and we had already embarked on a process of moving each of the specialties to a new-to-review ratio. Most specialties were absolutely fine. One or two were resistant; those two was a medical specialty and urology. The medical specialty, we took a little bit longer but we got them there. In urology, that was a really difficult problem to get them there. Of course, if you are not adopting the correct new-to-review ratio, you are building up an increased new-to-review backlog and making a greater rod to deal with later. So, our new-to-review ratio in Urology in the Southern Trust was greater than the peers in Northern Ireland; that was set out in the regional Urology Review. We had some elements to work with. 10:38 10:39 10:39 10:39

56 Q. You speak about --

CHAIR: Again, if you could, just try and remember to

slow down a little bit. We are trying to get a note, as well as the stenographer getting a transcript. I know it's very difficult but if you can just try to slow down a little bit, please. Thank you.

57 Q. MS. McMAHON: I get reminded of that frequently as well so we are both in the same boat. That's probably why I am not saying anything. It seems fine to me. 10:40

One of the things you referred to in your statement is the issue of the capacity gap, that the Trust had agreed there was a capacity gap? 10:40

A. Yes.

58 Q. Could you just explain what that means and in what way the Trust established that?

A. Okay. The capacity gap is a concept that is usually agreed with the Trust as the provider and the Health and Social Care Board as the commissioner. Trusts can often talk about a gap but until it is agreed and set out with a commissioner, it's not an agreed position. It is where the population requirement for a particular specialty is greater than the resources that you have to provide care for that need. That capacity gap could be insufficient consultants in the specialty; it could be due to insufficient theatre capacity and theatre nurses and anaesthetic staff to be able to run all the inpatients. It could be a whole range of things. But in terms of urology, it was around the numbers of consultants and also the middle grade staff, because we had serious gaps in middle grade staff as well, which 10:40 10:40 10:41

contributed to the overall pressure within the service.

59 Q. If I can just feed your answer back to you to make sure that I understand it. The Commissioner wants a certain service and the Trust said well, if you want that, this is what's needed to meet that, is it as simple as that, and therefore we require greater access to staff or funding? Is it done that way? 10:41

A. Well, the simplicity of the statement implies that the Trust is using all the resources optimally, and of course we know that that was not the case. The Trust has an absolutely key responsibility to make sure that against the norms that are set for the Trust, be those from the Commissioning Board or be those from outside, within the national scenario, the Trust has a responsibility to make sure that whatever resources we are given for that specialty, we are using those. That comes down to things like your Outpatient clinic and how many new patients and how many review patients you were seeing in your Outpatient clinic; how many patients are being operated on as a day case as opposed to an inpatient, because all of these have direct impacts on the use of our resources. 10:42 10:42 10:42

60 Q. In order to establish if resources were being used optimally, were the consultants engaged in the process of establishing what the capacity gap was? Is that something that they would be asked about and consulted on, I suppose? Would they be aware of that or is it much more high level? 10:42

A. I can't speak for the time before me because

I inherited the regional review as a done deal, shall we say. It was published in, I think, April 2010 and I had started meetings with the consultants from January 2010, I think. All of the work establishing what the capacity gap was at that stage had been done prior to me coming into post, so I can't say whether the consultants had been involved at that stage.

I think going forward, though, the metrics that we looked at in terms of the numbers of patients on the PTL, the Patient Targeting Lists, the number of patients who were waiting to have an operation, the number of patients who were waiting for day cases, the number of patients who were waiting for urodynamics, the numbers of patients waiting on the Outpatient list, and the review backlog, all of that would have been known to the consultants because that was the crux of the conversations to have with them. Martina would have brought the most up-to-date position so that we were using that data on the table at those Monday evening meetings to talk about the need for change. They were our evidence to bring, they were the consultants' evidence. You would usually use that in the discussions with the consultants to say how are we going to handle this? What do we need to do? What's the process doing this and the time scale? Who is going to do what? So, we brought that to the table for those discussions on a Monday evening.

61 Q. You have mentioned the consultants were concerned about

obviously staffing and their ability to meet the demand?

A. Yes.

62 Q. We don't need to go to it but for the Panel's note at WIT-15811, at paragraph 17.3 and 17.4 of your statement, you give an example of receiving an email from Mr. Young. Your paragraph says: 10:44

"In relation to junior staff, I received an email on 6th August 2010 from Mr. Young Clinical Lead for Urology regarding junior staff and the need to clarify the funding for same and specifically for the action plan for urology." 10:45

A. Yes.

63 Q. You detail your response. 10:45

"My action in response to Mr. Young was to request the Head of Service to clarify the budget position before proceeding. This was the corporate requirement across all services due to the budgetary constraints imposed on the HSC by the Department of Health at this stage. No post would proceed to recruitment without a clear funding position and agreement by SMT scrutiny that the post would proceed to recruitment." 10:45

So, you responded to that by asking that the proper lines of securing that that post would proceed were followed through Mrs. Corrigan?

A. Yes. That specific request was in relation to a

clinical fellow. I think the date of that correspondence is germane in that that is the changeover of the junior doctors. I think probably that meant that we had a gap in a specialty registrar in the service. We had not been given the number of trainees for which there was funding, and that was Mr. Young quite rightly asking the question about could we appoint a clinical fellow who would work part-time within the service for the unit and would have a part-time research role. I just needed to establish that the funding for the clinical fellow was in the service; I think Mr. Young was quite clear it was. I just needed to establish that it was before we could bring that through for approval and go to appointment. 10:46 10:46

There was always a struggle to maintain the middle grade staff within urology, partly because at that stage my understanding was it was a national training programme and we didn't always get the number of trainees that we should have had. 10:47

64 Q. The Inquiry has heard evidence of staffing difficulties within Urology, which appear to continue currently?

A. Mm-hmm.

65 Q. Mr. O'Brien would certainly raise his concerns around the adequacy of the staffing in order to meet clinical demands and to carry out good clinical practice? 10:47

A. Mm-hmm.

66 Q. Was that a familiar theme during your tenure, that the consultants and medics within Urology felt that they

just couldn't meet the demand and were overstretched?

A. I think that statement is true. I mean, the Regional Review said we should have had five, a five-person team, and we had three. But we had to set out our implementation plan and the detailed job plans to deliver against the full activity that the Commissioning Board had set out before we could get approval to proceed to recruitment, and that became a very lengthy process. So, therefore, we had no permission in the system to increase our consultants until we got to that point. But we also had, as I have alluded to, gaps in middle grades which exacerbated the pressure. We had a seven-session ICATs doctor. ICATs is a service which is usually staffed by GPs with specialty interests who will take some of the workload from the consultants against an agreed specified list of symptoms or diagnostic categories. Unfortunately, our ICATs doctor who had seven clinical sessions was on long-term sick leave, and so that meant that instead of that being a potential route to review many patients, those patients who needed to be reviewed who could have been reviewed by the ICATs doctor then had to remain within the consultant review list. That was a theme throughout my whole tenure. So, we lost seven sessions a week, which was a very significant number of sessions. 10:47 10:48 10:48 10:48 10:49

Then, when you don't have a full complement of staff in training, you have difficulties again because if you

have a specialist registrar with you at an Outpatient clinic, you can increase the numbers of patients. Okay, you have a teaching workload to do but you can usually increase the number of patients being seen, usually on the review side within an Outpatient clinic, and that wasn't the case. So yes, staffing pressures were an issue all throughout.

I think at one stage we did appoint a consultant locum, who stayed with us for a short period. I know that in 2012, one of the three consultants decided to return to England. So, we had a gap for I think of the order of three or four months. We were -- and I think had appointed a locum at that stage but we were already within the recruitment process to move the three-person team to a five-person team. So, the consultant gap was small number of months. I know it was still a significant impact but it wasn't a prolonged period. I strove very, very, very hard in every specialty to keep our consultant posts full. It was a real theme to make sure that we had all of our posts filled across both hospitals and that any necessary gaps were as short as possible.

67 Q. You do say in your statement at paragraph 28.5 that you spent "considerably more time with the Urology clinicians than the clinicians in any other specialty in acute medicine across a range of over 16 specialties across both hospitals."

A. Yes, that, in fact, is true. That's because of the

Monday evening meetings. If you have a fortnightly meeting with consultants over 16 months, that is a lot of time. The meetings were all at least 90 minutes and often there was the informal conversation after the meeting, so you wouldn't really be leaving the room until 7:00. That's two hours every fortnight, so that amounts to a lot of time.

68 Q. You also speak to the difficulties in bringing about change in behaviours --

A. Yes. 10:51

69 Q. -- in order to meet targets and performance metrics. I will just read what you say at paragraph 29.5. For note, it is at WIT-15822.

CHAIR: Call some of this up because I think it's easier for the witness and us to follow when you are reading it out. 10:51

70 Q. MS. McMAHON: "The issues of changing the behaviour of the consultant team to meet the required new-to-review ration of patients, and new clinic templates in Outpatient clinics to increase the day case rate and lower the inpatient elective workload and to meet the BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the 10:52 10:52

the requirements for change tailored to each individual's practice."

Just in relation to the last sentence, how often would you have had to write formally to consultants to set out the requirements again of what they needed to do? 10:52

A. I don't think I wrote to any other consultant across all the specialties. We achieved the changes that we needed to achieve, both in relation to Outpatient new-to-review ratios, but also in new pathways for patients from the Emergency Department through to specialties and vice versa. All of those changes across the many ranges of specialties and many changes to reform and modernise were achieved without final resort to a written letter to the consultant. 10:53

71 Q. Would that have been something -- we will go to an example now of one from Heather Trouton to Mr. O'Brien. If I can go to AOB-00255, dated 1st July 2011. You will see it's to Mr. O'Brien from Heather Trouton and the subject is "Issues and actions from meeting held on 9th June 2011". 10:53

A. Yes.

72 Q. I just want to read this out. It says:

"Following our discussions on Thursday 9th June 2011, please see following a summary of our discussions and agreed actions. Dr. Rankin outlined the Trust requirement for updated job plans to be completed prior to end of June 2011. Dr. Rankin also placed a meeting 10:54

in the context of the Regional Urology Review and the necessity of demonstrating the provision of an effective, efficient and productive Urology Service if further funding was to be secured from the Regional Board. This productivity was also set in the context of the SBA capacity modelling exercise under way for all specialties across all Trusts." 10:54

The second point is about job planning.

"Mr. O'Brien to submit current breakdown of activities to Mr. Mackle for planning into updated job plan as per Trust action for all consultants Trust-wide to agree an updated job plan by the end of June 2011". 10:54

That was subsequently submitted on Thursday 16th June.

The review backlog:

"Heather Trouton to meet with Mr. O'Brien to discuss the way forward in managing the review backlog in a timely manner. Heather Trouton to set up meeting. Also to ensure that responsibility is taken to manage all Outpatient appointments in such a way as to only review those who clinically require review and thereby reduce the formation of a review backlog unnecessarily. A discussion was also had regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog or 10:55 10:55

review appointments". I presume that is "of review appointments"?

A. Yes.

73 Q. A mention of an issue we will come on to speak about.

10:55

"Patient admission for surgery: Patients are not to be brought in the days prior to surgery for IV fluids and IV antibiotics without discussion with and agreement from both Ms. Sloane as Clinical Director and the consultant microbiologist. All patients are to be 10:56 brought in for elective surgery on the morning of surgery, with the exception of the very complex patient who requires essential inpatient management prior to major surgery."

10:56

Then we have urodynamics consultant input.

"It was agreed following discussion that Mr. O'Brien would require 20 minutes per patient to review the results of the urodynamics studies and agreed/provide 10:56 a management plan for each patient. This would be factored into workload but does not require a full dedicated urodynamics session."

Then there was a note on pooled lists. 10:56

"There was an agreement on the need to manage all day-case patients in a chronological manner and to support Mr. O'Brien in managing the chronological

booking process. Sharon Glenny, the Operational Support Lead, and Andrea Cunningham, Service Administrator for Urology, will contact Mr. O'Brien to discuss support input required".

10:57

The cancer pathway:

"Discussion was had around specialist interest within Urology with regard to Outpatient time required to see day 4 cancer patient. It was agreed a 30 minute slot would be required.

10:57

"Discussion regarding the leadership requirement of all senior staff inclusive of consultants to give confidence to overall department nursing staff regarding patient care and to take action to improve patient management rather than projecting a negative and critical attitude within the clinical team.

10:57

"I would appreciate if you would advise if the above is an accurate reflection of discussions had and actions agreed or if any amendments are sought."

10:57

Is that a document you are familiar with? Have you seen that?

10:57

A. Yes, I have.

74 Q. Would you have seen that before it was sent to Mr. O'Brien?

A. Yes, yes.

75 Q. May I take that to mean that you agree with all of the contents that were put in it; it was reflective of issues that needed to be discussed at that time?
A. Yes.
76 Q. Just in relation to the point 8 where there's mention of the leadership requirement of all senior staff inclusive of consultants to give confidence and to take action to improve patient management rather than projecting a negative and critical attitude within the clinical team, was that something that you had direct experience of? 10:58 10:58
A. No. I'm trying to remember what caused that to be part of the conversation. My recall is hazy but I think there had been some examples of just negative discussions within the ward. All staff have a responsibility, but especially senior staff, in terms of keeping the system buoyant. If there are negative issues around discussing those, opening those up for discussion and getting them resolved and moving on. So there must have been something that had happened, otherwise we probably wouldn't have had that discussion in there but it's a very carefully worded paragraph. 10:58 10:59
77 Q. Some of the issues we will look at shortly when we look at your hand-over on your first day in role specific to Urology, and to Mr. O'Brien. This is dated halfway through your tenure, July 2011? 10:59
A. Mm-hmm.
78 Q. Would you agree that some of the first day themes seem to still be an issue?

A. Yes, some of them are still there but many of the themes are being managed appropriately but it's just a useful time to remind. I mean, the pooled list is an interesting one there. We had already put a process in place with Mr. O'Brien, who had always scheduled his inpatients list himself, but I had put a process in place fairly early in 2010 that Sharon Glenny as OSL, and Martina Corrigan, sat with Mr. O'Brien to make sure that we had patients being booked in chronological order for their inpatient episode. 10:59 11:00

79 Q. Just from discussion around the culture and the mood in relation to change, if we could bring up WIT-15872. I may have got the wrong -- I think I have the wrong Bates number, with the Chair's indulgence I will maybe read from my own and get the correct reference. Hopefully you will recognise this paragraph. 11:01

"On reflection, while there was a significant demand pressure on the Urology Service, there was a general resistance to change in clinical behaviour in the service. Nonetheless, when change was required in order to implement improvements for patients and to implement Team South Urology as part of the Regional Review of Urology, two consultants did make these changes in their personal behaviour. However Mr. O'Brien did not always make the changes required and there were times when change was agreed and implemented for a period of time before he reverted to the previous behaviour. He therefore was unable to or 11:01 11:01

chose not to amend his behaviour."

15782, thank you. There it is at paragraph 1.12. I don't know whether you want to read that again, or having read it out to you -- 11:02

A. That's fine.

80 Q. Was that something that persisted during your period in post, a resistance to change or, as you say, perhaps an inability to change?

A. Resistance or inability. Certainly that was a theme throughout, and particularly in the Monday evening meetings, that an issue for change might be agreed and perhaps that was then retrenched or rescinded the following meeting. In terms of making changes in clinical behaviour, whilst help was offered, there was a resistance to making that change. I think the only thing that was requested was additional secretarial time. There was no other help sought in thinking about how he could change his administrative processes to free up time for clinical work, which is primarily what his job was around, the relevant administrative processes to undertake the clinical requirements of the job. 11:02 11:02 11:03

81 Q. Both you and Mr. Mackle met with Mr. O'Brien on occasion to discuss issues. You have detailed one of those at WIT-15827, at 30.2A. If we look at the paragraph just preceding that, you can see that. You will see the question there about informal meetings within Urology. You say: 11:03

"Virtually all meetings with Urology staff regarding patient care and safety were scheduled meetings due to the need to identify a suitable time which did not impact on the consultants' clinical schedules. These meetings were scheduled with the urgency required and all out detailed responses to other questions. The only two informal meetings that I can recall are detailed below". 11:04

Then you detail both meetings. If I could just look at 30.2A. 11:04

"A meeting at my request as Director, Mr. Mackle as AMD and Mr. O'Brien Consultant Urologist. The meeting took place at the end of the working day after Mr. O'Brien had completed his main theatre list. I had been notified that day that Mr. O'Brien had not been triaging his red flag referrals and was travelling to the BAUS conference in Barcelona the following day. Mr. Mackle and myself impressed on Mr. O'Brien the requirement and importance of triaging red flag referrals. The permission to attend the conference the following day was refused unless the red flag referrals were triaged before travelling the following day. This resulted in red flag referrals being triaged and Mr. O'Brien travelled to the conference. I have no notes of this short discussion which took place on late April 2010. The red flag referrals continued to be 11:04 11:04 11:05

triaged appropriately for a period of time. The approximate timing of this meeting with Mr. O'Brien was confirmed to me by Mr. Mackle."

Now, that was obviously a meeting that you felt you needed to be at in order to move the matter forward? 11:05

A. Yes.

82 Q. I think that was a conference ultimately Mr. O'Brien wasn't able to attend because of the ash cloud?

A. The ash cloud, yes. 11:05

83 Q. But would that have been a pretty draconian response, to tell a consultant he couldn't attend a conference unless he did his triage?

A. Yes. I don't think that response -- I don't think any other consultant had that kind of response. But we were trying to impress on Mr. O'Brien the importance of this. There were times when he did agree with it, and there are certainly a couple of letters where Mr. O'Brien has written to Mr. Mackle and myself confirming that he will triage red flag referrals within the appropriate waiting times. There were times where we did get him to do that but we could not be confident that he would continue to triage within the appropriate time. That's why we had to have a very, very tightly managed weekly system of understanding where the red flag referrals and the urgent and the non-urgent referrals were within the Urology Service, and particularly when Mr. O'Brien was Surgeon of the Week. 11:05 11:06 11:06

84 Q. What was your feeling about the fact that the threat of a sanction like that seemed to elicit a positive response from Mr. O'Brien? I know you mentioned earlier you weren't sure if he was unwilling or unable to bring about change but on this occasion it seems to have been successful? 11:07

A. Yes. It certainly resulted in the referrals being triaged, but not in a sustainable way to be doing that, you know, of an evening after a whole day theatre list. But it certainly was giving him a message, this is important and it has to be done. But he knew at that stage that we were monitoring him, and it was out of that monitoring that we were able to identify that the red flag referrals were not being triaged. 11:07

85 Q. Now, you mentioned the second meeting was at your request? 11:07

A. Yes.

86 Q. "I had been hearing from several people that Mr. O'Brien did not appear to be himself. He was operating in theatre that day and I left a message for him, please come and have a chat with me on his way out of the hospital after completing his theatre list. At around 6:00 p.m. Mr. O'Brien joined me in my office. I said there were people concerned about him and I was therefore concerned for his welfare. I asked if there was anything which I could help him with or did he need to talk to anyone in the Trust or seek help with Occupational Health? He said he did not need help and was very surprised at the approach from me but thanked 11:07 11:08

me for it. I have no notes of this meeting and cannot date when it took place, except that it was likely to have been after the period of weekly/fortnightly weeks with the urologist to agree the implementation plan with Team South Urology." 11:08

A. Mm-hmm.

87 Q. Now, had someone come to you to bring your attention that Mr. O'Brien didn't appear to be himself?

A. That's correct, and I think that exemplifies the openness of the communication within the system. I 11:08 don't recall who had mentioned it to me, it may have been Mr. Mackle, but obviously there was a sense in theatre because this was Mr. O'Brien's all day theatre list, his main theatre list, that he didn't seem to be his usual self. So, that had come to my attention. 11:09 You, of course, are concerned for all members of staff; their welfare is partly your responsibility. I was very pleased that he did respond to my message and came up to see me, and we sat down and had a conversation. But he was not prepared to -- I mean, whether there was 11:09 anything significant worrying him, I don't know, he didn't allude to it. But we had, as always, a very civilised conversation, and he thanked me for it and left. There was a 10, 12, 15-minute conversation and that was all. 11:09

88 Q. Mr. O'Brien has, and will again I'm sure when he gives evidence, raised many issues around the lack of support, the lack of resources, the pressures he was under as a consultant clinician in the Trust, and his

belief that he was unable to carry out his tasks because he wasn't being properly resourced in various ways. Did he ever come to you specifically for help in relation to issues around resources? Did he come to you directly, or were those indications of concerns brought via him and the other consultants? 11:10

A. Mr. O'Brien never approached me directly about resources. The only approach directly that I can recall was from Mr. Young in relation to the filling the clinical fellow post. There certainly would have been no direct approach to me from Mr. O'Brien. I mean, I think that this meeting after his theatre list was the only occasion that I met Mr. O'Brien on my own during the tenure of my post. 11:10

89 Q. The previous meeting with Mr. Mackle was another meeting, and other meetings were in relation to more wider group of system-wide -- 11:10

A. Yes, absolutely. There would have been other members of staff present.

90 Q. I just want to bring your attention to a transcript of a meeting Mr. O'Brien had with Dr. Johnston, if we can go to AOB-56323. We might need to go to the first page, if we go back a few pages. This is not a meeting you were at? 11:10

A. No. 11:11

91 Q. But there's some reference to you in the meeting and I just want to ask you about it. The first page is AOB-56314. You will see the date at the top, it's 11th June 2018. What this is, Mrs. Rankin, is

a transcript of a recording of a meeting, a recording made by someone who attended the meeting. Mr. O'Brien was at the meeting accompanied by his son, Michael O'Brien, with Dr. Johnston and this is a transcript of it. 11:12

If we can go back to 56323, just down to line D. I just want to read this extract to you and let you comment, if you wish. Dr. Johnston says: 11:12

"Yes, according to many of the staff, there was difficulty and not always only difficulty with yourself. It was cropping one with Urology was particularly bad I understand, and it occurred on occasions with some of the consultants, that they had 11:12 particular difficulty getting you to agree and to do this triaging of the non-red flag cases. That's how we would describe them. If these patients were not to be triaged by you because it was time consuming, what was going to happen to them? Mr. O'Brien: Before the 11:13 default went in. Dr. Johnston: That's what I am talking about, the default in the past. Mr. O'Brien: Prior to the default? Dr. Johnston: Yes, prior to that. It went on for many, many years. Gillian Rankin had various meetings with you, I understand, to try and 11:13 get you to triage them and you... Mr. O'Brien: I don't recall having one single meeting with Gillian Rankin about it. Dr. Johnston: She clearly remembers some quite difficult meetings with you"

Mr. O'Brien: She had difficult meetings with me about the number of people we, and with my colleagues, terrible meetings, but I am not going into that detail but I don't have a memory. 11:13

Dr. Johnston: She didn't go into any detail either, just to let you know, but she did describe them as very difficult.

Mr. O'Brien: They were difficult and contributed significantly to our third colleague leaving." 11:14

We have just gone to a couple of meetings that you say you had with Mr. O'Brien, one was with Mr. Mackle, and there were no notes of those meetings

A. No. 11:14

92 Q. You would say to that that it's not true that you didn't have meetings with Mr. O'Brien about triage?

A. Oh, there's many, many notes of meetings on record, and often written correspondence after those meetings, which evidenced that we did discuss triage with 11:14 Mr. O'Brien formally on many occasions.

93 Q. We have just used the one in your statement as an example of that with Mr. Mackle?

A. Yes.

94 Q. Because of the recollection about the conference and 11:14 the potential sanction. That is the example.

A. Yes.

95 Q. Chair, I wonder if we could take a break at the moment?

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

96 Q. MS. McMAHON: I just want to briefly look at the review backlog issue and the plan around that. That can be found at WIT-15803. You have set out your role in the process at paragraph 13.3(a). I will just read this out. 11:31

"The director was responsible operationally for the reduction in the review backlog. Most actions were undertaken by the surgical division. Some evidence of actions taken to address the issue by the director was..." 11:31

Then firstly: 11:31

"To explore the interface with primary care to seek new review pathways where clinically safe to review patients in primary care. This could reduce the number of patients being reviewed in secondary care. This was subsequently followed by a small workshop involving the consultants and a group of GPs to discuss three to four clinical pathways which have been drafted for discussion." 11:32

11:32

Now, do you recall those workshops? Would you have been in attendance at those?

A. Yes, I think I was.

97 Q. Was the idea behind those to gain understanding as well

as buy-in into the process to try and reduce the backlog of reviews?

A. Yes, it would have been. I mean, perhaps a little bit of context in the background here. In my previous role in the Trust as Director of Older People and Primary Care, I had pointed an Associate Medical Director, a GP, into that role into Older People and Primary Care. Dr. Beckett was very well-connected to the GPs; he had long played a leadership role in primary care across the Armagh and Dungannon, one of the historical legacy Trusts. So, I knew that, having worked very closely with GPs and met most of the GPs across the totality of the patch during that post of Director of Older People and Primary Care, I knew that we could have a conversation with them about developing pathways for patients on the discharge from hospital, which would reduce the reviews. So, yes, it was an open conversation to bring the GPs to the table. Then we would have had processes with the GPs committee and other committees in the area to take those to a wider agreement with GPs and then to start to implement them. 11:32 11:33 11:33 11:33

98 Q. For the Panel's note, the minutes of the Urology Primary Care meeting of 17th June 2010 can be found at WIT-26620.

11:33

Then, the second point in relation to your actions:

"The evaluation of specialties against the review backlog checklist was sought by myself from each AD.

The response from the AD or SEC on 3rd August 2010 is attached and it states that the discussion in the division identified compliance with a lot of the suggestions or audits work in place to provide some of the information. It did provide some new food for thought."

So, this was a collective learning about the best way to achieve your ultimate goal of reducing the backlog?

A. Yes. Yes. Yes. 11:34

99 Q. If we go down to point 5 on that minute, on the next page:

"It also included a formal discussion and subsequent letters to each consultant regarding the new-to-review ratios for their patients. The data published in the Regional Review identified that the new-to-review rations for consultants in the Southern Trust were higher than their colleagues in other Trusts. This therefore was a contributing factor to the review backlog and needed to be addressed. After discussion with the consultants at a Team South project team meeting, letters were sent to each consultant".

What that seems to illustrate is that the consultants were aware both of the reasoning behind the need to adopt new ways of approaching this, and also expectations on their clinical practice in order to bring about this change?

A. That's correct. The fact that I was -- I took the action of writing to the consultants meant that I felt I hadn't got sufficient agreement. The agreement and the movement to the new Regional Review ratio was agreed with two consultants and subsequently implemented, and that is evidenced in the performance data. But Mr. O'Brien would not accept this, even though the new-to-review ratio that was which had been adopted by the AUS, the national urological society. It may not have been the most up to date or it may have been about to change but, at that point in time, the Commissioning Board had adopted that very reasonably as the metric to be met, and that was why we were using that with the three consultants. 11:35 11:36

100 Q. You go on to say in your statement: 11:36

"There were periodic improvements in the review backlog in Urology but it just wasn't possible to sustain those".

A. That's correct. We certainly -- it was very closely monitored. We were fully aware of the risk of having a huge backlog in review patients. The Board, the Commissioning Board, were aware of the risk and we sometimes were able to get funding for a certain number of extra review backlog clinics to see an agreed number of patients. All sorts of reasonable approaches were taken to reduce the review backlog, but really very difficult when you have, inside the system, you have a consultant who is contributing to the size of that 11:36 11:36

review backlog by not adopting the correct new-to-review ratio. It was quite clear in the regional report that the Southern Trust were out of kilter with their peers in Northern Ireland, let alone their national peers. Within the Southern Trust we were able to move two consultants to the new review, which then was fine, but we were not able to move consistently Mr. O'Brien. There was times when he moved to a new system and then he reverted to the previous behaviour, and that was a characteristic throughout the journey. 11:37 11:37

101 Q. You have set out some of the possible reasons why the improvement wasn't able to be sustained at WIT-15805, paragraph 13.4 onwards. I just want to read these out. You say: 11:37

"From memory, my recall is that there were periodic improvements in the backlog in Urology but it was not possible to sustain these. This was in part due to the following factors: 11:38

1. Increasing demand which was greater than the service could treat."

A. Correct.

102 Q. "2. Insufficient clinic sessions available to review all those patients in the backlog given that the three consultants were working full-time and working additional in-house sessions at weekends, evenings, to treat patients needing day case or inpatient surgery." 11:38

Just those first two. The two seemed to be more focused on availability of staffing and resources to meet the demands?

A. Yes. Those were certainly issues at the time, yes. 11:38

103 Q. Number 3:

"Insufficient progress was made on some of the actions required to fully address the backlog. An example of this was that both Mr. Young and Mr. Akhtar agreed to 11:38 amend their clinic templates but Mr. O'Brien refused to amend his clinic templates in October 2010. The clinic templates for all three consultants were amended to reflect the BAUS guidance with effect from mid-November 2010. However, Mr. O'Brien's clinics started to 11:39 overrun by two hours for each clinic and this was not a sustainable position for the associated nursing and support staff needed at each clinic. The result was that the number of new patients per clinic for Mr. O'Brien was then reduced by two new patients. This 11:39 meant that Mr. O'Brien saw five pure new patients each week than if he had adopted the BAUS guidelines for clinic templates, and the number of reviews required would have reduced if he had agreed to move from his ratio of one-to-two from four, and to adopt the BAUS 11:39 guidelines of a new-to-review ratio of one-to-two."

So, the crux of that paragraph is that Mr. O'Brien's own individual way of working or inability or refusal

to engage with the suggested approach of BAUS that was adopted by the Trust actually resulted in an increase -- or decrease in capacity to deal with patients?

A. It did, yes. The BAUS guidance was required of us from the Commissioning Board; it wasn't that the Trust had decided to do this. This was part of the regional implementation, that across the three teams within Northern Ireland we would all follow the same guidance so that patients had all the same access to services no matter where they lived in Northern Ireland. 11:40

104 Q. Was the guidance time-limited in there was -- was it a 10-minute or 15-minute slot for patients?

A. I think the first clinic appointment for a patient was 20 minutes, and review, it may have been 10. I mean, I am not sure on those details but that sort of order. 11:40 20 minutes for a first patient and 10 for a review. The day four cancer patients required a longer slot.

105 Q. For the follow-up review for someone who may have a tumour or some form of cancer, a 10-minute slot, would there be an argument from a clinician's perspective that that is perhaps inadequate? 11:41

A. I think when you are talking to a cancer patient at the point of diagnosis and talking about the preferred treatment plan, that's the day four cancer patient who needed a longer slot, which was agreed. I think that 11:41 was in the minutes of the meeting that Heather Trouton had chaired that we looked at just a few minutes ago. But those, the 20 minutes and the 10 minutes, those are prescribed nationally. Those are what all the

specialties would be doing. It means you need to be very organised in terms of the approach you are taking to the patient, and keeping notes throughout that.

106 Q. And were the other clinicians able to adhere to those time slots? 11:41

A. They were.

107 Q. You have mentioned in that paragraph that the clinics overran by two hours. This obviously had a knock-on effect to other support staff as well if they were running late? 11:42

A. Mm-hmm.

108 Q. Did you see those clinics running late or how did you come to have that information about the lateness of the clinics?

A. Oh, that was brought to me by Martina Corrigan. 11:42 I think this was an afternoon clinic, possibly in Banbridge. Instead of having a finish at 5:00, it was finishing at 7:00. The nursing staff had not been rostered to be there at 7:00 and may have had other commitments to go to. The support staff, the reception 11:42 staff and administrative staff that are always present at a clinic, they were not rostered beyond that. So certainly all the staff would have stayed on on an ad hoc basis, very willingly, there was a great culture of wanting to do the right thing, but it was not possible 11:42 to do that on a sustainable basis. So, it came to me through Martina at that stage.

109 Q. Just in relation to timeframes and staffing in order to meet the capacity envisaged by the implementation plan

of five consultants, there was a submission that the Team South implementation plan to the Health and Social Care Board in November 2010, and the approval to proceed came in July 2011?

A. Mm-hmm. 11:43

110 Q. Then there was undertaking a process to develop the job plans for the consultants, for the five consultant model, and that took several months?

A. Yeah.

111 Q. Was that negotiation and discussions with the other consultants or was that more of a HR issue? 11:43

A. No, that was discussions with the consultants. I wasn't personally directly involved in those discussions around the job plan. I wouldn't have been involved in job planning discussions. My role was to make sure that all of the information on the activity to be delivered was available. The fact that that had been agreed now with the Health and Social Care Board meant that we had agreed the activity for Outpatients, for day cases, for inpatients. So, that now needed to be turned into the job plans for the five-person model. 11:43 11:44

I think, probably from memory, we already had an outline of those five job plans ready but there was still an ongoing discussion about subspecialty interests and how those would be handled. For instance, Mr. Young always dealt with the stones and he did lithotripsy. There were other subspecialties that we needed to handle within the five-person team, and so 11:44

that needed separate discussions that Mr. Mackle would have been involved in with HR and Performance Reform in terms of the data around the activity.

112 Q. Who would have taken the lead? If it wasn't you, who would have taken the lead in those discussions with the consultants? 11:44

A. It would have been Mr. Mackle.

113 Q. Mr. Mackle. Now, you got the final approval in July 2011 but the five consultant model job plans were signed off only in March 2012. Is that an unusually long period of time or does the process normally take that long to get to the point where you can actually recruit? 11:45

A. The process does take a long time but I think that that was inordinately long. I think part of the pressure there was the pressure the consultants were under running the service. They were almost doing additional in-house waiting list clinics in the evenings and on Saturday. They didn't do any on a Sunday; that was quite clear, I'm very happy. 11:45

Consultants had been asked would they do additional theatre sessions and evening clinics, and it was their choice to pick those up. So, I suspect that had been a very busy winter which had contributed to the pressures but it did take longer than you would have hoped, longer than we had hoped. Of course, once the job plans are agreed with the consultants internally, there's then an approval process with the Health and 11:45

Social Care Board. We've then got to go to the specialty adviser for Urology, who was Mr. Patrick Keane at this stage, so you've got to get them back. So, there are various hoops you have got to go through before you can actually get to advertising for those new consultant posts. 11:46

114 Q. Given that the full implementation plan could not be brought to fruition until the five consultant model was in place --

A. Yeah. 11:46

115 Q. -- did that cause you any sense of frustration? I think it wasn't in place by the time you left.

A. A considerable amount of frustration because my sense was that there would be considerable motivation from the three consultants internally to actually get this agreed and out to recruitment as quickly as possible, because the money could be not be pulled down against the new consultants until they were agreed. That motivation didn't appear to be aligned in the way that I thought it might have been. 11:46

116 Q. Now, IEAP and performance targets were also part of your role. You do say in your statement that this predated your appointment, this process?

A. Yes.

117 Q. But its requirements by the time you took up post had been implemented, and your belief was that each consultant was clearly aware of the requirements of the IEAP? 11:47

A. Yes.

118 Q. And the timeframes and the metrics. That goes back to what we spoke about earlier when you talked about getting the information back on what the targets and the performance metrics were?

A. Yes, that's correct. 11:47

119 Q. Would it be your view that the IEAP placed a primary obligation on the Trust to ensure that the service was sufficiently staffed and resourced to enable the consultant to triage referrals? Do you think the burden was on the Trust to properly resource a system 11:47 that they put in place, or performance metrics that they wanted to achieve?

A. That wasn't the system that we were working in and I suspect it's not the system we are working in today. The system is a joint system between the commissioner 11:48 of the services against the population need with the provider providing the services. So, the Trusts at that stage now - my memory is very clear - the Trusts would have not had the permission to appoint a consultant to any specialty without the express prior 11:48 permission of the Commissioner. In fact, there were instances where individual Trusts went out to appoint a new consultant for a specialty that they felt was under considerable pressure, and they were asked to pull that appointment because it would not be funded by 11:48 the commissioner. Trusts on occasions went out to fund -- to appoint a consultant on nonrecurrent funding, which of course meant that you would be looking for recurrent funding from the Commissioner but if the

Commissioner had not approved that before going to recruitment, the Trust would have been asked to pull the recruitment. So, it was a very tightly controlled environment in terms of resources at that stage.

11:49

We were also at that stage taking efficiency savings out of the service, so each Trust had a percentage reduction within its overall budget. That, of course, filtered down to directorates. So, whilst we were seeking to improve the quality of service, seeking to 11:49 deliver against all of the targets that were set out for every specialty, we were also taking funding out of the system. It was a very, very difficult triangle to square, or to, you know, put around. Very difficult.

120 Q. Was it your view that the staff in place at the time, 11:49 the numbers and the way in which the structures were set up, used at their optimum, were sufficient to meet these performance metrics? Or did you think that there was an argument that there had been a push of responsibility on to the consultants to meet these 11:50 targets when they already felt overstretched with their clinical duties?

A. No, there was no specific push on to consultants at all. There was a recognised capacity gap but I think when you recognise that there was a 98% increase in 11:50 Urology referrals over a six-year period, which included daytime when I was in post, that's a very considerable rate of increase. I think the Regional Review, when I reread it very recently, indicates that

they had estimated what the projections would be, but they recognised that might not be entirely how it worked out because they were moving some of the procedures from Urology to general surgeons, and there were some unknowns in the system. It almost implied that they would have to look and see, once they had implemented this, whether there was sufficient capacity in the system. So, I think it was known that certainly at that time with the three consultant model, there was insufficient capacity. All of the agreements to run additional clinics and theatre sessions was with the agreement of the Board because they funded it non-recurrently. Also, to place contracts with the private sector for an agreed range of procedures. We always agreed the range of procedures in there. 11:50 11:51 11:51

Those were only done with the agreement of the Board. When the backstop, as we called it, the waiting time for particular, whether it was inpatients or day cases or Outpatients, when that backstop moved, that was with the agreement of the Commissioner. When we couldn't meet the IEAP time standards, that backstop went out to maybe 17 weeks and sometimes to 36 weeks. We were being judged against our performance of those new backstops. Those recognised that there was a capacity gap, but that was recognised as a joint approach between the Commissioner and the provider, the Board and the Trust. 11:51 11:51

121 Q. The IEAP was, of course, the framework against which

the framework of all services, not just Urology, were being assessed?

A. Yes, that's correct. Urology would not have been the only specialty that was not meeting the specific targets in IEAP, there were other specialties, but I think Urology certainly was one of the ones with the greatest mismatch between demand and capacity. 11:52

122 Q. Just before we are both told off again, maybe we can both slow down and then we won't lose a stenographer this week. But you will be glad to hear we have worked our way to your first day in the job, so I am going to look at 1st December 2009 to see what the specific - that's a more general landscape of what you inherited - but the specific issues. You set them out at WIT-15780, at 1.2. You say: 11:52 11:53

"Issues in relation to the Urology Service were raised with me on my first day in post, i.e. 1st December 2009. This was to a meeting chaired by the Chief Executive which alerted me to the current and ongoing issues the Regional Review of Urology had reported but was not yet signed off by the Minister. The development of the implementation plan for Team South Urology had commenced, and I subsequently chaired a weekly/fortnightly meeting with the consultants involved to get agreement on the implementation plan and its implementation." 11:53 11:53

If we move on to WIT-15820. 28.3, sorry.

"Specific meetings were not held on a regular basis".

You have identified this as an outlier meeting but it sets out the issues you were informed about on 1st December 2009. 11:54

"... meetings on a range of governance issues chaired by the Chief Executive with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services," which was your post at the time. 11:54

"The range of issues on the agenda included: Demand and capacity and the need to optimise the use of clinical sessions, quality and safety, the Medical Director to discuss with Mr. Fordham seeking an urgent professional opinion on A, the appropriateness and safety of the current practice of IV antibiotics; B, triage of referrals and one consultant refusing to meet the current standard of triaging within 72 hours; C, red flag requirements and one consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately; D, chronological management of theatre lists for theatre with one consultant keeping patients' details locked in the desk. 11:54 11:55

"Action agreed that if there was no compliance,

correspondence would be sent regarding the implications of a referral to NICAS if appropriate clinical action was not taken."

Now, they were the general issues that were brought to your attention. Was this information from the Chief Executive or was it from the Medical Director at the meeting? Can you recall the way in which the information -- was it just on an agenda and it was discussed generally, or did someone actually speak to a narrative of these issues at that point? 11:55 11:55

A. I don't recall the specifics of the meeting as to who was speaking to each issue. I'm sorry, I don't have that recall. It is first day, and baptism of fire.

123 Q. It certainly seems to be a very specific list of issues and we move on to the detail of some of that. Just in relation to point B, where it says "triage of referrals and one consultant refusing to meet the current standards of triaging within 72 hours", was that a reference to Mr. O'Brien, do you know? Did you know at that time or... 11:56 11:56

A. Almost certainly that was in reference to Mr. O'Brien.

124 Q. Was there any suggestion that rather than him refusing, that it was his view that he just simply was unable to meet referrals within 72 hours due to other competing clinical demands? Was there any context to that sentence at the meeting, or it was simply put forward as a refusal? 11:56

A. I don't recall, I'm sorry.

125 Q. The issue in relation to the chronological management of theatre lists for theatre, with one consultant keeping patients' details locked in the desk, that sentence, I'm not sure if the first part of the sentence explains the second part or how they sit together, the alleged locking of patients' details in a desk with the chronological management. I know it's a long time ago but what was your understanding of the point that was trying to be made by that issue? 11:57

A. I think the understanding that I took away was that Mr. O'Brien, in personally scheduling his theatre lists - in other words, nobody else was involved - he was therefore scheduling patients potentially out of chronological order. All the other surgeons would have met with a member of the team; there was the Operational Support Lead, there were secretaries, and most other surgeons would have done that with somebody else and they would have worked through the PTL, the Patient Targeting List and taken off the longest waiters to ensure that they had the right case mix for a theatre session, be that a four-hour session or all day eight-hour session. Obviously, neither surgeon can make that determination; you have to get the right mix of operations to make the best use of that time in theatre. That's my understanding of what that point was about. I then set about setting in a new system. 11:57 11:58 11:58

126 Q. Just on one analysis, the locking of patients' details locked in a desk would seem to be good protection. You are disagreeing with the context of that?

A. Yes. No, no, absolutely not good protection. It should not have been locked in a desk and should have been available to the system and known about in the system, so that if the patient was consulting any other specialty, that they would have been available to them. 11:59

127 Q. Was there any suggestion behind that, that notes had been needed to be available and weren't?

A. No, none at all at that stage.

128 Q. If we go to WIT-15871, you list the specific issues in relation to... 15781. Those are the general issues in Urology, and these are the specific issues then that you -- 11:59

A. Yes.

129 Q. -- were aware of from day one, I think.

A. No, some of those -- that is a list of all of the issues that I encountered during the tenure, so they would not all have been known about on day one. 11:59

130 Q. Well, they provide some context to the wider, more generic issues and some specific issues that were brought to your attention with the Chief Executive? 12:00

A. Mm-hmm.

131 Q. Was that your official hand-over, that meeting? Was it specifically for you as a new person in post?

A. I don't know. I don't know what the reason was for calling the meeting. It just happened perhaps to be on my first day, but it certainly meant that I was briefed about the issues I was dealing with. I also knew I had the support of everybody around the table. 12:00

132 Q. At paragraph 1.7 you've summarise the issues that you

were aware of during your stewardship.

"The specific issues in relation to Mr. O'Brien related to the need to change behaviour in relation to some clinical practices and some administrative practices. 12:00
The range of issues included triage of red flag referrals, i.e. referrals of people with potential cancer and non-urgent referrals; B, the scheduling of patients for surgery without due regard to urgency in chronological order; C, the surgical operation of 12:01
cystectomy; D, the use of IV antibiotics for inpatients; E, referral of patients requiring prostatectomy or cystectomy to the Belfast Trust, and the implementation of the regional MDM multidisciplinary meeting to discuss each patient with 12:01
cancer and agree their treatment; F, service capacity gap which impacted on the waiting time for patients for Outpatients clinics, day case surgery, inpatient surgery and review Outpatient appointments, and breaches of the 31-day and 62-day standards for 12:01
patients with diagnosed cancer; G, failure to retest results when received and before filing the patient notes, irrespective of whether the patient has an Outpatient appointment booked; disposal of some patient notes and information in the bin of a consultant's 12:02
office."

They are all specific to Mr. O'Brien?

A. Yes.

133 Q. Now, if we can go to WIT-15820 and paragraph 28.3(b). Now, after your initial meeting on 1st December where your brief was handed over, you had a meeting with Mr. Young?

A. I did. 12:02

134 Q. Was that just you and Mr. Young or was there anyone else at the meeting?

A. No. Dr. Loughran as Medical Director was present at the meeting, and Mr. Mackle as the Associate Medical Director for Surgery. I think there were the four of 12:02 us. I am not sure that Heather Trouton was at the meeting.

135 Q. You also had a meeting on the same day with Mr. O'Brien?

A. That's correct. 12:03

136 Q. You describe that at paragraph C at WIT-15821.

"The 7th December meeting. Follow-up meeting with Mr. O'Brien, Consultant Urologist, after the 1st December meeting. The key points of discussion and the 12:03 necessary actions are set out with agreed actions by Mr. O'Brien to review current patients waiting to determine if urgent or routine, to put all urgent patients on to immediate lists and other immediate actions with key staff." 12:03

Was that the first time you had met Mr. O'Brien?

A. Yes, it was.

137 Q. Given the list that you had been made aware of on

1st December about Urology, did you reflect those matters of concern to him at that meeting and indicate that things needed to change, or what was the tone?

A. That would have been my recall. What I would have done would have been created the agenda for the meeting on 7th December as the agenda that we had had for the meeting with the Chief Executive on 1st December. It's enough work to do without creating new agendas. So that would have been the request to Emma, to set that out as the agenda for the 7th December meeting and to go through all of those issues. 12:04 12:04

138 Q. At that meeting was there any pushback from Mr. O'Brien, or explanations as to what his version of the issues were from a clinician's perspective? Did he try and explain why, for example, he wasn't able to meet some of the targets? 12:04

A. I think it was a strange meeting in a way, and I think the notes of that meeting reflect that, which I would have done, because not only are you usually chairing the meeting but you are also taking the notes and sending out the note afterwards. There were a lot of different issues raised, which I think the note of the meeting reflects, which I hadn't expected. As I say, this was my first encounter with Mr. O'Brien. We must have discussed all the issues set out in the Chief Executive meeting, but the note reflects a range of other things that were also brought in. It wasn't necessarily a meeting of minds at that stage. 12:04 12:05

139 Q. I think I have written down the reference to the note

incorrectly so I will not be able to go to it just at the moment unless someone can give me the correct version. I normally rely on Mr. Lunny to have the answer. We will come back to the note of that.

It was certainly six days into your role as Director of Acute Services and you were straight in meeting Mr. O'Brien and Mr. Young?

A. Yes, that's correct.

140 Q. At WIT-15799 you set our a further list, down the bottom, please. Paragrah 12.7 "Evidence of Additional Meetings and Actions" regarding the Urology Service meeting the IP Performace Targets. The email sent in pursuance of that. This seems to be an issue that you were on top of, if I can use that phrase, to try and bring about the change that was required in order to meet the targets? 12:05 12:06

A. I was certainly very much aware of it. Because we were seeking to modernise and to make the considerable changes to implement the Regional Review, it did have my personal attention. Obviously there were a lot of actions done within the system through the Assistant Director, Heather Trouton, and through the Head of Service, Martina Corrigan, and also the clinicians, but at that stage in my sense in the post, and with also a new assistant director, I felt that we needed to work this together. So yes, it did have a lot of my personal attention, just to ensure that things were done in the way they needed to be done and in the time 12:06 12:07

scales that they needed to be done.

There were many demands on our attention at that stage and this could very easily have gone off our radar and that would not have been a useful place to be. This needed to be kept on the radar in focus until we got to certain points of agreement and got things implemented.

141 Q. If we just go to point D on the next page. It's just an example of one of the meetings on 9th June 2011 where you chaired a meeting with Mr. O'Brien, Mr. Mackle, and Mrs. Trouton to discuss a range of issues, including performance to meet the requirements set by the HSCB for Team South Urology, the review backlog, patient admission for surgery, urodynamics, pulled lists and the cancer pathways. You have attached that. 12:07 12:07 12:08

Even at this remove, it seems that many of the issues that were first-day problems continued to require your attention in order to try and get them resolved? 12:08

A. Well, things like the review backlog, we were putting in actions to address that but we never got the review backlog completely contained. That would have been miraculous if we had. 12:08

Patient admission for surgery. That's presumably patient admission on the day of surgery, we were moving in that direction. But all of things are processes, they are not something that happens overnight. So, it

would have been considering the process of where we had got to and what more needed to be done; were there particular cohorts of patients for particular procedures which were still being brought in the day before and why was that? There would have been discussions to try and understand what was happening. 12:08

Urodynamics. I think my recall around that was the number of patients in a session taking place in the Thorndale Unit. It never seemed to me that we fully utilised the fact that we had the Thorndale Unit, so that would have been a conversation. 12:09

Pooled lists. Whilst the right thing to do, I'm not sure we ever got all three consultants to agree to a pooled list. There were occasions when if one of the consultants had a consistently longer waiting list, we agreed cohorts of patients could move from that consultant's list to another consultant's list. That could have been in all the directions across the three consultants, not only specifically Mr. O'Brien. 12:09 12:09

The cancer pathway was always a point of discussion. We continued to have small numbers of breaches along the 31- and 62-day pathway and we were working on actions to address that, such as the one-stop haematuria clinic and the one-stop prostate clinic which then were implemented later on in 2011 to try and remove the breaches in the pathway. So, that was 12:09

always in discussion. I wouldn't say that they had not been addressed, they were in the process of being addressed and some had been addressed.

142 Q. They were still a work in progress?

A. They were still a work in progress, absolutely. 12:10

143 Q. Mr. Lunny has risen to the challenge and come up with the reference for the meeting. So, it's at WIT-11852. This is the note of the meeting on 7th December?

A. Yes.

144 Q. You will see present was Dr. Loughran, the Medical Director, Mr. Eamon Mackle, AMD, you and Mr. O'Brien, we will just go through the notes. Are these notes subsequently sent to other attendees to confirm their accuracy, or is this -- 12:10

A. Oh, yes. They are sent out as a draft for anybody to come back to amend and then go out. Absolutely. 12:10

145 Q. The key points of discussion.

"1. The Trust expects in line with the NI Integrated Elective Access Protocol that all patients will be treated by clinical priority and chronological order. Those patients on Mr. O'Brien's lists as clinically urgent may not be clinically urgent. No agreed process in place for the consultants and junior staff on what is urgent and routine. If juniors designate as urgent 12:11 wrongly, the patient status is not amended to routine. Agreement to review whether urgent or not by Monday 14th December."

And that was to be actioned by Mr. O'Brien.

Are you aware was that actioned by Mr. O'Brien, those particular steps to review the categorisation?

A. That would have been reviewed because otherwise it would have come up during performance meetings. That's really about an individual consultant-led team agreeing what the criteria are for juniors in terms of their decisions of putting patients against a routine or an urgent list, designation on a waiting list. 12:11 12:12

146 Q. To ensure uniformity of approach in the categorisation?

A. Yes. That was usually consultant led.

147 Q. "Number 2. Agreed to put all urgent patients onto immediate list. Action Mr. O'Brien". 12:12

Again, was that something that was recurrent at future meetings or that was deemed to have been done at the time?

A. I don't know that that was done at the time because I put the process around Mr. O'Brien that he did not schedule his lists himself. I had the Operational Support Lead, Sharon Glenny, and either Martina Corrigan or one of the theatre schedulers would have met with Mr. O'Brien to schedule his list. That was an ongoing process throughout my ongoing tenure; I didn't relinquish that. 12:12 12:12

148 Q. I just missed your last sentence there.

A. I didn't relinquish, I step down that process during my tenure in post.

149 Q. There was a change in approach then?
A. There was a change in approach.
150 Q. The scheduling would be not so much centralised but --
A. All the other consultants scheduled their theatre list with somebody else, who then took it away to actually implement it. Mr. O'Brien was the only surgeon who did the scheduling of the Patient Targeting List himself and so, therefore, we had no visibility at the point in time of who he was scheduling. And that's where this comment relates to. So, I put a process around him to support him in the process of scheduling but to make sure that the longest waiters within the urgency category were those that were being taken first. 12:13 12:13
151 Q. Just while we are on that, the scheduling of patients, you say Mr. O'Brien did that on his own. Was he supported in that role by a scheduler? 12:13
A. He should have been but he was refusing that support, as I understand it at that time.
152 Q. The new arrangements to standardise the procedure around the scheduling of patients, was that something that was adopted by other consultants in Urology? 12:14
A. I don't think there had been a problem in terms of the other consultants.
153 Q. Was it your understanding that it was only Mr. O'Brien who allegedly didn't schedule the admission of patients in chronological order? 12:14
A. That is my understanding, yes.
154 Q. It was your understanding then that once this system of chronological scheduling was asked to be adopted by the

consultants, that it was actually implemented and you were assured of that, that that process was in place, save for concerns around Mr. O'Brien?

A. Yes, I was assured of that. The Tuesday morning meetings, performance meetings, each head of service had their PTLs, and they were then monitoring them in detail because they knew they were going to be asked about them the following Tuesday and the following Tuesday and the following Tuesday to make sure that the patients were being taken off the Patient Targeting List in chronological order according to their designation of urgency. 12:15 12:15

155 Q. Just for the Panel's note, you say at your statement at WIT-15872 (g):

"The systems put in place were successful as they removed the sole control of scheduling of surgery from Mr. O'Brien and ensured the rules were applied". 12:15

A. Yes.

156 Q. Point 3, back to the notes, the minutes of 7th December. 12:15

"Current problems perceived in system: Patients are getting letters of offer from IS". 12:16

IS is?

A. Independent sector.

157 Q. "Even though they have already received an in-house appointment. Clinical management plans are not

accurately put on PAS. Example, flexi cystoscopy planned for annual review is booked for three months. Suggestion of separation of dictation and onward management booking, action review and process mapping of systems", which is something that was Heather Trouton's responsibility? 12:16

A. Yes.

158 Q. Now, this seems to be some aspect, it could be said, as breakdown in communication among different systems. Would that be fair to say? 12:16

A. Yes. There were always difficulties in terms of patients going out to the IS in the early days, about which patients were going out and confusion. We worked very hard on streamlining that and I think towards -- you know, the farther we went on, the better the systems got. It's not good for patients to receive an in-house appointment and then get a letter that they are going to the IS and to be confused as to which appointment do I attend. 12:17

159 Q. Again, it was about communication systems as well as efficiency of the service provided? 12:17

A. Yes. Yes.

160 Q. Was that review and process mapping of systems carried out by Mrs. Trouton?

A. Yes, it would have been. I mean, I don't recall the details of it but we would have known in the system if that hadn't happened because the problem would have still been there. 12:17

161 Q. The way in which you have set up the governance

feedback loop to you, it seems that you probably would have been made aware one way or the other that that hadn't been done, or the problems were persisting and needed it done again?

A. Yes. I mean, my system of having one-to-one meetings with the Associate Medical Directors and the Assistant Directors, and those were always monthly but might have been weekly or fortnightly, depending on the urgency of issues that were being addressed. Those flexed depending on what was on the agenda but I would always have had a copy of this in my file for that individual to then go through the progress against the actions that were in there so that things were always tracked. If needed, they then came out into the directorate governance meeting with the ADs, or the directorate governance meeting with the AMDs and ADs. There was a linkage between all of these things, they didn't stand alone. 12:17 12:18 12:18

162 Q. It sounds as if the systems you developed were flexible enough to meet either immediate concerns or things that required long-term planning and implementation? 12:18

A. Yes. Yes, they had to be.

163 Q. Number 4 on the 7th December note of the meeting:

"Pooling of lists is acceptable if patient consents and is aware they may be treated more quickly by another surgeon. Need to agree who has clinical responsibility post-operatively for regional surgeon or operating surgeon". 12:18

That was to be actioned by Mr. Mackle and urologists. That was a case of if people wanting to be seen quicker, they would get whatever surgeon was available for them? 12:19

A. Yes. Yes.

164 Q. The issue then was the post-operative. Was that also something that doesn't seem to have recurred as an issue?

A. I am not sure that we got to the point of pooling 12:19 lists, except for occasional situations which I alluded to a few moments ago, where if one waiting list was considerably longer, we agreed a cohort of patients for a particular procedure to move from one surgeon's list to another. I don't think we genuinely got to a single 12:19 pooled list that we then took the longest waiters off on all occasions.

165 Q. That would have been something that would have you needed buy-in from the consultants as well; that needs to be driven from them? 12:19

A. Yes.

166 Q. That's reflected in the last line:

"The urologists need to agree which patients' conditions can be put on a pooled list. Action 12:19 urologists and Heather Trouton".

Would it be fair to say whether someone can be put on a pooled list is dictated a lot by their clinical

presentation as well as their pathology, really?

A. It depends on a range of things, not least what the procedure is that's to take place within theatre. I mean, I may be wrong but I don't think we got to a truly pooled list in Urology during my time.

167 Q. Point 5 on the 7th December notes.

"Red flag system: The NI standard is the patients with potential cancer are tracked by the red flag system to ensure they are seen within designated time scales. This system is not used at all at present, mainly on principle because the system is blunt and does not create the degree of clinical priority across all red flags, nor does it reconcile with non-cancer clinically urgent. The use of red flag is mandatory and reflects clinical evidence, NICE and NICaN. Agreement to develop a subdivision of red flags for use in specialty. Action Mr. Mackle and urologists."

Would those comments about the red flag system and the bluntness of it in relation, in particular it seems, to non-cancer clinically urgent, is that feedback from Mr. O'Brien at that meeting or was that already an issue that was just being brought to that meeting with him?

A. I don't know whether that had already been recognised in the system but that was being brought by Mr. O'Brien to this meeting. He did not agree with the red flag system which had been implemented by the Commissioning

Board in Northern Ireland.

It was never a perfect system and lots of people had issues with it that GPs could refer patients with a red flag when there is a consultant who read the details of the referral, they decided that they felt that the parent was not a red flag but they were not able to downgrade it. So there were occasions when there was certainly a feeling across many specialties that the red flag system was overloaded, but that wasn't in our gift to change. The gift that we had was to implement the red flag system that the Board had set up. Mr. O'Brien always had a different view of that red flag system. 12:21 12:22

168 Q. Was it within your gift to develop a subdivision of red flags for use in Urology, I presume? 12:22

A. No, no. I mean, I am surprised that that is there because we did not follow through on that.

169 Q. Do you think there was a general confusion about the use of the red flag system, given the apparent reasoning as to why one size didn't fit all; it continued to make suffer from individual interpretation? 12:22

A. No. I think my note may be slightly confusing but, you know, that I can accept. The red flag system was very clear: If a GP referred a patient on a red flag, that was a red flag and the acute secondary care system had to respond clearly as that patient was a red flag. It was black and white, except it was a red flag, 12:22

apologies. But there was no confusion in the system, the red flag was a red flag. It was only if, through diagnosis or through investigation and biopsy it was proven not to be a red flag, it was only at that point then it was not a red flag. 12:23

170 Q. You don't have any recollection of the existence or practice of a subdivision?

A. I was aware that Mr. O'Brien wanted to have his own subdivision but it was not one that was practised in the Trust. 12:23

171 Q. You can see that the note suggests that there's an agreement for that?

A. I do see that but there was never work done on that that I'm aware of. In the light of day when I look at that and when I thought about it, we wouldn't have followed through on that. 12:23

172 Q. Number 6:

"Need to clarify what POA goal signifies against the patient on the waiting list and whether if a patient is not medically fit for procedure, the clock stops". 12:24

A. Yes.

173 Q. Again, that's trying to standardise what the codes mean in relation to actual practicalities of treatment?

A. Yes, yes. A POA was very new at that stage and we were working through the process, and this was just a refinement that needed to be put in place. 12:24

174 Q. Number 7 relates to pre-op assessment: "Needs review as patients can be called unnecessarily."

A. Well, that's in relation to patients being called if their surgery is not within three months. Their pre-op assessment has to be within three months of the date of their surgery, so you have got to put the potential date of surgery on the POA assessment so they are not called and then they have to be called again, which is not useful to either the patient or the system.

175 Q. There is a window for the pre-op assessment and it can't be repeated?

A. There is, yes. 12:25

176 Q. Number 8, just a sentence on its own. "Confidence in Trust destroyed due to ward reconfiguration".

A. Yes.

177 Q. Just a sentence hanging at the end of the notes, nobody has to action that. I am just wondering the origin of it and maybe a bit of context to why that finds itself in the notes. 12:25

A. It was obviously brought to the table by Mr. O'Brien and it was a theme that was running through the Urology consultants at that stage. My predecessor had undertaken a bed audit, in other words looking at the occupancy of beds in what was designated as a separate Urology ward, and looked at the reasons why patients were in bed - were they emergency admissions, were they elective inpatients - and looked at their lengths of stay. I suspect that that had been a requirement to undertake in the workup to the Regional Review of Urology. 12:25

The results of that bed audit had showed that there were more beds in the single-designated Urology ward than were actually required. So, a ward reconfiguration had taken place which meant that the Urology beds and the ENT beds were brought into the same physical space. The urologists were not content with this. It had been implemented several months before I came into post and I had had no role in it, but it was certainly still a subject of conversation. In fact, Mr. O'Brien and Mr. Young, and I think probably Mr. Akhtar as well, wrote to me in January just a few weeks after this, talking about the unsafety, lack of safety because of the ward configuration. We met them with the Medical Director to understand concerns and to care about any clinical issues which they felt had arisen that were causing this perception of a lack of safety. 12:26 12:26 12:26

178 Q. If we could maybe look at some of the issues that the surgeons did raise with you at this point. If we go to WIT-15919. The question is asking about concerns that Mr. O'Brien may have raised. You say: 12:27

"To my knowledge Mr. O'Brien raised a total of concerns across three occasions regarding patient care and safety during my tenure in post. Two of these concerns were raised by Mr. O'Brien in response to requests from myself as Director of Acute Services regarding clinical behaviour. There was one concern regarding patient safety raised by the three consultant urologists, 12:27

including Mr. O'Brien. This was raised in a letter on 18th January 2010."

I think this is what you have just referred to?

A. Yes. 12:28

179 Q. "The concerns are detailed below, along with the action taken in response". I just want to set these out.

Point A:

12:28

"I received a letter sent on 18th January 2010 from three consultant urologists, including Mr. O'Brien, outlining concerns regarding the potential appointment of a locum consultant urologist in order to help address the urgent list of patients awaiting surgery. 12:28 The letter also raised the issue of compromised inpatient care and safety as a result of the recent ward reconfiguration".

That chimes again with the note from the meeting? 12:28

A. Mm-hmm.

180 Q. "The action taken was an immediate meeting held by the Director on the day of receipt of the letter. The meeting involved all three consultant urologists, Mr. Mackle, AMD, myself and, from memory, Dr. Loughran. 12:29 Each of the issues was discussed and actions agreed as set out below. In relation to the appointment of a locum consultant, a range of measures to address the long waits for theatre were agreed, which would ensure

that no patient was waiting longer than 16 weeks at the end of March. This required the surgeons working additional hours and, on the basis of this agreed position, the Trust agreed to cancel the locum appointment. 12:29

2. In relation to the compromised inpatient care and safety as a result of the recent ward reconfiguration, the recent correspondence from Dr. Loughran, Medical Director, regarding the process of clinical incident 12:29
reporting was discussed, and consultants advised to identify concerns over safety. Consultants were requested to immediately report any cases whereby patient safety was compromised so that urgent action could be taken. The letter of 20th January 2010 sent 12:30
to the consultant urologists after the meeting also stated: "We would further appreciate if you could let Dr. Rankin know when you have submitted the required forms so that she can ensure a speedy response." 12:30

Did you get any --

A. No.

181 Q. No. "B. Re referral triage and amending clinic templates to reflect new-to-review ratios. The letter from myself to Mr. O'Brien dated 22nd October 2010 12:30
indicates a previous related letter from myself and Mr. Mackle to Mr. O'Brien to which Mr. O'Brien had replied on 27th September 2010. While the initial concern was not raised by Mr. O'Brien, the

correspondence identifies the concerns which he continues to hold with regard to implementing certain aspects of the implementation of the Team South Urology. These are set out below."

12:31

In your letter of 22nd October 2010, the following points are made. This is your reply. So, you made:

"1. A commitment to triage referrals within a week and red flag referrals within a day, conditional on the cohort of consultants being sustained." 12:31

A. Mm-hmm.

182 Q. Now, that was an agreement then --

A. That was Mr. O'Brien agreeing to commit to triage of referrals within a week and red flag referrals within a day, assuming the cohort of three consultants remained in place. 12:31

183 Q. Thank you.

"2. Refusal to amend clinical practice to undertake new appointments in 20 minutes and review appointments in 10 minutes." 12:31

A. Yes.

184 Q. Again, that was not moving on the appointment timeframes that were set down -- 12:32

A. Yes.

185 Q. -- by BAUS?

A. That's correct.

186 Q. "Lack of undertaking to reduce new-to-review ratios to

one to two as an interim step through clear discharge pathways with primary care".

A. Mm-hmm.

187 Q. "4. We are willing to ask you to reconsider the issues which have been in discussion over many months. Please confirm by Thursday 28th October your agreement to amend the clinic templates". 12:32

Then you attach the letter. So your recollection, that is that once again, there was a tension between the expectations of the service -- 12:32

A. Yes.

188 Q. -- and the requirements that other consultants, certainly in relation to the time slots, triage and the amendment of the templates, had already adopted? 12:32

A. They had agreed to adopt them. I think we implemented them in November, hence why my seeking a response from Mr. O'Brien by the end of October, because we had agreed that we would implement them in November of whatever year that was, 2010 or 2011. 12:33

189 Q. I am just going back to the year. 22nd October 2010?

A. Yes.

190 Q. Do you remember was there any response to that? Was there a particular indication that there wouldn't be any movement on these issues, or was it anticipated that there had been some understanding that Mr. O'Brien would be expected to adhere to the same standardised approach as other consultants in certain respects? 12:33

A. I don't recall anything further from Mr. O'Brien, and

I think it was at that stage that we went ahead and implemented the new clinic templates, the new clinic times, in November 2010. That, I think, then was when we found that the afternoon clinic in Banbridge was overrunning by two hours. 12:34

191 Q. I will just read the rest of this, even though I am going to take you to something slightly out of sequence. I am going to take you to some letters that Mr. O'Brien has exhibited where he has identified some issues. They are 2010 and I see this paragraph moves on to 2011. If you bear with me, I won't lose my place. 12:34

"On 25th August Mr. O'Brien sent an email to the Head of Service regarding the request to read test results when they were received". 12:34

In fact, I am going to go against what I have just said because I am going to be coming on to the test results issue, so we will double park, if you can forgive me -- 12:35

A. That's all right.

192 Q. -- and we will go to some of Mr. O'Brien's letters. AOB-02010. There's a digit missing in that. Let's go to the reply to see if it includes the original letter, WIT-17487. This is a letter from you and Mr. Mackle? 12:35

A. Yes.

193 Q. We go back up, dated 20th January 2010. You have received a letter from them on 18th January --

A. Mm-hmm.

194 Q. -- outlining your concerns about the consultant urologist?

A. Yes.

195 Q. The first part of the correspondence is at AOB-00138. Sorry to jump about. The documents are held in different files so we just want to make sure the Panel are aware of the original letter. This is dated 18th January 2010 and it's to you? 12:36

A. Yes.

196 Q. And it's from Mr. O'Brien. This is a correspondence from Mr. O'Brien to you. We will stick with this and see where we go. 12:37

A. Okay.

197 Q. This is Mr. O'Brien setting out his concerns. To put it in context, Mr. O'Brien has provided us with his correspondence to the Trust detailing his concerns and obviously the Panel want to engage with that as well. 12:37

"Dear Dr. Rankin, it is with shock and disbelief that we learned from you on Monday 11th January 2010 that the Trust had appointed a locum consultant urologist without any consultation with us and without our participation in due process of appointment. It remains for us incredible and untenable the excuse that one of us could not be contacted when the appointment was apparently made during the third week of December 2009. In addition, we can only conclude that the failure to inform us until Monday 11th January 2010 was with intent rather than oversight. 12:37

Previous appointments of locum consultant urologists have always been conducted in consultation with, and with the active participation of, us in the due process of the construction of job descriptions, advertising, 12:38
shortlisting and interviewing. This involvement has proven to be an indispensable component in the time-honoured method of ensuring that any appointee is qualified and adequately experienced for the post with the ultimate objective of ensuring, so far as is 12:38
possible, patient safety, and our collective experience and awareness of the manner in which the Trust has made this appointment is unprecedented. Our concerns regarding the manner of appointment..."

12:38

Then he goes on to make comments about the appointee, alleged appointee.

If we just move on down towards the end, the general thrust of that is the appropriateness of the individual 12:39
for the post. He says:

"As urologists we find ourselves unable to support the Trust's appointment and incapable of advising the Trust on this deployment. During the past year and despite 12:39
our expressed concerns, the Trust proceeded with its ward reconfiguration resulting in compromised inpatient care and safety, as feared. In addition to significantly diminishing the specialist status of our

department, compliance with the loss of radical pelvic surgery as proposed by the Regional Review of Adult Urological Services similarly has the potential to compromise patient care and safety and will certainly diminish the status of our department further. The capacity to provide enhanced urological services in the future is entirely dependent upon the ability to recruit and retain specialist staff, and that is entirely dependent upon the attractiveness of the department's current status at any point in time. We would earnestly request that the management of the Trust seriously reflect upon its actions and proposals before any prospect of a future has been completely eliminated. If it is the case that only a general surgeon can be appointed, we fear that we may have already arrived at that point." 12:39 12:40 12:40

That is signed by Mr. Akhtar, Mr. Young and Mr. O'Brien. The signatures are not on that but it is sent from them on their behalf? 12:40

A. Yes.

198 Q. That's a document you have seen. I presume it arrived to you?

A. Yes, absolutely. It's a document you receive and your heart falls to your shoes when you receive it and you know you have to respond very, very quickly. That's why I held a meeting with the three consultants on the day that I received that letter, on 18th January. The outcome of those discussions was sent back to them on 12:40

20th January so I moved very, very quickly.

I would totally agree with a lot of the sentiments in that letter. I genuinely do not recall who had been responsible for appointing a locum. If the locum was appointed in the third week of December, I can't think it would have been me because I only had been in post from the beginning of December, so it may have been happening and it may have concluded in the third week of December unbeknown to me. 12:41

I would totally agree with them that they should and must, of course, be involved in that process because only they can make an assessment of whether the candidates who are available have the suitable training. So, there's no issue about that point. 12:41

The failure to inform them of that later on in January, that was certainly an oversight as opposed to intent. I will never forget that Christmas and New Year, my first Christmas and New Year working in the Acute Services with the pressures and having to come in on Sunday 3rd January to cancel all elective work for the Monday because we had no beds in the hospital, they were all full of emergencies. So, I have a very, very clear recollection of that period within a few weeks of taking up posts, so that was certainly an oversight. 12:41 12:42

As a result of the letter and the conversations with

them, we immediately pulled the appointment of the locum, offered to go out again to get a locum, but you can see from the note of the meeting and my letter to the surgeons that they then presumably offered and agreed to do additional work internally, and that was the conversation. Now, that was never something that was required of any consultant, any specialty. When we had funding for waiting lists initiatives, WLIs, as we call them, that offer was made to all the consultants and there were many picked it up and many said I can only do this particular session in the week, or I can do the second and fourth Saturdays, or I can do whatever and we would have accommodated all of that. There was never any compunction on any surgeon to do that. I see from this correspondence that they offered to do additional sessions to treat a certain number of patients on the list who needed to be treated, which presumably had been the driver of bringing in a locum, which predated me. 12:42 12:42 12:43

199 Q. Which meant then the locum didn't need to be appointed because the capacity had increased internally? 12:43

A. Yes, I immediately stepped it down because (A) they were dissatisfied so it was never going to work; but (B), as they were saying the person who had been offered the job, was not appropriately qualified. That's not a step you take, I mean somebody has to be qualified to do the job. If they haven't the urology experience, then they can't be appointed into a urology job. 12:43

200 Q. Just a phrase you used there, "they were dissatisfied so it was never going to work", is that reflective of a mindset or a culture amongst medics where you have to get their agreement to implement any change?

A. I think if you are bringing a new member into a small team of three people and you are bringing a fourth member in, unless they have credibility within that team, it's going to be very, very difficult to make it work as a full working team. It's purely about the credibility of the experience that the person brings to the job. 12:44 12:44

201 Q. Now, there's mention in the letter of the ward reconfiguration which resulted in "comprised inpatient care and safety as feared". Now, you had said previously that you hadn't received anything back about concerns about patient safety. What did you understand that to mean there? 12:44

A. Well, at the meeting that I held on the day I received this letter, I, of course, raised it, and I think Dr. Loughran was with me at the meeting because it was still so early in my days of tenure in this post that I felt it would be important to have the Medical Director. We often co-worked meetings. There was a real trust in the Trust that could you co-work any of these scenarios with colleague directors if you were concerned. This obviously is very concerning when you have a consultant body and a specialist in a specialty area talking about comprising inpatient care and safety. We asked about examples of what had caused 12:44 12:44

them to write this and no examples were forthcoming at the meeting. Otherwise, I would have reflected that in my response to them, and I don't recall any being -- any specific examples being made.

12:45

We then asked, as is revealed in my letter to them, that they would immediately, if they did have a concern about any particular patient, they would raise an IR1 but also alert my office, leave a message with my office and I would be looking at that IR1 immediately 12:45 and discussing with them what the issue was and seeing what needed to be done. If I had received any examples of unsafe care where safety was comprised, I would have been actioning that. It wouldn't have been me alone, it would have been me with Mr. Mackle or the Chief 12:46 Executive as needed, there was an absolute focus. If there was a demonstrable lack of inpatient safety and care, we would have acted on that, without a doubt.

202 Q. So you had the meeting on 18th January and then the written reply was the 20th? 12:46

A. 20th January, yes.

203 Q. That was the reply we had previously seen, Chair. If you'd like me to bring you back to give you a note, it's WIT-17487. I am having that confirmed that the letter of 18th January 2010 is the one that we just 12:47 took you to in your statement at 64.1(a). We have gone through the detail of it, not the actual physical letter, but the Panel have that note.

A. Yeah.

204 Q. Just in relation to other issues that were brought to your attention, I wonder if we could go to WIT-51785. This is from Mr. Young's Section 21, where he says:

"Following the 2009 review, I felt my role as lead clinician was very much supported by the immediate line management system of Heads of Service and Clinical Directors covering Urology. They have been supportive and deeply involved in all the projects our department have put forward. In the immediate period following the review, it was my opinion that Dr. Rankin, Director of Acute Services, although chairing our steering group, was not as supportive of our department's personal thoughts on the recovery plan. This is my personal opinion as she did not fully follow my suggestions. I had thought her approach to appointing three consultants on one day unwise in 2012, and especially in the way the interview panel had been constructed. She also did not agree to the Outpatient clinic template we had suggested at the time which actually did ultimately become our template. Subsequent directors of Acute Service were supportive." 12:48 12:48 12:48 12:48

I just wanted to draw your attention to that reflection of Mr. Young in relation to his engagement with you. Were any of those concerns from him articulated to you at the time? 12:49

A. No, I'm not aware of this. I suppose my response would be that when you are seeking to make quite considerable

change to working practice, that is an inevitable consequence. As I was leading that change and very visible, I would be the focus for that, but that's the way the system works.

12:49

The issue appointing three consultants in one day unwise in 2012 and the way the interview panel had been constructed, I had no control over that. That was in the control of the -- that was the Trust policy on appointing consultants. The panel was constructed by 12:49
HR to appoint the consultant, and the Chair of the Panel was usually the Chair of the Trust or a designated non-executive member of the Trust, so I had no role in that process. I was a member of the panel, invited to be, so any discussion in terms of 12:50
varying the panel members or the approach would have been with HR.

205 Q. Do you think the extent to which you liaised with the clinicians was sufficient, was appropriate?

A. Well, the liaison with the clinicians would have been 12:50
at that weekly/fortnightly meeting during that prolonged period of 16 months. We then would have reviewed our progress against the review implementation, such as that meeting that we looked at half an hour ago that Heather Trouton had written the 12:50
note of. That was in June 2011. We would have met with the consultants for specific reasons subsequent to that. I mean, the second half of 2011 into the first part of 2012 was around the job planning because

everything else in the implementation plan was in place or being put in place and was work in progress. As I say, the second half of 2011 and the early part of 2012 were the discussions with the medical staff and with the consultants about job planning, about which I wasn't directly involved. As we have already alluded to, those were quite protracted discussions.

206 Q. Just for the Panel's note of other concerns that were raised, we have already gone over the issues. It's Mr. Weir's concerns regarding ward reconfiguration raised in 2009. That can be found at AOB-82229.

Now, we will go on to look at the Trust governance documents as they informed the Trust Board when we look at the issues that arose and how they were reflected to the Board, okay. Just in relation to the specific concerns raised by Mr. O'Brien and others, those specific concerns weren't reflected in the Trust governance documents. You've stated that in your witness statement at WIT-15924, paragraph 67.1, where you have said:

"The specific concerns raised by Mr. O'Brien and others were not written down in Trust governance documents. I am unable to give an explanation for this. However, it would not have been usual practice at that time to record such specific issues as raised by Mr. O'Brien in Trust Board or directorate risk registers. These risk registers generally identified risks which existed

across a range of systems in the Trust or across a full directorate. The specificity of risk would more likely be identified in divisional risk registers. This may have been the position on the journey of recording risks at that time and may have subsequently been further developed." 12:53

We have taken one example of a risk that was raised in relation to patient care and safety in the ward reconfiguration, and in the letter it mentioned the removal of the radical pelvic surgery to Belfast. There was a suggestion that that would comprise patient safety, but your evidence to the Inquiry is that no one ever brought any manifestation of those alleged patient safety issues to you, or they were never evidenced when you asked for them. 12:53

A. I think there are possibly two issues there. One is the specific risk that Mr. O'Brien had raised. I would have expected those to have started on the service specific risk register with Martina, then for discussion of that process and come up with a system. 12:54

Obviously, the other balance to that is the paper that went to Trust Board specifically around some of the issues. We will come on to that later, as you have indicated. 12:54

The other issue in there about prostatectomy, that was a requirement within the Regional Review, and also from

the guidelines which NICaN, the Northern Ireland Cancer Network, had set out and agreed, in 2008 I think, in the Urology group, of which Mr. O'Brien was a member, I understand, and then subsequently became Chair of. So, that clinical guidance was set within Northern Ireland, was adopted by the Regional Review for the implementation of urology, and so should not have been a surprise to any of the urologists working anywhere in the system in Northern Ireland. It had been agreed that radical pelvic surgery, including prostatectomy and cystectomy, would move to the Belfast Trust at an agreed time when they had the resource to handle the increased referrals, because they obviously needed to build their capacity in terms of consultants and theatre time, et cetera, to prepare for that change. 12:54 12:55 12:55

207 Q. That decision to move the radical pelvic surgery was done after a review was undertaken. The decision was made after that to centralise, I think, to centralise it to Belfast due to the nature of the surgery and the apparent rarity with which it was being performed. 12:55

A. That was the issue. NICaN had set out that -- NICaN guidance had set out in 2008 that radical pelvic surgery for malignant reasons would move to Belfast. The numbers of cystectomies being undertaken in the Southern Trust was of the order of two to four per year. That wasn't defined by one surgeon; that could have been all three surgeons doing one cystectomy per year. By this stage, in the surgical world in the UK, it was becoming quite the norm that you did not 12:56

continue to operate and to undertake a procedure if you were only doing one per year. That was not deemed to be sufficient. In some surgical specialties, there were some requirements for surgeons to be undertaking 25 of a specific procedure in a year to maintain their skill and expertise and be able to continue providing that. This was a thrust from the Board, quite correctly, that that kind of major surgery would move to the Belfast Trust. 12:56

The timing of the move of cystectomies, for benign reasons, moving to the Belfast Trust, coincided with the end of the review of the benign cystectomies. There was not an explicit link made that I was aware of but there certainly was a time coincidence there, which was rightly done. 12:56 12:57

208 Q. The consultants at the time in Urology, were they consulted about the move, or do you understand the nature of their engagement around the decision of that, or was it not necessary for that to take place? 12:57

A. Mr. Young was on the steering group. Mr. Young sat with me and the Director of Performance and Reform as a full member of the regional steering group at which that decision was taken. In fact, the notes of the meeting in November 2010 came out saying that it had been agreed that all benign cystectomies would move to the Belfast Trust. Mr. Young, on reading those minutes, it went back to the Chair of that group, Beth Molloy, Assistant Director in the Health and Social 12:57

Care Board; the late Beth Molloy. Mr. Young went back to Beth to say that he didn't remember it being agreed that cystectomies for benign reasons would move to the Belfast Trust.

12:58

I think Beth's action then was to talk to Mr. Mark Fordham, who was the independent urologist appointed to be part of the review. Mr. Fordham's reply, if I recall, was to say that there no specific guidance on this but he would expect, and would expect a patient to 12:58 expect, that somebody who was undertaking a cystectomy would be doing enough of them during the year to maintain that skill.

Unfortunately, there was no formal correspondence from 12:58 the Board at that stage to underscore the fact that the decision had taken the decision that the regional -- the steering group had taken the decision that the cystectomies for benign reasons would move.

I identified confusion in our system in the summer of 12:58 2011, and I wrote the letter that I always regard for-the-avoidance-of-doubt letter, benign cystectomies for benign reasons no longer occur in Craigavon; all those patients are to be referred to the Belfast Trust. That might explain some of the confusion around it. 12:59

But we got it clarified and there were patients who were referred very, very urgently for prostatectomy and cystectomy for malignant reasons. I think the speed of

that happening was what surprised Mr. O'Brien and Mr. Young, the fact that patients who had been booked for surgery were moved to the Belfast Trust even after they had been booked. In the correspondence that Heather Trouton at my request was having with Beth Molloy, the Board, on the timing of this, Beth was on leave at the time and Dr. Corrigan replied on behalf, and her email was explicit - move these patients ASAP - not even spelt out - move these patients ASAP, and by the end of the day those patients had been referred. In fact, one patient had their surgery earlier in the Belfast Trust than they would have had with us. All five patients who were referred were seen within a week in the City Hospital in the Belfast Trust. So, all patients were correctly seen and served appropriately. 12:59 12:59 13:00

209 Q. The next part I would like to move on to is how the information around the concerns and that issue in particular were communicated to the Board. I just notice the time, so it might be...

CHAIR: So back again at two o'clock then, everyone. Thank you. 13:00

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

210 Q. MS. McMAHON: Just before I move on to the topic I discussed with you before lunch, one of the other governance oversight metrics I wanted just to ask you about, if you have any knowledge of, is the clinical audit as a governance tool. 14:00

A. Yes.

211 Q. Do you have any knowledge of what methods of clinical audit there were in your time and how you became aware of any issues arising from those? 14:00

A. Clinical audit, as I recall, and the support for clinical audit, was handled/managed through the Medical Director's office. I recall asking at some stage, I don't recall when it was, but I recall asking had there been and were there any ongoing audits in Urology, and I think I was told there weren't. 14:00

I then undertook to see if there were any national audits going on through BAUS or any other professional organisation in relation to Urology at that stage, and there weren't and so I wasn't able to follow through on that. We as a Trust had always wanted to participate in national audits, and I have many examples where we did participate: The Sentinel Stroke Audit, the Fracture Neck of Femur Audit, Emergency Department ICNARC for Intensive Care. So, we had many examples of where we did contribute to national audit so that we 14:01 14:01

could measure ourselves against our peers across the United Kingdom.

The results often of those audits came to Trust Board. I can remember Dr. McAllister presenting very proudly the ICNARC results to a meeting of the Trust Board because we were holding our head with the best of the UK intensive care units. So, I was disappointed not to be able to find a tool that we could use within Urology. So, I cannot recall any results of audits from Urology coming to me, or being made aware of them. 14:01 14:02

212 Q. The way in which any clinical concerns would have come to your attention, was that through the Clinical Director or the Medical Director? Were they at meetings they were identified? 14:02

A. They could have come through that route, they could have come through an informal route. You have to be able to have the formal systems, but obviously the ability to listen when things come to you through different routes, which they often did. That was the best of a system, to have both the formal routes and the informal routes. 14:02

213 Q. One example of that may be the use of IV antibiotics?

A. Yes.

214 Q. Which occurred during your time? 14:03

A. Yes.

215 Q. If we look at your statement at WIT-15876. That begins at paragraph 50.9. I am just going to read out the context of this before asking you a couple of

questions.

A. Mm-hmm.

216 Q. Your statement says:

"The concern regarding the use of IV antibiotics was raised with me by the Chief Executive at the meeting held on 1st December 2009", and we have previously seen the notes of that. 14:03

A. Yes.

217 Q. "The use of IV fluids and IV antibiotics have become part of local urological practice for the treatment of recurrent UTIs over many years and had been identified in spring 2009 during an audit of bed usage. It was considered to be unusual." 14:03

14:04

Just if I could stop you at that point. Considered to be unusual by the person reporting it to you or considered generally among the medics who brought it to your attention that it was unusual?

A. "Unusual" is maybe not the correct word there. I think it's my word in terms of writing my statement. I'm not sure it was taken from anywhere. 14:04

218 Q. That's fine. I will go on.

"At that time, the Trust discussed with the clinicians involved and subsequently took expert advice. The therapy was deemed not to be evidence based. About 35 patients were in the cohort at that stage and it was agreed that each member of the cohort would be reviewed 14:04

with a view to ceasing IV therapy. When I came into post, the cohort had reduced considerably to approximately ten patients. The Commissioner had sought assurance that this treatment had ceased and that no patient had central venous access required for the injection of the antibiotics."

The actions taken were as follows:

"Request a further review of the cohort of patients by the consultants in order to cease the practice. B, implement a process which required the consultant urologist to discuss a patient in respect of whom they wished to prescribe antibiotics, and the Clinical Director and the consultant microbiologist. This process would ensure that no patient was prescribed IV antibiotics inappropriately".

Then you have referenced an email of 6th July 2010 from the Head of Service to the Director, which was you:

"... an update on those patients still receiving IV antibiotics identifies that none of these patients had been discussed with the Clinical Director and consultant microbiologist". 14:05

A. Mm-hmm.

219 Q. "In terms of assurance that these processes were or were not working, regular information on the cohort of patients previously receiving IV therapy was reviewed

and any recent use of IV therapy highlighted. It was then checked if the decision to treat with this therapy had been taken jointly in discussion with the Clinical Director and the consultant microbiologist."

14:06

Then you attach an email of 24th August 2010 which identifies the patient cohort, and the position of this cohort as at July 2010 and updated for August 2010. You say:

14:06

"The list showed that both Mr. Young and Mr. O'Brien had continued the practice of IV therapy in both those months. The number of patients treated with IV therapy in July was 13. Mr. O'Brien treated nine patients and Mr. Young treated four patients. In August it was three patients; Mr. O'Brien treated two patients and Mr. Young treated one patient. The number of patients treated using IV therapy had reduced but was still continuing."

14:06

14:07

Then you say in paragraph E:

"On 2nd September, as an outcome of the meeting held the previous day, the Medical Director wrote to the Director of Acute Services seeking assurance that the practice of treatment with intravenous therapy had stopped completely. The Director of Acute Services wrote to the two consultant urologists on 2nd September 2010, inviting both consultants to attend a meeting

14:07

with" yourself "and Mr. Mackle regarding the practice with three patients."

You then sought an updated position on 2nd September 2010 on patients receiving IV therapy prior to meeting with the consultant urologists. That meeting then subsequently had to be cancelled. You haven't been able to find the note of the subsequent meeting with the consultants but you confirm that you wrote to Dr. Loughran on 14th September following the meeting with them to say: 14:07 14:08

"Here are the documents Mr. Mackle and I used to discuss with Mr. Young and Mr. O'Brien separately last Thursday. You may wish to use in your correspondence to Dr. Corrigan." 14:08

The issue there was a practice that was identified as not being clinically required or clinically approved, and a process was put in place that should that practice wish to be carried out on a particular patient, that there would be some level of oversight and engagement with both the Clinical Director and the microbiologist? 14:08

A. That's correct. 14:08

220 Q. Was that process put in place by the Medical Director in collaboration with you, or was this entirely a medical problem to be sorted out by the medical management?

A. I think we implemented -- we discussed it and agreed the approach jointly. It was very much a joint approach. At that stage, the Trust were doing a lot of work on antibiotic stewardship and there were antibiotic ward rounds being introduced in specific wards. One of the actions was to move quite quickly to introduce the antibiotic ward round by Dr. Damani into the Urology ward. But there was some consultants who didn't want to be told which antibiotic to prescribe for patients and were less inclined to take the advice of the consultant microbiologist in the Trust, a very imminent consultant of national and very international repute. We were very fortunate to have Dr. Damani on our staff at that stage. So no, it was a joint approach by Dr. Loughran and myself. 14:09

221 Q. The issue at that time was not just in relation to the type of antibiotic prescribed but the route by which it was administered?

A. Both of those, the type of antibiotic and the fact that it was being given IV, which sometimes meant specific access had to be created to enable that to happen. 14:10

222 Q. Do you have any knowledge of any risk assessment that was undertaken at that time in relation to the benefits of giving people the treatment that they were receiving from Mr. Young and Mr. O'Brien to stopping that? Was that something that you know or might have assumed that the clinicians involved in assessing this practice would have considered? 14:10

A. I have no knowledge of that. I mean, I was aware that

it was a long-standing practice that had been practised within the Urology Unit in Craigavon Hospital. I understand that a letter had been published in relevant Urology journals. Quite clearly, the advice and guidance from the Commissioner to the Trust prior to me taking up post was that this was not an evidence-based practice and should not continue.

223 Q. You have just mentioned that the practice was referenced in a Journal of Infection in 2011. I will bring you to that. It's at WIT-82743. 14:11

Now, you are trained in practice as a medical practitioner as well. I won't claim to have any particular knowledge about this but the Journal of Infection 2011 where this was being published, this is 14:11 published by way of a letter?

A. Okay.

224 Q. So you can see on the right-hand side, Vincent Koo, Michael Young and Aidan O'Brien. Now, that's been submitted to the journal and been published. Were you 14:12 aware of that at the time?

A. No, completely unaware of it. This is the first time I have seen it. Of course, a letter is not a peer-reviewed substantial evidence-based piece of research that would be accepted in today's world, 14:12 albeit this was August 2011. It's a letter. Quite clearly, you know, there's information there. I haven't read the article so I don't know what it's actually saying.

225 Q. But it's a presentation of information rather than, as you say, a peer-reviewed --

A. Yes, that's correct.

226 Q. -- piece of scientific research that's been undertaken and the results reported. The results are reported there but it's in a different format than perhaps you as a medic might expect? 14:12

A. Yes, it is. Necessarily being from one unit, it will have a relatively small cohort of patients. To be evidence-based, you would usually be looking at a much, much larger cohort and multi-centre trial to produce something that was evidence-based and therefore moving into routine practice. 14:13

227 Q. Now, as regards the success of the systems that were put in place to try and rectify this, you refer to that, if we can go back to WIT-15883 at paragraph G. You reflect on the system. You say: 14:13

"The system and agreement with the consultants put in place was largely but not completely successful. The number of patients who were subsequently treated with IV therapy were of the order of one or two per year. Mr. O'Brien required repeated reminders of the process to be followed, such as the meeting chaired by myself on 9th June 2011 involving Mr. O'Brien". 14:13 14:14

Then the issues and actions from the meeting on 9th June are set out in a memo of 1st July from Heather Trouton. We have seen.

A. Yes.

228 Q. Was it your understanding that clearly based on that, there was a resistance to adopt the new process that had been put in place, presumably as clinically appropriate but also as a safety valve? 14:14

A. Yes, there definitely was resistance and it was very difficult to completely eradicate this. I think by the autumn of 2010, we had it largely eradicated. We put in place a couple of strands of work. One was the multidisciplinary approach involving Dr. Damani and the 14:14 Clinical Director, of whom there were three in succession who handled this. We also, aligned to that, asked the ward to identify to Mrs. Corrigan if they knew of a patient who had a planned admission for IV antibiotics. So, that became an action that was put in 14:14 place so we were aware then if there was a planned admission and we could then take appropriate action to ensure that there had been a multidisciplinary discussion and, if not, there was one put in place.

14:15

The other main action that we put in place was a new pathway agreed with Mr. O'Brien and the other two consultants, that there would be a community pathway for oral antibiotics which then the patients went through. 14:15

Set against that, part of the dilemma here was that some of these patients had actually become dependent on this as a treatment that they actually phoned looking

for. So, we had to be very careful about handling that. The process of the community pathway using oral antibiotics was successful in adopting that, but I know that one of the subsequent breaches after that -- I think I have knowledge of two breaches after this particular period of time, and one of those was a patient who actually wanted to come in, and we had to work very hard to handle that situation.

229 Q. There's an example of an email around a further breach, if we go to TRU-259913. 14:16

A. Yes. That's the breach I was referring to.

230 Q. So that's the patient I think you are referring to?

A. Yes.

231 Q. And this is an email from Mr. Mackle sent 30th January 2012 to Sam Hall, copying you in and Martina Corrigan, 14:16 "IV antibiotics". I will read it without referring to the patient:

"Dear Sam. I have been advised that a patient may have been admitted last week by Mr. O'Brien and under his 14:16 instruction was given IV antibiotics, necessitating a central line to be inserted. I have checked with Dr." -- named the doctor -- "and he advises me no discussion took place prior to administration of antibiotics. I would be grateful if you could formally 14:17 investigate this and advise me of your findings."

This was a period of time, it seems, almost a year and a half or a year and four months following the initial

alert over the practice. Then I think there were quite rapid recommendations that the new pathway and approach had to be adopted?

A. Yes. Yes.

232 Q. How difficult is it from a governance perspective to deal with an individual, whether it's Mr. O'Brien or anyone in the Trust, who seeks to, or by his actions, circumvents systems in place to ensure that there's a standardised approach to clinical care, or at least their actions trigger the appropriate response? 14:17 14:18

A. It really is very difficult because some systems are electronic and automated and you can use the ability to alert when something is going to happen or has happened. I am sure we will come to some of those scenarios. Some of the other systems, when you don't have the ability to have electronic flag, they are human systems, and human systems always have the potential for failure so they can never be completely foolproof. But you expect people working in the Health Service to automatically understand about safety and to learn whenever there are processes going on which are not in the best interests of patients as seen by most of the world. So, it is difficult managing somebody who has a view that whatever they are doing is the safest thing, despite the rest of the world disagreeing with that. 14:18 14:18 14:19

233 Q. Was there ever any consideration of sanctions or any action in relation to a clinician who is not following what the Trust have said the process should be?

A. When we come to the cystectomy issue, as I am sure you will, there was a screening of a performance concern at that stage, so there was a formal process at that stage. I don't think we took any action after this particular episode in relation to the IV antibiotics, given that we had eradicated it, with the exception of this breach. That's a contradiction in terms, I appreciate that. But the cohort had moved into a community and oral antibiotic route, with the exception of this patient. My recall of this patient was that she had phoned and was looking for this treatment, which made it very, very difficult.

14:19

14:19

234 Q. You have just mentioned the cystectomy issue and the review, the MHPS review, of that particular process. Could you just give us the background to that as you recall it?

14:20

A. Yes. My recall is that the Trust received a letter from Dr. Corrigan, a physician in public health medicine in the PHA but aligned to the Southern area. And Diane had been undertaking -- she had noticed a higher rate of cystectomy for benign reasons in the Southern Trust in comparison to the other Trusts in Northern Ireland. The order of cystectomies at that stage was, I think from memory, two to four per year but that was greater than had been expected. She brought that to Dr. Loughran's attention. I think on the day that we received that letter, Dr. Loughran and myself and Mr. Mackle met to discuss the appropriate approach. I think also Kieran Donaghy, the Director of

14:20

14:20

HR & Organisational Development was present.

235 Q. He was. We can actually go to that paragraph on your statement, if it helps your memory. WIT-15872, paragraph (b). I think this was an immediate meeting on 1st September -- 14:21

A. Yes.

236 Q. -- that was held.

A. That's correct.

237 Q. This is where you set out the concern raised by the Commissioner? 14:21

A. Yes.

238 Q. A letter was sent. Then the next paragraph is the meeting that you are referring to?

A. Yes, that's correct.

239 Q. I will just read this paragraph: 14:21

"The immediate step taken was a meeting held on 1st September between Dr. Loughran, Mr. Mackle, Mr. Donaghy, Director of HR & Organisational Development, and myself. At this meeting, it was agreed that 14:21 a formal independent review of the appropriateness of the treatment of cystectomy was required. The action determined was to commence a local review in line with the guidance provided by the document Maintaining High Professional Standards in the HPSS. This process 14:22 included a case note review of each patient who has undergone a cystectomy in the previous ten years. Mr. Young and Mr. O'Brien would have been informed of the meeting. They were to be met by myself and

Mr. Mackle in the next few days to discuss both the review of cystectomies by an independent assessor, and the parallel at that time was the use of IV therapy".

You have said in paragraph 3 there: 14:22

"The terms of the local review, the review brief, into the incidents of cystectomies was set out in a document to formalise the document, the review process, in order to share with Mr. Young and Mr. O'Brien". 14:22

Just to be clear, this MHPS review is not an investigation into any individual at this point. This was an MHPS guidance document review into a practice?

A. That's correct. 14:23

240 Q. Is that right? Then you say at 4:

"The review brief was shared with Dr. Corrigan as requested by the Chief Executive, and both Mr. Young and Mr. O'Brien were kept informed of the process." 14:23

A. Mm-hmm.

241 Q. One of the points I was going to bring you on to but we will discuss it now:

"The Trust Board were informed of the screening of 14:23 a performance concern through a written confidential briefing in September 2010, and this was presented to the confidential section of the Trust Board by the Director of Acute Services."

Do you recall how long that process took to review the cystectomy, the ten-year look at patients?

A. Yes. I think Mr. Mackle undertook a case note review initially and then determined that, as he was not a urologist, the process needed to be undertaken by a urologist. I think Mr. Marcus Drake was appointed. 14:24

242 Q. Mr. Drake?

A. By memory -- from memory, I think we had an initial verbal report in March, the following March, but the final written report, I think, came the following summer. 14:24

243 Q. Do you understand that Mr. Drake, did he speak to the consultants concerned, Mr. Young and Mr. O'Brien, or indeed any of the Urology consultants? 14:24

A. I don't know whether he did. I suspect not. I think it was purely a case note review. Because of the numbers of patients on the issues around patient notes, it had to be arranged that Mr. Drake came over to Craigavon to actually do that case note review on the spot as opposed to notes being sent over to him. So it took a while for him to free diary and to come over and to do that. 14:24

244 Q. So this would be something you informed of as it progressed rather than you being involved in? 14:25

A. Yes, yes. I was not involved in the process other than setting up, agreeing the review, and then making sure that people were kept informed and then acting on the results of the review.

245 Q. I take it perhaps from your answer, given your slight distance from the actual carrying out of the review, you don't have any knowledge of whether Mr. O'Brien or Mr. Young, or any of the consultants, were informed that this was being carried out in line with MHPS guidance? 14:25

A. They were certainly informed; I would have been involved in that part. As I have said in my statement, the review brief would have been given to them, so they were fully aware of that. I don't recall how they were informed about the outcome of it the following summer but that, I'm quite sure, would have happened. 14:25

246 Q. Do you recollect the outcome of the review by Mr. Drake?

A. Yes, Mr. Drake, I think, used the words that "supported but indeterminate", it was kind of a middle ground, which didn't say it shouldn't have been done but didn't say that all of... It was an unusual way, perhaps, of setting it out. The decision-makers in this process, though, were through Mr. Mackle, as the Associate Medical Director to the Medical Director. Dr. Loughran, on the basis of the report from Mr. Drake, decided to close the case and wrote to Dr. Corrigan accordingly. 14:26 14:26

247 Q. Where does this sit, this review, with the decision about the radical pelvic surgery being moved to Belfast? Was that in around the same time, did one influence the other, or what was the understanding at that point? 14:26

A. I have no knowledge of them both being collected but when I look back at the timeline of all of this happening, quite clearly the Regional Review had made the decision in November 2010 that all cystectomies, all radical pelvic surgery was to move to Belfast when Belfast had the capacity to take the patients. There was the confusion that I alluded to earlier around the --

248 Q. Benign?

A. -- pelvic surgery for benign conditions, and we sorted that out by the following summer. We got Mr. Drake's report I think in the July of that summer, and in the September we were instructed by Dr. Corrigan to move the prostatectomies and cystectomies that had just been booked - I think it was about the third week in September - they were transferred to Belfast ASAP, i.e. that afternoon. So there was a time coincidence of those coming together. Dr. Corrigan would have been in receipt of Mr. Drake's report. It was heard in Beth Molloy's absence who told us to refer patients ASAP in September. There may well have been a link but I was not aware. It's only when I look back at the time scales and put the timeline in that I realise that there was a coming together on the timeline.

249 Q. Was there an understanding or was it ever discussed whether cystectomy was included in the overarching definition of radical pelvic urology surgery?

A. Well, I'm not a urologist but the meeting of the regional steering group in November 2010, according to

the minutes that were sent out, took the decision that all cystectomies, for benign or malignant reasons, would move to Belfast. Mr. Young wrote to Beth Molloy to say that he did not recall a decision being taken around cystectomies for benign reasons; he did not agree with that and didn't think the decision had been taken that cystectomies for benign reasons were being moved to Belfast. An opinion was sought from Mr. Fordham, who was the independent urologist on the Review Team. Mr. Fordham responded to say that whilst there was no guidance, he would expect that patients would expect to have their surgery undertaken by somebody who was doing sufficient of these in an annual basis. 14:28 14:29

There appeared to be doubt around that in our system later on in the middle of 2011, so I wrote formally to all three consultants saying for the avoidance of doubt, all cystectomies, for benign reasons and malignant reasons, are to be referred to the Belfast Trust, and then that's what happened, to include all of the malignant radical pelvic surgery in September because the Belfast Trust were now in a position to accept them. 14:29 14:29

250 Q. We can see the briefing note then that you sent in relation to this setting that out at TRU-259524. It's a briefing note of September 2010. This is to the Board?

A. Yes, that's correct.

251 Q. The "Clinical Issues in Urology Services Briefing Note to the Trust Board, Confidential".

The background on the IV fluids and antibiotics, we have already gone through. You are updating the Board in relation to that. The indication is there are still some patients, in the last paragraph, being treated, "but the cohort has reduced considerably" it says in that. Then the next line is a background to the IV antibiotics and central venous access. The background then on the cystectomies. So there are three issues in relation to this going to the Board? 14:30 14:30

A. Mm-hmm.

252 Q. You have said that the current action in relation to the cystectomies is: 14:31

"In line with guidance from the National Clinical Assessment Service, the Trust has commenced a process of screening with the file of each patient who has undergone cystectomy in the past 10 years will be reviewed by the Associate Medical Director for Surgery and Elective Care, and professional advice of a UK urologist with direct knowledge of this field will be sought as required. Our report of the screening review will identify if no further action is required or if a more in-depth analysis is required. Each of the two surgeons has been informed of this screening in discussion and in writing." 14:31 14:31

Then a further update on that is on the Regional Urology Review. You say:

"One of the requirements of the implementation of the review is that all radical pelvic urological surgery is moved to the Belfast Trust. This now explicitly covers radical pelvic surgery for both malignant and benign conditions and the Trust is in a discussion currently with HSCB and Belfast Trust regarding each individual case during the transition period." 14:32

I think that's just about almost two pages, that update, which covers four of the major issues in Urology at that time, or four of the issues that you felt it was necessary to bring to the Board's attention. 14:32

A. Mm-hmm.

253 Q. Would you be the decision-maker as to what goes into these briefing reports or would some others come to you and say I think the Board need to know about this? What's the process behind that? 14:32

A. I think it had been agreed with the Chief Executive which areas I would cover. The draft of this report was sent to the Chief Executive prior to it going formally into the Trust Board papers. There is a real dilemma for Trust Board papers and the four members of the Trust Board in terms of reading all the wealth and depths of material which comes to the Board. I think at that stage we were looking to make sure that the 14:33

Trust Board were aware of the issues and they had all the information. But something like this would have been discussed in more detail at the Governance Committee of the Trust Board, the quarterly meeting that we talked about earlier. Obviously this was a paper that was in Trust Board papers and so any question could have been asked which I would have endeavoured to answer. Quite often there was quite a lot of discussion about these things immediately after the presentation. 14:33

254 Q. Would there be discussions around patient risk or safety? Would those sort of conversations arise, given the myriad of issues that have been brought to the Board's attention? What was the appetite for discussing patient risk at those meetings? 14:34

A. Oh, the appetite for discussing patient risk was centre table, absolutely centre table. There was no issue about that.

I mean, some of the other issues in relation to the Urology Service were not known about at this stage, at this point in time. It's only after September 2010 that some of the other issues became apparent. But, no, the appetite for patient safety issues was very, very -- was absolutely centre stage. The Trust Board Governance Committee would have started at ten o'clock in the morning and sometimes didn't finish until two o'clock in the afternoon. It was a really serious meeting and you had to be very prepared. I mean, 14:34 14:34

Katherine Robinson talked about being prepared for meetings with me at 9:00 on a Tuesday morning. Boy, was I prepared for the Trust Board governance meeting. You know, I went in armed with all of my papers and files and everything in my head. They were serious meetings that you could be quizzed and integrated about a range of things, and I didn't usually like to be found wanting in terms of information in response. I think Katherine Robinson shared that view, she didn't want to be found wanting as well. 14:35

255 Q. It seems in the lead-up to this you had gained assurances along the way that would be reflected in this note, so I presume that is in preparation for the Board's questioning --

A. Yes. 14:35

256 Q. -- of Patient Safety issues or are there any concerns you might have around patient risk?

A. Yes.

257 Q. And conversations of that type did take place?

A. Oh, yes. They did take place, yes. 14:35

258 Q. Just for the Panel's note, there's another update for the Board on 25th November 2010. The Trust Board confidential briefing note of November 2010 is at WIT-12603. Maybe we will go to that one, actually. WIT-12603. 14:36

This one is after the previous one, the previous note that we saw, the review of patients on IV fluids and antibiotics.

"The clinical review and development of a management plan for patients which excludes routine IV fluids and antibiotics has been led by Ms. Sloane, Clinical Director for Surgery and Elective Care. The review has been completed for 13 patients. It has been decided by the Clinical Review Team to undertake a review of the whole original cohort of patients and it will take several more weeks to complete this. No patient in the cohort now has a central venous line". 14:36

A. Mm-hmm. 14:37

259 Q. Just move down, please. Again, the review of cystectomies, the update on that:

"The clinical review of the records of the small cohort of patients who have had surgical removal of the bladder is underway by Mr. Mackle, AMD Surgery and Elective Care. This will be completed in the next few weeks". 14:37

And the Regional Urology Review, the update is:

"Transfer pathway of patients with urological cancer requiring radical pelvic surgery or radiotherapy has been agreed. All patients are now being transferred to the regional urology centre in the Belfast Trust". 14:37

That follows on from the previous note?

A. Yes, it does. I mean, that last sentence, actually looking back on it, that was not the case. Obviously

the Belfast Trust were not yet in a position in November 2010 to accept patients. They only were accepting them from late September the following year. But that was obviously my understanding at that stage but it transpired to be not the actual specific timeline.

260 Q. Before we move on to the MDMs and the centralisation of some of the meetings around that and the difficulties with that, I just want to bring your attention to something that Ms. Sandra Hewitt had said in her witness statement at WIT-62007. She is referencing the material that was given to the Board. She is a Board governance --

A. Board secretary in my time.

261 Q. Board secretary for governance?

A. Yes.

262 Q. So she was responsible for getting the papers together and the information ready so that the Board had the information in time for their meetings and were informed. Paragraph 43.1. She says:

"I think the clinical and social care governance arrangements were not fit for purpose in that more connection was required with the corporate governance arrangements. As referenced in 41.2, the only information that was escalated and shared with Trust Board about clinical concerns in Urology was from two briefing papers Dr. Rankin provided on IV fluids and antibiotics and cystectomies in 2010. In my view, the

relevance and depth of information that was escalated and shared with the Trust Board members did not provide them with robust assurance that concerns had been addressed, nor enable them to make any informed decisions. I did not have any concerns specifically and therefore would not have raised them."

Your evidence seems to be that those papers were the gateway into which you could have been interrogated on the substance of what you had written. 14:39

A. Yes.

263 Q. The actual attendance at the confidential and then the wider Board meetings --

A. Yes.

264 Q. -- was where you were stress-tested as to your assurances that you could give the Board; would that be fair? 14:39

A. That's a very fair assessment. Of course, I suspect that Sandra's comments referred to the Trust Board meeting. They don't reference the Trust Board governance meeting, which was a subcommittee of Trust Board, where there was a much, much deeper dive into the range of governance issues, much greater detail. From recollection, that Trust Board Governance Committee at that stage was chaired by Ms. Brownlee as delegated by Mrs. Balmer, who was Chair of the Trust. That's the visual that I have in my mind. 14:40 14:40

265 Q. That's the order of post-holders?

A. Yes.

266 Q. You mentioned the capacity of Belfast to undertake the responsibilities, I suppose, for the radical pelvic surgery following the review?

A. Yes.

267 Q. I just want to go to something you said in your statement at WIT-15884. It's paragraph C. At paragraph A you've said what we have already discussed, that the surgery would move. At the end of paragraph A, the second-last line, you said: 14:40

14:41

"This process of referral to another clinical unit within a specialty is usually undertaken through the regional MDM process, where a patient is discussed and a collective decision recorded and implemented. The receiving consultant or clinical unit has therefore agreed the referral of the patient". 14:41

A. Yes.

268 Q. So if it had been the case that if it was required that the patient would be transferred to the Belfast clinicians, then that would be done through the normal having a conversation about it and deciding if that referral was appropriate? 14:41

A. That's correct.

269 Q. Then at paragraph B you have said:

14:41

"The members of the MDM are necessarily the consultants in the specialty, radiologists presenting the diagnostic test results, pathologists presenting on the pathology of the malignancy, the oncologists setting

out the chemotherapy and radiotherapy required for the patient before and after surgery. All these specialties required to be present for an effective MDM process. The MDM process also discusses the discharge of the patient back to the original Trust for follow-up care."

Then paragraph C:

"After the regional decision was taken to move all radical pelvic surgery to the Belfast Trust, there were difficulties setting up the regional MDM process through the Belfast Trust. This was due to the lack of a consultant oncologist for the Urology Service at that time within Belfast. The Southern Trust set up the local MDM to test systems and prepare for linkage with the Belfast Trust." 14:42 14:42

A. Mm-hmm.

270 Q. Was that one of the reasons why there was a delay in the transfer over of the radical pelvic surgery, or is that incidental to that; is that just another operational issue that had clinical impact? 14:43

A. I'm not sure whether there was a linkage. There may well have been a linkage there, because it certainly was a very difficult time for the Belfast Trust because I think they appointed an oncologist who then didn't take up that particular role with those particular body tumour groups, moved to a different role and then they had to appoint somebody else. There certainly was 14:43

a very long lag period from when we were being asked to set up an MDM and being asked to effectively link through to the Belfast Trust. I suspect that that did contribute to part of the delay in referring patients but I'm not completely sure on that. 14:43

271 Q. The Panel have heard evidence around the difficulties with staff retention in various disciplines --

A. Yes.

272 Q. -- and the impact that has on the MDM, and this is going right back to 2010? 14:44

A. Yes. We also had a shortage of consultant radiologists. We had several radiology consultant posts vacant at that stage, as had most of the NHS in the UK. That has since been addressed by significant increase in specialist training numbers in the specialty. 14:44

273 Q. I think you have said in your statement as well that the issues regarding the presence of an oncologist from the Belfast Health and Social Care Trust attending the MDM continued until the end of 2011. For the Panel's note, that's at WIT-15887. 14:44

A. Yes.

274 Q. I want to move on to the retained swab issue. Just for general note for the Panel, it's dealt with at Dr. Rankin's statement at WIT-15890 to 15892. You have dealt with in that statement and you have revisited it in your addendum statement. I think it may be easier if I read the part of your addendum statement. 14:45

A. Okay.

275 Q. The reason why this might be better chronologically is because you have interspersed your original narrative with new material. If I just go to the new material or just go to the old material, we don't get the full picture. I'm afraid I am going to have to read this out and then everyone will have your evidence on that, if that's okay? 14:45

A. Okay.

276 Q. That's at WIT-96714. So, in reference to this issue, you say: 14:46

"A significant clinical incident occurred regarding the retaining of a swab after surgery on 15th July 2009 which was only identified when the patient was admitted as an emergency in July 2010. A post-operative CT scan was undertaken in October 2009 as planned and identified an abnormality. Although not identified as a retained swab, one of the deferential diagnosis was recurrence of the patient's cancer. A root cause analysis review of the case was required and undertaken. The final report of the RCA was taken to SMT in December 2010. The RCA identified that due to a backlog in Outpatient reviews, the patient was not seen in Outpatients for the 12 months after surgery, at which stage he was admitted as an emergency." 14:46 14:47

This is the lady who came in for an operation and had the CT scan; subsequently presented herself at A&E with abdominal pain?

A. Yes.
277 Q. And the retained swab issue was identified and removed?
A. Yes.
278 Q. Your involvement in this is around the report and the RCA? 14:47
A. That's correct.
279 Q. A report was prepared.

"A draft of the report had been shared with the Commissioner as required and this resulted in a letter 14:47 from Dr. Corrigan to Mrs. Burns, AD for Clinical and Social Care Governance, on 14th November".

That should say 2011. You were right the first time, I have been informed. 14:47
A. That's correct.
280 Q. It was incorrectly changed but you were right the first time. In this letter, Dr. Corrigan states:

"The report records that it was the practice of the 14:48 patient's consultant urologist not to review laboratory or radiology reports until patients attended for their Outpatient appointment. I believe this highlights an area where the Trust would have considered action to be appropriate. I am writing to ask whether this issue 14:48 has been taken forward, for example by considering whether there's a need for a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting

Outpatient review."

So two issues that emerge from this are the issues around reading results and what became known as DARO?

A. Yes. 14:48

281 Q. I think DARO was -- is that your invention or your suggestion?

A. Well, I don't know whether I coined the acronym but discharge awaiting results was certainly a standard operation procedure that I introduced as a result of 14:48 this because as soon as I received the draft report in October 2010, before it was submitted to SMT governance and on to the Board, I already started to take action to address the issue.

282 Q. You then go on to say: 14:49

"While the draft report was formally shared with Dr. Corrigan resulting in her letter of 14th November 2011, the issue of medical staff reviewing test results before filing, whether or not the patient is awaiting 14:49 an Outpatient appointment, was understood by the Trust as a clinical risk and as learning from the RCA prior to the receipt of this letter. The Trust took the necessary action to understand the current practice of medical staff in each specialty. In the Directorate of 14:49 Acute Services this was to discuss and assess the risk in each specialty through discussion with the consultants at specialty meetings."

This was as a direct result of the report?
A. Yes.
283 Q. The Panel can find a copy of the SAI report, and this is Patient 95, at WIT-17471.

So, you got a copy of the first draft -- a draft of the report first came to you in October 2010?
A. That's correct.
284 Q. Was it you or others who decided there were two immediate actions required as a result of this initial report? 14:50
A. I think it was myself.
285 Q. So, the first action, you said, was:

"To set out an operating process for Radiology staff to implement. A notification of urgent reports to the referrer or cancer tracker was written and implemented in early November 2010. On 20th November 2010, the Head of Urology Services assured the Medical Director's office on request that the notification of urgent reports to the referrer or cancer tracker had been implemented and is in operation." 14:50
A. Mm-hmm.
286 Q. Can you just explain what that process you put in then was? 14:51
A. Yes, the CT scan for the patient who the RCA was written about, the radiologist had identified there was something odd on the investigation but didn't actually contact the referrer to say there's something strange

here, I don't know what it is but there's something strange here.

What this procedure was about was that the person who was reporting the investigation in Radiology was required, if there was something untoward identified in the investigation that could be cancer or recurrent cancer or something very serious, they were required to make contact with the referrer or the cancer tracker so that the result did not sit unnoticed and unread in the system. So it was a push action, if you like; the radiologist, or a radiographer on their behalf, making a link back to the referring clinician or to the cancer tracker. 14:51 14:51

287 Q. So it was a way of flagging up? 14:52

A. It was a way of flagging up, yes.

288 Q. So it wouldn't just wait until a next review or perhaps an audit review?

A. Yes.

289 Q. Now, do you recall that the findings and recommendations of the RCA looked at the method by which the nurses accounted swabs during the surgery? 14:52

A. Mm-hmm.

290 Q. And that that was a responsibility of the scrub nurse?

A. Yes. 14:52

291 Q. And that there had been some lack of clarity around the method they undertook; is that your understanding?

A. Yes, yes.

292 Q. They made recommendations in that regard?

A. That is correct.

293 Q. I just want to take you to WIT-17471. I will take you to the report. This is the findings of the RCA and we will look at the recommendations. We don't need to go into the detail of this, it's the governance issues that arose as a result of this, but I just want to ask you about it. It says "Conclusions, Recommendations and Learning", WIT-17481. It said: 14:53

"The method of recording swabs which were temporarily used in the patient cavity that day in theatre is inconsistent. A standardised protocol for the counting and recording of all swabs across all theatres needs to be implemented urgently. The responsible scrub nurse in this case is unclear because there were two scrub nurses. When the scrub nurse hands over to another scrub nurse, he/she should sign off the current state of swabs in use and used. The first post-operative scan of 1st October 2009 was not reviewed at routine follow-up because there was no follow-up for 12 months due to the length of the Urology Outpatient Review waiting list. The Urology waiting list for post-operative follow-up needs to be cleared. Several abdominal X-rays were performed on the patient re-admission but the swab was missed by several doctors. This was presumably because they had never seen a retained swab on a radiograph before previously. This case should be presented with the radiographs at surgical and medical morbidity and mortality meetings 14:54 14:54 14:55

to demonstrate the appearance of a retained swab."

Just on down then, it set out the local recommendations:

"All swab and instrument counts must be interruption free and, where possible, the same circulating nurse completes the count. Swabs that are temporarily used in patient's cavity must be recorded on the white board and struck through when removed until operation complete. The record must not be rubbed out. As far as is operationally possible, the same nurse should remain as the scrub nurse for the entire operation. Signing off of swab status must take place by the swab nurse if there is a change-over. It needs to be recognised and reaffirmed that time is required at the end of the operation" - I presume that's "for" - "the scrub nurse to ensure that all swabs, instruments and equipment are accounted for. Where possible and practical there should be a surgical pause before wound closure. The findings of the RCA will be presented at the next Radiology Peer Review discrepancy meeting." 14:55 14:55 14:56 14:56

A. Mm-hmm.

294 Q. "Presentation of case with radiographs at Radiology surgical and medical M&M". "Reduction of urological outpatient follow-up waiting times." 14:56

A. Mm-hmm.

295 Q. The other recommendations seem very fact-specific and context-specific. I know there was a mention at the

delay and review may have been as a result of the Outpatient follow-up waiting times, but do you recall if there was any action taken as a result of that last recommendation from the RCA?

A. Specifically in the waiting times? A review? There was ongoing action happening at that stage. We were already working on specific action plans and we had specific meetings around the review backlog. I think somewhere in my witness statement and associated papers, there is a clear action plan with maybe eight or ten actions around the review backlog, things like one of the Clinical Nurse Specialists reviewing the actual cases, and in agreement with the consultants, some patients could be discharged, some could be reviewed by the nurse, some could be referred back to primary care. So, there were a range of various actions going on in relation to the review backlog and those continued. 14:57 14:57 14:57

I mean, there possibly was a six-monthly review of those actions to see what more we could add into them. One of those actions was the workshop with GPs. That was one of the actions on a review backlog action plan, to see and get agreement with the consultants as to which patients could be more quickly be discharged into primary care with, of course, the proviso that they could be referred back if there was any concern and they would be seen very quickly. 14:58 14:58

296 Q. The second issue that then emerged from this was the

DARO?

A. Yes.

297 Q. You referred to that in your addendum statement, if I could just pick up again where I left off. It's WIT-96717. We have looked at the first one, which is the issue around the triggering of the result, the anomaly. The second one, I will read what you have said: 14:58

"The second immediate action was undertaken through the Administrative and Clerical Staff Review, which was commissioned by SMT and the Trust in 2010, which provided the vehicle to set out a new standardised process for discharge awaiting results. In order to undertake the administrative and clerical review, I set up a project board for Acute Services, chaired by myself with a project manager assigned from within Acute Services. Heather Trouton as AD for SEC undertook a key role. This resulted in many variances in administrative processes across the legacy Trust being standardised through a process mapping exercise involving clerical staff from all parts of the Acute Services Directorate. There were five different hospital or community clinic locations where consultants provided Outpatient clinics. As these were across three legacy Trusts, standardisation of processes was of key importance. One of the areas which had an initial focus was to develop a standard operating procedure for administrative and secretarial 14:59 14:59 14:59

staff to manage results in the context of discharge awaiting results. This was signed off and first implemented in November 2010 with workshops involving all clerical and administrative staff. This SOP was reviewed in November 2011, and again reviewed and a revised version was implemented in October 2012. An additional action taken through the administrative and clerical review was to develop a specific SOP for secretarial and typing staff regarding the management of results. That was implemented in October 2011." 15:00 15:00

You go on to say:

"The AD for Surgery and Elective Care sent an email on 25th July 2011 regarding the issue to all Heads of Service for further assurance after previous discussion that test results were being read as soon as the results were available. The Head of Service for Urology sent this email to the consultant urologists on 27th July 2011, and this resulted in an email response from Mr. O'Brien on 25th August 2011. In this email, Mr. O'Brien raised eleven points regarding the potential impacts of reading the test results when they were received. This resulted in an email from Mr. O'Brien being forwarded to the AMD, Mr. Mackle, who raised this with myself, identifying a governance issue as Mr. O'Brien does not review the results until the patient appears back in Outpatients. A conversation followed with Mr. O'Brien without success in terms of 15:00 15:01 15:01

changing his clinical behaviour. The email sent by myself to Mr. Mackle, the AD and Head of Service, on 8th September outlines a high level plan as I was going on summer leave. The AD replied to state she would look at the processes in other specialties in order to present current working processes in other areas should the need occur."

15:02

Then the additional text you have put in is:

15:02

"I continued to raise the issue of not reading results when received with the AMDs. Heather Trouton, as AD for SEC, at my request, in an email of 8th September 2011, undertook a scoping exercise of the baseline position across all divisions in Acute Services. This scoping exercise identified that in the main, results are read in a timely manner, although variances in how this has been done have been highlighted. This was set out in the Trust letter of response to the HSCB in late 2011 regarding the request for assurance and a policy for the review of results when received. The detailed results of this scoping exercise set out the practice of each surgeon was sent by Heather Trouton to Margaret Marshall, copied to myself on 30th September 2011."

15:02

15:02

15:03

Then in September 2012, you wrote again to the Acute Services Assistant Directors stating:

"Despite all the efforts, these procedures have not

been implemented. I have no evidence on what information I have received to state this. I requested the ADs to urgently review and implement in their division, and stated that we would be auditing charts to see what is happening. On 26th September 2012, I received assurance from Ronan Carroll, AD for Cancer Services, Anaesthetics, Theatres and Radiology, that the DARO SOP has been implemented and staff workshops undertaken." 15:03

15:04

I read that out, it sets out the chronology of attempts to get this process that was agreed implemented. It's clear from what you have written that the HSCB were also pushing for an assurance?

A. Yes. 15:04

298 Q. Just so I understand the way in which the HSCB becomes engaged in looking for assurances, once they know that the Trust has gone to undertake a process of introducing an SOP for a certain issue, do they become then active in following that up, or is it possible that they also require the Trust to introduce certain measures that they then seek reassurance on? Which direction does it flow in? 15:04

A. I think if the Trust had not indicated that they were taking measures, the Board would require you to take those measures. There would be no doubt about that. I think the fact that we had set out the actions that we were really taking, and of course there would be a lot of informal conversations about this, in addition 15:04

to the formal correspondence that you've seen in the bundles. Dr. Corrigan would have been fully aware of what we were undertaking. I mean, she would have been meeting our staff in various different meetings and would have been fully aware of what was going on. 15:05

299 Q. It's clear that almost two years later, September 2012, there's still a push to get this fully implemented. It's clear that the staff have been informed and workshops have been undertaken. Was that a source of frustration for you, that you were still having to seek 15:05 assurances periodically, given that the report was written in 2010?

A. I think it's the sort of situation that you would always want to be seeking reports on assurance. I mean, the system was largely working the way it should 15:05 do. It wasn't perfect; there certainly was at least one outlier.

The thing that I really wanted to get in place, which really trumped all of those other processes, which were 15:06 key, but the most important thing was the electric Radiology system being able to red-flag an alert. The Radiology system that we were using was the regional Radiology system. For regional read slow progress, because if you needed to get an amendment very quickly, 15:06 it was very difficult to introduce a development of a software system that you needed very quickly. It was very, very difficult to influence a regional system to get that change in place. My understanding now, from

the papers I have seen in relation to the Inquiry, my understanding is that that change did come into place before I retired from post.

The change that I was looking for was the facility to have an alert in the Radiology system when a consultant had not read -- a consultant or the appropriate doctor who had ordered the test had not read the results of that test, and you could set the time scale in which you want that set. That could be a week after the results were published. We also had to be able to write a report to be able to get that information from the system. By automating it in that way, you then had an absolute visibility of who was reading the results and in what time scale. You then had a mechanism to have a report evidence on the table with which you could have then a very straight conversation with a consultant or a specialist registrar from their trainer, or a staff doctor, or whoever was looking -- whoever was ordering the investigations. 15:07

That was coming in as I was retiring but, for me, that was the most important development that I wanted to see in place. The rest were processes to manage patient safety until -- which would continue, but I also wanted this electronic change in the Radiology system. 15:08

300 Q. You mention that then at paragraph E of your addendum statement?

A. Yes.

301 Q. Where you have said halfway through:

"The Trust undertook the implementation of the reporting process for laboratory, i.e. blood test results. In relation to the need for report from the regional urology system, a software upgrade was sought through the BSO, Business Services Organisation, to enable such a report to be made available. From memory, the facility for a consultant to tick a box when they read a Radiology result was made available in 2012." 15:08 15:08

That's information you received from Mr. Mackle.

"A report on which results had been left unread was then feasible", but you don't recall that being available during your time? 15:08

A. No. I didn't ever see a report, no.

302 Q. I just want to take you to the SOP for discharge awaiting results, WIT-96725. This was formalised in November 2010. At 96726, the next page, paragraph 3 at the top of the page, it says: 15:09

"If a patient is awaiting results prior to a decision regarding follow-up treatment being made, they must be recorded as discharge (DIS) on the system and not added to the Outpatient waiting list for a review." 15:09

Then if we look at 96732 on the same document under the

title "Management and Monitoring". It says at the top:

"Please note a patient must not be added to the Outpatient waiting list if they are awaiting results and no decision has been made regarding their review date."

Is it your view that a patient should not have been placed on DARO if the consultant had already decided that the patient required review in December 2010, irrespective of the result of the investigation performed before then? In other words, if the consultant had already considered that a review was necessary irrespective of the outcome of the result, that they should not be placed on DARO. Is that your understanding of how DARO operated? 15:10 15:10 15:10

A. Yes. I think the consultant has to read the result and then determine the review time scale, particularly when we had great difficulty being certain about the review date, given the review backlog which all the consultants were aware of. One of the things that is absolutely key in this standard operating procedure is that when the results are read and the decision is made as to when to review the date that they are put on the waiting lists for review, is the date of the investigation, not the date when the secretary or the administrative person is actually doing the work on PAS. 15:11 15:11

So that's a key thing in there. The patient does not lose their place on the waiting list for review because they are put on the DARO list. Their review appointment is dated from the date of the investigation which the consultant ordered, and so they don't lose their place. That's absolutely key and important to the understanding of this particular standard operating procedure; the patient is not disadvantaged in any way. The only thing it is advantaged is their results are reviewed and seen. 15:11 15:12

303 Q. So they don't fall off?

A. No, they don't fall off and they are not lost in the review backlog. That was the whole purpose of this, to make sure that these patients are visible on a list so that that list can be viewed by consultant, reviews can be checked, but the patient is not losing their place in the ordering of the review backlog or the review process. 15:12

304 Q. You finish your last part of your addendum statement, and I will just read this out, it's just a small couple of lines: 15:12

"I do not have evidence to state whether the systems were successful in rectifying the problem as they were only being implemented late in 2012", just prior to your retirement? 15:12

A. Yes. That relates to the development of the Radiology system having the ability to have an alert that a result had not been read by the consultant or

referring doctor. That's purely in relation to that statement. The DARO was working clearly long before that, and the process to guide secretaries around the management of results.

305 Q. You also were Director of Acute Services at a time when there was an issue around Mr. O'Brien placing notes in the bin? 15:13

A. Yes.

306 Q. I don't think you were involved in any part of that process? 15:13

A. No, no.

307 Q. And that was a governance concern that was triggered by an ancillary member of staff identifying that issue?

A. Mm-hmm. Yes, yes.

308 Q. Were you content the way in which that process was dealt with? 15:13

A. I was.

309 Q. You were aware of it at the time and the steps that were taken to seek to address it with Mr. O'Brien?

A. Yes. The steps that were taken were the usual steps that would be taken within the Trust's policy for disciplinary issues. So, the policy was followed and i was content. I was aware it was happening and made aware of the result, but other than I had no involvement. I couldn't have or shouldn't have. 15:13 15:14

310 Q. For the Inquiry's note, that is in Dr. Rankin's statement at WIT-15892 to 15893.

We have referenced the times at which you let the Trust

Board know of the issues. I just want to give the Panel a note of some entries that were made on the risk register of similar issues during your tenure. They were recorded. Just let me find my notes.

15:14

On the Directorate Risk Register, the Panel will find reference to the cancer performance risk, with the highest risk in Urology. The actions were an escalation policy, action plans drafted, meeting with Urology team and working towards one-stop clinics is on 15:15
the register at WIT-16415. That's noted as risk 2991. You are looking for it on 26th May 2011.

Then at WIT-16417, noted at risk 3166 on 25th June 2012, there's a note that says: 15:15

"Urology access waiting times increase from 36 weeks for inpatients and day cases. At this point 36 weeks was the agreed backstop position", and you note with the Health and Social Care Board. "First ICATs 15:16
appointment increased from 17 weeks currently being addressed via approval to go to the independent sector. Appointment of new consultants."

A. Yes.

311 Q. A further example of the risks on the Directorate Risk 15:16
Register is at WIT-16417. That's noted at risk 3191 on 3rd September 2012. It says:

"62-day cancer performance. Trust fails to meet

performance standard due to increase in red flag, capacity issues, inability to downgrade and regional issues."

The action is: "Daily monitoring of referral of patients on 62-day pathway, escalations to Head of Service, AD, when patients do not meet milestone on pathway. Monthly performance meetings with AD, Head of Service, and escalation of all late triaging, with actions to develop one-stop pathways for haematuria and prostate cancer." 15:16 15:17

The final note of the divisional risk register this is for SEC and CCS, WIT-16427. That's risk 2943 on 7th April 2011. 15:17

"Urology cancer pathway delay. Action: 1st October 2011, one-stop prostate clinic commenced. 6th October 2011, one-stop haematuria clinic commenced. 23rd January 2012, one-stop prostate clinic fully operational." 15:17

Just again for the Panel's notes, when Urology didn't meet the IEAP requirements, the service performance was also discussed at the SMT monthly governance meetings under the guise of the performance report -- 15:18

A. It certainly was.

312 Q. -- which went to the Trust Board?

A. And it also was discussed at the Trust Board governance

meeting as well, and in the monthly Trust Board performance report.

313 Q. Reference to the performance report to the Trust Board on 29th April 2010 can be found at WIT-16014, WIT-16023, and WIT-16042. A further performance report to the Trust Board, dated 27th May 2010, to be found at WIT-16089, WIT-16098, and WIT-16117. 15:18

You say in your statement at paragraph 37.16, I think it was you that brought the never event -- 15:19

A. Yes, that's correct.

314 Q. -- idea or process or procedure, whatever way you want to frame it, I think to Northern Ireland. It hadn't been existing in the Trust prior to that?

A. No, that's correct. NHS England had a concept of identifying a list of never events, which included a section on never events in relation to medication. That was taking learning from all of the significant events that had happened across the -- well, NHS England, presumably. That was not in usual -- that was not in use in Northern Ireland but it seemed to me, as I was seeking to develop the clinical governance approach in the Southern Trust and to deepen the understanding, that will be a useful tool to introduce within the Acute Directorate and to then use that to help with our learning. Not that I wanted to have any never events, because they are really a list of very, very significant events such as wrong sight surgery, wrong limb surgery, significant medication being given 15:19 15:20 15:20

through the wrong route; things which usually result in catastrophic consequences.

I discussed it with each of the AMDs at my one-to-ones with them. They all agreed, and I took it through our Acute Clinical Governance process in the Acute Directorate. I took it to SMT governance and it was approved there. That was my usual route of having discussions with individuals, first of all, and then taking it through the Acute Directorate processes, clinical processes, and then taking it to SMT. It, of course, was approved at that stage, that was a formality. Then we introduced it, so that was used subsequently. 15:20 15:21

315 Q. Just for the Panel's note, the email with confirmation of the adoption of that is WIT-16983. 15:21

Now, just a discrete issue with you in relation to Mr. Mackle. Mr. Mackle, I don't know if you listened to his evidence at all? 15:21

A. I listened to some of it, yes, yes.

316 Q. You will remember Mr. Mackle, it was indicated to him that he had been bullying Mr. O'Brien --

A. Yes.

317 Q. -- in that wider context. Mr. Mackle refers to this in his statement at WIT-11773. That's not the correct page number. 11769, thank you. Go to paragraph 92, just to give you the context. I will read out: 15:21

"In 2012, I am unsure of the exact date, I 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 had been bullying and harassing him". 15:22

None of that is accepted but this is Mr. Mackle's statement.

"I was called into an office in the administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down a corridor to Martina Corrigan's office. Martina 15:23
immediately asked me what was wrong and I told her of what I had just been informed. In approximately 2020 I truthfully had difficulty who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for HR. I now have a memory of same but 15:23
can't be 100% sure if that 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 was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any 15:23
further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director."

For the Panel's note, Martina Corrigan speaks to this issue in the same terms in her statement, WIT-26313.

Do you recall this conversation with Mr. Mackle?

A. I do, yes. 15:24

318 Q. Just to give us an idea of the proximity in time, had he just been informed of this allegation when he spoke to you or it was a day later, or do you have any recollection of when in time you were told by him about it? 15:24

A. I don't recall exactly when it was but because he was quite clearly not himself and was very pale, he was not his usual bubbly self with lots of information, I think it must have been the same day.

319 Q. Did he come to your office or how did it come about that he told you this? 15:24

A. He came to my office. I can see him standing in my office.

320 Q. Was it specifically to tell you this; he hadn't got a prearranged meeting or anything? 15:25

A. No, no.

321 Q. You feel he made his way there because of --

A. Yes. Yes, he did.

322 Q. Do you recollect the words that he used or the phrases he might have used to tell you what had just happened or what had happened recently? 15:25

A. No, unfortunately I don't recall the specific words. I recall having the conversation and I recall advising him as to what action I would suggest that he takes,

and I can recall him being visibly upset, but I can't recall where he said he had received the information from or --

323 Q. Or who had --

A. -- or who had said it to him at all. I don't have that recall. I can recall saying to him -- Mr. Mackle was the Associate Medical Director to whom the Clinical Directors linked, and they were in a sense his ears and eyes and feet for the various specialties across both hospitals. At that stage, Robin Brown, the senior surgeon in Daisy Hill, was the Clinical Director for surgery across both Daisy Hill and Craigavon. But Daisy Hill and Craigavon are 22 miles apart, so what usually happened on a day-to-day basis was that because Mr. Mackle was present in Craigavon, if there was something bubbling that he could deal with very quickly, he dealt with it and would have informed Mr. Brown that it had happened and what he had done about it, which saved Mr. Brown often the journey and therefore the time. 15:25 15:26 15:26 15:26

All I said to Eamon was, pull back, don't play the CD role in Craigavon, your CD is Mr. Brown and Mr. Brown knows the urologists of old, surely Mr. Brown should be dealing with the day-to-day urology issues, and if you do need to meet with Mr. O'Brien, because I am sure you will need to in the future, you will always have to have some conversations, just make sure that there is somebody else present, whether it is Martina Corrigan, 15:26

Heather Trouton, myself, somebody else. That would be the usual advice you would give somebody so that was how I left it.

324 Q. Did he indicate to you where the source of the alleged allegation came from? Did he mention Mrs. Brownlee to you or anyone else? 15:27

A. I can't recall specifically. I now know that but I don't know whether I now know that because I now know it or it was said to me at that stage. I think probably it was said to me at that stage. I'm not going to be cast iron about it but I think it was said to me at that stage. 15:27

325 Q. Did that allegation ever emerge in your time? Did anyone ever approach you about it; was it ever formalised in any way that you can recall? Was there any discussions between you and anyone else -- 15:27

A. No.

326 Q. -- around that? Did Mr. Mackle ever raise it again as an issue?

A. No, I don't think he did. I can't recall. I mean, there was nothing further around that. There was no further discussion around bullying. I would have had conversations with him, I am sure, at one-to-ones in relation to how Mr. Brown was getting on handling the general surgical issues on the Craigavon site, but there was nothing specific in my memory that I can offer. 15:27 15:28

327 Q. Did you have any concerns from a governance perspective that Mr. Mackle stepping back from overseeing Urology

would result in less oversight generally, or a reduction in - I think you have referred to soft intelligence - that sort of information feeding its way back to various people? Were you concerned at all about that? 15:28

A. No, because he wasn't stepping back. Essentially he was still the AMD for Urology, he was just not also acting as the Clinical Director for Urology. It didn't stop soft intelligence because the fact that Mr. Mackle was a working surgeon in the system and was continuing 15:28 that. Eamon wasn't the only person from whom I got soft intelligence, there was soft intelligence coming from a range of sources. So no, I had no concerns at all because Eamon was still the AMD, all we were doing was giving the Clinical Director their rightful place 15:29 in terms of the Urology Service. Michael Young worked to Robin Brown and Robin Brown, then in terms of the Clinical Lead, the Clinical Director to the AMD.

328 Q. You have also mentioned that he might be advised to be accompanied by the Head of Service or the Assistant 15:29 Director from the non-medical side if he was meeting Mr. O'Brien?

A. Mm-hmm.

329 Q. Were you ever aware that either of those two post-holders attended meetings with Mr. Mackle and 15:29 Mr. O'Brien as a result of Mr. Mackle's review on this?

A. I mean, I suspect that there would have been ongoing meetings routinely that Mr. Mackle would have been present about general things, but I have no knowledge

of anything specific after that. I mean, that was in 2012 and I retired in 2013. So no, I have nothing that I can add into that particular narrative.

330 Q. I think we have got to the stage of your learning. Just before I say that, I just want to ask you about job planning and appraisal. Have you any involvement in that, the objectives for consultants or setting any -- 15:30

A. No.

331 Q. You had no involvement in that? 15:30

A. None.

332 Q. That short-cuts another page.

If we look at your learning and reflections that you have set out in your witness statement at WIT-15928, 69.1, you say: 15:30

"On reflection, and setting out the range and number of issues in urology Services, I believe that the following is clear: The service was under considerable pressure due to increasing referrals and was insufficiently resourced to meet the catchment population needs. The long-term absence of the ICATs Urology doctor contracted for seven sessions per week, contributed to the consultant pressures as they had to see all referrals in Outpatients. There was also additional pressure due to the consultant clinical behaviour of Mr. O'Brien which meant that smaller number of patients were seen in each Outpatient clinic 15:31 15:31

and more patients were reviewed that consultant peers would review. There was also little appetite in the service to agree protocols with primary care to review certain cohorts of patients. There was poor professional practice, which had been long-standing. 15:31
It proved to be very difficult to get engagement with Mr. O'Brien to change his behaviour. When changing his behaviour was agreed, the specific behaviour was not always sustained and he would revert to previous poor practice. An example of this was when Mr. O'Brien 15:32
agreed to triage referrals within the required time standards. It became apparent subsequently that this change in behaviour was not sustained and required regular checking."

15:32

You were asked about what you were considered to be the learning in terms of governance. At paragraph 70.1, WIT-15929:

"There are several points of learning from a governance 15:32
perspective which are set out below. When a service is under pressure with insufficient resources to meet the population need for a prolonged period, it might be reasonably assumed that the risk level within the service may increase. 15:32

B. A service under pressure to meet population need may have little appetite or space for the development of implementation plans and then implementing this

change. However, it could reasonably be assumed that most services and the senior staff in those services would welcome the opportunity for growth of the service and improvements in services for patients.

15:33

C. Systems to collect data to provide the full functionality required to identify staff behaviour and provide the required reports to monitor this behaviour are not always available at the point in time when needed."

15:33

You reference the regional Radiology system.

"D. Governance systems which require action on behalf of all staff, for example, being open about concerns or completion of clinical incident data on the Datix system take time for staff to be trained, time for the processes to become embedded, and time for staff confidence to use them to build. This process is a journey of improvement for a large organisation rather than an overnight change.

15:33

15:33

E. It is difficult to monitor all consultant behaviour. If there is evidence of agreed changes in behaviour not being sustained, then additional action should be considered, particularly where this involves what might be regarded as required clinical consultant behaviour, especially when this is outside the accepted normal behaviour of peers."

15:34

Then when you were asked do you think there's a failure to engage with the problems within Urology Services, you say:

15:34

"I believe that there is a failure to engage fully in the following ways: There was resistance to change in clinical behaviour; resistance to change was the general sense in the Urology Service. However, when change was required in order to implement improvements for patients, two consultants did make these changes in their personal behaviour. Examples of changed behaviour are changing clinic templates, and the new-to-review ratios to reflect BAUS guidance; setting up the local MDM multidisciplinary meeting in preparation for the regional MDM; agreeing new patient pathways such as one-stop clinics. These two consultants also undertook additional work, such as triaging on behalf of Mr. O'Brien when he failed to cooperate in undertaking this process in the required time standards. Mr. O'Brien tested the new clinic templates and his clinics regularly overran by two hours. He was therefore unable or chose not to amend his behaviour in Outpatient clinics."

15:34 15:35 15:35

15:35

Then you go on to say:

"It is difficult to state what could have been done differently within the Trust without reference to

outside professional bodies to change the behaviour of a single consultant who was resistant to change and refused to acknowledge that there was a requirement to work within a clinical system, where the Department, the Commissioner, and the Trust had set out the parameters". 15:35

Then you give the examples of some of the standards that would have been anticipated to be adhered to. You say at the last sentence there: 15:36

"However, perhaps earlier action may have been appropriate in seeking an external assessment of competence to practise." 15:36

We have discussed most of the other issues where you are making practical suggestions that have been brought out by the examples that we have relied on?

A. Yes.

333 Q. Is there anything else in your statement that you wish to speak to, or any other issue that you feel needs addressed that we could look at, or anything you would like to add generally to your evidence at this point? 15:36

A. Thank you for the opportunity but I think you have provided me with the opportunity of setting out all of the things that I wanted to say. Thank you. 15:36

MS. McMAHON: I have no further questions.

CHAIR: Dr. Rankin, I think we should have a short break before you are questioned by my colleagues and

myself for a short period of time, hopefully. Let's come back at 3:55 then.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

15:56

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIR: I am going to ask Mr. Hanbury, first of all, I think he has a few questions for you. 15:56

334 Q. MR. HANBURY: Thank you very much for your very clear evidence, I just have a few clinical things.

Going back to the Regional Review and the five consultant model, you expressed some, I think, 15:56 frustration that the job descriptions and the plans come through or the sort of process of advertising didn't come through as quickly as you would have hoped. Is that a correct interpretation?

A. Yes. I think the five person job plans took a long 15:56 time to gain agreement of. They had been in high level discussions for quite a long time until the summer, I think, of 2011, but it took through the winter, I think, to get final agreement on the detail of all of those five job plans. 15:57

That time, of course, included the approval from the Commissioning Board and approval from the special adviser Paddy Keane. So, there was those two other

hoops, of course, have to be gone through. Perhaps in hindsight it wasn't such a long period to actually get that in place, but we were then able to move to recruitment, I think, in March 2012.

335 Q. So that wasn't necessarily a criticism of the local urologists, it's all the loops together? 15:57

A. No, it is all the loops together. Obviously you are very keen, once the Board had agreed and the funding was there, you were very anxious to get to the position of being able to move to a position of a five consultant model in place and ease the pressure on three existing consultants, so it was in that generality. 15:57

336 Q. One or two other things from that sort of modernisation agenda that you had then. The flexible cystectomies and how many there were on the lists, do you remember any numbers there approximately? 15:58

A. I wouldn't recall the numbers, no. I mean if I was in conversations I would have recalled, 10, 14. I can't remember. I may be mixing that up with scopes. 15:58

337 Q. It was in double figures, not single figures?

A. I am not too sure about that. Perhaps I shouldn't quote any numbers at all because I am very unsure.

338 Q. On the same theme, the Outpatient clinic templates and the sort of one-to-two. Do you have any recollection of numbers there; is it one-to-two and working out the 20 minutes and 10; was it sort of four new and eight follow-up, or five and ten and/or six and 12? 15:58

A. The detail, I am sure, is in the papers but I wouldn't

be sufficiently sure to quote that.

339 Q. Okay. You mentioned clerical support for admission processes, particularly with admissions; a four-person unit. We heard yesterday from Mr. O'Brien's secretary there didn't seem to be a lot of secretarial admin to help admit flexible cystectomies and urodynamics and that seemed to rely on the secretary some years later?

A. Yes.

340 Q. Was that something that you felt had improved?

A. Well, the situation was that the Trust of part of the efficiency savings across the whole of the Health and Social Care sector driven from the Board, was we had too many admin and clerical staff. I think there wasn't a fundamental understanding of how important admin and clerical staff are to the running of the system and the roles that they play. There was definitely a thrust to reduce the number of admin and clerical staff. In fact, the link of one consultant having 0.5 whole time of a PA was driven by the Commissioner. We actually had to make an allowance to grant Mr. O'Brien a full-time secretary because we recognised that he needed it, and I funded that from within the Acute Directorate budget so there was an overall requirement to reduce.

15:59 15:59 15:59 16:00 16:00

That was one of the drivers for the admin and clerical review which the Trust corporately set out and which we have talked about this afternoon, that I chaired a group to look at the admin and clerical review

processes. I suppose there was a grain of truth in terms of what the Commissioner was saying because there had been an amalgamation of 19 organisations into the five Trusts, four plus the Ambulance Trust, so there may have been a degree of duplication. The review that 16:00
I was doing within Acute was to look at standardising those processes and see where we had duplication, where we had doing the same sort of thing but lots of different ways, which is never useful because then if somebody is moving around, they don't know which 16:01
process they are following. There was a grain of truth in it but it did result in perhaps paucity of admin and clerical where there might have been some.

341 Q. Thank you. Moving on. Just one question about national audits. There were national audits going on 16:01
for things like nephrectomy and percutaneous day surgery, and national prostate cancer, which was actually not BAUS, it was the Royal College of Surgeons. We heard from Mr. Haynes that there was a sort of negative impact on that for information 16:01
governance, although that came from central... Were you aware of any --

A. No.

342 Q. -- negative influence from the higher Trust Board --

A. Not in my time. There was always a very, very positive 16:01
embracing if there was a national audit, we will participate.

343 Q. And national audits were happening in other specialties?

A. Yes. We participated in the Sentinel Stroke Audit, in the Fraction Neck and Femur national database, in the ICNARC, the intensive care database. The renal dialysis unit, we had had been contributing to that for a very long time. The renal dialysis unit was in Daisy Hill. So yes, there was a real thrust that if there was an opportunity to be peer-reviewed and to contribute to national audit, we were doing that. We would move resources around to provide the staff, the information staff, to actually gather the data to contribute to the audit. 16:02 16:02

There were also GI audits, I can't remember whether it was Crohn's or whatever. There were consultants who were keen to lead those because it was the right thing to do, to measure yourself against your peers across the UK. 16:02

344 Q. Thank you. Just got one more question, if I may. It's the retained swab case. Obviously the first thing that went wrong then was a wrong swab count. We sort of glossed over that but, in the RCA, there was an observation that there were two methods of counting swabs? 16:03

A. Yes.

345 Q. And there was a change over, which is not unusual in a long urological operation, cystectomy and nephrectomy together. That is understandable, there was a change of personnel. 16:03

A. Yes.

346 Q. Did you receive reassurance back from the Theatre Directorate that that counting problem was solved?
A. Yes. Each RCA or SAI or process to investigate an action -- an incident, had an action plan set out and with onerous time scales against each action. They were not signed off until I had assurance that all of the actions were in place. Those RCAs would have routinely been on the agenda for the Acute Clinical Governance meetings until people were perhaps fed up with them. But unless the actions were assured and signed off and implemented, then they wouldn't come off the agenda. 16:03 16:04
347 Q. Thank you. That's all.
DR. SWART: These are quite general questions so hopefully you won't need any figures for them. You clearly put a lot of emphasis into developing the governance structure? 16:04
A. Yes.
348 Q. You have described that, and some of our witnesses from later times have referred to that. What was still on your to-do list that you would have liked to have done if you could have done something that you thought was important? You have mentioned the national audits, and clearly there was a paucity of data? 16:04
A. Yes. 16:04
349 Q. But is there anything else in that line that you saw in terms of desirable?
A. I think the journey that we were on in terms of embedding the culture of if an incident occurs,

recognise it as an incident, discuss it, report, let's learn from it.

350 Q. Yes.

A. That learning process, and making sure that the culture was around learning from an incident as opposed to let's hide it, we don't want to know about it or own up to it, that journey of opening the culture was a journey in progress. That's a really, really important organisational journey. That's what the core thrust of the corporate review of clinical and social care governance was about. I am sure you have heard about that and seen the documents around that. That was absolutely the core of what we were seeking to do. 16:05 16:05

As you well know, it takes a long time to change a system. That required all of the staff working day in, day out in the wards and Outpatients in every which part of the hospital to embrace that culture, to recognise. I mean, there were still times when a senior leader, a senior clinician would come to me and say, 'by the way, I quietly want to tell you this has been happening for a long time, nobody has been prepared to own up to it but did you know', and you go gulp, deep breath time, 'right, what do we need to do'? So that's -- 16:05 16:06 16:06

351 Q. In that vein, a lot of people, mainly I think after your time, had said that there was a very big emphasis on performance and that data for performance was looked at very carefully, but that there wasn't much robust

data to cover quality issues other than when things went wrong, and that, therefore, one didn't necessarily know, for example, if cancer peer review standards were not being met, or if people weren't following policy, or if people weren't using best Royal College guidance. 16:06

Was that something you recognised in your time and did you have any views on that?

A. All that data was there. All the cancer review documents were there, again with clear action plans. 16:07 All the RQIA inspections, announced and unannounced, were clear, they were always in Trust Board papers, they were in my directorate governance papers, the action plans against them were in directorate governance papers. 16:07

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

A. No, I wouldn't have at all. Whilst we as a Trust joined CHKS and we engaged in the process of 16:07 contributing our data to CHKS, I think in my time it only got to maybe a divisional level, it didn't get to specialty level. There was a process of cascading, cleaning and assuring the data. Certainly I think there was a basket of 23 metrics that we were measured 16:07 against, and we rated highly in the UK against that, but those were largely around performance and that's maybe where the perception has come from.

353 Q. I think that is what they said.

A. Yes.
354 Q. They said this is performance.
A. Yes. The audit of clinical practice and having an audit against that either locally or nationally, no, I felt that was a gap. 16:08
355 Q. It also comes across that quite a lot of the things that were in place during your time were dependent on very robust chairing of meetings, having a vision, a lot of personal energy?
A. Yes. 16:08
356 Q. How much of it was very dependent on that? Were you able to hand that over to your successor in a state where they understood how much you had kind of given your heart and soul to it? Just my perception; it might not be quite right. 16:08
A. Yes, you are right, you are right. There was a lot of personal energy, and 12-hour days were the norm. My successor knew the system inside out; had been a healthcare practitioner in the system and had grown up in three different roles within the system and she then took on the role. Unfortunately, my last day, 31st March or 30th March, she was involved in a car accident and when she took over, she was actually in a bed in the hospital as a result of that car accident. So, therefore, hand-over was not quite as it might have been. 16:08 16:09

The files were there. My secretary, who is in the room, now fulfilling a different function, had all of

the files. I left a pile of files that were specifically for reference in terms of the following system. My successor knew all of the meetings that I would have put in place, was fully aware of those having been in different roles and contributing to those meetings. But certainly the Urology file was in that file, that pile of files, for her reference, with the invitation from me that I would happily meet with her at any stage to have that face-to-face discussion and hand-over. 16:09

357 Q. I mean, the reason I asked it is that some of the meetings you put in place weren't necessarily continued, and it was more in a general governance, you know?

A. Okay. 16:10

358 Q. Having put all that in, and I've had experience of this myself, it's usually dependent on it being sustained?

A. It is.

359 Q. And you know that.

A. Yes. 16:10

360 Q. The other thing that comes through, I think, through a variety of sources is that the Trust is very large?

A. Yes.

361 Q. It has a very broad span of control?

A. Yes. 16:10

362 Q. There are lots of tensions around that in terms of what gets to the Board and who has time to do what.

A. Yes.

363 Q. Also, the issue of what the role of the Commissioner is

versus what the role of the provider is, and who really bottoms out the strategic planning and the key decisions. Would you agree that seems to be a tension from your experience?

A. It has always been. The flavour of Northern Ireland, where you have integrated Health and Social Care, whilst it has many, many, many advantages for patients, or should have - it doesn't always work out that way - but patients, people, clients, whatever you want to call them - they are people at the end of the day - there are inherent difficulties in -- 16:10 16:11

364 Q. So, the system?

A. And the reconfiguration of the 19 Trusts into the Trusts as they are today meant that some of those difficulties are internal to the Trust as opposed to between Trusts. 16:11

365 Q. Yes.

A. And what funding goes where and who gets preferential treatment when the pressure is really on, what goes where, how do you equate adoption of children or safeguarding of children with the newest treatment of patient with such-and-such, it's a really, really, really difficult circumstance -- 16:11

366 Q. My question was really just around that. How do you, as a provider, then really fight your case with commissioners for more funding when you have so many things to pipe for that aren't really equivalent in terms of your ability to assess are more risk to patients and families? 16:11

A. Yes.
367 Q. Because in England, there's sort of emphasis on everything must go this way?
A. Yes, yes.
368 Q. Has it caused more benefit, has it resulted in more benefit? This is just a general view in terms of your experience of trying to manage in a provider. Or has it caused more tension? 16:12
A. I think coming from the professional background where I have been, I haven't been in clinical work since the middle 1990s, so I had been a director in the Northern Ireland Health Service for the guts of 20 years, and my sense is that the overall result is benefit. 16:12
369 Q. Yes.
A. But because there is the opportunity to provide something really special and really important for people at their time of need - and that can work very, very well in an integrated way - but it does provide -- it does cause a lot of tension at commissioning level and at management in Trust level in terms of how do you balance all of those competing priorities. It is a difficulty. 16:12
370 Q. Because we see some of this in this Inquiry in terms of the difficulties, and also clearly the tension between money and quality? 16:13
A. Yes.
371 Q. And so it goes on. In dealing with the specific Urology issues now, and particularly with Mr. O'Brien, on your very first day in 2009, one of the mentions is

if this doesn't get better, let's get a proper plan with NCAS. Fast-forward to the end of everything and there's never been a practitioner intervention.

A. Yes.

372 Q. Even more than that, I quite can't see a serious attempt to actually sit down with Mr. O'Brien and indicate the depth and breadth of the problems and put a support plan in. Would that be an unfair comment, or is that something that you recognise from your time, that that wasn't done? 16:13

A. I think that's something that I recognise. When I look over the range of issues, with the benefit of hindsight --

373 Q. That helps a lot, of course.

A. It does help a lot, absolutely. The retrospective scope in this particular case shows you the timeline of what was going on and where, and the multitude of issues. I suppose -- 16:14

374 Q. Why is my question really. Why?

A. I don't know why. We didn't stand back and take that long look. We should have. 16:14

375 Q. Do you think it was anything to do with lack of engagement with the medical hierarchy, which has since been sort of highlighted as possibly medical hierarchy working separately from operational? Or was that something that was not there in your time? 16:14

A. I don't know. I mean we did work very, very closely together.

376 Q. I realise that.

A. There was no doubt there was a great deal of co-working and cooperation. Whether it was to do with the general busyness of the fact that everybody was dealing with so many issues across the range of services, I can't really say why that didn't happen. I think it should have happened when I look back now and I see the range of issues, and perhaps that should have happened. I mean, we would have had many informal conversations about the Urology Service, and the consultant in particular. It's not that it wasn't known and wasn't in discussion. 16:14 16:15

377 Q. No.

A. But nobody said right, let's put this all down on the table, let's look at this in the round and see what we need to do. 16:15

378 Q. Who should have? Whose job was that, do you think?

A. It would have been a combination of the Medical Director and myself. Either one of us could have said 'time to do this'.

379 Q. Yes. 16:15

A. And neither of us did.

380 Q. Okay. Thank you very much.

CHAIR: I just have a couple of questions. One of the documents that we looked at earlier today was the letter of the consultants in response. I think it was January 2011, maybe, 18th January, about the ward issue. 16:15

A. Yes.

381 Q. I just wondered, the onus was then put on the

consultants, well, bring us evidence of how patients are being harmed. I just wondered did anyone think to go and talk to the ward staff, the nursing staff or anyone like that? Was there ever any discussion?

A. I think that would have been done informally automatically and we would have known if there were issues. If the nursing staff were raising issues about safety, we certainly would have heard about those. 16:16

382 Q. So, if I am reading you right then, are you saying that you were really challenging the consultants to prove what they were saying? 16:16

A. Yes, because if they were raising issues of safety, they had to give us evidence of what they were talking about. I couldn't manufacture the evidence. There was nothing sitting in the IR1s, there was nothing sitting in Datix because I had went and had a look at that. I had no evidence which indicated that there was a lack of safety. 16:16

383 Q. There was no soft intelligence coming your way from anyone else? 16:17

A. No. I was only six weeks into post at that stage so I hadn't had time to start gathering the soft intelligence hugely. It's the sort of thing that develops once you have built those relationships with people. There was nothing in the formal system at all. Yes, you are right, it was a challenge back to the consultants, and it was a genuine challenge back, that if they had brought that evidence or that indication that they were alluding to, we would, of course, take 16:17

an action on it. I mean, I don't know what that action would be because I don't know what the issues would be. You cannot raise an allegation like that without substantiating it with evidence, and no clinician who really means business will raise that. They will come with the evidence and say I am worried about patient care because look at this, look at this, look at this; okay, let's get into deep conversation about this and see what we can do.

384 Q. Okay. One other thing: You were asked by Ms. McMahon about the conversation you had with Mr. Mackle about this allegation of having being the cause of bullying Mr. O'Brien? 16:17

A. Yes.

385 Q. Do you recall any conversation with Mr. O'Brien himself where you were told by him that he wasn't to have any more -- or you said he wasn't to have any more dealings with Mr. Mackle? Do you remember anything? 16:18

A. No.

386 Q. I am just going to tell you, you may or may not be aware if you are following the Inquiry proceedings, that Mr. O'Brien recorded a number of meetings that he held? 16:18

A. No. The only meeting I had with Mr. O'Brien on his own was when I had heard that he wasn't himself in theatre and I asked him to call up with me after theatre. That was the only occasion that I met Mr. O'Brien on his own. I do not recall any occasion when Mr. O'Brien sought to meet with me. He didn't usually seek to meet 16:18

with me.

387 Q. I am not even suggesting that he did. I am just going to read a couple of extracts. There was a meeting on 7th February 2017 that Mr. O'Brien had. This was when he was going through the MHPS proceedings in 2017. 16:19

A. Okay.

388 Q. He had a meeting with the NED, the non-executive director, who was assigned to him for the purposes of the MHPS. He said in the course of that meeting, because we have the transcript of it: 16:19

"Yes, I sought and obtained an assurance from Dr. Rankin and from Eamon Mackle himself, particularly from Dr. Rankin, that I would have had no more dealings or meeting with him because I was on the point of a 16:19 breakdown as a result of his treatment over a period of years."

You don't recall anything like that?

A. Oh, no, and I think I would recall that. 16:19

389 Q. Yes. Mr. O'Brien gave evidence to the Inquiry and he said he had a number of -- he was invited, to put it politely, or summoned to a number of meetings with you and Eamon Mackle over a period of time: 16:20

"From 2010 up until -- I can't remember when this relates to. They were anything but. They were not pleasant. They were brutal. Being told that I had to obey my political masters, having allegations fired at

you."

Now I am assuming he is talking about the meetings about Team South and the setting up?

A. I presume so. Yes. 16:20

390 Q. Is that your recollection of these meetings? Was brutal a fair description, to your mind?

A. No. The meetings -- all the meetings that I held with clinicians, managers, staff, all had an agenda at the meeting. They were conducted politely, with respect, 16:20 every meeting. I wouldn't tolerate any different behaviour. There would have been straight talking, but I suspect that if you are being asked to change so much of your clinical behaviour and you don't agree with it, you are going to use -- you are going to reflect on 16:20 those meetings as perhaps brutal or difficult.

But no, the meetings -- I mean the meetings, there was quite a large cohort of people around the table with the three consultant urologists, myself, Mr. Mackle, 16:21 Heather Trouton, Martina Corrigan, somebody from HR, somebody from Finance, somebody from Performance; a big group but all with a single focus of actually developing the implementation plan. But as we know, Mr. O'Brien didn't agree with a lot of the parameters 16:21 of that plan and didn't want to change his behaviour.

So no, there was nothing untoward in any of those meetings. They would all have been conducted politely

and with respect. Perhaps we disagreed about things or we didn't get the agreement that we needed, but there was nothing. I can recall no difficult altercations. Certainly I wouldn't have any raised voices in the meeting, anything like that. I would call a halt to the meeting and call out that behaviour. 16:21

CHAIR: Thank you.

You will be glad to know I have nothing further I want to ask you, Dr. Rankin. I know you were scheduled to come again tomorrow morning, but you will be relieved to hear we don't need to hear from you tomorrow morning. So, thank you for your time. 16:22

10:00 tomorrow morning,then, ladies and gentlemen. 16:22

THE INQUIRY WAS THEN ADJOURNED TO 10:00 A.M. ON THURSDAY, 8TH JUNE 2023