Urology Services Inquiry

Oral Hearing

Day 85 – Thursday, 8th February 2024

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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THE HEARING COMMENCED ON THURSDAY,
8TH DAY OF FEBRUARY, 2024 AS FOLLOWS:

CHAIR: Good morning, everyone. Ms. McMahon.
MS. MCMAHON: The witnesses this morning, both witnesses to give evidence on behalf of HSCB and SPPG. We have Mr. Paul Cavanagh, who is the Director of Hospital Care, Strategic Planning & Performance Group in the Department of Health; and Sharon Gallagher, who is a Deputy Secretary, Health Service Operations Group in the Department of Health, and also the Chief Executive of the SPPG. They are represented this morning, and I'll just let Mr. Henry introduce himself for the transcript. 10:04 10:04
MR. HENRY: Good morning, Madame Chair and Panel members. My name is Philip Henry and I'm instructed on behalf of the SPPG and I'm with Ms. Vivienne O'Neill, my instructing solicitor from the DSO. 10:04
CHAIR: Thank you very much, Mr. Henry.
MS. MCMAHON: I understand Mr. Cavanagh will affirm and Mrs. Gallagher will take the oath. 10:05

MRS. SHARON GALLAGHER, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS:

10:05

MR. PAUL CAVANAGH, HAVING AFFIRMED, WAS DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS:

1 Q. MS. MCMAHON: Thank you both for coming in today to

give evidence for the Inquiry. We decided that you would both possibly be more useful giving evidence together; we have received Section 21s from both of you and, by the very nature of them, they overlap in certain degrees, but I know you both have expertise in different areas that are of interest to the Inquiry, so you've kindly agreed to give your evidence together.

I just want to go to your Section 21s, first of all, so that they can be properly put before the Inquiry as evidence.

If I start with you, Mrs. Gallagher, your response to your Section 21 notice, no. 66 of 2022, can be found at WIT-66157, and that's dated 14th July 2022, and if we go to WIT-66179 -- I'll have to come back to that. If we just confirm the signature page on that one.
We'll go to Mr. Cavanagh's statement, WIT-104243.
I hope we have better luck with this one. Yes, there's your name at the top of it. The notice is dated 5th July 2023 and your signature should be found at 104366, WIT-104366. Do you recognise that, Mr. Cavanagh, as your signature?

A. MR. CAVANAGH: I do.

2 Q. And it's dated 3rd November 2023. And do you wish to adopt that as your evidence?

A. MR. CAVANAGH: Yes.

3 Q. I just need to confirm the signature page for Mrs. Gallagher, so if I could ask Ms. Horscroft just to

confirm that for me. Just while that's happening, Mr. Cavanagh, perhaps you could give us a brief outline of your background and your career to date, to the point that -- your role in the SPPG.

A. MR. CAVANAGH: Sure. I started my career in the voluntary sector. In 2002, I came to the Health Service, initially as a Health Action Zone Manager in the Western Health and Social Services Board. I worked in a number of senior management roles, and then in SPPG -- or, sorry, in the Health and Social Care Board - that's going to confuse me throughout the day, apologies - in the Health and Social Care Board, I was Assistant Director in 2009, of commissioning, specifically with responsibility for the Western Area, and I also developed some regional responsibilities through that term, including commissioning an ambulance service regionally. And then, in 2020, I became Interim Director of Planning and Commissioning, and then, in 2022, became Director of Commissioning, and subsequently that has become Director of Hospital Care, as a Director of Commissioning role is largely looking at hospital issues, so we felt it was more appropriate for that to be the title. 10:07 10:08 10:08 10:08

MS. McMAHON: Thank you for that. I know what you are going to say because I get told it as well. There is a transcript being taken, and we have to be mindful that people are trying to transcribe what we say. 10:08

CHAIR: We tend to speak very quickly in Northern Ireland, but if you could just slow down --

MR. CAVANAGH: I will do my best, Chair, of course.
CHAIR: Thank you. It is just for the stenographer, who I could see was struggling slightly with the speed of your speech. Thank you.
MS. McMAHON: We'll both keep an eye on it from each other and we'll see how we get on. 10:09
MR. CAVANAGH: Of course.

4 Q. Mrs. Gallagher, if I could just come back to you in relation to your signature. If we could go to WIT-66272, and you'll see the signature at the end of that statement. Do you recognise that as your signature? 10:09

A. MRS. GALLAGHER: I do.

5 Q. And the date is 17th October 2022, and do you wish to adopt that as your evidence before the Inquiry? 10:09

A. MRS. GALLAGHER: I do.

6 Q. Thank you. And I wonder if you could do the same, give us a summary of your career to date and your current position.

A. MRS. GALLAGHER: Of course. So I have been a civil servant for over 35 years, I am a senior civil servant. For the last 11 years, I have worked for the Department of Health. I moved to take over what was the Health and Social Care Board in September 2020. At that stage, it was an Arm's Length Body, so I held the role of Deputy Secretary in the Department and Chief Executive. With the closure of the Board, I'm no longer a Chief Executive, but I remain a senior civil servant in the Department of Health. 10:09 10:09

7 Q. And with responsibility of SPPG?
A. MRS. GALLAGHER: That's correct.
8 Q. Now, just at the start of the evidence, I wonder if you could just give us a brief understanding of the way in which HSCB became SPPG and what was the thinking behind that? 10:10
A. MRS. GALLAGHER: I can, yes. I have been involved, actually, in this work since the outset in 2015 when the Minister made a decision to close the Health and Social Care Board and review the model of commissioning in Northern Ireland. It has been a little bit stop and start since that point because we have had the administration down on a number of occasions, twice, and, of course, we have had Covid in between. The rationale behind the closure of the Board and the review of commissioning was primarily based on the Donaldson Review of 2015, but also, as I understand, from the Minister's observations at the time, which was that the system in place was overly bureaucratic and complex and that there needed to be more responsive decision-making and accountability. 10:10 10:10 10:11

Additionally, the commissioning process was based very heavily on the NHS process, which was on competitive tendering, and that wasn't something that was conducive within the Northern Ireland context, primarily because of the size, but also, of course, because of the demand capacity deficit, which was growing at that time, and the constrained financial position. 10:11

So, in effect, we were purchasing services from Health and Social Care Trusts who weren't able to deliver, and the principle was that you purchased services from the best provider, but there was no prospect of moving from one provider to another. So a very clear rationale and mandate at that time in 2015. As things emerged, it was decided to decouple the closure of the Board and the new commissioning model and that was primarily to derisk any potential negative impact on the commissioning of services, so to protect service provision. 10:12 10:12

In terms of the closure of the Health and Social Care Board, the legislation for that was passed in 2022, and the closure was effected from 1st April 2022. 10:12

In terms of that legislation, that stood down the process for commissioning, so we had a commissioning plan direction, a commissioning plan, Trust delivery plans and service and budget agreements, which was ostensibly the contract between the Commissioner and the providers, so that process was stood down under the legislation. And at present, we're currently working through a new process for commissioning under the auspices of the Integrated Care System Framework, which sets the broad framework for commissioning in Northern Ireland moving forward. 10:12 10:13

So we're very much still in transition, despite the genesis of this work since 2015. However, I would say very strongly that the practice of how we commission services hand in glove with the Public Health Agency remains very much in place, because at the time of inception of the Health and Social Care Board and the Public Health Agency, there was a view that there would be a single organisation, and the Minister at the time decided to split those organisations, but one organisation cannot discharge its responsibilities without the other. So I do not employ people with professional experience to input to the commissioning process, that comes from PHA, and equally, we provide the administrative and the financial skill and experience in terms of PHA and how they commission their services. I'm sorry, that was a little bit long-winded, but it is very, very complex, and I'm more than happy to answer questions as we go on in that regard. 10:13 10:14 10:14

9 Q. That's very helpful. That's about my first 20 questions dealt with! But rather than unpick it at this point. 10:14

A. Yes, Ms. McMahon.

10 Q. Well, we're both on form today. So, what we'll do is, I'll take that as your complete answer, but probably unpick some of that as we look through what happened and some of the procedures and processes. Just at the outset, before I do ask questions around that, have you had the opportunity to watch any of the Inquiry 10:14

proceedings or to read any of the transcripts, if you could answer separately?

A. MRS. GALLAGHER: I have, yes.

11 Q. And you, too, Mr. Cavanagh?

A. MR. CAVANAGH: I have watched a number of hearings online and I have read quite a number of the transcripts, yes. 10:15

12 Q. So you'll have an idea and obviously a significant overview of what the issues are, and some of the evidence that's come before the Inquiry, it would perhaps be too high to say critical, but certainly questions some of the HSCB involvement and some of the decisions around that and the potential for better working relationships, and you'll understand that the Inquiry's focus is to find out what happened, to inform recommendations, so the questions are asked within that context, and I will put some transcript and statement extracts to you for you to comment on, as appropriate, and I might touch upon some of the issues that you have just mentioned. 10:15 10:15

Just taking a step back under the old guise of the HSCB, the roles and responsibilities, and they have been set out in Mr. Cavanagh's statement at WIT-104255. Just to give a little bit of background to that at paragraph 30. So you say at paragraph 30: 10:16

"The HSCB had responsibility for commissioning Health and Social Services and for putting in place systems to

monitor performance against ministerial targets and using indicators provided by the Department with a view to improving those services, as well as ensuring finite resources were used efficiently."

10:16

Now, that paragraph seems to encapsulate a lot of both the functions of the HSCB but some of the issues that some people take issue with. And I just want to ask you, in general terms, before we get into the detail, you've mentioned the issue around commissioning, and I wonder if you could explain to the Inquiry the role that the HSCB has in considering the effectiveness of governance processes by Trusts through which services are commissioned?

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A. MRS. GALLAGHER: So, the Health and Social Care Board or the Strategic Planning & Performance Group has no oversight on the governance arrangements within Trusts. Whilst the Department has set the legislation, and that's clearly set out within the 2011 Framework, which is still extant, it is the responsibility of the Trust, as an Arm's Length Body, with its own Executive team and Board, to ensure that there is the appropriate clinical and corporate governance arrangements in place.

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10:17

13 Q. So maybe the onus is on the Trust to have their house in order, as it were?

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A. MRS. GALLAGHER: It is.

14 Q. And does that mean that, in real terms, HSCB, SPPG rely on assurances given by the Trust as to the

effectiveness and robustness of their own systems?

A. MRS. GALLAGHER: I guess it's fair to say that Health and Social Care, as you know, is a very complex system. There are multiple organisations, as is set out in terms of how we work together as a system. The responsibility lies with the ALB, with the Trust, as we've just described, in relation to its own arrangements. In terms of the services that we commission, we commission on the basis of safe services. I mean, paramount in all of our thinking within the Health and Social Care system is safety. So we commission safe services in our service specifications, we set out the safety standards and the clinical standards and guidelines that we would expect working with the Public Health Agency, but it is up to the Trust to ensure that services remain safe and are delivered with the utmost attention to the safety of the patient and putting in place the environment and the governance arrangements to ensure that that's the case. 10:18 10:18 10:18 10:19

In saying that, we don't rely on the assurance of the Trust in itself, so we work with the Public Health Agency in terms of our performance management approach and our broad approach to working with Trusts to secure -- so we have clinical networks, for example, in place in practically all specialties, and that brings together Clinicians, Commissioners, including ourselves in SPPG, and the PHA and service users and carers, in 10:19

order to improve our service delivery and maintain quality in the services. We regularly work with peer reviews and audit teams in England, so we recently have had GIRFT reviews on a range of issues, including Orthopaedics, Urgent and Emergency Care, are two of the most recent ones, and we are involved and take part in audits regularly in terms of giving us information and intelligence and understanding the quality of services within Northern Ireland. 10:20

In addition to that, we oversee the process for Serious Adverse Incidents and complaints and we have a role in monitoring and triangulating that information in order to ensure system learning -- organisational learning, first of all, and then system learning and, of course, we have the RQIA, who undertake reviews and will advise the Department in relation to the Trust's quality of services and the environment in which those services operate, including its governance arrangements. 10:20

15 Q. Thank you for that. We'll come on to look at the SAIs and the process around that and the efficiency and efficacy of that process. But I wonder if I could just take a step back and look at the HSCB. If we carve that off, that was the dominant body at the time relevant for the purposes of the Inquiry. I know SPPG is now the new iteration of that. But if we look at HSCB as it existed at that time, our understanding is that it was an Arm's Length Body equivalent to RQIA, the Trusts' PCC, PHA, all of the organisations 10:21 10:21

mentioned in both the Framework Document and the grounding legislation, they all came around at the same time, April 2009. And given that they were on the same level, if I can put it that way, did that present any difficulty in oversight, when you look back now, given the reconfiguration of SPPG, that HSCB had such a significant role in commissioning, in guaranteeing safe services, do you feel now that that structure perhaps hindered HSCB in carrying out their role in that way? 10:22

A. MRS. GALLAGHER: Pre the closure of the Board or -- 10:22

16 Q. Yes.

A. MRS. GALLAGHER: I don't believe so. The Health and Social Care Board was mandated, as we've just described, to commission services, to commission safe services, and that was a dual mandate with the Public Health Agency. Akin to the description in relation to the Trusts and other organisations, they had systems and structures. The Health and Social Care Board had systems and structures in place to ensure that safe services were commissioned and that the oversight arrangements, including the Board of the Health and Social Care Board, were kept abreast of how the Health and Social Care Board was discharging its responsibilities in that regard. 10:22 10:23

17 Q. And you mentioned a few moments ago the Framework Document. We've heard a little bit about that both from PHA and in other evidence. Now, that's dated September 2011, and it is reflective, I think, of what was anticipated to be the outworking of the legislation 10:23

at the time, 2009. Now, given that the legislation has changed, 2022, and certainly from evidence from the Public Health Agency this week and from evidence that you will give from both your statement and Mr. Cavanagh's, there's been what could be described as a fairly significant change around the restructuring and the commissioning in Northern Ireland. Does that mean that that Framework Document is out of date and a new one is imminent, or what's the position so that bodies will understand what's expected from them and what their duties and responsibilities are in healthcare? 10:23 10:24

A. I think it's a very reasonable comment, Ms. McMahon, that the Framework Document needs to be updated, and that process is currently in place and well-advanced. The main provision that was removed from the legislation in terms of the process for commissioning, is clearly set out in the Framework and, of course, that is no longer valid. So it was not possible to update the Framework Document in advance of agreeing the final arrangements for how commissioning would take place, which is currently coming to a conclusion in the consideration of how ICS NI, the Framework For Commissioning, would play out in the future. So the work to finalise the new commissioning arrangements is taking place and that will allow, then, the ultimate updating of the Framework Document. 10:24 10:24 10:25

I would add, however, that whilst that process is still

continuing, there is absolute clarity in terms of both my mind, and I think you heard Mr. Dawson say earlier this week, we work very closely together, our teams work together in joint enterprise in terms of commissioning safe services every day. What isn't clear and what needs to be clarified is the Framework Document setting out that approach moving forward.

A. MR. CAVANAGH: Maybe, Ms. McMahon, if I can add, I mean, yes, some of the elements of the commissioning process have changed; we don't have commissioning plan direction, we don't have commissioning plan, so, therefore, there's no formal document, as such, is signed off each year in the way that was. But in terms of the day-to-day work that someone like me does, in terms of working with Trusts where services might be vulnerable, where there are challenges in delivering on the -- kind of, the requirements that we have, we work so closely with PHA, it would be impossible for me to be talking to Trusts without having liaised with PHA - indeed, have them in the room with me to have those conversations, having someone with a public health medicine background, with a nursing background, and so on, that adds to someone like me, who doesn't have a -- I'm not a Health and Social Care professional, but it adds, then, to the discussion and debate and ensures that we actually are asking the right questions and coming to the correct conclusions in terms of how we take forward some of the challenges facing Health and Social Care.

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18 Q. I think the Inquiry heard evidence from the Public Health Agency that would suggest their involvement in probing some of the SIAs, and some of the investigations --

A. MR. CAVANAGH: Absolutely. 10:26

19 Q. -- led to other avenues of concern being highlighted and addressed. So if the Inquiry thinks that evidence shows the importance of PHA, then that can be reflected. But just on that point, while we're on the point of the PHA and their particular role, we heard 10:27 about their clinical expertise and their health professional expertise across the board and how valuable that is, and we see the outworking of that in some of the examples. But just as the 2009 legislation was reflected in the 2011 Framework Document, we can 10:27 anticipate that the 2022 legislation will be reflected in the new Framework Document and, indeed, the way in which services are delivered and commissioned?

A. MRS. GALLAGHER: Absolutely, absolutely.

20 Q. Now, you will know, I think, that the wording of the 10:27 2022 legislation does change slightly in relation to PHA. There had been an understanding or a requirement, it was mandatory in the 2009 legislation that both PHA and HSCB would approve commissioning together, a sign-off that would be -- both organisations would 10:28 agree on. That seems to have changed under the 2022 legislation and, while PHA clearly have a role in informing, advising and contributing, the ultimate decision around sign-off on commissioning lies with

SPPG. I wonder if you could just give us a little bit of background around that and what, in real terms, that means for commissioning in Northern Ireland?

A. MRS. GALLAGHER: Yes. And maybe if it's helpful to the Panel, I led on the legislation, in line with the work that I have been doing on the closure of the Board and the renewal of the -- or the revision of the commissioning approach. It was never the intention and is not the intention to have a first amongst equals and that SPPG will have ultimate autonomy. So the intention is that PHA and SPPG will continue to work closely and to commission service in joint enterprise. The provision -- the detail in that, in terms of the process, we are currently working through, and, as you quite rightly say, Ms. McMahon, that will be reflected in the Framework Document. But, in practice, whether it is set out clearly in the Framework Document or, indeed, in legislation regarding a sign-off, it is impossible for SPPG, for me, to commission services, me or any of my team, to commission services, without the imprimatur, without the experience, without the intelligence of the Public Health Agency. And if we look at some recent examples in terms of example Long Covid or even services that are significantly changing, so maternity services in the Northern region, for example, those recommendations, the recommendation on the change in services in the Northern region, came conjointly from myself and the Chief Executive of the PHA, Aidan Dawson. So that reinforces and evidences

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our shared responsibility in relation to both commissioning and decommissioning services.

21 Q. I suppose from the outworking of the expectation around using each other's experience, that properly reflects the process that will be undertaken? 10:30

A. MRS. GALLAGHER: Absolutely.

22 Q. But from a purely legal perspective, if we look at the legislation, it's clear that the ultimate decision lies with the SPPG?

A. MRS. GALLAGHER: I think you have made a very valid point and, in reflecting and amending the Framework Document from 2011, we will need to be absolutely clear that the responsibility, in terms of commissioning, is very firmly a joint enterprise. Ultimately, there may, and I can't think of any circumstance to hand where PHA and SPPG might come to a different view, but, ultimately, the Department will have a role in terms of listening to views, understanding the perspective and taking the advice and understanding of the professionals in the Department at that stage. 10:30 10:31

23 Q. And the previous body, the HSCB, it existed, as other Arm's Length Bodies, with a sponsorship branch at the time, and do you recall which one it sat under?

A. MRS. GALLAGHER: Which of the civil servants? At one point, it was myself. It has been various colleagues at given points in time. 10:31

24 Q. And there was a Board as well for HSCB, an Executive Board?

A. MRS. GALLAGHER: Indeed.

25 Q. And commissioning then would have gone to both Boards, PHA, HSCB --

A. MRS. GALLAGHER: That's correct.

26 Q. -- and they ultimately would have signed it off? Now, the Panel is aware that the ultimate accountability is with the Department, with the Minister. But the situation now, as I understand it, is that SPPG doesn't have a Board; it is direct line with the Permanent Secretary, with the Minister, is that correct? 10:31

A. MRS. GALLAGHER: That's correct. 10:32

27 Q. And your experience, and I understand it's early days, but in your experience of that particular model of accountability and decision-making that has moved from, arguably, a layer of oversight, removed from having a Board, which you may say not, you may say it allows for greater oversight, but I'll let you answer the question; what's your view on the efficiency and the benefit of the model that's now in place, SPPG, directly with the Permanent Secretary, with you as, as I understand it, a Grade 3, what do you think are the benefits of that? 10:32 10:32

A. MRS. GALLAGHER: I suppose the one thing that I would say, very clearly, is, my accountability hasn't diminished in any way. I'm accountable to the Permanent Secretary and ultimately to the Minister, accountable to the Departmental Management Board also in terms of discharging my responsibilities, and I report directly to the Permanent Secretary in terms of my area of work. So there's very clear governance. 10:33

It isn't the governance as set out through an ALB arrangement with the Board, but there are very, very clear governance arrangements post the closure of the Board.

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I have some experience, actually, of having worked within the Department when the Board obviously was still open, and at one point I was the Director of Performance Management, and there was a Performance Management Directorate, obviously, in the Health and 10:33
Social Care Board, and that represented double-running, a duplication of effort. So when I took up that post, and I have some experience in other departments working in Performance Management and as Director of Performance, my first, I suppose, priority was to 10:34
understand my role vis-à-vis the role of the performance team in the Department, and it was very unclear, and, in actual fact, routinely, the role, my role and the role of my team, was to take the information and the insight and the understanding from 10:34
the Health and Social Care Board and put that in a way that, if you like, in a formation that would be more in line with the Civil Service, so in making a submission to a Minister, for example. But I would have used their intelligence, their understanding and their 10:34
workings, and all I was doing was providing the administrative support around that. So there was, very, very clearly, duplication of effort there, double-handling and that involved a senior civil

servant, myself as a Director, an entire team of people, that was, in essence, replicating the efforts of the Board. So, before the closure of the Board, I put forward a recommendation, which was agreed in the Department at the time, that, actually, we would dissolve or close down my role as Director of Performance, and the Director of Performance in the Health and Social Care Board reported directly into the Department to reduce that layer of duplication because it was adding no value. 10:35

28 Q. Now, the restructuring of SPPG, just before I move on, because you've mentioned the structure and the way in which it now operates, we've heard evidence from some Arm's Length Bodies, and we'll hear more in the next sitting of the Inquiry, around people's perception that they could only go so far with what they knew or what they could influence, that groups butted up against each other, almost. So, for example, the PHA took things as far as it could, but couldn't actually tell the Trust 'get your house in order', if it wanted to say that; there was no sanction, there was no way of trying to influence beyond its own statutory remit and the Framework Document. Does the SPPG, now moving or now sitting in a slightly - these are my words - elevated position beyond the other Arm's Length Bodies and with direct ministerial accountability and with you at the helm, is there any potential or possibility that there will be a greater influence if there are clear governance issues from a Trust that may require more 10:35 10:36 10:36

than just letters or advice or conversations, is there a greater possibility that you would have powers to try and ensure that issues around governance, that it would be clear to you, perhaps, are being addressed, rather than just trying to persuade people to address them? 10:36

A. MRS. GALLAGHER: So I think it's important that, because I'm a civil servant, I still understand my role and responsibilities and discharge that with respect to the Strategic Planning & Performance Group. It is key that all of us understand our responsibilities, not 10:37 just in terms of performance but in terms of safety and quality, governance, financial management, and I have no -- personally, have no additional responsibility, now that the Board is closed, in that regard as it relates to the Trust and their delivery of services and 10:37 their governance arrangements. I'm saying this quite clumsily, I know, as I say it, but the complexity or the federation of the system of Health and Social Care is set out and built on the basis that there is responsibilities on all of us and all of us discharge 10:38 that responsibility. Clearly, either as a Health and Social Care Board or as a Strategic Planning & Performance Group, if something arises or if we learn about something that we are concerned about, it is our responsibility to take action in that regard and that 10:38 wouldn't matter whether it had been the Health and Social Care Board or SPPG.

So I don't have any elevated status simply because I'm

a civil servant and work to the Permanent Secretary, but I would equally have a responsibility, as a senior leader, as all of us have in Health and Social Care, to be mindful of and responsive of issues as they arise and how they are being dealt with. But the primacy in terms of dealing with issues within the Trust, remains with the Trust arrangements, the Trust Executive Team and the Trust Board, ultimately, and, of course, the Chair of the Board reports to the Minister, ultimately; that's a ministerial appointment. So the responsibility of the Board and the Board's Chair is to ensure that the governance is in place and that the organisation is agile, responsive and puts safety and quality as key within their operational focus. 10:39 10:39

A. MR. CAVANAGH: If I might add, Ms. McMahon, to describe it as hierarchical, I think is probably missing some of the complexity, in my view, because a lot of what's required, and indeed the 2011 Framework talks about a duty of cooperation for all of the organisations, and that cooperation is key in all of this. So we may come to the table and feel that a service could be delivered in a different way or there are different ways of organising ourselves, but it's incumbent on us to actually bring the evidence and to actually show that good practice is working elsewhere which could be applied here, or that a Royal College has saw, sort of, an approach which we could replicate and draw upon, so it's incumbent upon us to have that evidence. We also look to opportunities for clinical cooperation as well, 10:39 10:39 10:40

and some of the cooperation goes on through our Cancer Network Clinical Reference Groups, through multidisciplinary teams and so on, so all of that is important, but, ultimately, it's about recognising that all of us have roles. So it's not, as such, first among equals hierarchy; it's about each of us being clear about our roles, and I think what we have tried to do is come with a kind of weight of argument and a weight of evidence in order to actually, then, engage with Clinicians, engage with managers, to ensure that we do actually deliver the change that we believe is required, but also recognising that there's compromise and there's understanding some of the nuances as well within our individual services within Northern Ireland more generally, and I think we have, throughout the years, been much more responsive to that, rather than necessarily being, sort of -- you know, calling on, this is a must-do, this is a cooperative system that needs to work together in order to meet the challenges that we have. 10:40 10:40 10:41 10:41

29 Q. Yes. And the Inquiry has heard around the importance of collaboration and listening and communicating and the factors that influence that, both weaknesses in processes but also in individuals' use of processes --

A. MR. CAVANAGH: Yeah. 10:41

30 Q. -- if I can put it generally to you like that. But is it the case, given your answers, that you consider that the systems in place are appropriate to deal with governance concerns arising?

A. MRS. GALLAGHER: I think the evidence from both the Hyponatraemia and Neurology Inquiries would suggest there's more to do in relation to governance, in relation to workforce, in relation to safety and quality, in relation to systems and information, and there's always learning. There are processes, policies, procedures in place, but there's always the human element in that, and it is how people adopt those policies and adhere to them, and I guess one of the things that has come out very strongly is the principle of being open and encouraging people to speak up and encouraging people to be open and honest, including, and most importantly, clinical professionals. So there's always more to do, and I couldn't stand here today and say, given recent experience and given why we're here today, that there isn't always a focus on learning. 10:42 10:42 10:42

31 Q. Thank you. And given the HSCB role and SPPG role in commissioning services that are safe, I think you have mentioned patient safety is paramount, reduction of risk and anticipation of risk and having some vision around that and reducing that, they are all expected, I presume, within the commissioning process. When you became aware of the extent of the problems through the Inquiry and that the Inquiry have been dealing with, what was your reaction? How did you feel about that? 10:43 10:43

A. Hugely concerned, hugely concerned for both the patients, the families, and a very real responsibility to understand how we put it right, and we were

transparent in that regard. At the time, the previous Permanent Secretary, Mr. Pengelly, set up the oversight arrangements, the Urology Assurance Group, and the Panel may know that I am a member of that, as is Paul, and that was to oversee the process, to ensure that the process was handled efficiently and effectively and as quickly as possible and sought to assure those impacted by what's happened in this. So I think the overriding feeling was, yes, concern.

32 Q. And, Mr. Cavanagh, what was your reaction? You had experience dealing with some of the SAIs, you probably had more direct contact with Trust staff than anyone else in SPPG or HSCB, when you realised the extent or the issues, the breadth of the issues and perhaps the depth of some of them, the long-standing nature of them, what was your reaction?

A. MR. CAVANAGH: I think similarly concerned. I mean, just in the first weeks of, really, in August 2020, trying to understand what had happened and trying to work out just how many patients were of concern and also then those patients who may have come to harm. I think I really was very focused on trying to get to grips with the extent of the problem and also, I think, to think about how we, as a system, could have and should have known earlier, but the reality was, it came in the way that it came, but there were various routes into the Trust over the years where I would have thought there may have been opportunities for these issues to be raised, but they weren't raised, because

I've checked through all of our records. But that sense of concern and that sense, as well, of also trying to get a handle on exactly what had happened, I think was quite challenging in those early weeks around the issues. But I think we were focused on very much supporting the Trust at that stage and also trying to understand what was happening at that stage as well, but it was very concerning and very worrying, and ultimately, and as it turned out, there was 2,112 people who were in the first cohort for the lookback back to January 2019. You know, every one of those individuals will have had worries, will have had contact from the Trust; some were found to have had clinical and non-clinical concerns, and each one of those individuals, as well, have families and so on. And I think there was just a sense that we need to act as quickly as we possibly can to reassure people and also ensure that their clinical care is appropriate and safe. 10:45 10:46 10:46

33 Q. And can I take from your answer that it is your position - and, Mrs. Gallagher, you can answer this as well - that you could have been informed of these issues earlier and you should have been? 10:46

A. MR. CAVANAGH: Whether we should have been, I think we were informed at the point when the Trust felt that an Early Alert should be raised. 10:46

34 Q. And that was 2020?

A. MR. CAVANAGH: And that was 2020. Up until then -- and I have, as I have said before, looked at transcripts,

and so on, and I've read some of the things that various Trust colleagues were dealing with through that kind of ten-year period up to 2020. But, I mean, given that there was issues in terms of kind of reduction in the Consultants' sort of, you know, clinical time, and so on, during that period, I would have thought there would have been opportunities to mention that there was a Clinician who was on restricted duties, for example. I don't think that was ever raised, so --

35 Q. Do you think it should have been? 10:47

A. MR. CAVANAGH: Well, given that that was an impact on the Trust's capacity, I would have thought that it should have been, that particular issue. The issue of why that was, was not really our concern, but there was no doubt that there was an issue that a Clinician's capacity had been reduced for a period due to sort of HR issues, or whatever that might have been within the Trust, but we didn't require to understand exactly what was happening with that Clinician, but we did need to understand that the service was continuing to be delivered in the way that we had commissioned it, to the extent that the Trust could deliver it with the capacity they had available.

36 Q. And that means that patients are kept safe?

A. MR. CAVANAGH: And that means that patients are kept safe. Safety happens at the point of care, so we have got to ensure that, at the point of care, that the services that are being delivered do actually deliver safe services. We want to ensure that we are

commissioning quality services that lead to that safety at a point of care, and that's why we do all that we can to ensure that the services that we commission are evidence-based, are based on best practice, based on good clinical guidelines. 10:48

37 Q. Sorry, go ahead, Mrs. Gallagher.

A. MRS. GALLAGHER: Sorry, I am not sure if Paul had finished, but I just wanted to answer your question, Ms. McMahon. In terms of should we have been informed, we should not or we would not have expected to be 10:48 informed in terms of the Clinician or the Clinician's -- or any potential issues in terms of the way he conducted his services. That's a matter for the Trust. So there's systems in place around that, including the annual appraisal, the role of the 10:49 Responsible Officer, which is primarily to ensure that a Clinician provides safe services and then, ultimately, the MHPS procedure. So we would not have expected to have been cited on any of that, that is absolutely internal to an organisation and, as the 10:49 employer, the Trust has responsibility in that regard.

In terms of the SAIs, we would expect to be apprised, we were apprised in terms of the SAIs, and the learning from this and also from both the Neurology and 10:49 Hyponatraemia Inquiries has allowed us to consider our approach to information that we receive through SAIs and complaints and Early Alerts and how we strengthen our role, as SPPG, in terms of our response to that.

So I suppose, in answer to your question, it depends what it is that you are asking would we expect to have known, because, on any level, I would not expect to be cited on a Clinician, on any issues in relation to a Clinician. 10:50

38 Q. And a slight caveat to your answer may be that you're working on the basis that any internal processes that are undertaken by the Trust, are undertaken properly and efficiently and effectively and, if that were not to be the case, that's a matter for the Trust, you say? 10:50

A. MRS. GALLAGHER: That's a matter for a Trust, and, you know, no pun intended, but you have to operate on a basis of trust, but trust within a construct that sets out clear roles, responsibilities, policies, guidance, and you have to operate on the basis that the Board of 10:51 the Trust pays attention to that and responds to issues as it arises. The role of RQIA gives the Department an independent assessment, of course, and that is another mechanism for us to understand whether there may be challenges. And equally in terms of governance and how 10:51 a Trust and the Trust Board conduct themselves, you know, there is an accountability process back into the Department and, every six months, there is an assurance statement to the Department which sets out compliance with the agreed policies and guidance and procedures 10:51 and that provides assurance to the Department in that regard.

39 Q. Do you have anything to add to that at this stage, Mr. Cavanagh?

A. MR. CAVANAGH: No.

40 Q. I just wonder then, given what we now know and what you now know from the Inquiry and from the evidence and given that I think we've agreed that the patient safety and reduction or elimination of risk is the foundation of your commissioning intention, what's the tipping point for SPPG, what's the tipping point for you to be informed of concerns? When would you think it unreasonable for the Trust to try and manage things in-house, given your focus on patient safety? 10:52

A. MRS. GALLAGHER: I'm not sure there is a tipping point, as such. I'm not sure, because of the complexity and the range of services, that it could be as straightforward as, here's the point at which. I think very hugely important that, within the Clinical Governance arrangements within a Trust and their broader oversight, fundamentally it is the role of the Board of the Trust to oversee and ensure safe services. So, where issues arise and there are a number of escalations obviously between the senior team, then the Committees of the Board and then up to the Board, but the Board would need to be satisfied themselves that their organisation is providing safe services. 10:53

Where, through intelligence, either SAIs or through audits or work, for example, on GIRFT, we become -- we, in terms of SPPG, become aware of issues, we will absolutely work with the PHA to engage with that Trust to outline those concerns and they will have been 10:53

involved in that process, and to put in place improvement plans in order to ensure that services are safe.

41 Q. So it really does require each link in the chain to be strong: the Trust Board, the Trust, the Senior Management Team, people looking from the outside in, everyone has to adhere to what's expected from them? 10:54

A. MRS. GALLAGHER: It's absolutely a federated model. I mean, we all work, and that's while it's called a Health and Social Care system, all of us play a part, all of us have a responsibility, and, you know, the golden thread through all of that is safe services. You know, the systems in place for governance are akin to any other organisation, in that you would look at corporate governance, performance and finance. That would be your three core areas for any organisation, public sector/private sector, voluntary and community sector. Within health, there is another element added, and that's safety and quality. So our Governance Framework asks for assurance on all four areas, and organisations are held to account on those four areas equally, with safety and quality taking equal standing to performance, to governance and to finance. 10:54 10:54 10:55

42 Q. Now, you have mentioned the Hyponatraemia Inquiry and the Neurology Inquiry, and obviously this Inquiry will have recommendations of its own based on the evidence. 10:55

A. MRS. GALLAGHER: Indeed, indeed.

43 Q. I just wonder what the plan is around those recommendations; as far as I understand, they are not

all implemented. Is there a plan or funding or assistance plan for Trusts to bring those into the reality of their governance processes? What's the current position?

A. MRS. GALLAGHER: So I'm conscious I talk with two hats, as Head of SPPG but also a part of the Senior Team in the Department and a member of the Departmental Management Board. The Department has set up an Inquiries Implementation Programme Management Board, and what it is doing is bringing together the recommendations from the Hyponatraemia Inquiry and the Neurology Inquiry. The Neurology Inquiry, as you know, had 76 recommendations. A plan has currently been developed and, importantly, there is a plan and an Assurance Framework that has been developed and will be published very, very soon. And the role of the Inquiries Implementation Programme Management Board is to oversee the implementation of those recommendations. The reason why we have brought together the recommendations from both previous Inquiries, and I would offer that any recommendations from this Inquiry would equally be seen in that context, is so that we can look at the cross-learning between the Inquiries and ensure that we put in place actions that actually meet the desired intent, and that's why, for the first time ever, as I understand, we have developed an Assurance Framework co-produced with patients and with patient representatives and carers, to ensure that the actions are delivered and meet the required

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outcome.

In terms of your question about money, money is a vexed issue, as we know, and we're in a very challenging financial position. Not all of the recommendations need additional funding. Obviously, there will need to be resource input to that, be that through civil servants or Health and Social Care personnel and expertise, but, in the main, many of the recommendations point to review of current procedures and processes that sit at the heart of Health and Social Care. So, for example, review of the Early Alert system, review of SAIs, there would be an open framework that we're looking at, all of those are, in some guise or another, already in place, and it is about refreshing those and revising those with the insight of those that use our services and also, obviously, the recommendations from the Inquiries and, indeed, RQIA as it relates to SAI. So money is a factor, but not the only factor, and it shouldn't be a restricting factor for us. 10:57 10:57 10:58 10:58

44 Q. And in that context, is it anticipated that the Trust may receive funding specifically in relation to recommendations that require it in order that they may implement them, given that this will be the third Health Public Inquiry making recommendations broadly around governance? 10:58

A. MRS. GALLAGHER: I mean, our financial position is challenging. Clearly, when a Trust -- and, as you

know, part of the responsibility of the Strategic Planning & Performance Group is the resource management, so understanding the allocations to each Trust and how it uses that funding. There's roughly around 10% overhead of any service delivered that goes to the overheads around that, the supporting mechanisms, if you like, which would include management overheads, audit overheads and others. The systems and structures are in place. What seems to have come out of previous inquiries, and it is for this Inquiry obviously to provide their recommendations in terms of the evidence that it will hear, but it is the adherence to some of the policies and processes that we have in place and how we create a culture where people call out early and loudly where they see action or behaviour that they think will cause harm or has the potential to cause harm. I guess I go back to the human factors in that and the culture around that, because systems and policies and processes, in itself, will not solve that.

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45 Q. Now, the Inquiry has heard, and will hear more evidence, I think, alleging that Urology Services was not appropriately resourced, not appropriately funded, in comparison to other services generally, but specifically not to meet the demand capacity that was in existence from the review in 2009, and we'll move on to look at HSCB involvement in the review and other issues. But just as a general point, what's your understanding of the funding around Urology and whether there's any merit in the suggestion that it wasn't

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properly resourced or funded from the outset and the problems just got worse?

A. MRS. GALLAGHER: So I think it's a matter of public record that there is not enough money at the minute to meet the demand. I mean, we are in a demand capacity deficit. Waiting lists in Northern Ireland are longer than anywhere else in either England, Scotland or Wales, and that is something that, as a Senior Team in the Department, we pay huge attention to. Over 50% of the block grant is allocated to health, so around 7 billion a year is allocated to health. When I developed the Delivering Together Strategy back in 2016, which was to be a ten-year long-term plan, what it said at that time, and what the Executive agreed, is that we needed enough money to run services and we needed additional money to transform services over and above what was needed to deliver services. We simply have not had that investment and that funding. So it is a matter of public record that no service is currently achieving or receiving the funding that's required to meet the deficit, and, in that regard, it is really important that we balance -- that we provide safe services, because the provision of throughput or access does not come at a premium to safe services. And as part of the approach in terms of how we deal with waiting lists and how we manage priority, it is based on clinical need.

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46 Q. I suppose the question perhaps was badly worded, but it is more from the inception of Urology Services, from

the point when there were different teams set up and there was an understanding, at least then, of the demand, or the demand has increased significantly, obviously, and the -- perhaps the funding and the ability to meet that has clearly reduced, but there is a suggestion that things were not right from the start and they could never possibly get right as they were always playing catch-up; is there any merit in that? 11:03

A. MR. CAVANAGH: If I might. I mean, the Inquiry knows that our demographics in Northern Ireland are changing rapidly from a very young society, we're an ageing society now; therefore, our demand on Health and Social Care services is increasing, I suppose, in line with that shift from a younger society to an older society. In all of our Acute Services, indeed in all of our Social Care Services as well and our Primary Care Services, we have considerable increases in demand, and every part of our system is under pressure and looking for more resources. Urology has been attended to, I think, over the last 15 years, considerably, in comparison to other acute specialties, who might also say, 'well, I wish we had got what Urology investment was put in'. Some 13 million has gone in over the last 10/15 years for Urology Services. So, on that basis, we have recognised that Urology was an emerging specialty in the 1990s, required a considerable amount of attention from about 2007/2008 onwards, and has received that attention, and I think it's been attended to considerably with investment. Wouldn't it be great 11:03 11:04 11:04

to put yet more money on the table, but we are a financially-constrained system, we are having to make choices between this service and that service, but I think Urology has done considerably well in a very challenging environment. I think only one other acute specialty has received more funding in the last 15 years than Urology, and I think that gives you a sense that it is very much one where a fair amount of work has gone into it. But as with all of these things, even when you put money on the ground, when we have the investment to make, the challenge then is actually to use that money and to use that investment effectively to recruit the staff and to actually develop the services. We also have a considerable workforce crisis not only in Northern Ireland, the UK and Europe, but worldwide - a workforce crisis where we can't actually recruit the Consultants that we require. I mean, we have invested, in the Southern Trust, in six Consultants, and it's been a challenge to have six Consultants in work throughout that period. We also have funding available for a seventh Consultant, should the Trust be table to recruit, but haven't, at this point, been able to recruit. So I think a fair amount of attention has been given to Urology. Yes, it would be great to offer more funding, but the funding just isn't there, but the choices we have made is where we have prioritised Urology over other Acute Services, for all the right reasons, given the demand and challenges that they faced, but there is always going to be a

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challenge as demand is rising so fast.

47 Q. And given what you now know about the issues that arose in Urology within the Southern Trust, was -- on reflection, was there ever a point at which HSCB was approached on the basis that funding was needed to mitigate against anything that has subsequently emerged? 11:06

A. MR. CAVANAGH: Not specifically in that way. There was more funding required because demand was rising and the service needed to grow, but nothing specifically in relation to that. 11:06

A. MRS. GALLAGHER: Ms. McMahon, just in terms of Paul's comments there where he said that Urology probably was, I can't remember the words he said, but 'I wouldn't want that' -- 'I wouldn't want the investment in Urology and our priorities in that to assume that Urology took first order amongst other specialties'. The investment in Health and Social Care is very finely balanced and considered across all specialties and, indeed, in relation to primary care, community care and hospital care, and it is a very challenging financial position. So all areas need to be given due attention and there is a very considerable thought process and consideration given to the allocation of funding, because whatever you give to one area means that you cannot give to another, so that balance is really important, and I am sure Paul's reflection -- 11:07 11:07 11:07

A. MR. CAVANAGH: That's right, that's right.

A. MRS. GALLAGHER: -- didn't mean that, but it's very

important that that comes across.

48 Q. And I think that we are very conscious of the fact that we're concentrating on Urology and there is an entire Trust and, indeed, an entire health system across Northern Ireland that has to go into the complicated algorithm of funding, but obviously our lens is slightly skewed in that respect, and any context you can give to help us understand that is always welcome, so thank you for that. 11:08

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Just as a narrow point at this stage, you mentioned the Donaldson Report, I think, and there have been a few other - Bengoa - other reports, and we're jumping about a bit, but just while it triggers in my mind to ask you the question. There has obviously been lots of 11:08 suggestions around reform of healthcare and possible models that might improve, given the constant reduction in funding, or at least the funding not being as certain as you would perhaps like it; what's the position around that now? Given that they may be seen 11:09 to be slightly out of date, but now we have a new Minister in place, there's an opportunity, I suppose, for senior members of the Department like yourself to have a more global look at this, what's the thinking in the room around the Health Service? 11:09

A. MRS. GALLAGHER: In relation to Delivering Together, which was, as I say, the Strategy developed in 2016, the burning platform remains exactly the same, and the Strategy that set out at that time, in terms of

reconfiguration and transformation, those things are as valid now as they were then. The problem is that things have got considerably worse in the meantime. Since that point, I mean, there's common parlance or a common view that nothing has happened, that these things, these documents have sat on the shelf, and that couldn't be further from the truth. With a Minister, and under the Minister's imprimatur when there has been no Minister in place, as the Department and as a Health and Social Care System, we have continued to take forward improvements and service developments across a range of areas. Our Cancer Strategy, we have an oversight group and we're bringing forward many of the actions there. Some clear examples in terms of elective, so we have centralised sites that deal with day cases for elective surgery and overnight elective surgery, in order to provide centres of excellence that will increase our throughput. Multidisciplinary teams in primary care have been set up to allow social workers and physiotherapists and others to address patients' needs within the community at local level, and there are a plethora of other initiatives that we have brought forward.

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I guess the challenge remains. We have operated in the space of the art of the possible, but there is a frustration for all of us within Health and Social Care, and beyond, that, without the sustained investment to transform services in the long term, that

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you can put part of a new system in place, but, without all of it, you don't yield the benefits. So the steps that we have brought forward, the interventions that we have brought forward, are positive, but are not delivering the expected gains that whole system approach would provide.

49 Q. We'll probably come back to some of those particular issues towards the end of the evidence, but I asked all of that scene-building in order that we can look at, then, what happened within Urology, look at some of the detail of that and, as far as you can, explain to the Inquiry or provide reassurance around whether that could happen again or what's now in place that mitigates against the possibility of information being missed or not being asked for. 11:11 11:12 11:12

So, just given I'm going to move on to that, I wonder, Chair, if it would be appropriate to have a break at this point?

CHAIR: We'll take a short break now and come back at half past eleven. 11:12

THE HEARING RESUMED AFTER THE SHORT BREAK AS FOLLOWS:

CHAIR: Thank you, everyone. Ms. McMahon. 11:34

50 Q. MS. MCMAHON: Just before we move on to look at some of the detail of the engagement with the Trusts, I just want to clarify something. You will know we're dealing with a transcript, a live transcript, and I'd asked you

a question around could you and should you have known, and, Mr. Cavanagh, you'd said about you might expect to know if a Consultant was on restricted duties. Now, it's been changed; it was "unrestricted", "un", as opposed to "on", and that's been changed. But just to clarify that factually. 11:35

A. MR. CAVANAGH: His duties were restricted, is my understanding from the various transcripts that I have read.

51 Q. Well, in actual fact, he was either in work or not in work -- 11:35

A. MR. CAVANAGH: Yeah.

52 Q. -- rather than restricted while he was in work. But I just want to put that on the transcript and make that point clear, but we're both clear now about what you said and my understanding of it, so I just wanted to correct that. 11:35

A. MR. CAVANAGH: Okay.

53 Q. If we look now, if we go back to your statement and look at WIT-104269, paragraph 88. I am just bringing you to this because I want to ask you about the monitoring arrangements that are mentioned in this, so I just want to put that in context. And you say in your statement, Mr. Cavanagh: 11:36

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"I have extracted the HSCB Commissioning and Performance Management processes from the 2011 Framework Document which were used to ensure quality and safety in secondary care services below. At

section 4, it states: 'The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes'."

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Now, we'll look in a moment on the issue of targets and performance and other matters that witnesses have commented on. But just in relation to the HSCB having appropriate monitoring arrangements, could you just run us through what those are or what they were at this time? 11:37

A. MR. CAVANAGH: Sure. I mean, there was probably a number of levels that monitoring would have happened at this time in, sort of, the 2011 period through, perhaps, to mid that decade. There would have been 11:37 performance meetings with each Trust on a regular basis. I mean, I can't recall whether it was sort of monthly or bi-monthly, but certainly, on a regular basis, each individual Trust would have met with the Health and Social Care Board and with PHA in meetings 11:37 at Director level to discuss their, I suppose, their progress against the various objectives and the various targets that have been set and also whether that was an opportunity for Trusts to also explain where there was any deficiency in delivery, as to why that was, and 11:37 that could be for a whole range of reasons.

54 Q. And given the reconfiguration in the process that SPPG now sits, is there any change in monitoring arrangements currently or is it effectively the same

process of engagement?

A. MR. CAVANAGH: Probably -- I mean, in many ways, much the same process. I suppose our Directorates have changed to some extent. Sharon has already mentioned about the strategic performance piece now being much more directly into the Department, even before SPPG came into being. But there is ongoing meetings at Director level with the Trust on issues of performance, at which PHA would also be in attendance. 11:38

A. MRS. GALLAGHER: If I could add to that, Ms. McMahon? 11:38

55 Q. Yes, please.

A. MRS. GALLAGHER: So the new structures in terms of SPPG has -- the Director of Performance also has safety within her area of responsibility, so that there is a triangulation of not just meeting agreed access targets, but also in terms of safety and quality. In terms of the frequency of meetings, at Director level that would be less frequent, as you would imagine. Below that, in terms of Service Leads, so the people that manage the detail of the commissioning, that happens day and daily, and actually, the Performance and Transformation Executive Board, which is chaired by the Permanent Secretary and which I sit on, colleagues from the Department and all of the Trust's Chief Executives, including the Public Health Agency, has a report every month which has an analysis of our performance and, also -- it has the position on the performance and the analysis around the performance, so the expectations and how we're delivering. So there's 11:38 11:39 11:39

a whole machinery in terms of not just the day-to-day routine engagement, which will include looking at service improvements and supporting improvement plans, but also that escalation and line of sight right through to the senior cohort across Health and Social Care. 11:40

56 Q. And is that a new arrangement for communicating?

A. MRS. GALLAGHER: That is a new arrangement. PTEB was set up, so, in 2020, during Covid, the Minister at the time, there was an addendum to the Framework which moved us into more command-and-control situation to manage Covid. The Rebuild Management Board was set up at that stage for two years. After that, we had the Performance and Transformation Executive Board, which was set up, and that looks at how we recover from Covid and how we manage our performance right across Health and Social Care. 11:40 11:40

57 Q. And what's the benefit of that new structure? What does that replace that wasn't there before? What's more enhanced now? 11:40

A. MRS. GALLAGHER: So I guess the most significant change, or evolution, actually, because this started some years ago, and I talked about ICS NI and our new commissioning approach, it's long been recognised that we need to operate in a collaborative way; that, with restricted resources, scarce resources, we need to work together in order to optimise the resource that we have in a relatively small geographical area and with a relatively small population size, and that sits at the 11:41

heart of the ICS Framework and our approach moving forward. In that context, then, the leadership, in terms of not just the Department and SPPG and PHA, but the Trust Chief Executives regularly engage in relation to the strategic issues and challenges that we face, because we see this as shared problems that will need shared and collaborative solutions, so that's the key evolution. And PTEB not only looks at performance, but it also looks at transformation. So the points that you made earlier about, has anything changed and is anybody looking at waiting lists and whatever, we have a line of sight into the activity and a strategic oversight of the broad activities that we're trying to advance in a very constrained financial environment.

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A. MR. CAVANAGH: And worth also adding in that we will have regular bi-monthly cancer performance meetings, so it's specifically focused on the non-issues in relation to cancer across all of the various tumour sites and also the modalities. And we also then, since 2015, have had a Urology Planning Implementation Group, where we actually talk about the specific issues around Urology, some of those improvement opportunities and, also, some of the performance challenges.

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58 Q. I'll probably take a slight advantage of having you here with two hats on, just to ask you the questions around commissioning. You've mentioned the integrated care system - sorry, I just had a blank for a moment - and I think you said about a collaborative and a more -- effectively, a more global look at needs and

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service provision. Does that, in effect - I mean, moving away from the old commissioning model - does that, in effect, mean that you have greater flexibility -- or your team and the team you work with have greater flexibility about identifying where services may more properly be focused so that waiting lists effectively can be dealt with by providing service efficiently where needed, rather than trying to provide them across the entire region? 11:43

A. MRS. GALLAGHER: There is probably, I would suggest, two separate issues there, Ms. McMahon. The first one in terms of optimisation or maximising the resources that we have, and that's something that we do day and daily, in terms of, I referenced earlier the clinical networks, but also my team, and, in particular, looking at things like theatre utilisation, for example, DNAs, and in terms of optimising the services that we're delivering at the minute and ensuring that we look at our pathways to make sure that we optimise the access, given the very scarce resource. One example, for example, for new outpatients - we have around 347,000 people waiting for their first outpatient assessment - over the last year-and-a-half we've reduced the percentage of DNAs by 1%, which doesn't sound a lot but it actually translates to 18,000 access, additional access for patients. So there's that focus in terms of safety, but, also, I mean, we have what many would regard as a very significant budget, but it's not enough, and part of my responsibility is making sure 11:43 11:44 11:44 11:44

that we do the best we possibly can with the money that we have available.

So, I guess from that point of view, a real focus in terms of performance management and ensuring we do more for less, and if you forgive me, I've forgotten your question and I am going to have to ask you to repeat. 11:45

59 Q. It's okay, everybody does that, and I've forgotten it as well, so I should listen to myself.

CHAIR: Flexibility. 11:45

MS. McMAHON: Flexibility. Thank you, Chair.

A. MRS. GALLAGHER: Thank you very much, Chair. I am going to use my pen and write down next time.

60 Q. Me, too.

A. MRS. GALLAGHER: So the other piece in terms of flexibility, I suppose it is worth saying that 97% of the health budget is recurrent, in that it goes to baseline position, because most of our health budget is to -- is on staff, is on staffing. So there's limited flexibility in terms of new services, for example, or new initiatives. And our focus is, again, on looking at the resource that we have across specialties or across any area, not just in Acute Services, but in Primary and Community as well, to understand where best we can make those investments in order to get the best outcomes for the money available. So I think this moves to the role of PHA and ourselves working together in relation to ensuring safe services, ensuring quality services, but also the counterbalance in terms of 11:45 11:46 11:46

making sure that we are as effective as we can with the scant resource that we have.

61 Q. I have had to ask other witnesses the impact of having no Minister in place and you're the first one I have been able to say, now that we have a Minister in place, is it anticipated that that will accelerate the potential for the advances that you say would best deliver healthcare in Northern Ireland or perhaps provide more funding, or is the funding pot already established around that? 11:46 11:47

A. MRS. GALLAGHER: So, I mean, we know that it is a very challenging financial position across the public sector. It is, of course, welcomed that we have a Health Minister and indeed an Executive in place, because there are very difficult decisions that will need to be made. Ultimately, there is a lead-in time for any significant change, and I talked earlier about Delivering Together some nearly ten years ago and the need to maintain current services, because you cannot put a new service in place and leave a gap in service provision, so you need to keep a service running in order to bring forward a new service, and that needs additional money. We're not in that space at the minute. And what I guess is important to us is how we make best use of that resource. One of the things that we have introduced, and Minister Swann, of course, was our previous Minister, but Minister Swann put in place arrangements to allow the Regional Prioritisation Oversight Group, which brings together senior 11:47 11:47 11:48

Clinicians to make decisions about the prioritisation of resources across the region, so that we don't have a postcode lottery in terms of each of the Trusts and their waiting lists and that we look at it from a regional perspective in terms of either moving patients or moving Clinicians to provide services and manage waiting lists at a regional level, and that's the emphasis and I suppose one of the key changes played out in the way commissioning was and the way it is now, because if you think that we were -- if you can imagine, under the previous arrangements, we would have held a Trust Chief Executive to account specifically for the service that they provide locally, and whilst, of course, that is still important to understand activity and performance at a local level, we now look at that much more through a lens of how we can operate as a regional system in order to make sure that a cohort of patients right across the province are seen on a basis of equality -- or equity, I should say.

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62 Q. And when you look back now at the previous arrangement, and you have mentioned about the Chief Executives, you have mentioned about Directors around the table and the importance of collaboration and communication, when you look back, and the Inquiry's evidence has been that there was a significant turnover in Chief Executive in the Southern Trust over a relatively short period of time, and also some staff movements, some perhaps key staff movement at times that may have, arguably, let intelligence around issues fall through the gaps at

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points, do you have a view as to the importance of stability around leadership in a Trust and, also, specifically in relation to the Southern Trust, do you now, in hindsight, looking at that, feel that that contributed in some way to the issues, before the Public Inquiry, not coming to the surface sooner? 11:50

A. MRS. GALLAGHER: I don't think I can speak with authority about how it impacted in relation to the Southern Trust. I think, as a general rule of thumb, all of us would prefer stability in leadership positions, particularly in very complex areas, but, having said that, you know, I said at the start I'm over 35 years in the public sector, I have very rarely enjoyed a position where we have been in a stable environment, and I suppose in that scenario it is key that people understand the roles and responsibilities that are attendant to their job at any point in time, but I can't comment in particular in relation to the Southern Trust. 11:50 11:51

63 Q. Mr. Cavanagh, you had more experience dealing with Trust staff. Did, at any stage, you feel that perhaps the absence of continual leadership at the helm or movement of some Directors impacted on your relationship with the Trust or your ability to engage with them on issues of concern? 11:51 11:51

A. MR. CAVANAGH: I suppose I was engaging with the people that were there at the point in that way. I mean, certainly the Trust had challenges at Chief Executive and Director level. At Assistant Director level,

Service Manager level and so on, there actually was a fair amount of consistency and constancy in relation to that, so there were people who had actually an ongoing sort of relationship with Urology Services and with governance issues and so on, so, in that way, there were people who I was able to actually engage with through the process who were actually there seven, eight years before and did actually have, I suppose, an ongoing sort of knowledge of the issues. 11:52

That said, I think the Directors who came into place did seem to get a grasp on what was happening, did come up to speed. And I suppose the thing that I would constantly emphasise is, at the point that we were looking at this issue with the Early Alert in July 2020, we were in the midst of a pandemic, and it was a very challenging pandemic, and Southern Trust and every Trust in Northern Ireland were considerably challenged to continue to provide services. So trying to look at that as well. I think I saw it from my perspective, and I was a new Director at that stage as well, but had a fair amount of experience, too. I think it was also that we were trying to support each other through a pandemic, whilst also recognising that other issues were happening within the Health Service, such as the Urology issue, which we were also trying to manage in tandem. So it was a time both where we were keen to ensure our roles, but we also knew that we had to work together and ensure that we actually got through what 11:52 11:52 11:53

was going to be, I suspect, the most challenging time of any of our careers.

64 Q. Well, we will look at the SAI process and the awareness of HSCB around that in a moment, which predates Covid, and obviously, with the benefit of hindsight, which we have now, things may seem more clear, but I'll give you the opportunity to comment on that. 11:53

There has been general comments from some staff, and perhaps criticism as well, that there was too much of a focus on performance and outcomes on the data, rather than the detail behind it, perhaps, and that there was possibly a failure to look at the quality as opposed to the quantity of service provision -- the quantity as opposed to the quality. I think I said that the wrong way round. But I just want to look at what some witnesses say in relation to that. 11:53 11:54

Just, first of all, as a description in the way in which information was provided back, if we go to the Section 21 of Paula Clarke, at WIT-37594, at paragraph 53.2, and she says: 11:54

"I recall that compliance with time limits for Urology Services against the protocol was monitored through performance reporting within an overall Performance Management Framework." 11:55

Then, she says:

"As advised in my response to question 51, performance on the access targets was reported at every public Board meeting and compliance with elective access targets was also the subject of regular performance meetings with HSCB and DHSSPS, as performance across all Trusts was reported regionally in their Board meetings. I recall that compliance with the IEAP was an ongoing issue for assurance from Operational Directors into performance reporting, that I became responsible for as Director in September 2009. An example of this can be referenced in the monthly performance report for October 2015, presented to the Board on 26th November 2015." 11:55 11:55

Then, if we move down, she just mentions about other avenues of providing information.

Now, clearly there is a defined mechanism by which performance targets are fed to the Board, HSCB, and, under the auspices of commissioning, you properly have regard to those figures, but as a general proposition that there was too much focus on targets, what would both of you say about that? 11:56

A. MRS. GALLAGHER: I would say that there's an emphasis on performance management, and that's performance management not just in terms of targets but also in terms of safety and quality. As I said earlier, it is absolutely imperative that we provide safe services. 11:56

The performance targets that are set within Health and Social Care, if you look at the cancer access targets, they are targets that we monitor and performance-manage constantly because those targets dictate and allow access arrangements for those with cancer. So it's important that we monitor targets across all areas because access is as important for safety or for reducing further harm and minimising the potential for further harm. So the very strong view put across on occasion is that we were only interested in performance management from a, if you like, a throughput type of way, as if we were in the business of, say, a factory or something, and I would absolutely refute that. That couldn't be further from the truth. 11:57 11:57

The sad reality is that since I have been involved in health, some 11 years, we haven't met the ministerial targets, and we have worked with providers to ensure that we can do the best with what we have, given the demand position. In 2017, we brought a new Performance Management Framework, which, in the first place, put the onus on performance management within the Trust, which is where it should be as part of the Framework, but, also, it set out a new arrangement for performance improvement trajectories which were agreed with the Trusts and that acknowledged the fact that the previous targets could not be met because of the demand and that we were acknowledging that and working with the Trusts on what was reasonable in relation to what they could 11:58 11:58 11:58

deliver, so stretching targets but deliverable targets.

Equally, in terms of Covid and our recovery from Covid, the targets set there have been agreed with Trusts and they have been under the purview of, firstly, the Rebuild Management Board, as I've described earlier, and then the Performance and Transformation Executive Board, but the targets that we monitor are agreed with the providers on the basis of what is safe and what is possible. 11:59

So I would absolutely refute the fact that we have a singular focus on one aspect of a very complex, multifaceted area of work, because, fundamentally, what's important to us, all of us within Health and Social Care, is safe service, but making sure we do as much as we can with the resource that we have available. 11:59

A. MR. CAVANAGH: And building on that, and I agree fully with Sharon's point; I mean, the IEAP, the Elective Access Protocol, is about fairness in the way that we manage our waiting lists, so it's about, firstly, being clear about the clinical priority of a referral, as to whether that patient is red flag suspect cancer, whether they have an urgent need that is non-cancer, or whether they are a routine patient and where their, I suppose, their daily living is being impacted upon, they tend to be within the routine category. We manage then, firstly, on that clinical prioritisation, and 12:00 12:00

secondly, then, chronologically, so the date that the GP sends in the referral becomes the date that you're on the waiting list across those categories. So that's about fairness, and I think that's the reason that we introduced it, because, in the past, it hasn't worked in that way, and I think it was important there was a consistent approach across the region in relation to that, too.

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We talk about our Service and Budget Agreements as well, and the Service and Budget Agreements are the things that we signed with Trusts, which very clearly said this is our expectation of delivery. As Sharon has already pointed out, they didn't always deliver against that; indeed, one of the targets in '19-'20 was that they would begin to increase their delivery towards their commission volumes, but part of that SPA also look at the number of patients who would be reviewed. So review patients are not a target, but it is important that we ensure that people on their pathway are actually seen in a timely way as well, so our clinic templates tend to be new outpatients and review outpatients as well. We also build in some outpatients with procedures so that if a patient comes in who can actually be dealt with on that day with a bit of additional time, that allows a Clinician to do that as well.

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So, again, it's multifaceted, but it is not as simple

as to say we are purely focusing on the targets. The targets are important, because, from the public's point of view, they want to ensure that they get timely access as best as we can in the constrained system that we have, but also, importantly, to ensure that we actually are looking at the way that the service is being provided, the challenges faced by the Trust to provide those services, that's what those performance meetings or those cancer performance meetings, those meetings of Clinicians and Clinical Reference Groups within our Cancer Network, that's what those discussions are about; they're about quality and about the challenges, and increasingly, then, through some of the newer structures that we have, it's also about trying to manage at a regional level to ensure that there isn't a postcode lottery in the way that we provide services as well. 12:02 12:02 12:02

65 Q. And are Clinicians involved in setting targets?

A. MR. CAVANAGH: They are, they are, absolutely.

66 Q. Are they asked about the reality of the targets? 12:02

A. MR. CAVANAGH: Targets come from clinical advice. You know, this is the -- they are based on clinical advice from Royal Colleges, from various sort of bodies who are Clinicians on the ground. So it's not that we just create those targets; these targets are based on clinical advice. There is a reason why we want to see -- why a patient who has suspect breast cancer, why we feel that they should be seen within 14 days, because, clinically, that is the optimal access that 12:02

that individual needs, and, when we miss those dates, that means that the optimal access has been lost and, therefore, the opportunity to provide the best care is also diminished in relation to that. Targets are important because they are clinically based. 12:03

67 Q. So if it was the case that Clinicians were informing the Trust or, via the Trust, the Board, that the targets weren't possible because of capacity, are you saying that the targets are effectively immovable because they are dictated by clinical expectations 12:03 around care?

A. MRS. GALLAGHER: I think that's the problem we find ourselves in at the minute. We have a demand capacity gap and it's a huge worry for all of us in terms of ensuring that those that need to access services, do so 12:03 in a timely way.

68 Q. Are you trying to maximise the treatment for people but you are confined by the clinical outcomes, given how they present, so you can't keep changing the turnaround or the timeframes? 12:04

A. MR. CAVANAGH: Yeah, and I mentioned the three levels of clinical prioritisation. So a routine patient may be appropriately a routine patient today, but if they can't be seen for a year, they will be going back to their GP, they may end up in an emergency department 12:04 and it may actually be that they will be raised to an urgent patient or maybe even a red-flag patient. So the reality of waiting long also means that the person's condition may deteriorate and then they may

need to be reprioritised, but there is a clear process in relation to that and that's why we need to also sort of meet our demand, but, as Sharon says, that is the challenge, that is the pressures that, day and daily, the Health Service is facing in Northern Ireland. 12:04

69 Q. And there is evidence that elective care is not happening, that there is -- there are people who are on the waiting list who are not deemed to be urgent or red flag?

A. MR. CAVANAGH: Our capacity is such -- 12:04

70 Q. That you're not getting to those people?

A. MR. CAVANAGH: We are certainly not getting to those people in a timely way and, increasingly, as our demand increases, it is becoming more challenging to reach them at all. 12:05

A. MRS. GALLAGHER: I think elective care, absolutely, is happening, and we're back to pre-Covid levels in most areas and there is an absolute focus. I have a full team dedicated to supporting the Trusts in terms of elective care activity and how we optimise services 12:05 there. I talked earlier about the regional approach to prioritisation because we do have a challenge in terms of, sometimes we have money but we can't recruit, and there are many areas where we have challenges in terms of our ability to recruit doctors, nurses and those 12:05 that work within that specialty and we have to do the best with what we have, but elective activity is happening but we have to prioritise based on clinical need.

71 Q. Just so I'm clear because I asked the question, is that across all Trusts that elective care is effectively being carried out?

A. MRS. GALLAGHER: Absolutely.

A. MR. CAVANAGH: Yes. 12:06

A. MRS. GALLAGHER: Absolutely.

72 Q. And there's no restriction on that at the moment?

A. MRS. GALLAGHER: The only restriction is in relation to resource, the financial and the human resource, in order to do that, which is why we're working as a 12:06 collaborative under the purview of the Performance and Transformation Executive Board, to make sure that, as a system, we understand the broader position on waiting lists right across the piece and that they are being managed to best effect. 12:06

73 Q. And when you mention about the new Integrated Care System, and we talk about waiting-list times, targets, that in the Trust, and perhaps other Trusts, were not met, even though it was anticipated that they probably couldn't be met, given the targets that existed the 12:06 year before some of the plans. So, for example, in 2018, there was -- Urology was clearly under pressure with its figures being very high, but the plan in 2019/2020 didn't seem to reflect that, the figures were expected to meet the designated targets. It seems a 12:07 bit of an end-sum game to expect targets to be met, when you know in advance that they are not going to be met. How do you get out of that cycle?

A. MRS. GALLAGHER: I think that's one of the things that

we recognised, and we talked about the Service Budget Agreements; the reality is, they were very rarely agreed and signed off, and the length of time it took to work through that commissioning system of, you know, the Commissioning Plan direction, the Commissioning Plan, the Trust Delivery Plans, it took nearly a full year, and at that stage it was redundant, it was out of date. So where we are at the minute is, in terms of our approach moving forward, is understanding what 'good' looks like at a regional level. So much more in the benchmarking rather than getting down to the micromanagement of activity at Trust level. So you talked earlier about more flexibility; we want to give Trusts more flexibility in terms of how they use their resource to better meet patient outcomes, because they have the Clinicians and the team of people, the logistics around them, the environment around them, they will know best how to manage their areas. So it is very much a move away to micromanagement and very, I would say, a very low level -- or high level of scrutiny down to target level and more about how we manage the shared resource within Northern Ireland to meet the demand that can't be met at the minute.

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74 Q. And one of the characteristics of the shared resources has been, and you can inform us if it is going to be going forward, non-recurrent funding and the challenges that presents and some of the complications. I just want to ask you a couple of questions about that, but I just want to let you know what some of the other

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witnesses have said about that. If we go to WIT-35950, and this is Aldrina Magwood, paragraph 34.2. And she says, just at the end of the first sentence:

"I can confirm that, during my tenure in a range of roles in the Trust, the scale of the deterioration in Trust performance against ministerial targets coincided with reductions in non-recurrent funding allocations from the HSCB that enabled the Trust, at specialty level, to purchase additional capacity to mitigate risks. The Performance Team in the Trust, working with the Assistant Director of Finance, had a role in liaising with the HSCB and securing independent sector capacity and/or additional in-house waiting list capacity, with non-recurrent funding allocations made available by the HSCB. For example, in 2009, when I first joined the Trust from the Southern Health and Social Care Board, the waiting time targets were being achieved across all specialties in Northern Ireland, but were fully reliant on non-recurrent funding to do so. Between 2009 and 2014, the Trust received its share of system level non-recurrent elective care funding and there were further plans to allocate this recurrently non-recurrent funding on a recurrent basis, to put this on a more stable footing in Trusts, including the ability to secure permanent recruitment solutions, etc. These plans were developed and led by Michael Bloomfield, the then-Director of Performance and Service Improvement at the HSCB.

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Regrettably, this was not progressed when new Department of Health leadership arrangements were put in place as part of the closing of the HSCB and, also, from 2015 to 2019, the funding allocations for elective care reduced and the unscheduled care demand increased. 12:11
Regrettably, when I left the Trust in 2022, the Southern Trust's position from 2015 with respect to elective care waiting times has moved from a relatively better position (compared to other NI Trusts) to having among the longest waiting times for outpatient, 12:11
inpatient day case and diagnostic services. At the same time, the Trust continues to have significant over-performance against service and budget agreement activity in unscheduled care."

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Now, the point that Ms. Magwood is making there is that there was an anticipated recurrent/non-recurrent funding model that it was hoped would try and deal with some of the issues, given the waiting times and the escalation in delays, and that didn't carry itself 12:11
across to the new arrangement. Could you give us a background of that or what the thinking was, if that had been identified as a possible solution at that time, why it didn't find itself in the new regime?

A. MRS. GALLAGHER: I guess what I would say, 12:12
non-recurrent money is non-recurrent money, and, in the main, the money secures staff, Health and Social Care staff. If that money isn't recurrent, then any Trust will leave itself in a position where they will have

to -- they will be in an overspend position at the end of the year because they are using non-recurrent money. So the point that Ms. Magwood makes, in terms of non-recurrent money have an impact in terms of your ability to plan ahead and to employ staff on a sustainable basis, is absolutely correct. 12:13

The closure of the Board, to my mind, has had no impact in terms of the recurrency of non-recurrent money because you simply can't make non-recurrent money recurrent and, in the main, the non-recurrent money has been used for waiting-list initiatives, which have been targeted and developed in conjunction with the Department, the Board/SPPG and the Trusts, and that is still the case to this day. So there has been a ring-fenced amount of money for waiting-list initiatives, which has reduced over the years, but the key to that is using that money to best effect, and that routinely means the use of the independent sector once we have exhausted the in-house options available. 12:13 12:13

I suppose the other point that I would make, in reading Mrs. Magwood's evidence, is that there is a difference in performance levels and backlogs and longer backlogs, because Trusts and individuals can be very, very effective and performing at a very high level, but the demand is such that waiting lists will continue to grow. So even though a team could be hugely effective and doing their utmost in relation to patient care on 12:14

any level, the demand capacity gap, that is well-rehearsed, continues.

A. MR. CAVANAGH: Could I add maybe to dig down a little further, Ms. McMahon. I mean, we work on annual budgets, so, each year, there is one pot. It's not 12:14
that there is a non-recurrent kind of, sort of, annual pot. There is just one pot of funding. The funding that we cannot spend recurrently can then be made available in that year non-recurrently, and often that is for waiting-lists initiatives. Now, sometimes 12:15
in-house waiting-list initiatives, so Consultants in a particular Trust will do extra clinics using that additional non-recurrent money, or the independent sector, so we can actually sort of send some out to the services that are available at that time. So that kind 12:15
of annual pot is there. Our preference is, as much as possible, to use that funding recurrently, for us to put in place the services that we want to deliver year on year for the future, rather then -- but, unfortunately, either where a Trust can't recruit, for 12:15
example, that will lead to some slippage, which could be used non-recurrently where a particular Trust underspends, and the Southern Trust, for several years, did underspend in this period as well, that some of that also becomes slippage which, potentially, can be 12:16
used in that way.

So, on that basis, you know, non-recurrent funding is useful, it certainly does help to get you through the

year in terms of trying to manage the waiting lists, but as we increasingly have used that funding recurrently for those services, bringing in workforce, and so on, to actually deliver services on an ongoing basis, it means there's less and less money non-recurrently. Occasionally, a little extra money might come from another Department, which offers some help, but in the environment we now find ourselves, there just is not that kind of slippage across the whole of the public sector. So it is a challenging environment, but I understand the point that Mrs. Magwood is making, but, at the same time, it's also a reflection, I think, of some of the challenges of actually getting workforce on the ground and delivering services on a consistent year-on-year basis. 12:16

75 Q. Now, you have mentioned an underspend during that period of time.

A. MR. CAVANAGH: Sure.

76 Q. What way does that work for Trust? What's their ability to move money around or to redirect it? 12:17

A. MR. CAVANAGH: Yes, at the start of the year, a Trust will obviously bring forward its financial plan, which would come to HSCB to consider, would be agreed, there might be some debate, and so on, in relation to it, and a Trust will then embark on that plan on the assumption that they will spend the funding that they have available in that year. Sometimes, their plan -- in recent years, they are actually showing overspend, so they may actually need to make savings throughout that

year, but in those earlier years the Southern Trust would have actually been, I suppose, planning to use all of their funding without overspending, but as the year goes on, either because you can't recruit or because a particular service hasn't been able to be put in place, or for a whole range of reasons, you might find that your plan to spend hasn't led to spending it in the way that you had hoped to. And I think in Southern Trust case for a number of years, they actually found themselves in a position where they had to actually, I suppose, give back some of the funds that were available to them, for all those kind of operational reasons. 12:17 12:17

77 Q. So just going back to Ms. Magwood's comments around the funding and her understanding of what was to happen, and subsequently didn't, in her view. Just as a general issue, is there any change in the way in which funding will be allocated? Is there any potential for recurrent funding to become -- to deal with the waiting lists to be activated, or is it just trying to work out the pot and to see what's needed and direct it as the Trust indicate they need it? 12:18 12:18

A. MRS. GALLAGHER: I suppose there is a couple of layers on this. There is the annual budgets, which we have in place at the minute, which can be restricting in terms of, you can't plan for the longer period, so we have annual budgets; in the main, that will be recurrent funding. So, recurrent from the point of view, if we -- we know, for example, next year, we should get in 12:18

and around the same amount of money as this year. The non-recurrent allocations over previous years that came through the Executive, through the Department of Finance, have been ring-fenced for particular initiatives, mostly relating to waiting-list initiatives. Then, there is the underspends in terms of the budget allocations through the normal budget process, and that is where that money is recycled, if you like, within the system, in order to meet demand, where we can, in other places, but the non-recurrent money that was allocated through the Executive, through the Minister, is separate to our normal budget arrangements. 12:19 12:19

78 Q. Thank you for that explanation. I'll just take you to something that Shane Devlin, the former Chief Executive of the Trust, said in his Section 21, WIT-00091, just at the bottom. Just at the bottom box, can you see that on the screen, just on the right, "The commissioning process" the sentence begins? The question was asked: 12:20 12:20

"What has been your experience of the efficacy, or otherwise, of the bodies set out at (i) to (x) above..."

12:20

Which are Arm's Length Bodies.

"... in assisting or promoting service provision, good governance, clinical care or patient safety within the

Trust? What could be improved?"

And in relation to the Health and Social Care Board, he says:

"The commissioning process, through the HSCB, has struggled to deliver high quality services. This was recognised in 2015 by the then-Minister for Health, Simon Hamilton, when he announced that the HSCB should be closed. Since then, in my opinion, the HSCB has struggled to retain staff and has lost direction. To that end, the precision that was envisaged for commission has slowly died and the HSC has not had as much clarity as it should have had. In my opinion, this has been detrimental to service delivery." 12:21

Then, just to complete that, although we'll move on to SAIs shortly, he also says:

"With regard to regional SAI management, the systems and processes from within the HSCB have been slow and often ineffective. It is my understanding that the RQIA are soon to publish a new regional approach to SAI management, to be implemented across the HSC." 12:21

Can we just go back up, please. So, the first part, Mr. Devlin considered that:

"... the HSCB has struggled to retain staff and has

lost direction. To that end, the precision that was envisaged for commission has slowly died and the HSC has not had as much clarity as it should have had."

I just want to ask you to comment on those remarks from Mr. Devlin. 12:22

A. MRS. GALLAGHER: I guess it brings me back to the evidence I gave earlier about the reason for the closure of the Board and a review of the commissioning model, so it is well being acknowledged that there was a layer of bureaucracy in the system, but, in fact, that the commissioning model, which was based on the purchase or provider model, wasn't effective. I don't recognise the description as put forward from Mr. Devlin, with respect. In terms of the transition from the Health and Social Care Board to the Strategic Planning & Performance Group, as I mentioned earlier, I was appointed or put into that post in September 2020 in order to manage the smooth transition and we decoupled the closure of the Board and the review of the commissioning model to protect services. 12:22 12:22 12:23

I described earlier the enhancements to performance management, enhancements in - and we'll come on to the SAI position - but there has been an absolute focus to work in collaboration with the Public Health Agency in order to plan services in a way that's achievable. 12:23

I referred earlier to 97% of our budget is rolled over, year on year, for service provision on the ground.

What is missing from Mr. Devlin's evidence is the role and the responsibility of the Trust in managing the money allocated in delivering the service in their corporate responsibility on the four elements that I talked about earlier, two of which include performance management and safety and quality. And the 2017 guidance firmly states that the provision of services, performance management, sits at a primary responsibility within the Trust. So I don't recognise the description as evidenced by Mr. Devlin. 12:24

79 Q. Anything to add to that?

A. MR. CAVANAGH: I mean, like Sharon, I don't recognise it, either, because the reality is, so much of what we have been doing has been about promoting quality, not just in Urology Services but more generally, because the way that we're investing is very much in partnership with Clinicians, talking to Clinicians about how these services could be developed and ensuring that, actually, we are taking as much of that into account as is possible in the constrained environment that we find ourselves. That's why we have, sort of, Cancer Clinical Reference Groups for Urology and many other services, that's why we have the Planning Implementation Group for Urology; an opportunity for us to sit down with Clinicians and genuinely discuss how services can be made as high quality as we possibly can in the constrained environment that we find ourselves. 12:24 12:25 12:25

So, on that basis, I think there are many instances where we have looked to support the development of quality services and we have set aside our need to ensure that targets are met. I mean, one example that springs to mind is, in 2014, we said to the Southern Trust at that stage, we will set aside the requirements under our Service and Budget Agreement in order for you to blue-sky think, as the then-Director of Commissioning termed it, in order for you to blue-sky think in a way that will actually look at transforming your service and developing your service, and the Trust brought forward plans which did genuinely look to be an opportunity for us to make a step-change in that service and further investment was provided at that stage. So I think it's incorrect and I just don't recognise it in that way and, in many ways, I think it's a bit of a two-dimensional sort of reading of the work of Health and Social Care Board and certainly, now, of SPPG. 12:25 12:26 12:26

80 Q. I suppose to be fair to Mr. Devlin, he is no longer around as Chief Executive to see the outworking of some of the plans that were anticipated. 12:26

A. MR. CAVANAGH: Sure.

81 Q. But certainly that was his view at the point of his Section 21. I think you want to say something else? 12:26

A. MRS. GALLAGHER: Indeed. And I suppose just to remind ourselves that the commissioning process was stood down in 2020 before the closure of the Board, for the reasons that I set out earlier; we were in the middle

of Covid and our focus was on utilising our resource to best effect in managing and responding to Covid for two years. After that, we went into a Rebuild Programme, and I talked about this earlier, where we worked with Trusts in terms of agreeing our recovery from Covid.

In terms of the delivery of high-quality services, I mean, we've talked about this earlier. That sits within the purview of the Health and Social Care Trust, so the targets are part of the picture, but safe quality services sits within the domain of the Health and Social Care Trust. In Mr. Devlin's defence, our demand capacity gap has increased. That was made even worse by Covid. So the provision of high-quality services, as described by Mr. Devlin, had, of course, diminished because we were in a position with ever-increasing waiting lists and, you know, during a period of Covid and recovering from Covid. So I can understand why his perception would be that these things had conflated, but as I mentioned earlier, this is a very complex working environment, with many, many factors coming into play, and it is easy -- or one -- human nature tries to have a cause and effect; very rarely it's that straightforward - in Health and Social Care, it is multifactorial, as I mentioned earlier.

82 Q. Thank you for taking the opportunity to comment on what Mr. Devlin said. I just want to look at some of the ways in which you gather information or have

information fed to you in order to inform your roles and responsibilities. One of the groups that you engaged with was the Northern Ireland Cancer Network. I think, Mr. Cavanagh, were you involved directly with that? 12:29

A. MR. CAVANAGH: Mm-hmm.

83 Q. And that actually sat under HSCB until March 2022. Could you just outline to us your level of engagement with the Network and what way they informed your views on commissioning or planning generally? 12:29

A. MR. CAVANAGH: Sure. I mean, NICaN - the Northern Ireland Cancer Network - was hosted by the HSCB, as you say, and, throughout that period, HSCB, I think, benefitted from having a structure like NICaN to draw upon because it was a place where Clinicians came 12:29 together involved in cancer care, both generally and also in relation to individual tumour sites and services, and was able to then look at extant clinical guidance at that time and developed some quite groundbreaking, in my view, pathways and clinical 12:29 guidance for services across a whole range of Acute Services in relation to cancer care. So we have a fairly sophisticated process now available to Clinicians; they are guidelines by their very nature, but they are developed by Clinicians, so, in that way, 12:30 we look to Clinicians to implement those and use them as the basis of their practice. So it is an important organisation. It also was an organisation that was able to support a peer review process, largely because

we were able to piggyback a little on what NHS England were doing. We are a relatively small country here, there's only so much we can do in relation to peer review, so whenever we can link with countries in Britain, I think there is a real opportunity for us to learn and also to draw on some of their expertise around peer review.

So, peer review, throughout kind of the -- right up to about 2019, there would have been a process both of NHS England coming and visiting services here, but also of them reviewing self-assessment by Trusts as well, of how they felt their services were going, and a range of recommendations were raised through that. Some of those recommendations included issues around multidisciplinary teams, around attendance and quoracy and multidisciplinary teams. They also related to how we sort of had referrals from GPs and whether those were following extant guidelines as well and also how we triaged them at the secondary care level as well. So, an important organisation, very much a Clinician-driven organisation, but the Board then was able to benefit from all of that knowledge and actually then were very much advocating for the approach that NICaN guidelines were -- I suppose had developed.

84 Q. And the guidelines and protocols that came through NICaN, or from them, based on, I presume, evidence base and care pathways, were evidence-based --

A. MR. CAVANAGH: Very much so.

85 Q. There's no compellability on the Trust or Clinicians to act accordingly or to endorse those, but was there an expectation from HSCB that, given that they were evidence-based and coming from that source, that they would be taken on board? 12:32

A. MR. CAVANAGH: They were co-produced by Clinicians, and so the various sort of MDTs would have been involved in the Clinical Reference Groups that were developing the guidelines. So, on that basis, I think there was an expectation that the Clinicians would also bring those 12:32 back and advocate to their teams in relation to them, but, yes, they are guidelines, but they are guidelines that represent best practice and represent sort of what the clinical community felt was the best approach to delivering services. 12:32

86 Q. Was there ever any pushback from any of the Trusts or Clinicians, as far as you are aware, around guidelines or protocols or anything emanating from NICaN?

A. MR. CAVANAGH: Quite the reverse, in fact; I think they were embraced by Clinicians and by teams. 12:32

87 Q. I think it was confirmed - I just want to give the Panel the reference - it was confirmed at a NICaN Board meeting in February 2018 that:

"It is the responsibility of individual Trusts, all of 12:33 which are members of the Urology CRG, to adopt guidelines and protocols."

A. MR. CAVANAGH: That's right.

88 Q. So it falls to the Trust, and that NICaN Board minute

is at WIT-105092. What's the responsibility of HSCB generally in relation to guidelines and standards that are expected? We heard some evidence that it's a joint approach; Mr. Pengelly indicated that clinical standards to that extent are a joint approach - PHA, HSCB - and I say that with a slight nuance because the question was around the particular issue, but is there a responsibility on HSCB, or SPPG now, around ensuring that guidelines and protocols are adhered to by the Trust or adopted by them? 12:33 12:34

A. MR. CAVANAGH: I mean, there is a range of guidelines, and it is important to emphasise that. We have some NICE guidelines, as they are called - National Institute for Health and Care Excellence - which we do seek Trusts to adopt. The likes of our Cancer Network Guidelines, we feel are best practice and we will seek Trusts to adopt those as well. And Royal Colleges, and so on, will develop guidelines and I think we will take those into account, but they are not automatically adopted in that way, although Clinicians, obviously, have the opportunity to draw on that and indeed will be involved in some of the Royal College and other guidelines as well. So, on that basis, guidelines are the coming together, obviously, of the views of the clinical community and also the views of organisations delivering healthcare, and, in that way, I think they represent the standards that we want to work towards, and we generally will use those, then, as the basis of, I suppose, keeping under review that services are 12:34 12:34 12:34

delivered against those, should then represent quality.

89 Q. Yes. And they fall into the expectation of good governance that the Trust has to put in place itself --

A. MR. CAVANAGH: Certainly, from a Clinical and Social Care governance point of view, I think they are an excellent tool for Trusts to use in terms of assuring themselves that they are meeting, I suppose, the requirements of good governance. 12:35

A. MRS. GALLAGHER: If I might add to that, Ms. McMahon?

90 Q. Yes, of course. 12:35

A. MRS. GALLAGHER: In terms of the role of the Department, the role of SPPG and PHA and then the role of the Trusts, so, clearly, the Departments sets the standards and issues the guidance. In terms of SPPG and PHA, guidelines are guidelines and obviously some are more easily introduced and will need to be considered, you know, in terms of their individual application. We would use the clinical networks - we, as in SPPG and PHA, would jointly use, for example, some of the clinical networks to consider the implications of the guidelines, because, you know, there needs to be a consideration about how you introduce it. Some might require a resource implication, some might require a change in terms of the team, the multidisciplinary team, so there are many, many different guidelines that need to be considered, and some we need to support in terms of how that's implemented. 12:35 12:36

In relation to the Trust assurance, we have -- we work on a risk-based approach, so where there are clinical guidelines or other guidelines that we feel are hugely important in terms of -- there's the difference between safety and quality. So the guidelines generally fall into the good quality, which doesn't -- so a high-quality service is one that we all aspire to, but in the current environment, we need a fit-for-purpose service at the minute, but safety is absolutely top of the agenda. So, again, in the context of implementing guidelines, we need to consider what's feasible and possible with the resource that we have, human resource and financial resource. 12:36 12:37

91 Q. And if there is a resource implication for a guideline or a protocol that is to be implemented, is that something that's front-loaded by your understanding of that resource implication and, therefore, funding, or do the Trust have to identify that resource implication and ask you for funding for it? 12:37

A. MRS. GALLAGHER: Regrettably, it's not the case that, with new guidelines, there is additional funding associated with that. So part of the responsibility of the SPPG, supported by PHA, is to work with the Trusts in terms of understanding any financial impact on that, and, you know, it may or may not be possible to provide the additional funding, but, invariably, we're competing for funding across many areas, but funding doesn't follow with any new guidance. 12:37 12:37

92 Q. So the Trust have to deal with resource implications

from guidelines out of their existing pot?

A. MRS. GALLAGHER: In the main, yes, and that's where the balance comes in in terms of the extent to which guidelines can be incorporated or introduced and how you manage risk, because at times you might not be able to fully implement the guidance, and it is about risk management and the extent to which you can bring forward the guidelines in the way that were anticipated, but remembering, of course, that these are guidelines. 12:38

93 Q. So would it be a transparent process if guidelines weren't to be implemented because of resource implications, would everyone be aware of that? For example, if I was in the Trust and I said we haven't the capacity, the funding, to bring this guideline into reality, you, as the SPPG, would be aware of that from the outset? 12:38

A. MRS. GALLAGHER: So, in the first instance, then, the Trust would be acknowledging that, understanding that, and the Trust team and their Clinical Governance arrangements and their Leadership Team, both medical and non-medical, would understand the guidelines and would put in place arrangements in order to -- to the extent that they have the resource to do that. If it was something fundamental to safety and that was fed back to us, then that would be a consideration that we would need to give serious thought to. 12:39

94 Q. And that applies to NICE guidelines as well as anything coming through NICaN, any guidelines at all?

A. MR. CAVANAGH: Yes, that's right.

95 Q. MRS. GALLAGHER: Any guidelines.

96 Q. In relation to your Complaints Procedures and Standards, you have referred to these. If I could go to it at WIT-104277, at paragraph 119, and you say: 12:40

"The HSC Complaints Procedures and Standards are set out in two documents: Complaints in HSC Standards and Guidance 2009 and HSC Complaints Procedure."

12:40

And then, at paragraph 120, you mention that you formulated your own policy on the management of complaints. And if we go to 121, please, and you say - sorry, Mr. Cavanagh, this is your Section 21, if I haven't made that clear: 12:40

"As well as dealing with complaints against HSCB, the Board also analysed complaints made about Trusts, with a view to sharing, on a regional level, any learning from that analysis." 12:40

I just wonder, do complaints about Trusts come through HSCB/SPPG, do you get that information --

A. MR. CAVANAGH: No, Trust provide us with a report on the complaints that they have received, so they don't directly come to us. 12:41

97 Q. And then you analyse those complaints and look for themes?

A. MR. CAVANAGH: Hmm.

98 Q. So this is something akin to an SAI process, but obviously of a different ilk?

A. MR. CAVANAGH: Mm-hmm, that's right.

99 Q. And in relation to information that's provided by the Board around complaints, do they include complaints generally in relation to service or individuals or both? 12:41

A. MR. CAVANAGH: I mean, the ones that come through Trusts -- sorry, are you asking me about Trusts?

100 Q. Yes, the ones that you receive from the Trusts that you analyse -- 12:41

A. MR. CAVANAGH: So the ones that come through Trusts will generally be relating to patient experience, so that a patient has maybe -- you know, it can be issues around access to care, it can be issues around their experience of receiving care and, indeed, it can be issues around just kind of the environment, and so on, that they have received care in, so it's a fairly wide range of issues that people will raise with Trusts. 12:41

101 Q. You, also, if we go to paragraph 123, you say: 12:42

"The HSCB would review to identify any trends of concern or clusters of complaints. However, the information the HSCB received from Trusts was anonymised (both the complainants and the practitioners). Therefore, if complaints kept arising in respect of the same practitioner, unless this detail was specified by the Trust in the body of its report, the HSCB would not be directly alerted to this. The 12:42

HSCB's role was to identify trends in the more general sense. When identified, any resulting learning was shared on a regional basis."

So, like the SAI process, there's anonymity built in? 12:42

A. MR. CAVANAGH: Mm-hmm.

102 Q. Just in relation to the rationale for the anonymity for complaints through the Trust to the HSCB, what's your understanding of why it would be anonymous at your level? 12:43

A. MR. CAVANAGH: So, I mean, the complaints process, and indeed the SAI process, are about learning, so we're trying to learn from, I suppose, the experiences that people have in terms of complaints and, also, we're looking at learning, sort of, where staff are involved 12:43 and so on, so, in that way, it's about encouraging learning. The complaints process is anonymised because it's a report on the complaints that a Trust have received for the period that a report relates to, and, as I say, they are about learning, so, from the 12:43 complaints, we will look at if there are any particular trends and we will issue learning letters, newsletter articles, and so on, in relation to those.

103 Q. I know you listened to the Public Health Agency evidence and you will know that I asked them about the 12:43 wisdom of that, if there are complaints about one individual or one area. Do you have any view on that, as to whether, if there was a theme and the theme was an individual, then you could readily see how that

would be missed entirely by the process of anonymity, but do you have at a view on that?

A. MR. CAVANAGH: It's unlikely that we will, sort of, find out about an individual through that process. It is about learning, so, on that basis -- 12:44

104 Q. But you wouldn't find out about them through the process because it's anonymous?

A. MR. CAVANAGH: No -- absolutely, that's correct, of course, but it is about learning, but remembering that the Trust will know about if an individual practitioner 12:44 is involved and they have the necessary processes for them then to engage with that practitioner.

105 Q. But you have to know, do you not? Does the HSCB say, well, if the Trust know, they can tell us, and if they don't tell us, then that's up to them, is that -- 12:44

A. MR. CAVANAGH: The Trust don't have to tell us, but the process is about learning, so we want to learn.

I mean, one of the issues that springs to mind from the complaints process is, mealtimes, protected mealtimes; a number of patients came and said 'when we're in 12:45 hospital, we actually find it difficult to get our meals because we're off getting a diagnostic at mealtime, and things like that, and we're missing meals', so that was a really good example of where the complaints process led to us issuing a learning letter 12:45 to Trusts asking them to protect mealtimes. So the processes are there to learn. The Trusts have a different role as employers and they will have learned something about an individual practitioner through

their process.

106 Q. If we go to WIT-104282 of your statement, paragraph 137, just to read this in, and you say:

"The HSCB did receive anonymised complaints concerning the Urology Service in Southern Trust as part of the monitoring process. No trends of concern or clusters of complaint were identified within those complaints." 12:45

Then, you say at 138: 12:46

"As part of the review of Urology Services, a lookback of complaints was undertaken by a nursing professional for the year 2014/'15 (as distinct from the more recent lookback exercise). The 2014/'15 lookback involved a review of Urology complaints regionally from all Trusts." 12:46

And the information has been provided, for the Panel's note, at WIT-73243 to WIT-73244. 12:46

"No concerns, patterns or clusters of complaints were identified from the information reviewed by the nursing professional." 12:46

Now, given the information that's been provided to the Inquiry and the length of time during which some of the issues existed, I can see that there was no clusters or concerns identified, but do you think if there had have

been a way in which, where the issues emanated from, in other words, from a clinician, for example, then there may have been clusters or concerns that would have made themselves available on this preliminary lookback in 2015? 12:47

A. MR. CAVANAGH: I mean, I can't say, in terms of that review in 2015, whether -- whether that did relate to an individual clinician, and so on. It clearly related to a range of complaints relating to the Urology Services and, from that, there were no trends that were found. So, on that basis, the process was designed to, if a Responsible Officer from the likes of the Public Health Agency actually identifies that there is a number coming in from Urology, therefore it is reasonable to have a look, at that time, at those complaints and see whether or not any clusters or themes are emerging, they did that and they didn't see any, so, on that basis, that was the process and that was the process that was followed. 12:47 12:47

107 Q. Yes. I'll just give you another opportunity around this. Are you saying that even if the Consultant was named and there was a theme, you don't mind that that didn't reveal itself, that anonymity must dominate this process? 12:47

A. MR. CAVANAGH: Look, I can't say in this case; it's years. 12:48

108 Q. But as a proposition to you, if the revelation of a Consultant, for example, or any health professional, was a familiar name during some of the issues, would

that information not, of itself, reveal a theme, and do you not think that that has the potential to prevent you having information that might be important around patient risk?

A. MR. CAVANAGH: The professionals looking at that would be, in my view, keeping that in mind, so, on that basis, if it had looked like that was what was emerging, they would have identified that and followed it accordingly. 12:48

109 Q. And do you feel that was done in this case, now that you know what you know, and we're standing in a Public Inquiry, do you feel that the professionals did identify that and -- 12:48

A. MR. CAVANAGH: But the fact that we are able to say that, at this time, a professional saw that there were a number of complaints coming in around Urology, reviewed those complaints and concluded that there were no themes or concerns emerging, that's a sign that the system was doing what it was designed to do. 12:48

110 Q. With respect, I'll have to push you just a little bit on that, given that we are standing in a public inquiry? 12:49

A. MR. CAVANAGH: Sure.

111 Q. If you consider that the system did what it was meant to do, does that mean the system is useless? 12:49

A. MR. CAVANAGH: But it is designed for learning.

112 Q. And what was the learning -- what was the learning then?

A. MR. CAVANAGH: There was no learning because there was

no patterns or concerns raised. Had there been patterns or concerns raised, that would have led to learning which may then have lead to a learning latter, a newsletter article and so on.

A. MRS. GALLAGHER: If I might add to that, Ms. McMahon. Clearly the system didn't do what it was meant to do or we wouldn't have the situation we are in today. We are very keen to understand the learning in that. We have already made changes in terms of our own processes within SPPG to triangulate learning, to understand learning. Just to go back to the different processes where an individual is concerned or a medical practitioner is concerned, the wraparound on that in terms of the appraisal system, the revalidation system, which uses SAIs, which uses patient experience, which uses the views of colleagues in order to assess whether or not a clinician is providing a safe service, all of those factors come into play. The clinical governance around that, the management systems around that in terms of MHPS, it is the primary responsibility of the Trust and the Trust Board to make sure that that organisation provides safe services and employs people who provide safe services. 12:49 12:50 12:50 12:50

The Responsible Officer arrangements were put into play in 2011 and that was primarily to make sure that every doctor, if you like, had an external consideration in terms of safe practice. So there are many, many systems and processes and procedures at play here. 12:50

Clearly something went wrong. The SAIs, as my colleague has said, relates to system learning. We would not have expected an individual to be named. In fact the process dictates that they aren't named. To your question, if either inadvertently or not we were made aware of the potential for harm or harm by any professional, of course we would take action. There is absolutely no doubt we would take action, whether it sits within the current protocol or not. But the SAI process is really about system learning as opposed to managing the conduct or the practice of any individual medical practitioner or clinical practitioner. 12:51 12:51

113 Q. Yes. The Panel has heard evidence around the different parts, they are all moving parts, there is a menu of things available, including the MHPS you mentioned, there's obviously GMC, internal disciplinary, there are lots of oversight mechanisms that allow Trusts to deal with that? 12:52

A. MRS. GALLAGHER: Indeed.

114 Q. I'll take it your answer is premised on a belief that those systems should be operated as expected? 12:52

A. MRS. GALLAGHER: Indeed, indeed. Again, the role of the Board and their committees and obviously RQIA, as I pointed to earlier, can also undertake reviews in terms of -- where we would have concerns, for example, from the Department's perspective, if we were alert to concerns or if we understood that there may have been failings, then we would ask RQIA to investigate and to take a look at that. 12:52

I might just add that the '22/'23 quality and safety report that we produce in concert with PHA shows that there were 120,000 adverse incidents so those are handled at Trust level, 539 of them serious adverse incidents. So it points to the importance of Clinical Governance and learning at Trust level because all of those might point to indications of individuals or practices or environments that need to be addressed, that need to be developed and need to be changed. That's why the primacy of safety and quality, in particular safety, needs to sit at the seat of where clinical practice happens within Trusts. 12:53 12:53

115 Q. You have mentioned SAIs and some of the figures there and the high volume of those, now each of PHA, HSCB, RQIA all are responsible collaboratively for looking at SAIs and seeing about learning, which is obviously the key aspect of that, but we have heard some evidence around the delays of SAIs to the Trusts and I presume, or perhaps you can say, and not confined to the Southern Trust, that there are delays in SAIs, what's your understanding of the logjam around that? Are there plans to try and - I know we have the review, I know there has been some movement at a high level to look at this overall - but on the ground operationally when these potentially serious concerns are waiting and waiting, what's the plan to try and do something about that in the more immediate term? 12:53 12:54 12:54

A. MRS. GALLAGHER: So when I took up post, one of the

areas that I looked at in the first number of weeks actually was the number of outstanding SAIs. Interestingly, for an SAI to happen it needs Clinicians, it needs those people that are delivering services. Given the demand capacity gap and given the 12:55
competing priorities, it can be very, very challenging to get the resource that's required to conduct the audit, to conduct the review. As at today there are 539 SAIs in the system and many of those are experiencing delays. I put in place a process where we 12:55
risk manage the SAIs that are outstanding so that we constantly review and understand to see where the risk lies. In the main, 80% of SAIs are your first tier but, for Level 2 and Level 3, we keep a very close eye in terms of the action that is required, the priority 12:56
of those and work very closely with Trusts. So we now meet Trusts every two months to have the discussion about outstanding SAIs and the activity that they are taking to do that.

12:56

I wrote to Trust Chief Executives around two months ago, again outlining our shared concern, because I know that Trust Chief Executives and the Trust teams are as concerned about backlogs as I am. That is why there is a joint and concerted effort to manage the risk on 12:56
that, but it will take some time to meet the backlog because that backlog accumulated throughout Covid as well and recovery from that is challenging.

We have enlisted clinical leadership solutions actually to support the Trusts in order to undertaken some of the Level 1 reviews, the SAIs, but also to train Trust personnel and indeed our own personnel in SPPG and PHA to support the SAI process in terms of understanding the best way to manage and to deal with SAIs. If you might let me describe a little bit about the arrangements that we have undertaken within SPPG and PHA on SAIs. 12:57

So we now have a nominated officer that reviews both early SAIs and early alerts as they come in every day, that's a health professional that's based in PHA. Those notifications are issued to all of the directors and the senior officers to understand what has been received. There's a weekly group that reviews the new SAIs and Early Alerts to understand what's happening, 'is this something that we know about, if not does urgent action need to be taken'. There is a further meeting by directors and professionals, a multidisciplinary team that meets weekly to understand escalated issues, so where there's concerns. Once a quarter now we have put in place a multidisciplinary team at director level that looks at the triangulation of complaints, Early Alerts, SAIs and any other information that we have, including information, for example, from the Patient Client Council to take a temperature check and understand if there are emerging themes or issues. And, in addition to that, we have a 12:57 12:58 12:58 12:58

monthly forum between the PHA and the SPPG that Mr. Dawson and I co-chair that has two agenda items and two agenda items alone. That is performance management and service improvement and safety and quality. On the back of that we produced for the first time our safety and quality action plan last year which has now been added to the business plan in the Department, so sits under the purview of the departmental management Board and we are currently in the process of considering the review of last year, what went well and what we might plan in terms of addressing safety and quality issues and promoting learning for next year. 12:59 12:59

So there's been a huge emphasis. We've taken the learning from the Inquiries, we've taken the emerging information coming from this Inquiry and we have really made a concerted effort in terms of ensuring that the procedures and processes are as robust as they can be, but, more importantly, that we identify risk early and we manage that risk. Because it is not possible to -- it would be a simplistic view to say that we can simply deal with that backlog and take care of what has been generated over a period of years, particularly throughout Covid. But I can assure the Inquiry Panel and yourself here today that we have taken quite significant steps in that regard to reinforce the work that we do. 12:59 13:00 13:00

116 Q. Just from an operational perspective, the issues arising around individuals who perhaps know the

individual involved or are perhaps very close to the service provider or have other very competing clinical demands, is that part of the package of looking at that to see if that is an effective way of carrying out the preliminary investigation? 13:00

A. MRS. GALLAGHER: So I think there's an important point to be made in terms of, you know Ireland/Northern Ireland is a small place, health and social care is a small place, everybody knows everybody and this is part of what we heard through both Neurology and 13:01
Hyponatraemia and what will undoubtedly, I am sure, be under the consideration of the Inquiry Panel here today in terms of people feeling that they can raise concerns without prejudice and raise concerns without fear of retribution or anything else. So one of the key 13:01
strands - and I mentioned earlier the Inquiry's Implementation Programme Management Board that the Permanent Secretary chairs - one of the key strands under the safety and quality theme is looking at being open, how do we support people to be open and how do we 13:01
support people to call out behaviour even if they are not sure. Because all of us, I suppose, as human beings, there's a reluctance sometimes quite naturally to call out things in case you're overreacting or in case you're not seeing the full picture. But part of 13:02
what we want to try and promote is that, if you are concerned, even if it turns out not to be the case, we need to be open, we need to promote that culture.

MS. MCMAHON: Thank you for that context. I will be

moving on to more of the detail of the SAIs, but perhaps that's a convenient moment?

CHAIR: Yes, we'll come back at five past two everyone.

LUNCHEON ADJOURNMENT 13:03

THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIR: Thank you, everyone. Ms. McMahon.

MS. MCMAHON: Just before we get back on track in relation to the evidence, I just want to ensure it's on transcript. When I had asked you, gave you the reference that Mr. Devlin had said in his statement about the Trust's responsibility for patient safety and his views on the HSCB, I just want to put on record - you may not have seen the entirety of Mr. Devlin's Section 21, I don't know whether you have or not, but the Panel will know, and for the purposes of my question, that Mr. Devlin does address the responsibility of the Trust around patient safety throughout his statement and deals with that issue, so just on that discrete point, I just want to -- because I didn't think you had seen all of his statement, so I didn't want to ask you if you were aware of the contents, but the Panel will be aware of that and they have heard evidence from Mr. Devlin on that issue.

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Just before we go into the SAIs and have a look at some of the issues that arose that the Board were aware of, I just want to look at some of the concerns prior to July 2020, and we can find this, for information purposes, we can bring it up at WIT-104304, and starting at paragraph 230, just for the Panel's note, effectively, because I'm going the summarise this.

This is just the involvement of the HSCB from the inauguration of the Regional Urology Services, both in Craigavon and throughout Northern Ireland, in 2009, with the Regional Review of Adult Services, which was undertaken then by the DHSSPS, as it was, Service Delivery Unit. And subsequent to that, there was a Regional Stocktake of Adult Urology Services, and that was commissioned by the HSCB, and Mr. Cavanagh deals with that at 231, and I'll just read this out:

14:06

14:06

"In December 2013, the HSCB Director of Commissioning requested a Regional Stocktake of Adult Urology Services in Northern Ireland to assess what progress had been made in the five years since the review. The stocktake was undertaken in February 2014 and examined individual Trust performance..."

14:06

And then you have accompanied that with a copy of the Terms of Reference.

14:07

"The narrative report on the Urology Review Stocktake, which included suggestions for continuing to improve Urology Services, was shared with Trust Directors and HSCB ADs of Commissioning in May 2014."

14:07

Now, the Panel have looked at this previously, but just in relation to that, being, like, a five-year window, almost, since the beginning of Urology Services, would that have been custom and practice and is it still that

you revisit something that's new starting up and have a look to see what's going on and what might need to be done further?

A. MR. CAVANAGH: Urology Service predate 2009, just to emphasise that, Urology Services in Northern Ireland have been around since the 1990s, so the work that was done in 2009 was an effort, I suppose, to look at transforming and developing Urology Services, given that they had grown considerably in the previous decade. And then the stocktake, I think, at that stage, was, given the significance of the 2009 Review, an opportunity then to look back on what had been achieved and what was yet to be achieved. 14:07 14:07

I mean, I suppose it depends upon the area of work that we're looking at, but generally we will seek to keep under review where a review has made recommendations which requires implementation plans in order to progress those, so we'll keep that under review and, on this occasion, obviously, the Director of Commissioning chose to do a much more formal stocktake, which was reasonable in the circumstances, I suspect. 14:08 14:08

117 Q. You go on to say at paragraph 232:

"Following the stocktake, the Director of Commissioning wrote formally to all HSCB Trusts in July 2014 asking the Trusts to bring forward proposals for the establishment and maintenance of a robust, sustainable model for Urology provision through the submission of 14:08

an Improvement Plan."

Then, in paragraph 233:

"The Southern Trust submitted a Urology Improvement Plan to HSCB in September 2014, was subsequently given approval to begin implementation of the model." 14:08

Which we know started in December 2014.

14:09

At paragraph 234:

"The HSCB agreed that the implementation of the Improvement Plan by the Trust would take precedent for a period over delivery of agreed activity required within the SBA as noted in correspondence." 14:09

Now, just that particular sentence:

"The HSCB agreed that the implementation of the Improvement Plan by the Trust would take precedent for a period over delivery of agreed activity required within the SBA... "

You couldn't just explain what that means, in practical terms, for the Trust? 14:09

A. MR. CAVANAGH: Well, the SBA obviously has volumes of delivery expected in relation to outpatients, inpatients, surgery, day-case surgery and so on, so, on

that basis, what the Director at that stage was, I suppose, saying, was that we would set aside, I suppose, monitoring those, I think, for about an 18-month period, from memory, and allow the Trust some space to actually do some of their improvement and development that was required in order to progress the services, as outlined in their Implementation Plan.

118 Q. And is there any downside to that, if you move your vision slightly across to something else for that period of time? Is it your experience or was it, in fact, in any way significant on what subsequently happened around outcomes? 14:10

A. MR. CAVANAGH: It's likely the amount of capacity delivered would have reduced, which means, obviously, when you reduce the amount of capacity delivered, that's going to increase your waiting times, so there is a downside, but I don't actually know the detail as to what that looked like. 14:10

119 Q. In June 2015 then, subsequent to the service commencing in the way that was envisaged by the 2009 Plan, the Regional Urology Planning and Implementation Group was established and the purpose of that was to develop a system-wide approach to the organisation of Urology Services across Northern Ireland. There was a lot of activity in 2015; it was subsequently, then, that NICaN carried out a commissioning review, and then, in 2015, the Southern Trust Local MDT Peer Review. Just before we move on to the MDT Peer Review, NICaN's involvement in that period of time, June 2015, was that a way of 14:10 14:11

them informing themselves of the position so that they could best feed good practice back, or were they looking at the service from a critique point of view at that point?

A. MR. CAVANAGH: Yeah, the Cancer Network, I suppose they were developing guidelines through the period up to 2015 across a whole range of acute specialties and tumours sites, so what they were doing in 2015 was taking an opportunity to do, I suppose, effectively another stocktake, a peer review, as it was called, to see the extent to which those guidelines that had been developed in the previous five to seven years, were actually becoming embedded in the services. 14:11 14:11

120 Q. And you speak to the Southern Trust Local MDT Peer Review at paragraph 243, which we can find at WIT-104307, just down at the bottom, 243, please. And you refer -- the headline is: 14:12

"The 2015 Southern Trust Local MDT Peer Review."

14:12

And you say at 243:

"While I have been unable to locate a copy of the relevant outcome letter, the key themes arising across Cancer Services in the Southern Trust were summarised in the overview of the findings from the 2015 National Peer Review of Cancer Services in Northern Ireland." 14:12

And then you list the issues as follows:

"Procedures being undertaken outside specialist centre or by Consultants who are not members of or attend the appropriate MDT; absence or inadequate Clinical Nurse Specialist provision; delays in seeing routine referrals; shortage of Consultants in the specialty or overreliance on locum Consultants; absence of core membership of, or lack of attendance at MDT, leading to a significantly low percentage of MDT meetings being quorate; and lack of specialist Radiologist Or Histopathologist input to the services of MDT." 14:13 14:13

Just move down, please. Thank you. Then, you say at 244:

"In accordance with the agreed process, the Trust would take forward the local issues. The regional issues relating to Urology were taken forward via the Urology PIG and HSCB commissioning and are set out at paragraphs 252 to 256." 14:13 14:13

If we just go to paragraph 252, please. These are the steps:

"The delays for routine and urgent Urology appointments was taken forward by the Regional Urology PIG. Nephron-Sparing Surgery being undertaken outside of specialist MDT, Peer Review emphasised that this surgery was taking place in too many sites. In 14:14

response, HSCB commissioned the introduction of radiofrequency ablation for renal cancer in Belfast Trust as a treatment option and that the relevant interventional radiologist would join the specialist MDT as necessary. The Consultant Urologist in Southern Trust also in-reached to Belfast to undertake surgery within the specialist MDT; inadequate time for Urology specialist MDT, this issue was considered by the HSCB in conjunction with the Belfast and the South Eastern Trusts, ultimately leading to additional recurrent funding being made available to support additional capacity from November 2015, as outlined above; the development of regionally agreed referral destinations and referral guidance on the CCG, i.e. the electronic system used by GPs to make referrals; a medical workforce plan for Urology which was completed in 2017; expansion of the Urology capacity across the region - recurrent funding was allocated to Trusts in 2019 to increase the Urology Clinical Nurse Specialist workforce. In terms of the Southern Trust, this allowed the development of 8.5 clinical sessions for urodynamics and LUTS service and a further 8.5 clinical sessions for prostate biopsies and nurse-led PSA follow-up service." 14:14 14:14 14:15 14:15 14:15

Now, I read that in because I think it shows the benefit of the relationship between the HSCB, the Trusts and review outcomes being worked on collaboratively, and also to show that these things

seem to take a bit of time. You have got the 2014/'15 information, then there's some action at the time, I presume there's some sort of filter system where you do what you can immediately, but clearly, some of this required funding, an identification of needs. 14:16

A. MR. CAVANAGH: Mm-hmm.

121 Q. So, 2017. And it wasn't until 2019, when the Clinical Nurse Specialist workforce was funded, I don't think it was funded fully to the extent it was needed, but it was certainly enhanced at that particular time. 14:16

So if we could look at WIT-105622. Now, this is a Trust's own Peer Review Self-Assessment of Urology MDT in 2016, and we'll see at the top the network is NICaN, the organisation is Southern Trust, and the date of 14:17 validated self-assessment is 30th September 2016 and the MDT Lead Clinician is Mr. Aidan O'Brien. And if we could just go a couple of pages down, is this a document you're familiar with, the Self-Assessment Report? 14:17

A. MR. CAVANAGH: Yes.

122 Q. And is this something that's routinely done, or what's usually the chronology for this?

A. MR. CAVANAGH: It was done within this process, in that we were working with NHS England, they were supporting 14:17 process, so this is a form that they designed, which then was provided to Trusts then to complete. I think it was used over a four-year period, up until about 2019.

123 Q. And this then finds its way to the Board, presumably from the Trust?
A. MR. CAVANAGH: Yes.
124 Q. Yes. But it's not -- the Board don't direct this to be done or -- 14:17
A. MR. CAVANAGH: No.
125 Q. -- you are really just a receiver of this information. And is this one of the ways in which you receive information that, broadly, without being too specific, it broadly reassures you about what's happening and you 14:18 can gain some assurance about the service being provided?
A. MR. CAVANAGH: So the Peer Review process, completed by NHS England but sponsored by the Cancer Network, which we obviously were the host organisation for, so, in 14:18 that way, the Cancer Network, with all the Clinicians engaged in this, were committed to this process, so this is -- I suppose it comes to us, yes, as reassuring, but it also comes to us in the knowledge that there is a number of key issues that need to be 14:18 addressed by the Trusts, so, on that basis, there's also something of sort of understanding how that progresses in the coming years as well.
126 Q. And I suppose the context of my question was, this is a way in which the Trusts can let you know what's 14:18 happening?
A. MR. CAVANAGH: Yes.
127 Q. So, for present purposes, if there were existing concerns at that time that were impacting on patient

safety, whatever way we want to characterise the route, be it administrative or clinical, you would expect it to be reflected?

A. MR. CAVANAGH: Yes.

128 Q. If we just go to the end of the document. So the way in which this document seems to be set out -- so the concerns are usually set out, "immediate risks identified" and then "immediate risks resolved", obviously their own inbuilt sort of triage process, for the reader then to become immediately aware of anything that requires attention. Then "immediate risks resolution", "serious concerns identified", "not identified" in this case. Just move down, please. "Serious concerns resolution", obviously not applicable because there were no serious concerns resolved. 14:19

So, under the last category of concerns, the following is on the form:

"Availability of the Clinical Oncologist and Radiologist at all of the MDT meetings. The highest percentage increase in red flag referrals across the region. Operating theatre capacity and operator time." 14:19

And the "General Comments" say: 14:20

"The Urology MDT is a well-structured and attended MDT which is full constituted with core and extended members. Whilst the attendance by Urologists and

Pathologists, Palliative Care and Clinical Nurse Specialists has been very good, that of Radiologists and by Clinical Oncologists has been unsatisfactory. The MDT has been made every attempt to have this issue addressed and resolved. This has been a difficult and challenging year for the team due to the competing pressures of achieving targets with increasing referrals. A work programme has been developed which outlines the work for the incoming year. However, this is viewed positively as it includes many aspects to improve the quality of the service provided to our patients." 14:20 14:20

Then, the summary of the validation process:

"A Working Group was established to examine documentation. The group consisted of Urology Clinical Lead, Clinical Nurse Specialist, Urology Head of Service, the Head of Cancer Services and Service Improvement Lead. At regular intervals, the documentation was circulated to MDT members for review and comments. Feedback was received and documents were adjusted accordingly. The Self-Assessment was carried out by the Clinical Lead for Colorectal MDT, the Colorectal Nurse Specialist, the Head of Service and the Lay Reviewer. The Lay Reviewer also reviewed the Patient Information Evidence Folder." 14:21 14:21

Then, the Organisational Statement says:

"I, Aidan O'Brien, Lead Clinician on behalf of the Southern Trust, agree that this is an honest and accurate assessment of the Urology local MDT measures."

14:21

And that's agreed by Francis Rice on 28th September 2016. Mr. Rice was the then-Chief Executive.

So, just given the steps that I've read out from your statement, and presumably they flow from what's in this as well, that there was an attempt to plug some of the gaps, and we have heard evidence that plugging the gaps in relation to workforce specialty is a particular challenge, both in Radiology, Oncology and Urology, I think, across all of those specialties. But given the, one might say, limited nature of the specific feedback on the form around difficulties in MDT, would it be fair to say that HSCB took that at face value; you can't go behind that, you're expecting the Trust, the Clinicians involved and the Multidisciplinary Team to give you the information you need in order to assess risk?

14:22

14:22

14:22

A. MR. CAVANAGH: And the NHS England team, in their final report for the whole region, also reflected that issue of the MDT as well.

14:23

129 Q. What is the position around MDTs at the moment? There has been a lot of evidence around that and outcomes, and I know you have referred to it in your statement, about cancer trackers, and I think you have been

involved in trying to address that issue. Could you just give us a little bit of background about that and where we are at the moment?

A. MR. CAVANAGH: About the trackers?

130 Q. Yes, please. 14:23

A. MR. CAVANAGH: So trackers is something that I think we've been developing again probably for eight, nine years, and it's been -- you know, it's an important element of the, I suppose, the cancer team, in that you're looking for administrative staff who can 14:23 follow a patient through their cancer journey. It's a challenging-enough role, as you can imagine, but an important role because it ensures that, at various parts of the journey -- the journey is complex, there's diagnostics, there's various points where they are seen 14:23 for outpatient reviews, outpatient appointments and, indeed, potentially, surgery, radiotherapy, chemotherapy and so on, so a complex journey, so important, as much as possible, to deliver that. So we have grown the cancer tracker resource and it probably 14:24 has got us to the point where we're now tracking well to first sort of treatment. But then, beyond first treatment, I think we're looking to the wider team to actually support, kind of, the ongoing journey of staff. So I think cancer tracking is something that we 14:24 have brought to a good place to this point, but more to be done as well because we need to do it in the future also, be tracking the whole journey, which I think is one of the challenges for us going forward.

131 Q. Because some of the concerns that have arisen in the Inquiry extend beyond that point, and obviously the Panel are likely interested in what provision there now is in place to prevent a recurrence of that. Is it the case that the tracker provision is not fully in place and is it Trust-dependent, are the Trusts making decisions on their own around do we have the capacity financially to fill some of these posts and juggling their finances as you described earlier? 14:24

A. MR. CAVANAGH: In terms of what we are committed to, in terms of putting, I think, eleven trackers, or thereabouts, in Southern Trust, we have now provided enough funding for Southern Trust recurrently to have eleven trackers. I think we know that, given the rise in demand and also given the complexity of the pathway, we may want to go further with that, but, to this point, I think we have fulfilled what we set out to do a number of years ago. 14:25 14:25

132 Q. So, at this remove, would you be content that the issues that the Panel may consider arose as a result of MDT recommendations, perhaps, not being followed through as robustly as they might be, you think that that is unlikely to have the potential to recur? 14:25

A. MR. CAVANAGH: Trackers are part of the cancer team. They are not the only sort of people within the team who are following the patients' journey. You know, we have invested in additional Clinical Nurse Specialists, we have also invested in additional Consultant staff, medical staff and so on, so it's about looking at the 14:26

team approach, but we know that cancer trackers provide a particular administrative function, which is useful in terms of tracking the patient and ensuring that -- I think about once a week, that a patient is kind of checked in on to see where they are in relation to their pathway, but I think given the rise in demand, given the complexity of care as well, and care, as each year goes by, becomes a little more complex in a cancer space as well. I think we know that we have got to continue to grow the cancer team and look at how we develop that, in the knowledge that we also have financial constraints that is going to make that very challenging. 14:26 14:26

133 Q. I suppose from a sort of simplistic point of view, the process of cancer tracking is administrative -- 14:26

A. MR. CAVANAGH: Mm-hmm.

134 Q. -- in that regard. I know there are other Clinicians and healthcare professionals involved, but from an administrative point of view, and forgive me because I'm not involved in that, but it seems that it would be something that could be fairly easily done, and I don't minimise the people who do that, of course, by saying that, but the actual process of following up and checking that people have had their results, that they know their next appointment, the results are in, that what was anticipated would happen to them, did happen, and, in that regard, are you content that, if the Panel were to consider that some of those issues didn't take place because of the evidence they've heard, are you 14:27 14:27

content that that is unlikely to be repeated?

A. MR. CAVANAGH: Again, I'm a little lost in your question, if I'm honest, but I think --

135 Q. Well, I'll put it perhaps more simply.

A. MR. CAVANAGH: Sorry. 14:27

136 Q. Are there enough cancer trackers to track people who are getting cancer treatment?

A. MR. CAVANAGH: So there are enough cancer trackers to take us to first treatment, but, beyond that, I think the wider cancer team is looked to, to ensure that that 14:28 ongoing treatment is there. I think we now need to reflect on whether or not we need to develop cancer trackers further than what we have done to date, but we have reached where we set out to at this stage, but there is potential for us to go further. I mean, 14:28 I wouldn't underestimate how challenging the cancer tracker role is as well, from talking to colleagues in relation to it. These are challenging roles, despite being administrative. So, on that basis, I think they have to be seen in the wider team because it's not 14:28 really about the individuals, as such; it's that the cancer team is appropriately tracking patients and the cancer trackers have a role within that.

137 Q. And it sounds like it's been evolving for --

A. MR. CAVANAGH: For some years, yes. 14:28

138 Q. For quite a period of years?

A. MR. CAVANAGH: Yes.

139 Q. And continues to evolve. Now, are you informed by the evidence you have heard at this Inquiry of the

particular concerns around tracking and the issues that arose because of that, has that informed your deliberations and your plans?

A. MR. CAVANAGH: It has, but I should also emphasise that Trusts also raise these issues with us; you know, we have been growing trackers as a resource for some years. We recognise the value of trackers and I think we are looking at how we might develop that further. 14:29

140 Q. And just generally, the position in MDTs, is the current position, would that provide any more comfort to the Panel, given the quoracy issues that have arisen in the past around specialists being available and attending? 14:29

A. MR. CAVANAGH: I mean, it is a challenging issue. I mean, I have never managed an MDT, so I can only tell you from a bit of a distance in relation to it, but if I think about Oncology, Clinical Oncology involvement in an MDT, which was raised during the 2015 Peer Review, both regionally and also specifically with Southern Trust, you know, we -- since then, since about 2018, we have put in place an Oncology-Haematology stabilisation plan, put a significant amount of funding into that to grow the Oncology workforce as well as the Haematology workforce. So I would like to hope, with those additional roles now in place, those additional staff now in place, that some of those issues have been resolved, but I can't be sure, at the same time, because we haven't done any direct review in relation 14:29 14:30

to it. In relation to Radiology, we are very conscious of, we have quite a number of vacancies within Radiology, it's been a problem for some years now, so that Radiology challenge has been, I think, something that all Trusts have been faced with, and I think there will need to be some thoughts about how Radiology input can be done differently if there isn't enough sort of resource available to actually attend MDTs, but I think that's certainly an important issue. 14:30

And Pathology, the Histopathologist that's mentioned as well, I think, again, Pathology has had its own workforce challenges, but all of those -- across the whole system there are workforce challenges. It's about trying to make the MDTs function as best they can. The best way for them to function is, everyone in the room together talking about the individual patients on the agenda for that day, but, if that won't work, they will need to think also creatively about are there other ways to get those inputs on those patients at the point that it is required. 14:30 14:31

141 Q. And when these discussions are happening, both within your organisation and with the Trusts and perhaps other organisations, are they framed in the context of patient risk and patient safety? 14:31

A. MR. CAVANAGH: In terms of the MDT discussions or discussions about MDTs?

142 Q. Well, both, effectively. Is there --

A. MR. CAVANAGH: I can't speak to what happens within an

MDT. As I say, I have never been directly involved in an MDT; it's a clinical forum in --

143 Q. Well, in relation to the absence of some services, some personnel and perhaps trackers, are these being spoken about in a patient safety and risk context? 14:31

A. MR. CAVANAGH: Absolutely. I mean, MDTs are the focal point of cancer pathways. They are essential to ensure that patients are receiving the best care that is possible, so they are important. We are looking at them. I mean, as well, off the back of the 14:32 recommendations from the nine SAI Overarching Review, which took place in 2021, we have also been looking at MDTs through that process as well, so MDTs are something that we are focussing on, we wanted to more work in relation to them as well, but they are crucial 14:32 for cancer care, and that's why we need to actually do all that we can to make them work as effectively as possible.

144 Q. I wonder if we could look at Paula Clarke's statement at WIT-37595. So this is a Pathway Review carried out 14:32 by the HSCB. Paula Clarke describes it at 52.2 as follows:

"I have been reminded by reference to documents provided to me by the Trust Public Inquiry Team that, 14:33 in January 2015, when I was Director of Performance and Reform, the HSCB had completed a short pathway review to assess the systems and processes currently in place for the booking of Outpatient Services regionally, to

ensure they support the consistent application of the integrated elective access protocol. The performance against chronological management at specialty level within each Trust was analysed and those specialties with a higher percentage of routine new outpatients being seen out of chronological order, were selected for review. In addition, specialties where there was a particular concern regarding patients currently waiting over nine weeks, were also selected for review. Five specialties were identified for review across the region, including Urology. The report from this audit was sent to Mrs. Aldrina Magwood, as Acting Director of Performance and Reform, in June 2015/2016, by Mr. Michael Bloomfield, HSCB Director of Performance and Corporate Services." 14:33 14:34 14:34

I just want to make sure I get the right reference. 53.3, please. So, this is again reference to -- it just provides more detail further along in her statement, and she says at paragraph 53.3: 14:35

"In 2015/2016, during my tenure as Interim Chief Executive, the Pathway Review completed by HSCB and referenced in paragraph 52.2 assessed the systems and processes in place for the booking of outpatients in Urology Services against the Integrated Elective Access Protocol, with a specific focus on performance against chronological management. Key findings from that report were follows: 14:35

(a) Regarding triage times, it was reported that 'For the majority of Urology referrals, daily triage is now achieved, but there is a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff'. 14:35

(b) Regarding clinic templates, it was reported generally that clinic templates 'are carved out to new urgent, new routine and review slots in line with best practice'. For Urology specifically, it was reported that 'Since December '14, all clinic slots are designated red flags. Unallocated slots are notified to the Referral and Booking Centre who book with patients from the PTL, selecting urgent patients first and then proceeding to routines. Urgent patients are mostly being booked within four to six weeks, but the waiting time for new routine patients is currently at 40 weeks . 14:35 14:36 14:36

(c) With respect to chronological management, it was reported that 'In some specialties, for example, Urology and Ophthalmology, the Referral and Booking Centre will be contacted by referrers with information about a change in clinical priority and a second referral usually sent in. Staff will administer this on the system, retaining the patient's original date, but amending the clinical priority and appointment 14:36

time. This can mean that sometimes urgent patients will appear to have waited longer than routines'.

(d) Regarding booking processes, it was reported that 'The process for booking new routine and review patients is in line with regional guidance. In the new Urology model, all patients are now telephone-booked'."

53.6. Sorry, I just want to find a particular part of this. So we'll see at point (a) that I read out there at WIT-37595: 14:37

"'... a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff'."

I am conscious that, with hindsight, that jumps out at us, because it should do at this remove, but given the specific reference to that in the Peer Review and an indication that there's, potentially, a theme with one individual, if I put it like that, around the triage, this was a report that HSCB received. I don't know if you were directly involved in the receipt of this? 14:38

A. MR. CAVANAGH: No.

145 Q. But is that something that should have caught someone's attention? I know that we have talked about the Trust and the demarcation of governance accountability and in general terms about what's expected from each player in the healthcare provision, but would you expect that to 14:38

be something that somebody might be curious about and say, well, if it's one source, what are you doing about that?

A. MR. CAVANAGH: I mean, I suppose there was enough curiosity to write this in a report, that there was one Consultant who was out of sync with other Consultants and not achieving what was set out in the IEAP, but, ultimately, it was for the Trust to consider how they would, I suppose, bring all of their Consultants up to the same level that was required. I don't really think it was for us to become involved in that. I mean, I remember, while not being directly involved in this, whenever we were talking about developing clinic templates, when we were looking at rebasing our capacity, for example, there was a lot of debate among Consultant teams about whether or not it was realistic to have X number of new patients, X number of review patients, and some Consultants were more conservative than others. But ultimately, that kind of a debate was useful for us to be involved in but still needed to go back to the team and to the Trust for them to resolve and to actually have a degree of consistency in the services that they needed to deliver on. 14:39 14:39 14:40 14:40 14:40

146 Q. Well, going back to the question around this, would you accept at all that this is a potential point of knowledge on the part of the HSCB, that there is perhaps a specific issue around one Consultant that has been highlighted in this report?

A. MR. CAVANAGH: Of course.

A. MRS. GALLAGHER: If I might add, Ms. McMahon?
147 Q. Yes, of course.
A. MRS. GALLAGHER: I should, quite rightly, say it with the benefit of hindsight, that absolutely is stark. However, in terms of the turnaround time for one Consultant, you know, that could be for any amount of reasons at the time and there would be an expectation that the Trust would put in place whatever practice or whatever arrangements needed to take place to address that. So it's just to stress the benefit of the hindsight issue, as you quite rightly said, in terms of that coming out. 14:40 14:41
148 Q. And I appreciate that, but just slightly in the context of, if we, even hypothetically, work from a position that the Trusts were aware of this, this is a slight leaking outside the Trust of this information and -- well, I'll ask now. If that was reflected in a report you received now, would that be something that people would say, 'okay, we need to ask some questions around this', would it be more of a curiosity? 14:41 14:41
A. MRS. GALLAGHER: I think it's fair to say that if an individual, or even not named, was singled out in that way, we would want assurance in terms of what action was being taken in that regard, as part of the overall improvement plan. 14:42
149 Q. Sorry, I think I might have a digit out, I am just checking. I am sorry about that. If we just move down slightly. So Ms. Clarke says this at paragraph 53.5:

"I have some recollection of being generally aware of the issues raised in this report regarding daily triage and that the reference to turnaround time for one Consultant referred to Mr. O'Brien, as well as a general awareness of the recommendation that I believe was made by HSCB to five Trusts in the region, to agree a process for using the referral priority grading for a patient where the three-day turnaround standard was not being met."

Now, do you have any knowledge of that particular process where there was a change in approach when the turnaround wasn't being met?

A. MR. CAVANAGH: No, unfortunately, I don't.

150 Q. Just for the Panel's fuller note, the name of the report author seems to be Maria Wright from HSCB and she spoke to members of staff, and that's given in evidence by Aldrina Magwood at TRA-06022, and, in fact, I do want to go to that because I want to put it on record what she says about other individuals as well; it wasn't just Mr. O'Brien mentioned, I think. So, TRA-06022. So it starts at the bottom:

"Do you know where the HSCB got that information from that informed their report? Where did they find out this bit about 'a long-standing issue with turnaround time from one Consultant and referrals not returned from triage continues to be a key issue for booking staff'?"

And Ms. Magwood said:

"I think that would have been from Maria, who would have done the report, and I'm assuming that even having a heard and read Katherine Robinson's evidence here to the Panel, I don't think the Team would have been holding back with an honest issue if they had a challenge. They would have been reporting that." 14:45

She is then asked:

"So you think Maria Wright from the HSCB went out and spoke to members of staff and took evidence effectively." 14:46

And she replies:

"I think that was part of the review she was working in amongst the team, that would have been my understanding of how it was conducted." 14:46

So if we go to TRA-06027. So if we just go down to the line that says: "You have said", at line 11: 14:46

"You have said that it wasn't just Mr. O'Brien, do you think that that was an unfair representation in that report?"

And she says:

"I do in the sense of I think, like I said, I mean. Again I have to go back, it's some years, but I do recall that it uncovered quite a lot of issues we had in paediatrics, for example, and attention going into the work from the Director of Children's Services at that time to sort of address some of the challenges there. So those to me were the bigger system issues that needed addressed. 14:46

Naming one individual, I mean it's like anything from an information perspective, if you say one individual you know it is clearly naming an individual. For a report that was to do a review of an entire system 14:47 I thought it was unusual, it's an unusual comment."

I read that in for two reasons, first of all to inform the transcript and others that this was a wider review, dealt with other specialties, it wasn't just on 14:47 Mr. O'Brien. But that she said she thought it was an "unusual, an unusual comment". Is it possible, and I know you weren't involved, but is it possible that the inclusion of that comment was to identify that this was a very live issue for the Trust and that there were 14:47 concerns more broadly?

A. MR. CAVANAGH: It's something I have been discussing with colleagues in recent weeks, Ms. McMahon. Maria Wright does work for SPPG and did work for the

Health and Social Care Board but she also worked for a period for the Southern Trust. And I'm concerned that there's been a bit of confusion as to when Maria was working for Southern Trust and when she was working for the Health and Social Care Board. Now I'm keen to clarify it but I can't clarify it today. But I'm more than content, if the Panel wishes, to come back with further information. But I think there has been some confusion about Maria in particular because she did work for Southern Trust for a period around about this time. 14:48 14:48

151 Q. Well, that would be helpful to know who she was working for when she wrote this but it doesn't take away from the fact that the HSCB saw this report, that is not interfered by your needing to fact check whether Aldrina Magwood is correct in saying that it was HSCB staff, but we can do that? 14:48

A. MR. CAVANAGH: Sure.

152 Q. But the ultimate point was really about the potential knowledge and the timeline for that. 14:48

A. MR. CAVANAGH: Sure. Of course.

153 Q. But I don't think that's displaced by that information. I want to look at the SAIs. The Panel have heard a lot of evidence and from many, many witnesses around the SAIs so it would seem, having looked at the evidence through the HSCB lens that the main issues around when you were told, when you were informed and delays around that, certainly from the outset. I want to, if we go to WIT-104313. What I'm going to do is just summarise 14:49

the issues that arise from the various SAIs. Just move down please. That's where you start them in your evidence, at paragraph 261. And the first one is SAI RCA [redacted].

14:50

Now what's the expected time in which you're notified about an SAI, what is the current standard around that?

A. MRS. GALLAGHER: I believe it's 42 hours, 48 hours.

MS. McMAHON: Is it 72 hours after the incident, does that sound familiar? 14:50

A. MR. CAVANAGH: I'm actually not sure because that sounds like the Early Alert timeframe.

154 Q. Just at the top of that page, sorry I was trying to prompt you just so you will remember your evidence, but it says: "As per the SAI procedure outlined in section 14:51 3 of this statement Trusts are required to inform the HSCB within 72 hours of the incident..."

A. MR. CAVANAGH: Yes, apologies.

155 Q. That's fine, that's fine. "...of the incident being discovered." So there is that expectation that within 14:51 three days of the incident, or I presume earlier, depending on the serious nature of it, but 72 hours seems to be the outlier time?

A. Yes.

156 Q. This particular SAI you were notified via the SAI 14:51 mailbox on 22nd March 2016, which was ten weeks after the date of the incident. The final RCA report for this SAI, [redacted], was due to be submitted to HSCB within 12 weeks from notification of the SAI, in other words

by 14th June 2016 and the report was not received until 16th March 2017, which was 39 weeks after the agreed date of receipt. Just given those examples around both the initial notification and the subsequent report and given now that that's a relevant SAI for our purposes what, if anything, actions are in place for HSCB to take when timeframes are not met or do you have any sort of internal process by which you keep an eye on things and then go back to the Trust and say you are well out of your timeframes here and say what's happening? 14:52 14:52

A. MRS. GALLAGHER: If I could maybe pick that up, Ms. McMahon.

157 Q. Yes, of course?

A. MRS. GALLAGHER: I think the improvements that I described earlier will absolutely address those points, so in relation to the notification, the ten week delay, should that happen we would absolutely pick that up and we would be engaging with the Trust to understand the reason for the delay and that would be picked up in the bimonthly discussions in terms of escalations. In terms of the time elapsed to complete the review the risk process that we have put in place now, because I think I have described to you there are still delays within the system because of the need for the appropriate resource to investigate and take action. So I can't say that there wouldn't be delays to that extent now but what would happen is that those cases would be risk managed to make sure that any early 14:52 14:53 14:53

learning was put in place and that we understood we're cited on and had mitigated against the risk of a delay.

158 Q. Just so we understand if there was an opportunity lost within that timeframe, for example that SAI given the nature of the delay, what action does HSCB take? 14:53
I know you have now indicated a process by which risk is identified and managed early on, is that by way of learning both within the Trust or the location that the SAI emanates from but also more widely across Northern Ireland or what would your reaction be? 14:54

A. So one of the initial actions when the alert is received it's allocated to the DRO. But part of that consideration is what is the immediate learning both at Trust level and more broadly. So there's learning along the way rather than waiting on the final review. 14:54

159 Q. Another example is SAI [redacted], it has also got the reference [redacted]. This was a further SAI notified to the Health and Social Care Board on 21st September 2017. That notification informed that the Southern Trust had become aware of the incident on 14:55
12th May 2017, which was four months before the notification, and the report referred the concerns about the care of four patients during 2016.
Now the DRO forwarded queries to the Trust seeking assurances, and we can look at that at WIT-73691. If 14:55
we just move down slightly just so we can see the author and the recipient. So the topic is "serious", it's from "serious incidents", I presume that's a mailbox from your internal staff, "21st September 2017,

SAI notification form", and it is SAI [redacted], and it says:

"Lindsey, please see below DRO queries in relation to the above. The DRO requests an urgent response. What action has been taken to prevent further referrals slipping through processes like this? Has the Trust assured itself that there are no other Urology referrals have slipped through? Have they considered if this is likely to be a problem in other specialties? Also the DRO wishes to draw the Trust's attention to the attached SAI, which has a HSCB reference of S8146, and check if the cases in SAI below were found following a review prompted by this SAI as the case is not on the list of new ones?" 14:56 14:56 14:57

Now the Trust response to that is at WIT-73693. so WIT-73693, just two pages down, 73693. It is 29th September 2017, 10:40 from Corporate Governance in reply, and it says: 14:57

"Response to DRO queries.

1. What action has been taken to prevent further referrals slipping through processes like this?
(A) electronic referral process is being piloted which makes triage more accessible and timely. It allows easy identification of referrals that have not been triaged & reporting of same. 14:57

2. Has the Trust assured itself that there are no

other Urology referrals have slipped through?
(A) There has been a lookback exercise within Urology to identify any other referrals which were not triaged. This review is complete.

3. Have they considered if this is likely to be a problem in other specialties?
(A) If Consultants fail to comply with the IEAP process and there are delays in triaging this is escalated to the HOS and AD for action. SAI [redacted] was identified from review of a complaint sent by his family." 14:58

So that would appear to be an assurance provided that this matter was being dealt with. The electronic referral process is that a referral to e-triage at that point? 14:58

A. MR. CAVANAGH: Electronic referral comes from a GP to the Trust and then will be e-triaged then.

160 Q. Were you involved in dealing with any of these SAIs, was this something you were -- 14:58

A. MR. CAVANAGH: Not directly, no.

161 Q. Not directly. And the electronic referral process has been highlighted at that point, did that answer then give you some comfort around the likelihood of that? Would it give you some comfort, I realise you weren't involved directly, in the likelihood of reoccurrence? 14:59

A. Well we spent a lot of time over the last seven or eight years, not so much during the pandemic time, but promoting electronic referral, working with GPs,

ensuring that they are actually using the system and using it as appropriately in line with the guidance. So we put a lot of effort into it, a lot of meetings with GPs as well. So on that basis we remain keen to encourage electronic referral because it also helps at the point of triage because you have all the information in front of you to then e-triage.

162 Q. Would you have anticipated, and I am asking these questions knowing that you weren't personally involved in these, the previous SAI around triage as well and this one would you have expected the Trust to identify that this was another issue around triage now if that were to happen? 14:59

A. MR. CAVANAGH: I mean it looks like the DRO identified that, more important than me. I mean the DRO clearly recognised that this was an issue and I suppose the Trust have come back. It doesn't look like they have particularly answered that question in that response but I mean it does look like there was some connection there, yes. 15:00

163 Q. The answer is not particularly fulsome in providing reassurance about systems --

A. MR. CAVANAGH: I appreciate that.

164 Q. -- would you have expected the DRO to go back and say: 'I'm not quite sure that's the answer that I was hoping for or anticipated, can you provide reassurance given this is at least a second SAI where triage has been highlighted as problematic'? 15:00

A. I think, I mean DROs obviously are dealing with a lot

of cases at any one time. My experience of DROs is that they tend to follow through on those kind of issues. Fair enough this is an e-mail here. For all I know there could have been phone conversations, and so on, going on at the same time. But, yes, I would have hoped that the DRO would have exhausted the issue because he or she obviously had raised the issue in the first instance. 15:01

A. MRS. GALLAGHER: Ms. McMahon, if I might add just in terms of the process and improved process, so the Datix system which we use to log SAIs and manage it we have enhanced our coding mechanisms so that we can drill down in terms of the issues. That was a challenge that had come up throughout the previous hearings, our ability to identify all related SAIs. So we have enhanced that facility. We have also included a dashboard system where we can understand when SAIs were first reported and the time elapsed between each period. DROs now have view access to that as have the senior personnel in the safety teams and the multidisciplinary professional teams. So there is much more visibility in terms of tracking, in terms of time frames and the ability to escalate where timescales seem to be elongated, and I described the process of risk management earlier. The other important point is the ability for us to triangulate linked or potentially linked issues and not rely totally on the Trusts, albeit it is primarily their responsibility to do that. 15:01 15:01 15:02

165 Q. PHA in their evidence on Tuesday had mentioned about

the difficulty with Datix searches?

A. MRS. GALLAGHER: Yes.

166 Q. Is that remedied?

A. MRS. GALLAGHER: That's exactly it. About a year and a half or two years ago in response to, you know, what we were hearing around this we have put our own coding systems which complement the Datix coding systems but allow us to provide, to better interrogate the system, to better make linkages and to cross refer. 15:02

167 Q. Thank you for that. Just to complete the loop on that particular journey of that SAI, that was listed for discussion at the acute SAI professional group on 20th November 2017 to consider the Trust's responses and there was no indication of trends or requirement for the dissemination of regional learning. The SAI would be referred to the Regional Scheduled Care Group in respect of its views on timely triage and categorisation. Then on 10th April 2018 the Trust provided an update on the two local recommendations regarding clinical triaging and the escalation of triage non-compliance: 15:03 15:03

"Advised that actions had been completed which was forwarded to the DRO, who responded on 18th April 2018 to say she was content." 15:03

And the SAI was closed. So there was that further follow-up and engagement with the DRO providing information about that.

The SAI [redacted], this was notified to the:

"This was notified to the HSCB via the mailbox on 22nd September 2017, marked as a Level 1 review. The notification indicated that the incident had occurred on 10th July 2016." So there was a 62 week delay from the date of the incident until it was reported to the HSCB. There was a further delay of 115 weeks before the final review was submitted." 15:04 15:05

There's evidence in the bundles of the Chief Executive's correspondence from the HSCB which seemed to be fairly pro forma template letters saying: Get your SAIs in on time effectively. But there doesn't seem to have been any further follow-up and correspondence in that regard, is the position still the same, that a pro forma -- you're shaking your head, you know your answer before I say the question so I'll let you give us the information. 15:05 15:05

A. MRS. GALLAGHER: I apologise, Ms. McMahon.

168 Q. No. Go ahead?

A. MRS. GALLAGHER: I suppose there is still, and I think I referred to writing to Trust Chief Executives quite recently in a relatively formulaic approach basically to outline concern about SAIs, which is a shared concern, and to invite them to comment on that. So that is part of a routine process. But, importantly, the improvements that I have described allow for 15:05

identification where there is potential issues in terms of the management of SAIs at local level, the notifications, the actioning and the completion of SAIs. So the regular performance meetings, and I'll call them that because that's what they are, an engagement between my team, PHA, and the Trusts now have the opportunity to discuss any emerging or potential issues and that could include if a pattern emerged in terms of late notifications.

169 Q. Thank you for that. Chair, I just want to go back, I think I in error gave you a chronology for the wrong SAI and I just want to correct it on transcript. The sentences I read out were:

"Following consideration of the RCA report by the SAI Acute Professional Group on 6th June 2017." I then gave you a date of 20th November and then 10th April, when I said: "The DRO was content and the SAI was closed." Those actions refer to SAI [redacted], the very first one I spoke about. Apologies for that. I didn't ask you any questions arising out of that because you weren't involved so I didn't take you out of sequence. I just want that corrected for the transcript.

Just the last SAI I was speaking about, [redacted], the one that you have explained, the new, well the approach, hopefully, that may well trigger better compliance with the timescales, which I presume are still the same, the 72 hours? I don't see anything to suggest ourselves.

The last SAI that I spoke about:
"Following a review of this SAI by the acute services SAI Review Team on 30th June 2020 it was agreed that a newsletter article reiterating the importance of communication between all teams' specialties involved in the care and treatment of a patient would be issued. Also importance of communicating with the patient. Regional distribution of this learning was initially delayed due to the fact that PHA colleagues who were responsible for the drafting of articles and disseminating the newsletter were redeployed during the COVID-19 pandemic." 15:08

Then:

"An administrative error was noted in the HSCB system in August 2021 when the HSCB Governance Team realised that the Trust had not been advised the SAI was closed in June 2020 and that learning was to be distributed via a newspaper article. Agreed that learning would not be issued as there was a potential for much wider learning as at that point nine further SAIs regarding Mr. O'Brien's practice." 15:08 15:09

The administrative error I'm not going to speak to but in relation to the way in which learning is disseminated via newsletters does that happen frequently or after particular SAIs or what is the format for that method? 15:09

A. MRS. GALLAGHER: So maybe I'll speak to that, Ms. McMahon. I mean there is quite a range of ways in which we disseminate learning. Forgive me, I was looking at my notes here in terms of my evidence and it brought that up to date. I think I referred to the 22/23 Quality Report and that that evidenced that throughout that period there were 48 areas of learning that was disseminated to the relevant networks, clinical networks and groups for dissemination across specialties. There were 22 newsletter articles issued. There was one learning letter, so a learning letter is new learning, everything else is a reminder of learning that's already there or guidance that's there. There were three professional letters, sorry, two professional letters and five reminders of best practice guidance letters. We also used, I think Mr. Dawson referred to Echo, which is essentially pretty much like any other, like a Zoom platform or a Teams platform and it is used within Health and Social Care to share learning, to bring people together virtually, it is used to augment and wrap around the other communications that are targeted to specific areas or specific Clinicians or professional groups based on the nature of the learning. So there's a quite significant volume of learning that's issued as quickly as possible post the event. But I think you're absolutely right and it is fair to say that throughout Covid there was a hiatus in terms of our ability to issue learning and to undertake reviews and the process

15:09 15:10 15:10 15:10 15:11

in the way that we would have wanted.

170 Q. And the exceptionality of that time then is reflected in where you had to prioritise I presume?

A. MRS. GALLAGHER: Indeed.

171 Q. When you look at some of this now and you look at the SAIs and the potential drip feeding of red flags of what were happening and the issues that were arising do you think that the issues could have been identified earlier by HSCB even if they couldn't have acted on them immediately given your demarcation of governance accountability? Do you think when you look at this and you look at the timeframe and the information now as a whole, and I realise we're looking back, but when you look at that as a whole do you think there was a potential for concerns to be raised? 15:11 15:12 15:12

A. MRS. GALLAGHER: I think the nature of the processes that we oversee and manage in terms of complaints, and there was no evidence in relation to complaints of it being in this regard, the SAIs in terms of our process now and our ability to drill down more in relation to the nature of the issue could potentially have flagged up over a period of time that urology, there may have been issues in urology. What it would not still probably have flagged up, and I do accept that we have just referred to the reference of the single Consultant there, but what it wouldn't flag up is issues in relation to an individual Consultant necessarily but it would certainly start to create a picture about issues in certain specialties. Now that could be for many, 15:12 15:13

many reasons, including the delays that we have and the challenging working environment that we have. But certainly -- you can never say that enhancements to a system or a process is going to necessarily lead to a better outcome, that's never possible, but certainly we have put more robust arrangements in place to be able to understand the areas where issues are arising in a more robust way. 15:13

172 Q. And to be fair to you by the time the information gets to the HSCB it's been seen by perhaps quite a few people already? 15:13

A. Indeed.

173 Q. I'm not saying that you of all people should have identified this but if all of the organisational structures allow for oversight of governance collectively then the possibility exists that there maybe was a nudge in the right direction to be more curious? 15:14

A. I agree, and it's an important point you make, Ms. McMahon, because the premise on which we're all operating is to prevent it getting to SAI, prevent it getting to AI. So it's about making provision for safe services, for quality services in advance so that we minimise the amount of instances where SAIs occur, and that's really important. That's remains our priority, that we need to put our energies in to putting the systems, the environment in place, including the safeguards around clinical practice to ensure and mitigate against SAIs happening, albeit, you know, you 15:14 15:14

can't prevent things going wrong.

A. MR. CAVANAGH: Now I think increasingly DROs now talking together is an important feature of recent years as well. I think DROs in the past would have been working on individual SAIs and working through them but I think as the years have gone by those opportunities to talk together. Different DROs may have looked at different SAIs in relation to this but now they actually are having the opportunity to discuss those, and that may lead to, I suppose, themes, and so on, emerging much more readily off the back of that too. 15:15

A. MRS. GALLAGHER: Just to --

174 Q. Sorry.

A. MRS. GALLAGHER: Sorry, Ms. McMahon, just to emphasise that, that is a deliberate strategy that we have deployed based on the learning here. So I think I referred earlier to the DRO and a wraparound multi-professional team and that's to make sure that the learning and there's a broader line of sight so we engage and talk about the range of information and intelligence, not just from SAIs but from Early Alerts, from complaints, from whatever evidence we have from PCC and there's a Multidisciplinary Team approach and they meet regularly to discuss these matters. 15:15 15:16

175 Q. And without rehearsing the point about anonymity, but it's probably more fairly put in relation to SAIs given the frequency or the number of them that ultimately came through, and I know what you say about there being

learning, again is that another opportunity if you were to have known that there was an individual perhaps involved in certain aspects that a deeper review of practice or a wider look at issues may have been triggered at an earlier date? 15:16

A. MRS. GALLAGHER: I can understand why you would say that. I think the practice of a clinician is absolutely within the purview of the employer, of the Trust and of the Trust Board in terms of oversight. I would expect today as we sit if there are individuals 15:17 where there are practices that are not in line with what is expected that colleagues, the management team, others would identify that, that that would be picked up as part of their appraisals, their feedback, their revalidation and the processes that's in place to do 15:17 that.

A. MR. CAVANAGH: And remain strongly of the view that this is a learning system, that we are trying to draw out the learning and we're trying to encourage people to come forward with some of the challenges that they 15:17 face which are, I suppose, showing up in adverse incidents, serious adverse incidents. So we are keen that the report comes forward so that the learning then can be drawn out.

176 Q. Now in relation to your SPPG awareness of the issues 15:17 around Mr. O'Brien, you first became aware of those in the Early Alert process and were you involved directly in that, Mr. Cavanagh?

A. MR. CAVANAGH: I was involved in that, although it's

probably later in August 2020 before I actually become directly involved.

177 Q. Was that the point at which HSCB became aware that MHPS had been used?

A. MR. CAVANAGH: We had no previous knowledge of that. That was really in the initial conversations we had with Trust colleagues. 15:18

178 Q. Would you expect to know that? Would that be something or that's another operational issue --

A. MRS. GALLAGHER: It is. 15:18

179 Q. -- that doesn't need to come to you unless it needs to come to you. Would that be fair?

A. MR. CAVANAGH: That's right.

180 Q. This was another potential delay, the Trust didn't notify you within the required time, you have put this out at your statement at WIT-104327 at 313. We'll just read from 311 because it gives us the context of your knowledge. I think it became incremental as time went on, and you say at 311: 15:18

15:19

"On 21st August 2020 I received an e-mail from Jackie Johnston, Deputy Secretary, in the Department about an Early Alert, EA181190 received from the Southern Trust regarding Urology Services. The e-mail was also directed to Olive MacLeod Chief Executive of PHA. Jackie Johnston attached the Early Alert form from Dr. Maria O'Kane, Medical Director Southern Trust, which outlined the Trust's concerns about delays in treatment of surgery patients who were under the care 15:19

of a Trust employed Consultant Urologist. It also said that a lookback exercise had been conducted of the Consultant's work for a 17 month period (January 2019 to May 2020) to ascertain if there were wider service impacts. The Early Alert form noted the initial actions the Trust had taken."

Just moving on down:

"The Department's Early Alert system is designed to ensure that the Department and the Minister receive prompt and timely details of events (including potential SAIs) which may require urgent attention or possible action by the Department. The Early Alert notification sent by the Trust on 31st July 2020 provided necessary details to alert the Department and explained the Trust's efforts to ascertain the extent of concerns regarding the practice of the Consultant in question."

At paragraph 313:

"The Departmental Early Alert circular issued on 27th February 2019 requires organisations to notify the Department of any event meeting the Early Alert criteria within 48 hours and the notification pro forma must be completed and forwarded to both the Department and HSCB within 24 hours after notification. The Trust did not meet this requirement."

Just on that, I know we've looked at time frames before but I imagine there is a requirement to meet a certain timeframe because of the potential need to react?

A. MR. CAVANAGH: Yeah, absolutely. 15:21

181 Q. To the extent that this was late the HSCB were denied that opportunity. Do you feel that there was any impact of that delay operationally for you to take a view on the significance of this Early Alert and the act? 15:21

A. MRS. GALLAGHER: I think there may be two separate issues, Ms. McMahon, the Early Alert is as it is described, alerting the Department and the Minister in case there is potentially a fallout in terms of media or something that the Minister has to be alerted to. 15:22 The SAI, as we have just described, should be issued and that should trigger the work to address the issue. So the Early Alert process doesn't replicate or doesn't seek to supplement for a failure to issue an SAI.

182 Q. No, and I am sorry if I presented it in that way but 15:22 the point, I suppose, was the time frames are there to allow you to react appropriately at the right time?

A. MRS. GALLAGHER: That is exactly right.

A. MR. CAVANAGH: Yes, that is right.

183 Q. There certainly seems to have been a pattern in some 15:22 respects of delay?

A. MRS. GALLAGHER: There would appear to be.

184 Q. Just move down to 315 please. You say at 315: "The HSCB was not notified of the issue prior to

receiving the Early Alert. The Trust could have raised the issue with the HSCB earlier through established channels given that there would be an impact on service delivery due to any lookback activities."

15:23

And you go on to mention again about the pandemic and impact on that. But is it fair to say that you would have expected to know about this before the Early Alert? Would it have been appropriate for HSCB to be involved in advance of that step? 15:23

A. MR. CAVANAGH: There was a lot of staff changes in HSCB in this period. I came into post in the middle of July so in that way my predecessor had left at the end of May. Maybe some of those key contacts weren't available but others were available. And I think the 15:23 point that I am trying to make there is, you know, the Trust is talking to us in various forums in various ways, including lifting the phone and asking us questions and taking advice on various issues. Had they mentioned to someone in the Board at that time 15:24 that this was happening it is likely we would have said: Have you raised an Early Alert? But, as I say, the weeks went past and there was no contact whatsoever. So the informal channels were there, I'm not saying they should replace in any way the formal 15:24 channel, but I did find it unusual that there wasn't any contact whatsoever until the Early Alert actually arrives given the amount that was actually happening from early June right through to the end of July.

MRS. GALLAGHER: I think perhaps, Ms. McMahon, to augment Paul's evidence, we can't speak for what happened at that time in terms of any discussions or staff issues but what is absolutely paramount is where there is even the potential for harm that an SAI is sent so that we can act appropriately. We try to operate within, we do operate within that framework because if you work on informal mechanisms then, you know, that does not point to good governance. SAI is the accepted process. 15:24 15:25

A. MR. CAVANAGH: Yes.

MS. MCMAHON: Is it ever the case if there had have been conversations in advance of the Early Alert, if in the informal channels somebody said that's where we're heading, is there room for intervention or potential action from HSCB to try and mitigate either the Early Alert having to be issued or to identify the immediacy of the risk? 15:25

A. MRS. GALLAGHER: So if it's appropriate for an alert to be issued it's appropriate for an alert to be issued, we wouldn't be trying to talk people out of that or put in place any kind of mitigation or plans. That's the process and we work then to support and enable that process. 15:25

A. MR. CAVANAGH: The Early Alert has a certain function, and that function is to alert the Minister in the Department at the earliest opportunity that this is taking place. I think all that I am suggesting is that we might have encouraged the Trust to raise that 15:25

Early Alert much earlier but, as I say, the opportunity wasn't there.

MS. MCMAHON: I know we've talked about what the position is now, and I know the SCRR are processing a Lookback Review and the Panel has heard a lot of evidence around that, but from the SPPG - I'm getting used to the new language - from your perspective in relation to the oversight mechanisms that we've touched upon and you have explained very helpfully for the Panel are there any further updates or any further advancements or plans that you would like to share with us that the Panel can take into consideration when looking at governance structures currently in the Trust and within other bodies? I know you have talked about a lot of different... 15:26

A. MRS. GALLAGHER: I think it's fair to say, and I described some of this earlier, we are certainly on a journey, continue to be on a journey of learning. The work being led in the Department in relation to the Inquiry's Implementation Programme Management Oversight Board with the learning of previous Inquiries will of course continue to support and advise our actions, our governance and our system response. One of the strands of that work is governance. Workforce is another strand and safety and quality another strand. So there will be aspects of that that we will adopt and implement as a matter of course. 15:27

In relation to the lookback and the SCRR you'll know

that we are part of the oversight arrangements and we will continue to keep a watching brief on that to make sure that the appropriate actions are taken in the way they should, that families and patients are engaged appropriately so we continue to be part of that oversight arrangements and take the learning from that. I think it's fair to say, Ms. McMahon, if I have understood your question correctly, and I may not have, that we remain in a process and open to learning. 15:28

185 Q. The process seems to involve individuals at a very high level, the Permanent Secretary is involved in the groups and you are involved in the groups? 15:28

A. MRS. GALLAGHER: Absolutely. Our attention to this is at the very highest level of not just the Department, of system readers right across. 15:28

186 Q. Just to go back further, I know we have moved forward to learning but there was a question I had forgotten to ask in relation to the funding of an administrative exercise by the Board at one point to look at waiting lists and to shortcut it I think. The plan was that individuals on the waiting list would be phoned to see if they still needed treatment for whatever reason and that would allow the waiting list then to be properly identified who was waiting for clinical care and who no longer needed it for whatever reason. Now that was a process that was funded by HSCB, did the idea for that, you may not know that, did the idea for that come from HSCB or did the Trust ask for that in order to get a more realistic feel for waiting list numbers? 15:28 15:29

A. MRS. GALLAGHER: I think it would be a combination of both. That was part of our elective care strategy where we would cleanse the waiting list, but that's to ensure that there was no duplication and that there was follow-up of patients because some patients might have chosen to go privately or change in some circumstances. So it's routine practice to make sure that the waiting lists are up to date and we are recording and prioritising patients and following up in the right way. So the funding was allocated to the trusts and then they used that money in order to make contact with patients and assess whether or not they still needed to be on a waiting list. 15:29 15:30

187 Q. So that was always anticipated to be an administrative process? 15:30

A. MRS. GALLAGHER: There is clinical involvement absolutely.

A. MR. CAVANAGH: There is.

188 Q. The clinical involvement is done by a clinician at that point, the point of contact? 15:30

A. MRS. GALLAGHER: So the mechanisms of how that happens I am afraid I can't say but it's not simply an administrative process because clearly there's a risk that people might say they don't need the treatment anymore and that wouldn't be appropriate that, you know, you could take it at face value. 15:30

A. MR. CAVANAGH: I know similar exercises, I can't speak directly to this one, in similar exercises we have actually engaged GPs to be involved in some of that as

well, so that they bring some of their clinical expertise. In other instances we have drawn nurses into it. I suppose it also depends upon the particular issues. As Sharon says it's not purely an administrative exercise even though obviously administrators do the calls, sort of take the information, and so on, there is still a clinical requirement to actually ensure we're doing things correctly.

189 Q. That the appropriate decision is reached? 15:31

A. MR. CAVANAGH: Yes.

190 Q. Just the context for the Panel in asking that, if we could go to AOB-09344, (administrators) the background to this is Mr. O'Brien on review of one of his patients discovered that he had been removed or removed himself 15:31 from the waiting list following a validation call and Mr. O'Brien takes issue with that because of the clinical presentation of the patient. We'll see in this e-mail from Mr. O'Brien, 22nd September 2019 to Martina Corrigan and Mark Haynes. I'll read this in to 15:32 the record:

"Martina, I write to you regarding this 69-year-old diabetic man who had a stone obstructing his upper right ureter in 2015. He was managed by ureteroscopic 15:32 laser --"

I'll have to get a hand with that.

" -- lithotripsy."

Thank you. You would think I would know this by now.

"He was noted to have a grossly enlarged prostate gland on endoscopic assessment. I advised him that he would be better served by having his prostate resected. He was placed on the waiting list on 8th October 2015. On reviewing my waiting list during August I noted that he had been removed from the waiting list in July 2019. When I contacted him by telephone he advised that he had received a letter enquiring whether he wished to remain on the waiting list, or words to that effect. As his only systems were that of nocturia he replied that he did not wish to proceed with surgery. I requested an ultrasound scan, which has since indicated that he may not recurrence of stone in his right kidney, that he has inadequate bladder voiding with a residual volume of 190mls and would appear to have formed a stone in his bladder. I have again spoken to the patient by telephone advising him of the above findings. I have requested a CT urinary tract to more clarify his stone status. He has agreed to being returned to the waiting list for admission for TURP. I have dictated a letter to the GP requesting that he be prescribed Tams ulosin until admission for TURP in addition to requesting optimisation of diabetic control prior to admission. I hope that you will agree that it is appropriate that I bring such a case to your

15:32 15:33 15:33 15:33 15:33

attention. I believe it is entirely inappropriate that non-clinical staff should correspond with patient to enquire whether they wish to remain on a waiting list and entirely for the purpose of reducing the numbers of patients on waiting lists. Patients have the right to 15:34
decline proposed management but should be empowered to make decisions informed by clinical advice. I would be very reassured if this practice has been discontinued as you had already indicated. I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with. Thank you, Aidan."

Just go down please. Mr. Haynes replies on 22nd September 2019 at 21:05 to Mr. O'Brien and Martina 15:34
Corrigan:

"Thanks Aidan. As I have stated before I was not aware of the process until it had started and when I became aware had requested it cease. Where the process is 15:34
administrative only, i.e. checking patients not deceased and checking they haven't had it done elsewhere then it is fine. This process went beyond that and asked that if patients wanted the operation (no one wants an operation) and then I believed offered 15:35
them an opportunity of an OP review to discuss. Not only does this mean informed decisions are not possible by the patient (as no one is discussing the pros and cons of surgery) but it is also offering something that

we cannot deliver, i.e. a timely review appointment. I believe the process also raises false hope in patients that they may get a date for their surgery in the near future. Martina, do you know who led this work and are they able to provide the urologists with the details of all the patients who have either asked to be removed from the WL or requested a review OPA."

That's from Mr. Haynes. I read that into the record, Mr. O'Brien raised that issue of the potential that the process was carried out administratively only but with clinical implications, if I can put it like that. But from SPPG's point of view this was a post that was funded for the Trust to work out the best way they could employ that person to identify that but there was an expectation that there would be clinical input if a clinical input was needed in the decision making, would that be a fair summary?

A. MR. CAVANAGH: If it was done today that would be our exception and I would have thought in those days it would have then been our expectation. It seems strange that the Clinicians didn't feel sort of fully involved in the process.

191 Q. Thank you for that. Just in relation to the final issue about the operational Trust issues around grievance, formal grievance, were you informed or aware of advised of formal grievances submitted by Mr. O'Brien in relation to the Trust?

A. No.

192 Q. Would that be something that you would expect to know about?

A. No.

MS. McMAHON: Chair, I think I have covered the areas that I hoped to today. It may be the case, Ms. Gallagher, that you wish to say anything else in relation to your evidence or you, Mr. Cavanagh, if you think I need to cover anything else. If you wish to say anything at this point please feel free to do that. 15:37

MR. CAVANAGH: No, I am content. Thank you. 15:37

MRS. GALLAGHER: No, I am certainly content to answer any further questions or clarifications.

CHAIR: I think we will have some further questions, so I will start with Mr. Hanbury, first of all.

THE WITNESS WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS:

193 Q. MR. HANBURY: Thank you very much for your evidence. I have just got a few somewhat disparate questions, I don't really mind who answers them, so maybe you'll tell me. First just a small thing on regional learning following SAIs and we have spoken about DRO, is the DRO for a particular SAI, Serious Adverse Incident, someone from that specialty? 15:37

A. MRS. GALLAGHER: That is correct.

194 Q. They are.

A. MR. CAVANAGH: Not necessarily. Apologies. Apologies for disagreeing as well, Sharon. The DROs are Health

and Social Care professionals so in the case of healthcare it's often a Public Health Doctor, so somebody with public health medicine qualifications, although increasingly they don't necessarily have to be a doctor but in general they have been a doctor and they may have had some experience of the specialty. As you know doctors' training takes them through quite a number of specialties but they won't as such be a specialist in Urology, they will be a Public Health Specialist but they may have spent some time in relation to a particular specialty and they tend then with that to maybe look at the sort of Urology SAIs, and so on, but again not exclusively. 15:38 15:38

195 Q. It just struck me reading through the early SAIs that it was a slight shame that the three issues, which are principally triage, or the lack of it, not reading a report, or acting on that, and this old chestnut of changing JJ stents, which is a method of draining the kidney, which every Urology Department struggles with, and just literally a simple letter would have prompted other departments around the region to perhaps look at their systems. It's sort of more of a comment than a question. 15:39 15:39

A. MR. CAVANAGH: Yes.

A. MRS. GALLAGHER: Mr. Hanbury, apologies, I didn't mean to mislead you in any way, I guess the point that was making very crudely, and clearly incorrectly, was that we tried to appoint the most appropriate DRO from the basis of knowledge. So my apologies. 15:39

196 Q. Yes, absolutely. Thank you. This is probably one more for Mr. Cavanagh, with respect to some tertiary opinions outside the region for various things, and I know you were involved in that from your witness statement, the Inquiry is aware of two particular cases, one a cancerous case, I don't have to go into it in detail, and the other a very large prostate, for the cancer case the NICE guidance, which was accepted by NICaN, was that it should go to a superspecialist centre which at that time did not exist in Northern Ireland, that was one case. The other was a very, very large prostate which, you've heard of the operation TURP, but this was really just too big to manage that way and there is a laser version called a HoLEP which at that time wasn't available in Northern Ireland but actually now is so it is not the same now. My question is, and in fact in both cases there were unsatisfactory outcomes for various reasons, and I just wondered if there was any disincentive from your point of view that patients shouldn't travel to either Dublin or England or a specialist centre appropriately? 15:40 15:40 15:40

A. MR. CAVANAGH: We can provide services to patients outside Northern Ireland through our Extra Contractual Referral route - our ECR route, as it's called - and, on that basis, we can support patients to travel and to get the care necessary and also ensure that, within their care pathway, they continue to get aftercare back home as much as possible. Their Consultant here in 15:41

Northern Ireland will advocate for that, so they will seek -- if they feel that they need to go to a specialist centre for services not available here, their Consultant can apply to us and we will agree on the funding for that. So it's not as such -- we're not questioning the Consultant's sort of decision to treat, but, rather, we have to actually review kind of the funding, and generally we will approve those and the patient can go and get the treatment in the appropriate centre, so there's no real impediment to that, and Clinicians generally will seek to do that as well in the interests of their patients. 15:41 15:41

197 Q. But you need to Clinician to advocate that cause of action?

A. MR. CAVANAGH: It can only be a Clinician. As such, they are proposing that their patient go forward, and our expectation is, in the going forward to the specialist centre, that the Clinician will then receive them back to do the kind of ongoing care. 15:42

198 Q. Thank you. A commissioning question: Urology has, interestingly, got the sort of cancer and the urgent stones and the bleeds at one end, but, actually, at the other end, there's lots of not very urgent stuff - people requesting a vasectomy, maybe some fertility, erectile dysfunction, you can debate the relative merits. But in a situation where there's massive waiting times, was there ever a conversation about what we should and could offer that came between you and the Clinicians, the Urologists, for example? 15:42

A. MRS. GALLAGHER: I think in terms of the context within which we are operating, that's a very live question, particularly in relation to, say, for example, vasectomies, versus the investment in the more serious treatments. So those discussions and decisions are very live in terms of how we use the scarce resource within Health and Social Care to best patient outcomes.

199 Q. So that is an active discussion now?

A. MRS. GALLAGHER: Yes.

200 Q. Thank you.

A. MR. CAVANAGH: And we do have some GPs, for example, who can provide vasectomies, but the actual resourcing of that is proving a challenge for us. So we have looked at a number of ways that we can develop Primary Care Services, which would deal with some of those routine patients, and also looking at skill-mix within Secondary Care as well so that Specialist Nurses, and so on, could be doing some of the things that Consultants would have done in the past.

201 Q. Just two short questions on NICaN. On the subject of hormone treatment in prostate cancer, there was an observation by one of the Clinical Oncologists in Belfast, Dr. Mitchell, and we have heard from him, about the use of Bicalutamide. I don't have to go into it in detail, but he was moved to write an updated article for NICaN, which was circulated, but it didn't seem to be implemented, and I was a little confused about the process, really. I mean, from your point of view, if someone is engaged -- a senior Clinician is

engaged to update guidelines, and does that, would it be your expectation that that should be respected by the Urologist in the region?

A. MR. CAVANAGH: Yes, and I am a little bit surprised that it didn't follow through in that way, but don't know, obviously, the particular details. I mean, how it works, straightforwardly, is that the Clinicians talk together in the Clinical Reference Groups, and those Reference Groups relate to tumour sites and also to treatment modalities, and they are then bringing together sort of evidence issues, questions, and, from that, are developing guidelines, and those guidelines are being shared through -- agreed through the formal processes, but then shared out with the service and then the service then is taking those forward through MDTs. So, I mean, the complexity of a lot of the cancer issues, I also appreciate; there is a lot. I mean, having looked through, recently, all of the -- kind of the Cancer Network Guidelines, they are voluminous and they need to be voluminous, but I think that's not really an excuse for not carrying that through, so it is certainly something I will take back and consider further as well. 15:44 15:44 15:45 15:45

202 Q. Thank you. Just one thing on the NICaN. There was talk about the implementation of the red flag suspected cancer diagnosis and there was a comment back in 2019 that the NICaN Group would be happy to go forward with this, provided they had the capacity diagnostics, but, until then, they were not happy, they wouldn't agree to 15:45

implement; did that come to your --

A. MR. CAVANAGH: I mean, I certainly haven't heard it recently, but diagnostics is a challenge. Probably our biggest challenge in our cancer pathways is actually having diagnostic capacity, given the variety of 15:46
diagnostics as well that's required, so it is a challenge, an issue, but again don't know the particulars in relation to it.

203 Q. But at the moment, are you satisfied that the red flag criteria are being responded to appropriately by -- 15:46

A. MR. CAVANAGH: I believe there are, and having been in Cancer Performance Meetings with Trusts, they haven't been raised in that way with me.

204 Q. Thank you. Just moving slightly away, this thing about the waiting list initiatives, independent sector for 15:46
long waiters, who decided what category of patients would be treated? Was it the long waiters, the very urgent, the red-flag type? Did that come from the Clinicians or yourselves talking to Urologists?

A. MRS. GALLAGHER: A combination of both. So, I mean, 15:46
clearly we need to prioritise those with clinical need, but there was also some investment in terms of the long waiters and it was a balance in that regard, it's a constant balance being kept under review, depending on the amount of additional money that's received and 15:47
depending on sometimes the workforce available at that point in time. So, for some specialties, we're able to secure IS provision to allow us to, for example, in terms of cataracts, for example, very recently, we've

been very successful in dealing with cataracts through IS. They would not necessarily be of the highest order clinically, but, nonetheless, important to those people that need their cataracts removed. So, in general speaking, our prioritisation is based on clinical need, but there is the balance always to be had. 15:47

205 Q. Okay. A couple more, if I may. One, the Royal College of Surgeons of England did a document in about 2021 about the ten easy steps to surgical recovery - I mean, things like the surgical hubs we have heard about, the recruitment we've heard about, the difficulties. What's your comment about how you feel you're doing? 15:48

A. MRS. GALLAGHER: So I think -- I mean, we engage routinely with the Royal Colleges, we've worked with Mark Taylor, who is working with the Department very closely in terms of the Elective Care Plan and to our waiting list initiatives and also in relation to, I referenced earlier the Regional Prioritisation Oversight Group. Waiting lists are getting longer, it is a perennial problem, and it is something which our new Minister has already started to take very, very seriously. And with the limited resource we have, we need to think very carefully about how we use that resource in order to provide the best outcomes for all of those people. 15:48 15:49

206 Q. And, in particular, I'd advocate for surgical training, and it is the young surgeons, the young registrars sort of go on to put their tap routes down in Northern Ireland, and they should be looked after. That's a

comment, sorry. I shouldn't...
Final comment about GIRFT, or the Getting It Right First Time organisation, who visited the region last year, and obviously this is sort of a high-level report with similar suggestions, I guess. Do you -- how do you feel that that's going? Is that going to be a good influence to change and improve? Are they going to come back for deeper dives? What's the situation there? 15:49

A. MRS. GALLAGHER: So our relationship with GIRFT, and we've used GIRFT now for four occasions, if not five, in the last year to year-and-a-half, our relationship is very positive in terms of the learning and the plans that we can put in place in order to improve services. So we have looked to GIRFT to give us that external perspective and be able to benchmark across other jurisdictions to understand how we compare in that regard. So it is very positive relationship, and again, helps us to understand how we address the issues that we have with the broader resource, not just the financial resource, but the human resource, the personnel that we have available to us. 15:49 15:50 15:50

A. MR. CAVANAGH: And some of the issues are familiar to us, so, on that basis, we're building on issues that we're already in the process of addressing. Some of the issues are new to us and it's always good to get some new ideas as well, so I think bringing an organisation like GIRFT in does give us a chance to, I suppose, lift our head up a bit and actually see if 15:50

there is other ways of thinking about these things. So, certainly, I think we'll be doing a lot work on that in the coming months once the final report is published.

207 Q. Yes. And certainly subspecialising, for example, stones in Southern Trust -- 15:50

A. MR. CAVANAGH: Yeah, absolutely.

208 Q. -- and other Trusts with other things? Okay, thank you very much. I've no further questions.

CHAIR: Thank you, Mr. Hanbury. Dr. Swart? 15:51

209 Q. DR. SWART: Thank you for your various explanations about how things work, it's slightly clearer to me, I think. It's still quite hard to understand because it is quite complicated. I just want to start with a really sort of basic thing, really. A lot of emphasis on ministerial targets, people in the Trust saying, 'Well, if you say, "well, why didn't you look at this issue over there?" And they will say, "Well, you've got to understand, we're trying to do the ministerial targets and, basically, we haven't really got time for other things",' is the kind of atmosphere that you feel. And I think that leads to the statement they only care about targets, which you would absolutely refute, and I think the reason for that is that what you measure is what people think you care about. So accepting that it is the Trust's responsibility to measure quality and safety and to act on concerns and to have a system that supports that, I think there is 15:51 15:51

also merit, probably, in having an agreed set of quality and safety metrics more widely for Northern Ireland, not to beat people up with but to allow measurement for improvement. In the specialties, there is a lot of indicators that can be used, and I certainly have experience of that being used in a positive way. Would you agree with that as a premise, that there is room to do something like that?

A. MRS. GALLAGHER: I think that's a very fair comment, Dr. Swart, in terms of, I described earlier a process in terms of the new commissioning model and broader higher level outcomes and part of the document as it is being developed at the minute includes a section on safety and quality and what we would expect to see in that regard to provide assurance, so that's certainly within our thinking, very firmly in our thinking. 15:52

210 Q. So that sounds very positive. I am just interested in what the role of the Chief Medical Officer in the office under that is with respect to all of this and with respect to the PHA input that you have described, because it's not entirely clear to me how that guides some of the development of this work, if at all, or whether that's been specified or clarified anywhere that I have missed? 15:53

A. MRS. GALLAGHER: So the Chief Medical Officer's role is paramount in terms of issuing the guidance, the clinical standards across. They are disseminated through SPPG, and we monitor same. But ultimately, you know, the priority with the Chief Medical Officer is to 15:53

make sure that Northern Ireland is aligned in terms of NICE guidance and any other learning that is in place. It is for us, and then through to the Trusts and the providers, to implement that guidance, and we then provide assurances where it is appropriate. 15:53

I talked earlier about the business plan and the fact that we now develop a yearly or an annual Safety and Quality Report and that sits in the Department's Business Plan. That's co-owned by myself and the Chief 15:54 Medical Officer, and that demonstrates our joint ambition to provide a clear leadership across the system about the importance of safety and quality within the provision of Commission services.

211 Q. And one of the ways of doing this is measuring things. 15:54 I noticed in the Quality Strategy 2020 that was specifically mentioned, a set of indicators for each service was how it is referred to, and it didn't come to pass, it's not that easy to do, actually. But is there still a desire to improve that kind of system 15:54 because it's much broader than NICE, and so on?

A. MRS. GALLAGHER: It absolutely is. The 2020 issue, as you can imagine, was in the middle of Covid. We're still getting back to normal business. But I should say, and I think I have referred to this throughout our 15:54 evidence this afternoon, safety and quality is paramount in our thinking in the Department and in terms of what we do and how we do it. And our approach in relation to that, particularly in terms of the

learning, is starting now to, I guess, get back to where it should be post-Covid and we're trying to work through Covid and the recovery of Covid, but it's very important in terms of our priorities.

212 Q. And I am just interested in your views on RQIA and potential roles. So, obviously, in England, the equivalent would be the CQC and they go go into hospitals and do unannounced inspections and people have different views on the efficacy of that, but they do go in and look at everything in terms of governance and services, governance in the Trust, leadership and so on. Not everybody thinks it is valuable and there is a big conversation going on about, should you put in more regulation for individual Trusts, for example, or should you move towards setting standards and measure for improvement and only try and regulate when there is a real problem; what's your view on that balance? 15:55 15:55 15:56 15:56

A. MRS. GALLAGHER: I'm not sure I have a very informed view, to be absolutely honest. I think there is the need for both. The extent to which you can heavily regulate an organisation, but -- or a system, but this does come down to behaviour, it comes down to focus, it comes down to attention. And, you know, the culture around providing safe services, around speaking up, around being open, is, arguably, as important as the regulation of that, so I wouldn't profess to have a very informed view, but I think this is a matter for others to think through as we -- 15:56 15:56

213 Q. But do you agree it needs, you know, proper thought in

terms of --

A. MRS. GALLAGHER: I, absolutely --

214 Q. -- investment, because you could spend a lot of time and resource doing something that might not be the most important thing? 15:57

A. MRS. GALLAGHER: Indeed, indeed.

215 Q. On the safety agenda, something I'm quite interested in, there's been a huge amount of work done on this internationally. My own experience is mainly from England, and it is my view that if you want to align 15:57 people culturally, patient safety is the route in because everybody really can't disagree with it and it's a way of bringing people together. What is your view on the current work that's going on in England to reframe the safety agenda by changing the 15:57 classification of incidents, putting a lot more influence on the just culture, all of that sort of thing, is that something that it would be useful to piggyback on? Because it's been based on learning that says, actually, we're all struggling with the SAIs, the 15:57 time frames are being missed, maybe it wasn't the best way of doing it, after all, you know, this is all about involving people on the ground, staff and patients, in working out what went wrong and getting there a bit quicker, etc., there's a massive amount of work, but 15:58 you wouldn't want to reinvent the whole wheel on that, I would imagine. What conversations have been had in that regard since this was mandatorily introduced last year, the new Safety Framework Plan?

A. MRS. GALLAGHER: So I think I described earlier the work that sits under the purview of the oversight of the Inquiry's Implementation Programme Management Board, and part of their considerations in terms of SAI and the broader safety and quality piece is exactly what you have described what's happening in England and in other jurisdictions, and I think I described the process or the area of work that we're calling being open.

216 Q. Yes. 15:58

A. MRS. GALLAGHER: And that is our exploration in terms of what's happening elsewhere and how we adapt, incorporate and create a culture within Northern Ireland that promotes that as the way we do things.

217 Q. That sounds very positive. That group that you have set up, which also sounds -- it's absolutely the right thing to do. I mean, there are Inquiries all over the place, in England as well, and it is very difficult to implement all the recommendations and there is a lot of overlap. Safety comes through and culture comes through and I don't think people are really aligned as to what they mean by that exactly. How long is that Inquiries Group been set up now? 15:59 15:59

A. MRS. GALLAGHER: So we ran separate oversight groups for the Inquiries and it has conjoined around the last year, I can't be very clear in terms of when we moved to that position, but in and around the last year, and that was, as you say, to bring both together. 15:59

218 Q. And how do you think that's working? What's your

personal view of that?

A. MRS. GALLAGHER: I think it's working very effectively. We have patient representatives, we're engaging very closely through the subgroups that feed into that oversight process, so we have our reference group and, 16:00
importantly, and I described this earlier, this is not just about an action plan and clearing actions, this is about an assurance framework that has been independently developed, co-produced with patients and stakeholders in order to give a really strong 16:00
assessment in terms of, did this achieve what it was meant to do? Because, too often in the past, you will appreciate that boxes have been ticked and actions have been taken, but it didn't resolve the core issue, so that's been paramount in our thinking. 16:00

219 Q. Sort of, one of the things you have described, which sounds very positive, is your new process, if you like, for the SAIs and multidisciplinary, bringing all the leads for the SAIs together. I'm familiar with that way of doing things, and I think it helps a lot? 16:01

A. MRS. GALLAGHER: Yes, indeed.

220 Q. It also helps a lot to make sure that you get the patient input at the right place, which is not that easy to do, but it's a great thing. But in that spirit, you bring everybody together, you're getting 16:01
the patients in there. It's not mandatory for patients in Northern Ireland to receive copies of all their letters from clinics and procedures, which it is in England, and I can remember when that was introduced

and there was a certain amount of discussion at the time, but, overall, I think it's been very helpful. The patient is a great fail-safe for, did things happen when they should have happened? And all of that. Have you any observations on why that's not mandatory and what the blocks to that are? 16:01

A. MRS. GALLAGHER: It's an area that is currently under our line of sight, actually, in relation to the guidance and, you know, the communication with patients. We're currently working with Trusts to understand where they are in that journey and to work with them and support them in terms of moving to that position as soon as possible. 16:01

221 Q. And another thing you have talked about is the model of setting up an Integrated Care System way of looking at this, so, clearly, you have got integrated Trusts already, which should give you the right basis for that. A huge amount of work in Integrated Care Systems in England, not all of it has achieved what it was meant to achieve, and I understand you are having some advisors in, helping you with all of this. How do you see that working going forward in terms of bringing more partners in at the right time without creating another layer of governance and having a million more meetings and all of that, what's your strategy for that? 16:02 16:02

A. MRS. GALLAGHER: That's always the risk isn't it? I think Mr. Dawson described some of the work that we're doing, including independent advisors. It is

important to say that the ICS in Northern Ireland is not at all the same as the ICS anywhere else, so where we have landed this, and we have had quite considerable time to consider it, given the journey lapse since the decision to close the Board and change the commissioning system, so we have quite a bit of time to consult, engage, look at models, not just within Great Britain, but right across the world. Our approach is, I guess, in terms of a Framework rather than -- so the Framework is -- puts collaboration and integration at the heart of everything we do. So, you're absolutely right, we did have Integrated Care and the Trust provided Integrated -- and I commission all services on an integrated basis, so I commission Primary Care Services, Community Care Services and Acute Services. Many would imagine that that, in itself, would be an enabler for an integrated system, but, of course, it has limitations. So our focus has been as much on going back to people's behaviour and the culture of integration. So the new model that we've put in place sees three strands, and I know Aidan described a little bit of this. So, in the main, the core commissioning service continues to flow through SPPG, supported by PHA. So the money will continue, 97% rollover of services day to day. The Area Integrated Partnership Boards bring together the stakeholders at a local level. Importantly, they have no budget, but what they look at is their shared resource and assets the population health needs within their area, to

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understand how they work together and how they shape the commissioning agenda.
Then, the third level is an oversight arrangement, which will have stakeholders from Health but also from councils and from those stakeholders that have a stake holding in the determinants of Health and Social Care and they will provide guidance to the Area Integrated Partnership Boards, which will ultimately influence our commissioning. 16:05

So, what we have tried to do is, previously we allocated money to groups and departments and then there was a lack of line of sight up and down between Minister right through to local level and back up again, so the approach that we have developed is to reduce the potential for duplication and to have a clear alignment and understanding and a joined-upness that sits within SPPG in terms of all of the inputs, in order to inform how we commission services and what services we commission. 16:05

222 Q. So that's really interesting. What's been your -- you know, looking at the international systems, there are a few examples where they seem to have cracked this much better than we have in England, but just to use that as a benchmark. What's been your biggest learning from that, other than the communication, at a local level, that you've talked about? Is there anything else, as an enabler, that you have found internationally that is required to make that all work, do you think? A 16:06

completely open question. I don't actually know the answer. I just --

A. MRS. GALLAGHER: So I heard a comment quite recently, and it stuck with me: when you see one Integrated Care System, you see one Integrated Care System, and all of them are very different. I guess my reflections is that there needs to be clarity of purpose, so everyone needs to be looking in the same direction, everyone needs to understand what the priorities are, everyone needs to understand what the desired outcomes are and there needs to be that clear line between the decision-makers -- the Minister, the decision-makers, the Commissioners and the providers. Where things then start to -- where there isn't that clarity of approach then people start to do different things. So that clear focus that we're all in the same space we're pointing ahead. 16:06 16:06 16:07

223 Q. Yes. There's been a lot of learning from this Inquiry, I am sure, and how that's all pulled together is another matter. But what's your personal learning from having kind of been involved at various stages and thinking about it now in your current role, in terms of this is something that happened in urology, centred around one Clinician, but it's not really just about that at all, it's about a whole range of things, what's your personal learning? 16:07 16:07

A. MRS. GALLAGHER: You clearly kept the easy questions to the end, Dr. Swart! I guess as system leaders it is important that we are clear about our role within

health and social care. I think I described earlier in any leadership role, in any senior management role you're interested, obviously, in money and productivity and in governance. It's just as important that we are inquisitive and are asking questions and providing the leadership in all of those aspects. So I think creating the atmosphere within our own areas of responsibility and our own sphere of responsibility so that people understand what our priorities are and feel enabled and empowered to discharge their responsibilities in line with what we're required to do. So the whole issue of leadership and really understanding what it is you are there to do and how you contribute to a broader system, because none of us act alone, has come out as a reminder, if you like, to me throughout this process. 16:08 16:08 16:08

224 Q. If you had to do - your next step in terms of the changes you have been involved in and are still making - what would that be?

A. MRS. GALLAGHER: So we're in a really fortunate position because we're starting now to develop and put in place our arrangements for commissioning moving forward. There is already learning throughout this and that will continue to inform what we do. I mean, we have heard, and it has given us the opportunity, me the opportunity to reflect in terms of some of the propositions that's been put forward; you're only interested in performance and not interested in the entirety of work. Sometimes perhaps how we describe 16:09 16:09

things and, as you say, what we say matters as much. So it's important that we have absolute clarity and we are clear about our priorities and how we support people to do the jobs that they are there to do.

16:09

I mean, with any organisation across any sector there's too much to do and too little time to do it, and it is a matter of prioritisation and giving people the permission to say 'I can't do this because I need to focus on that'. Again that's a cultural piece in terms 16:10 of enabling people to do the right thing.

225 Q. Do you think there is any kind if opportunity at the moment, I mean there's this huge recruitment in Northern Ireland with clinical staff and others but I am particularly thinking about some of the things we 16:10 have heard about, there is a lot of change going to happen, this is a time for new things, is there a strategic group looking at how to maximise the opportunities for different kinds of recruitment in this atmosphere, is that going on, who is leading that? 16:10

A. MRS. GALLAGHER: So it's led by the Department. We have a workforce strategy, it sits under - I referred earlier to the Performance Transformation Executive Board which compromises of system leaders, Trusts and Department. The work of that group sits under the 16:10 purview of that. That is again a live debate in terms of what we do to attract, retain and keep our staff motivated in the broader sense.

DR. SWART: Okay, thank you very much. That's all from

me.

CHAIR: I think maybe -- did you want to say something in response to the last question?

A. MR. CAVANAGH: I was just thinking of the learning, I think it's an important question. I mean, I think 16:11
certainly the importance of MDTs and MDMs, I think, is something that we are now reflecting on considerably. The overarching report of the SAIs really did focus in on the importance of that. We have already done some work on it, around developing a self-assessment tool, 16:11
I think we need to do further work. I think there is something as well - unfortunately we can no longer participate in the NHS England peer review piece - but I think we now need to think about how can we develop our own peer review type programme. It might not be 16:11
quite in the way that the NHS England has done it. So I think it is important that, yes, clinicians will lead all of that, of course, but I think it's also important as commissioners that we're also setting a framework for that in the future. But MDTs are key. 16:12

DR. SWART: Thank you for raising that. I strongly agree with that. I think if you encourage trusts to self-assess themselves more frequently and make sure that the oversight at Trust level is led by an Executive and that is reported up through the Board, 16:12
there is a transformation in the focus on cancer. That is a mixture of quality and performance standards really when you think about it. There's no good getting everybody seen if you haven't got your MDT

working properly, and it should be possible to do that across Northern Ireland in the kind of way that you suggest.

226 Q. CHAIR: I have just a couple of things in terms of the SAIs. We know that the RQIA is going to report later this year on their review of the SAI process. But I am just wondering, we have thought and have discussed amongst ourselves, one of the reasons for the delay, both in all of these procedures, SAIs, the MHPS process, is getting people to do the job, you're asking busy Clinicians to carry out the work that's necessary. We have been looking at has consideration been given to a pool of people whom you can call upon and draft in to a Trust, for example, to carry out the work that is necessary in those fields, SAIs, MHPS? I mean, I spoke to Mr. Pengelly about this, the former Permanent Secretary, and he felt that having a body of people sitting within the Department just really wasn't feasible. But has any consideration been given to having a body of people who are willing to go in externally to the Trusts and do the work that's necessary to free up the Clinicians to get on to do their day to day work? 16:12 16:13 16:13 16:13

A. MRS. GALLAGHER: So there's two parts of that, if I might, Chair. First of all is in terms of the appraisal and the management of the individual. I suppose my background, I have been an HR RD, Human Resources Director. My personal view is the importance of understanding the individual and the appraisal, not 16:13

just every six months or a year, but that constant feedback, the observation and the engagement is best done by those that work with an individual. It is a requirement for all of us within our own organisation that we discharge ourselves in a professional way and from an evidence-based perspective.

So I would be open to all suggestions, but I think it would be challenging to bring others into an organisation to conduct appraisals and feedback in terms of individuals. 16:14

227 Q. I'm not talking about appraisals now, they would necessarily have to be done in-house. I'm thinking more of people coming in to carry out an SAI investigation or an MHPS investigation? 16:15

A. MRS. GALLAGHER: Indeed.

228 Q. Rather than -- I mean, for example, the MHPS investigation into Mr. O'Brien took an inordinate amount of time because trying to coordinate the times when Clinicians could meet, trying to coordinate the diaries is a big issue; and the same with the SAIs, trying to get people all together before that report can be finalised. I mean, certainly in terms of the SAI and learning, that is not ideal if you're trying to learn quickly? 16:15

A. MRS. GALLAGHER: Sorry, Paul, if I may. I think if you bring people in you're bringing experienced Clinicians, so they will be displaced from elsewhere which could be a potential problem. The reason why I referred to the

appraisals was, clearly the appraisals contribute to the MHPS process, so there's a graduation there. The SAIs, the RQIA has published its review and we're working on that basis in terms of its implementation. But again it talks about the training and the support of managers so that everything doesn't end up in an escalated way and that people are supported in order to make assessments on what needs to be escalated and how things should be managed in-house. 16:16

Again, I mean it would be for the Panel to consider the recommendations that comes from this. But sometimes it feels that, if you outsource to others, organisations lose a bit of that accountability and responsibility and it is someone else's responsibility. In my experiences, particularly in the public sector, the outsourcing of that doesn't necessarily mean a better outcome. But I'm open to being convinced on any level. 16:16

229 Q. One of the reasons that I am asking is that certainly we have heard evidence that the Trust would welcome having somebody come in, that it takes some of the difficulties with challenging people in-house away from them? 16:17

A. MRS. GALLAGHER: And I think on a very human nature all of us want to come in and do our jobs and the most difficult part of all of our jobs is challenging poor behaviour and all of us do that, particularly in senior management roles, it is part of how we make organisations work. So I think it's probably 16:17

reasonable for someone to say I would like that someone else to do that, but in reality it is for us as senior leaders to discharge our responsibilities in that regard would be my view. And that's a personal view.

230 Q. That's what you are here to give us. Just in terms of - well we will be making recommendations ultimately, obviously, based on the evidence that we have heard - but if you had all the funding that you wanted, what would you like to see happen, what one thing would you like to change to make things better in terms of patient safety and patient experience, what one thing do you think would make a difference? 16:17 16:18

A. MRS. GALLAGHER: So if we had all the money tomorrow we couldn't change this tomorrow. It's not one single thing that's going to make a difference. This is where I referred back to the work nearly ten years ago in terms of the Delivering Together strategy. This is about future proofing. We could recruit, if we had the staff to recruit we could use all of that money and bring more people online. But this is about systems and not structures, that was what Bengoa said. We need to transform the way we deliver services. We need to work with the public to understand what the future proposition for health and social care is. We need to move from an acute service to a prevention service, enabling and supporting people to keep well for longer. 16:18 16:18 16:19

So I think what I would -- my wish on that is that we would have the time and energy to put long-term plans

in place that help us effect that system change. Because we called it transformation for a reason, this is not about moving the deck chairs, it's not about reconfiguration, this is about significant change.

231 Q. It's not a quick fix? 16:19

A. MRS. GALLAGHER: It is absolutely not a quick fix.

CHAIR: Okay. Well thank you both very much, it's been very useful to have you both here together, so thank you for that. Is there anything else, Ms. McMahon?

MS. MCMAHON: No. 16:19

CHAIR: Well then, Ladies and Gentlemen, that is us. We are not sitting next week, for those of you who have children and have half term commitments enjoy and we will see you back again on the 20th, I think it is, Tuesday the 20th, whatever the Tuesday of the week 16:20 after next is. Thank you.

THE HEARING STANDS ADJOURNED TO TUESDAY, 20TH FEBRUARY 2024

16:20