Urology Services Inquiry

Oral Hearing

Day 9 – Tuesday, 15th November 2022

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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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON TUESDAY, 15TH DAY OF NOVEMBER, 2022 AS FOLLOWS:

CHAIR: Morning, everyone. Morning, Mr. May.

MS. McMAHON: Today we will be hearing evidence from Mr. Peter May, who is the current Permanent Secretary for the Department of Health. I believe Mr. May is going to affirm. 10:12

THE WITNESS, HAVING AFFIRMED, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:12

MS. McMAHON: Good morning, Mr. May.

A. Morning.

1 Q. You have already provided a detailed written witness statement to the Inquiry, that was dated 18th August 2022. I don't think you have your bundle in front of you, but in the bundle it runs from page 11 to 79. If I could ask that to be called up, at WIT-42367. Can I ask you just do you recognise that statement? 10:13 10:13

A. There's nothing showing on my screen at the moment.

2 Q. I have it on my screen. Still nothing there?

A. No.

CHAIR: It seems to be there's a problem with technologies on Tuesday mornings in the Inquiry, but hopefully it's easily sorted. 10:14

MS. McMAHON: Do you have a copy of your statement in front of you?

A. As it happens, I don't have it, I'm afraid. I can go

and get it. It's in the car.

3 Q. We can get you one that's a little bit closer.

A. It might be switching it on was the trick. Okay.

4 Q. You have it now?

A. I can see it now, thank you. 10:14

5 Q. You recognise that statement?

A. Yeah.

6 Q. If you go to the last page of that, WIT-42427. Actually I think your signature is at the very first page?

A. I have seen my signature and I recognise my signature. 10:14

7 Q. Do you wish to adopt that as your evidence to the Inquiry?

A. Yes. Can I make two comments on it, of fact? The first relates to paragraph 88 of the statement, where I refer to the Southern Trust having completed the MHPS 10:15 process. I think it's fair to say the timings are not accurate, are not correct in that respect.

The second is in relation to paragraphs 132 and 142 relating to Early Alerts and SAIs. Those two 10:15 paragraphs have got swapped somehow and each should be in the other place, so I would ask that that be corrected.

8 Q. Thank you for that. We will disregard paragraph 88 and then read those paragraphs as though they were swapped? 10:15

A. It's just that the paragraph 88, the timings are wrong in paragraph 88, so...

9 Q. The reason why you are here today is you are the current Permanent Secretary of the Department of

Health. Your predecessor was Richard Pengelly, from 2014 to 2022. Then before Mr. Pengelly was Andrew McCormack?

A. That's correct.

10 Q. You only took up post in April of this year? 10:16

A. Correct.

11 Q. So most of the key events had already occurred, so the Panel is aware of that. I am grateful for you coming along to give us an outline of the role of the Department. In your role you are the principal adviser 10:16 to the Minister for Health and the Accounting Officer for the Department. You say in your statement that you.

"... are required to ensure that the Department, and 10:16 any subsidiary of it, or arm's length body sponsored by it, operates effectively and to a high standard".

You have also indicated that your personal knowledge is limited, just as a caveat from the outset, and in 10:16 preparing your statement, you relied on a review of the documents held by the Department, and the recollections of your staff who had first-hand experience?

A. That's correct.

12 Q. There are four broad topics that I wish to discuss with 10:17 you today. Before moving on to that, is there anything you would like to say, in general terms, before we move into the detail of your statement?

A. Thank you for that opportunity. I would just like to,

firstly, apologise, on behalf of the Health and Social Care Services, and acknowledge the concerns, distress and anxiety for all the patients and families affected by both the Utology Lookback Review, and the matters relating to this Inquiry. I'm sure this has been a very anxious time for the patients and families concerned.

More broadly, the Inquiry is one of a number of public inquiries, which has been established by the Department. Some have been completed but there are a number that are similar in nature due to serious concerns raised relating to patient safety issues, and I do want to stress how important it is that we learn how we arrived here and improve the way these vital services are delivered. Finally, just to assure you that I am here to assist the Inquiry in any way I can with the genuine commitment to do all I can as Permanent Secretary of the Department of Health to ensure that the confidence in our healthcare systems can be restored. Thank you.

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13 Q. Thank you for that. The general approach to your evidence we will take today, probably the most brief will be your involvement with the issues regarding Urology since taking up your post in April 2022. Then a broad outline of the healthcare structures and the general relationship between the Department and the Trusts. Then I would like to look at a number of issues that emerge from your evidence, most

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particularly because those are the issues by which the Department and other bodies attain assurance from the Trust about Clinical Standards and governance in general, and then really just a mop-up of other miscellaneous issues that have arisen that I would like to give you the opportunity to comment on.

Finally, as the conclusion at the end of all of this, I will be asking you what observations you have about how the Department's systems and their processes are operating in general, and that will be out of the evidence I know you are going to give, and you have given in written form to the Inquiry about developments to date.

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Just before going into that, so the Panel are aware of your experience. You have set out your previous roles in your statement. You were the Permanent Secretary in the Department of Justice. What when did you hold that post?

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A. Between 2018 and 2022.

14 Q. Then you'd also been the Permanent Secretary for the Department for Infrastructure?

A. Between 2014 and 2018.

15 Q. How long, in general, have you been in the Civil Service?

10:19

A. 35 years.

16 Q. Your involvement since April 2022, I understand from your statement, is you Chair the Urology Assurance

Group?

A. That's correct.

17 Q. Could you just set out in terms what that group is and what it does?

A. Yes, certainly. It's a group that was established in had 2020. I think there have been 18 meetings so far. It draws together colleagues from a number of different parts within the Department and from the Southern Trust. It's got a series of Terms of Reference that have been set out. Its primary function has been to look at the review in relation to the lookback, to look at what more needs to be done in terms of any patient safety issues that arise. It's very much looking at what else needs to be done in order to provide assurance that we have addressed any harm that may have been caused by the circumstances. 10:20 10:20 10:20

18 Q. How often does the group meet?

A. I think initially it met very regularly. It meets less frequently. It's actually meeting later this week. So I think it meets based on need rather than on a fixed pattern, but as I said, there have been 18 meetings. It was meeting very regularly at the very start at the end of 2020, and less frequently since then. 10:21

19 Q. Would it be fair to describe that as a rolling review of issues that are emerging through the different processes the Trust have undertaken to get a full picture of what the current circumstances are as well? 10:21

A. Yes. So the Trust would provide an update at the start of each of the meetings, drawing out what further it

had discovered through the various pieces of work that have been set out, obviously looking also at work done by the RQIA and others, one of the Royal Colleges in terms of the lookback, so trying to draw together all of that information and then, as I said, to make assessments about were there any further intervention or action is needed; whether, for example, there is a need to extend the Lookback Review in any shape or form, and how best to do that. 10:21

20 Q. We will go on and look later on in your evidence at the developments with RQIA and things that they have undertaken for the Department, reviews they have undertaken and how that may inform governance. First of all, if I could set out in broad terms what the Department's role is. Obviously being a public inquiry, not everyone may understand there are a separation of roles and responsibilities. The function of the Department is to really formulate and implement policy and legislation, and oversee the allocation of healthcare resources. In doing that, the Department then doesn't provide healthcare as such, that is the role of the arm's length bodies beneath the Department. I understand, in our documentation, we refer to the Health and Social Care Board as being one of the key players, along with the Public Health Agency as being commissioners for healthcare, but I understand that that HSCB no longer exists in that format. Could you just explain the change that has occurred around that and what implications there may be for governance 10:22 10:22 10:22 10:23

in general?

A. Okay. The Health and Social Care Board ceased to be an entity in April 2022 as a result of legislation passed by the Assembly. The functions performed by the board have been subsumed within the Department of Health, within a group called SPPG, the Strategic Planing and Performance Group of the Department, so all of the functions that were performed by the Board are now performed by the Department.

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21 Q. In that change-over, is there any change in governance structures how they communicate with the Trust or feedback generally to the Department, or is it the same framework in place?

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A. It's essentially the same framework, albeit that inevitably the Board used to be an arm's length body of the Department, so that was a different relationship. Now it's within the Department, so it's changed the nature of that relationship. Like with all organisational changes, the full impacts take some time to work their way through.

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22 Q. The Inquiry have received a statement from the HSCB (as was) under the new guise of the -- obviously our Terms of Reference cover a different period so it's important for the Inquiry to understand if it is to make recommendations around any of the governance structures, if there have been any fundamental changes within that, so I can take that up with, I think it is Ms. Gallagher from the HSCB. Just by way of further understanding of where accountability lies and where

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the lines of governance are, the Department is required, under Section 5 of the Reform Act, to prepare a framework document, and we have a copy of that at DoH-35616. What that document does is set out the roles and responsibilities of each of the Health and Social Care bodies. I want to look at that very briefly so that we can understand then, first of all, the way in which information was expected to be provided to the Department and what may have gone wrong, but also to understand what other organisations may have done had they been given information, or what they did do when they were given that information. Is your screen working okay? 10:25 10:25

A. I've got the front page of the document up at the moment. 10:26

23 Q. If we go to page DOH-35622? I don't want to spend an awful long time on this, but I think it is important to set it out for both your evidence and future witnesses. You will see on that page there is a diagram setting out the Department as the overarching body responsible for healthcare. Beneath that we have the HSCB, Public Health Agency, RQIA, and the Patient and Client Council. Then the Trusts sit under the HSCB, and then other agencies as relevant. If I ask you to go to the preceding page of that, at paragraph 1.8 -- I am just going to read this out: 10:26 10:26

"To all of the Health and Social Care bodies referred to in this document that we have just looked at, remain

ultimately accountable to the Department for the discharge of the functions set out in their founding legislation. The changes introduced by the Reform Act augment but do not detract from that fundamental accountability". 10:27

So I don't think there's anything contentious about that, the Department has the overall responsibility.

Page DOH-35624 in that document refers to Performance Management and Service Improvement. This is described as: 10:27

"A process of developing a culture of continuous improvement in the interests of patients, clients and carers, by monitoring Health and Social Care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance to appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice, working with the PHA, the HSCB has an important role to play in providing professional leadership". 10:27 10:28

Then again at DOH-35627. In relation to the six Trusts, they are: 10:28

"... established to provide goods and services for the

purpose of Health and Social Care and, with the exception of the Ambulance Trust, are also responsible for exercising, on behalf of the HSCB, certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each Health and Social Care Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of Health and Social Care which it provides to individuals and the environment in which it provides them." 10:28 10:29

Again, I'm just setting this out so we know what is expected from each of the bodies.

10:29

Page DOH-35629 mentions the RQIA, that's the enforcement authority, and its job. You can ask it to provide advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be requested by the Department. 10:29

In general terms, the Department utilise the HSCB to commission healthcare services that is then provided by the Trusts?

A. Yeah, the SPPG, or the Board as was, commissioning is one of its three functions. Performance management and resource management are the other two. 10:29

24 Q. In relation to the actual delivery of healthcare, the lines of how that is delivered in Northern Ireland pass

through HSCB, they commission and the Trust provide. That will become important for the Inquiry when they look at what was done at various times, what the Health and Social Care Board may have known.

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The other important document, I suppose, for the purposes of the understanding of roles, is the Management Statement between the Department of Health and the Southern Health and Social Care Trust, which can be found at TRU-01864. I think this document was 10:30
in your bundle as well, Mr. May. It's the only copy that we have and it's dated, I think, 2017. What this document appears to do is it sets out the relationship between the Department and the Trust in the healthcare provision. Is it a document that you are familiar 10:31
with?

A. Yeah. I haven't spent a lot of time studying it but yes, all our arm's length bodies will have a Management Statement. They will all follow a very similar template, and then there will be adjustments made 10:31
depending on the nature of the individual organisation. It's a document on which often alongside the Management Statement, there would then be a series of delegations provided to each arm's length body that would specify, for example, the amounts of money that could be spent 10:31
without seeking departmental approval and the nature of, at what point, so if something is novel and contentious then it may need to come to the Department for approval before it can proceed. It's the core

document that defines the accountability arrangements for each of the arm's length bodies and is regularly reviewed at the moment. There's a proposal to move to something called a Partnership Agreement to change the way in which Management Statements operate to clarify better the nature of the relationship between Departments and their arm's length bodies as recognising the delivery part in the nature of much of the roles in many of our arm's length bodies.

25 Q. You have mentioned about it being reviewed. Is that a process of review is that's undertaken in conjunction with the Trust Board? 10:32

A. Yes, well with the trust including its Board, yes.

26 Q. Is there a plan to review that?

A. There's a proposal that all of the Management Statements -- right across government we're looking to move from management statements to partnership agreements, and there have been some documents produced that inform the principles that should be used. We are still at a relatively early stage of that work. Covid has, as in a number of areas, it's delayed the speed at which we have been able to progress that. 10:32 10:33

27 Q. Is it anticipated that that will result in any fundamental change in the accountability lines or the governance lines that currently exist? 10:33

A. No, I don't think -- it won't fundamentally change. That would need to go into primary legislation rather than the Management Statement.

28 Q. It isn't a case of something has been identified as

being absent or a problem that has resulted in the need for change?

A. No, I think it's more that, to caricature, the Management Statement might envisage a kind of parent-child relationship between Department and arm's length body and a partnership agreement might recognise there's more a partnership involved, so it's a different way of way of looking at the relationship rather than fundamentally -- there will still be an accountability line from the arm's length body to the Department in recognition, just as the Department is accountable to the Assembly for all of its functions. 10:33 10:34

29 Q. Just in relation to the accountability, I just want to highlight a couple of matters in this document as well. TRU-01867. This deals with responsibilities and accountability at paragraph 3.1. 10:34

"The Minister is accountable to the Northern Ireland Assembly for the activities and performance of the Southern Trust." 10:34

Over the page, TRU-01868, at 3.2.3, it gives reference to you:

"The Departmental Accounting Officer is also responsible for ensuring that arrangements are in place to continuously monitor the Southern Trust's activities to measure progress against approved targets, standards and actions, and to assess 10:34

compliance with safety and quality, governance, risk management, and other relevant requirements placed on the organisation, and to address significant problems in the Trust making such interventions as he/she judges necessary to address such problems". 10:35

And just over the page:

"Periodically carry out an assessment of the risks, both to the Departments and the Trust's objectives and 10:35 activities, and bring concerns about the activities of the Trust to the full Southern Board requiring explanations and assurances that appropriate action has been taken".

10:35

If I can just pause there and bring that home, as it were, and ask: in reality, what does the Department do to fulfil their role in overseeing the Trust and the quality of care, safety, governance and the risk management? 10:36

A. There are a range of different mechanisms that the Department will employ. Obviously the Department appoints the Chair and the Board of the Trust. In addition to that, it will seek reliance from the way in which the Board goes about its business, including the 10:36 way internal audit and external audit functions operate. There are twice annual assurance statements which each arm's length body completes, including the Southern Trust, and while that process and the one I am

about to describe was stood down during Covid they are being restarted this year, so there's also then an accountability meeting that will be held twice annually with the Chair and the Chief Executive of each of the arm's length bodies, and that is designed to go over any issues that have been identified in relation to the way in which the Trust, in this case, has carried out its business. I think it's important to note that Clinical Governance is not a responsibility of the Department; that sits outside of the remit. The Department doesn't have the skills or the capacity to do Clinical Governance, so that's a separate aspect, and is managed in a different way. 10:36 10:37

30 Q. When you say Clinical Governance sits outside the remit of the Department, where do you say it sits? 10:37

A. Again, there are a range of different ways in which Clinical Governance is managed. Partly there are professional bodies that oversee individual clinicians. Then there is the RQIA that will look at how the actual operation of various aspects of Clinical Governance operates and make recommendations as a Regulator. 10:38

31 Q. Would they make recommendations if there is clinical risk, just so I can understand precisely the issue around Clinical Governance. When RQIA make recommendations around areas of clinical risk they have identified, who do they then go to for action on that? Who do they see as being responsible for that? 10:38

A. The Trust would be responsible for responding to any inspection done in relation to the work of that Trust,

and the Department would then -- its oversight role would kick in to demonstrate that, would ask the Trust to demonstrate it had actually taken the steps that are necessary in order to comply with any recommendations. Obviously there may or may not be a dispute about whether the recommendations are accepted, but if those recommendations are accepted, then there would be a record kept as to the extent to which those recommendations have been implemented. 10:39

32 Q. Is it the case that the Trust can ask the RQIA to oversee their governance risk? Can they actually independently ask them to get involved in oversight or does that come from the Department? 10:39

A. I confess to not knowing the answer to that specifically, and I can find that out and come back to you, as to whether there is a statutory requirement that the Department has to technically sign off on any request. I know informally the Trust could ask the RQIA to assist them, but I don't know whether there's a formal loop that requires the Department's intervention or not, I would need to check that. 10:39

33 Q. That would be helpful. It would would be helpful to understand if it is the Department who must trigger the RQIA's involvement, how they might be expected to know about the existence of clinical risk or governance concerns, if the Department doesn't have direct involvement in that, so it's just to give another layer of understanding -- 10:40

A. Okay.

34 Q. -- in relation to that. The Inquiry have received a statement from Sharon Gallagher from the Health and Social Care Board (as was). We don't need to go to the statement, but I am just struck by the same language that has been used. She says also that: 10:40

"The SPPG does not have a role in evaluating the effectiveness of the Corporate and Clinical Governance procedures within the Trust". 10:40

Just for the Inquiry's note, that is at WIT-66188, paragraph 39 and 40.

A. The corporate governance aspect of that would be addressed by the Department through the Management Statement, and the various mechanisms that I have described. Just to clarify, it would have been done by the policy side of the Department, as it is now. Obviously it gets more confusing, the Board doesn't exist and is part of the Department, but its remit is to look at the commissioning and the performance of the Health and Social Care system rather than its Corporate Governance arrangements. 10:41 10:41

35 Q. In taking your evidence and Ms. Gallagher's, is it the case that the Trust self-regulates its own Clinical Governance? 10:41

A. As I said, the Regulator is the RQIA and I think that's the key aspect. You showed previously a diagram showing the Regulators on the diagram as to how the structures work, and that's how there's oversight

provided in relation to those aspects. Then, as I said, there are independent, the Royal Colleges and other statutory -- sorry,. The GMC and other bodies provide oversight in relation to clinicians, and there are various processes which doubtless we will come on to in respect of that.

36 Q. Just while we are on the RQIA, I wonder if we could just deal with that particular issue now? You begin your evidence on the RQIA at WIT-42412, and it's paragraph 144 for your note. 10:42

Just to run-through this, to get to the final point about the forthcoming review. At paragraph 146 you say that:

10:42

"In 2014, the RQIA was tasked to undertake inspections of acute hospitals."

I don't think there's been an inspection of the Southern Trust. We haven't got anything on the papers as far as I'm aware. To follow that up, if you have information on that that would be helpful. 10:43

A. I can check.

37 Q. Over at paragraph 149, you say:

10:43

"The RQIA's hospitals programme team had planned to undertake a series of inspections to Outpatients' Departments during 2021 and 2022 as part of the follow-up of the RQIA Review of Governance Arrangements

in the Belfast Trust."

I don't think that happened, did it?

A. No. As I said, it's been deferred. It's one of those things that, because of Covid, it wasn't considered the appropriate time to do that work.

38 Q. I wonder if you could just explain a little bit more at paragraph 151, the first sentence:

"Hospitals are not regulated in Northern Ireland, RQIA can however issue improvement notices where they find non-compliance with the 2006 quality standards".

Just for purposes of understanding, when you say hospitals are not regulated in Northern Ireland, what does that mean, for the purposes of governance? The reason why I ask you that is because we spoke about RQIA having the oversight of governance.

A. I think it is the Trust is seen as the unit to be regulated rather than the individual hospital.

39 Q. At the moment, the RQIA don't go into hospitals and carry out assessments that they would, for example, in nursing homes? Just in language people can understand, for the purposes of investigation, the RQIA's function doesn't extend to Acute Services?

A. I'm afraid that's something that I would need to explore further. I don't want to say something I don't know to be accurate so I'd rather respond more fully when I've had the chance to explore that.

CHAIR: Mr. May, in ease of yourself, we are very conscious that you are new to your current role and there's a lot of information that you wouldn't have at your fingertips, so we do appreciate you won't have all of the answers here today.

A. I have done my best to - as best as I can, but I'm conscious I may not know all the answers, apologies.

MS. McMAHON: Yes, I am just trying to establish the framework so we understand where we can look for further information. If we go to the last paragraph in that section on the RQIA at WIT-42415? I just want to tentatively ask you about the review of RQIA. Is that something you can provide information on?

A. So there's a fundamental review of regulation, and there's been a good deal of work already done in relation to that. I can give you a little bit more information in relation to that. A new regulatory policy has been drafted which would widen the scope of the services to be regulated and give the Regulator wider powers of enforcement. We are at the stage where that draft policy would be presented to an incoming Minister and we would seek their approval to launch a public consultation about the work that's been done in order to -- fundamentally that would need to lead to new primary legislation, because you could not give the Regulator new services to regulate or wider powers of enforcement without primary legislation to support that. It's part of a process that we are going through. We have done the first stage, which is review

of the policy. There would then be a consultation. There would then be a drafting of the legislation and passage of the legislation with any amendment the Assembly chose to make on its way to completion.

40 Q. That might be something we hear periodically throughout your evidence, the issue of things getting so far and perhaps not then getting across the finish line, in the absence of an Executive and a Minister. Could I ask you, just in general terms, what you can do about developments and recommendations? We will talk about the hyponatraemia recommendations, and obviously recommendations from this Inquiry, how far can you take that when there is no Minister in place? 10:47 10:47

A. It's difficult to answer that in abstract because the reality is that you need to look at the individual recommendations. In relation to, for example, the Hyponatraemia Inquiry, there's a well-established approach where the Minister has accepted or otherwise the recommendations, work is proceeding to implementation, that would not be affected at all by the absence of a Minister, save for where primary legislation is required. Clearly there's no means of passing primary legislation in the absence of a Minister or an Assembly to oversee that. The general rule of thumb in the absence of ministers is that civil servants should not take decisions that would normally have gone to a Minister. It is conceivable, certainly at the end of the last interregnum between 2017 and 2020, towards the end of that period, the UK Government 10:47 10:48 10:48

passed some legislation giving limited powers of decision-making to civil servants, and we wait to see whether that is something that's going to be reinstituted on this occasion or not. There's always a judgment to be made about how far it's sensible or possible to go. There's a question about whether we could launch, for example, a public consultation or not because that's not -- it's a decision but it's not taking a final decision, it's merely enabling the public to comment on something and other interested parties, and those sort of decisions will be taken on a case-by-case basis. 10:49 10:49

41 Q. Just another couple of examples from that, while we are on that topic. For example, the Duty of Candour issue that was one of the recommendations from the Hyponatraemia Inquiry. Is that a recommendation that perhaps will fall short in the absence of a Minister? 10:49

A. That's an area where the Minister had the chance to consider that issue and the policy direction that he set was he asked that further work be done before reaching a final decision on whether a legislative Duty of Candour should be introduced or not, and that work is being taken forward at the moment. We are trying to develop something called a 'being open' framework and some work is being done. We are using the Belfast Trust as our pathfinder, and the Belfast Trust volunteered to be the pathfinder for that work, so will involve an engagement with Clinicians about there being open framework, the development of that framework with 10:49 10:50

a view to them being able to advice to an incoming Minister around whether a legislative Duty of Candour would be the right way to proceed or not. There are, as so often in these areas, contrasting views with -- obviously the Hyponatraemia Inquiry recommended a statutory Duty of Candour on individual practitioners. That would be in advance of where the rest of the UK is currently, although recently there was a report done in relation to health matters in east Kent that have made some recommendations that are not dissimilar in relation to Duty of Candour, so we keep in close contact with our counterparts in England, Scotland, and Wales to understand how that is being developed. The initial work is around it being open framework in order to inform the final decision about whether a legislative Duty of Candour would be a good idea or not. 10:50 10:51 10:51

42 Q. If it is the legislative framework that is required to bring that recommendation into effect, it does, in short terms, require a Minister in post? 10:51

A. It does. It would, of course, have been conceivable for a Minister to have brought that forward when we did have a Minister and that wasn't a decision that our outgoing Minister took.

43 Q. One of the other matters that requires a Minister is one of the other recommendations from the Hyponatraemia, is the introduction of the independent medical examiner whose role would be to scrutinise hospital deaths not referred to the Coroner. It's at 10:51

WIT-85756, just so you can see it on your screen. You will see there's a non-statutory prototype at the moment. If you can speak to that?

A. There are non-statutory prototypes operating across all five of our Trusts, so when a doctor completes a medical certificate of cause of death, an independent examiner reviews the certificate, together with the patient's clinical record, and has a discussion with the certifying doctor about the circumstances of the death. I have actually visited and seen that in operation. The purpose is to ensure that deaths occurring in hospital are appropriately reported to the coroner when there's a need to do so. It should also reassure the family that the death certificate is reasonable and accurate, and that if any safety or governance issues are identified these are brought to the attention of the relevant Trust in order that immediate action can be taken if it's required. What we are now looking at, or the non-statutory office of the independent medical examiner is looking at is the most appropriate way in which a statutory service might interact with bereaved families, and how the system can include reviews of those deaths occurring in community settings which are usually certified by GPs. That's logistically a much more complex challenge. The prototype should provide all of the required information to inform the development of a statutory service for Northern Ireland.

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44 Q. Has that again found itself in the same area as the

Duty of Candour, in that there is a statutory framework required to make real that recommendation?

A. In order to move it from being a non-statutory to a statutory service there certainly needs to be legislation. That's stating the obvious. I think it's fair to say there's some further work to be done about how the community settings could be incorporated. It would be desirable, and probably preferable, to make a decision on the scope of the IME work at the beginning of the policy work to develop the legislation, and while we can see how it would work and does work in relation to Trusts, we don't yet have as clear a view as to how it would work in a community setting. As I said, the extra complexity with GPs is more significant. 10:54

45 Q. I think there's no doubt that there's a bit more work to be done in the operational outworkings of these issues, but the point, I suppose, for our purposes in understanding recommendations that this Inquiry may make and the reality of those taking effect, is that issues are percolating up from various inquiries, from recommendations, and in the absence of a Minister they are really not going anywhere else? 10:54

A. The work is proceeding to try to implement those that we have had a policy steer on, and we would look at any recommendations this Inquiry or any other Inquiry made to see what we could sensibly take forward. Any recommendations that require primary legislation would need to await a Minister coming into office. 10:55

46 Q. Just at the bottom of that page, WIT-85757. This is the update from your Department to the Inquiry on your website. There's the recommendation of RQIA review of series adverse incidents?

A. Yes. 10:55

47 Q. The recommendation, I think, has been taken forward and a report is now published in June of this year. Do you have an update on what's happening with that report and the recommendations made by the RQIA, given that SAIs, Serious Adverse Incidents, have played such a key role 10:56 in the documentation leading to this Inquiry, and will be subject to significant analysis by the Inquiry and various witnesses who will be called?

A. When the RQIA review was published on 7th July, the Minister gave a commitment to support the redesign and 10:56 implementation of a new regional SAI procedure, to ensure HSC staff, service users and their families were all supported as active participants in the review process. We are currently scoping the systems in other countries and drawing together Terms of Reference to 10:56 take forward the implementation of those recommendations, so that is not something that needs to await an incoming Minister because we have a policy steer from our outgoing Minister. We will continue to follow that policy steer until such time as we have 10:57 a new Minister. In this area I would assess it unlikely that an incoming Minister would come in and want to change the approach that has been recommended by RQIA, so we will proceed at the moment with this

work.

48 Q. Can you proceed to final conclusion with those recommendations or is it again another potential roadblock in that?

A. Obviously it's something we keep under review, but, on the face of it, I don't see why we couldn't proceed to take this work forward. I don't know whether there would come a particular point where a decision is needed that I would feel was beyond, would normally have been taken by a Minister, I would need to reflect on that, but a number of these things look as though they are things that could be developed in the absence of a Minister. 10:57 10:57

49 Q. Anything that falls into that particular criteria could have been made by a Minister, then it's effectively hands off? 10:58

A. As I said, subject to any decision that the UK Government may take to reintroduce some modest decision-making powers for civil servants.

50 Q. Just the assurance that you received by arm's length bodies you have referred to in paragraphs 11 and 12 of your statement, at WIT-42369. I just wonder if you could just explain them just a little bit more? Paragraph 11 refers to the period of 2003/2004 where: 10:58 10:58

"... the Department utilised controls, assurance standards as a means of arm's length bodies' boards providing evidence and assurance that they were doing their reasonable best to manage themselves in meeting

their objectives and protect stakeholders against risk".

I think that's even further back than you need to go. Paragraph 12:

"The current system from the 1st April 2018 is a revised approach of proportionate assurance was introduced whereby arm's length bodies provide assurance to policy leads in the Department with respect to their compliance with Departmental policy".

I just wonder if you could tell us how that actually operates?

A. Yeah. I think the pre-existing mechanisms were seen as being too cumbersome and placing a disproportionate burden on some of the smaller ALBs. The new arrangements were designed to be more proportionate, to streamline the approach, reduce duplication and provide clarity on the level of assurance required by the Department. So the key method by which the proportionate assurance is provided is through the midyear Assurance and Governance Statements that I referred to earlier, and that accountability process is the way in which exceptional issues are highlighted, that would then feed into the accountability meetings that are held twice a year, in addition to any performance concerns and other wider issues that may be relevant. That doesn't stop Chief Executives from

putting in place other arrangements within their own organisation to give them the assurances as Accounting Officer of their own organisation that they require.

51 Q. Just in general terms, when you receive assurances from arm's length bodies, is there any way that you test those assurances, how robust they may be or how strong they may be before you can take assurance from them? 11:00

A. You are continually taking an overview of the work of an arm's length body and you are drawing on the various different methods that you have. I would talk to the Chairs of the Trusts on a regular basis. I would have meetings with the Chief Executives, usually collectively, but obviously on specific issues on a one-to-one basis. As I said, there are then the internal and external audit arrangements are put in place and the Department reviews the way in which the Board goes about its business on a regular basis, so there are a range of different ways in which you build a picture up of an organisation. What we don't have the resource or the time to do is to drill down into each individual assurance that's provided in order to assess whether or not that is accurate. There is a very small team that would act as what's called the sponsor branch within the Department for all of the Trusts, and its role could not be to perform that very detailed checking role. Indeed, I'm struck by the fact that if you worked in Whitehall at the moment the amount of checking and assurance done in relation to arm's length bodies is massively less than it would be 11:01 11:01 11:01 11:02

in Northern Ireland, and some people inevitably are seeing that that is a potential way that a resource could be saved in Northern Ireland compared to Whitehall counterparts. Against that, there's always a challenge that if something goes wrong in an arm's length body, what did the Department know, how did it oversee? You are forever trying to manage and reach the right balance, and almost inevitably if something goes wrong then the balance is seen to be wrong and you should have intervened more, but by intervening more you create more bureaucracy, you create more stickiness in the system that actually makes it harder for high levels of performance to be achieved. That is always the balance and, as I said, you always try to look at what the risk profile for each ALB is and how much confidence from the interactions you have collectively, because it's very rarely the case that there's a problem in one specific area and it's not, you know, if you're looking at the Corporate Governance aspects that it's not then something that should be looked at more widely in that context. 11:02 11:02 11:03 11:03

52 Q. Thank you for explaining that, and an interesting point about the position in England. There is a tension obviously between providing the Service and overseeing it, in trying to maintain that tension and also meet the expectations of both the legislative requirements of the Department, the Framework, the Management Statement, the Policy and Procedures, but I think what the documents from this morning would indicate is that 11:03

effectively the buck stops with the Department as regards accountability. Would you agree with that?

A. Yes, the system of governance we have is that the Assembly is responsible for everything that happens within the devolved sphere in Northern Ireland, and the Department and the Minister are the key building block by which they then hold to account for the delivery of all of those aspects of Service that fall within that Department. 11:04

53 Q. I know you are not long in the job, but I wonder if I could just ask you some general questions about how you perceive things to operate at the moment? 11:04

A. Sure.

54 Q. Is it the case, from what we have said already, that the Department doesn't know what's wrong unless someone tells them? Is that too general a statement or do you have to wait until information makes its way to the Department? There's no proactive way of you seeking that information out. 11:04

A. I think, and I refer back to the diagram you helpfully showed at the very beginning, and I don't know if that can be brought back up on to the screen, but there are multiple ways in which the Department can gain information and knowledge, in addition to the more informal ways that I described just now. The work of the Regulator is the work of the various audit bodies, and so on, all are ways in which you gain wider information on a regular basis. 11:05 11:05

I'm just going to wait for this to come back up, if I may, to see if there's anything further that occurs when I see it again.

55 Q. I think what that does show is it shows where everyone sits in relation to each other, and you are relying on that to say that information can come from all of those sources; is that right? 11:05

A. There's a variety of different ways in which we get information, is the point. We haven't mentioned the PCC, but the Patient Client Council is another way in which information flows to the Department, as it does through RQIA. I think it felt too bald a statement to say that we need to be told something wrong in order to know there's something wrong. There's a number of ways in which there are designed to be checks and balances within the system, so if something is not working the way in which it should -- and I'm talking here in the corporate governance space, not the Clinical Governance space for the reasons I have described -- the Department doesn't have the same remit in relation to Clinical Governance, then there is a means by which things will come to the Department's attention and decisions can be taken about what is required. 11:06 11:06

56 Q. I think you have mentioned in your statement as well and Mr. Wilson indicates that the Department didn't know anything about what had happened in Urology until 31st July 2020? 11:07

A. Yes.

57 Q. None of those systems operated to bring that to the

Department's attention until that point. Is it your position, your view that that was proper, given that the issues that did eventually come to the Department were Clinical Governance issues?

A. I'm not saying that it was proper, I think it's a fact that it didn't come to the Department's attention until that date. I think there's always questions about whether there are things that could or should have been done differently and whether connections could or should have been made that would would have identified some of these challenges more quickly. I think that's obviously fundamentally part of the work the Inquiry is doing. I think we'd all think there are, would there be scope there for us to learn some lessons going forward. 11:07 11:07 11:08

58 Q. Just following on from that then. Do you think that the information that did become available in July should have been made available to the Department before that date, now that you know what you know about that information? 11:08

A. I think that the area it seems to me that, you know, could it, should it have been the case that a number of different pieces of information would have been brought together and that might have resulted in the issues being elevated earlier, so there were some SAIs, as I understand it, running in tandem with the MHPS process and so on, and I don't know whether -- I think that's the area where there could have been more, you might have hoped there would have been more of 11:08

a connection made, and that might then have identified it as more of an issue. I think that's probably the area I would suggest.

59 Q. When you said earlier that the Department don't get involved or have no role in Clinical Governance, does that mean that the Department can't intervene if required, or is the Department's power sufficiently broad to intervene where it sees fit to do so, if patient care and safety are an issue? 11:09

A. You can see from the way that the Urology Assurance Group has worked in relation to defining the -- looking at whether the scope of the Lookback exercise, Lookback Review exercise was sufficient, whether the SCRR process and overseeing all of that, so at a system level, the Department can intervene and require actions to be taken or work with, requisition RQIA to do work in relation to specific actions. What the Department doesn't do is to get involved in the individual decision-making of a clinician in relation to a patient, that's taking you into a different space. 11:09 11:10 11:10

60 Q. Just in your experience to date, what's your view of how effective the oversight mechanisms in place are generally, in general terms?

A. I think that's a very general question. Can you say a little bit more about what you're referring to in relation to oversight mechanisms? 11:10

61 Q. In relation to information making its way to the Department that may be a cause for concern and the robustness of that information, the frequency and the

time at which it's provided, and your ability to follow up on any concerns that you have, do you feel that you are satisfied that all of those issues are working as they should be?

A. I mean, the way in which information of concern flows to the Department is, broadly speaking, through the Early Alert System, and that's a system that is currently going to undergo a review. I think the Panel will have evidence around the number of Early Alerts, and there's been a significant growth in recent years around Early Alerts. I think some of that can be explained by Covid and the need to report outbreaks of Covid, and so on, but there is inevitably a risk that, over time, the filter that is supplied in relation to Early Alerts can get broader more things than go through the filter and more Early Alerts are raised. There's then a question: Does that mean that there's more to be worried about in the Health and Social Care system or more is being reported than was being reported previously? My sense is that, and then, as you say, a question about is there capacity to do something about all of those Early Alerts and so on. I think because one of the grounds for the early alert is that it may generate media interest and, at the moment, you'll not have to go very far in order to identify media interest in health issues. It may be that we need to look again at how we draw that filter in order to make sure that the Early Alerts are -- we are confident that we are only things that are of real

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significance that need to be looked into. There's always going to be a risk that something doesn't come forward because people don't feel it does meet the terms, or perhaps is not recognised for the significance that it has when it appears. I think anyone sitting here would be foolish to say that they have absolute confidence in a system of that nature. It's all down to human judgment and prone to human error in relation to how systems of that nature work. My sense is that if we develop a new Early Alert policy, try and make sure that we then do some work to make sure the guidance is well understood, because often words on a page can mean different things to different people. I think we are not clear at the moment that the policy is being implemented consistently so that's, I think, the reason why we need to get to that point. Again, I think that a review of the nature of that sort is something that I could advance in the absence of a Minister. I don't think it takes a decision by a Minister. What we are trying to do is make an existing policy work properly, as it were, rather than create a new policy.

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62 Q. The Inquiry will have heard about the RQIA review of SAIs. The RQIA itself being reviewed or looked at the powers. The Early Alert System is subject to review and possible change. The other matter you'd mentioned was Maintaining High Professional Standards, and that was mentioned as a way in which you receive information or seek to look at the robustness of governance in

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Trusts?

A. I don't think I made reference to something that we looked at. I think it was in relation to your question about how Clinical Governance is exercised, although I'd need to go back and review the transcript. 11:15

63 Q. I stand corrected on that point. If we look at it now, MHPS, there were two reviews of this procedure by which the Trust in considering the standards in relation to practice of Clinicians, and you referred to it in your witness statement in significant detail, but I think, 11:15 for our purposes, we only need to note that there was a review due to start in 2011, and then one again in 2018, and neither of those reviews, for a variety of reasons, actually took place. You do say in your statement at paragraph 109, which is at WIT-42400, and 11:15 you say:

"Turning to the future action to strengthen the MHPS policy, it is my view that a rapid but fundamental review of MHPS must be started and, most importantly, 11:16 completed as soon as possible and as a matter of priority."

I wonder if you could just speak to that statement and give us a little bit more detail? 11:16

A. First perhaps to give a little bit of context around how I see MHPS is sitting. It's part of a number of different mechanisms that exist, all of which have some bearing, and it may be useful to the Inquiry at this

stage. There's a professional appraisal process and job planning process that I understand was introduced in 2003. That was then supplemented in 2012 by the revalidation process that all Clinicians go through on a three-yearly basis that is run by the GMC, and then MHPS is something that sits, as it were, on top of and alongside those various mechanisms. The first review was in 2009. The second started in 2018. As you say, neither of those was completed. Before the Minister left, the outgoing Minister left office he agreed to proceed with a review of MHPS. We are hoping that review will commence early in the New Year. We are currently looking at identifying suitable individuals with an expertise who could come in and assist with that process. I think there were already some issues that were identified previously about the length of time it takes to get through the various steps, the clarity on roles, the need for clarity about which professional groups are covered by the MHPS process, including, for example, whether GPs and pharmacists are within the scope or not. But alongside that we have also more recently received the Neurology Inquiry report which makes further recommendations around MHPS, and obviously we'd want to take that into account. One of the things that I'm keen to do is not to see individual recommendations from Inquiries and do a kind of tick box thing but we have to kind of join it all up together because they are all part of a wider piece. We have already talked about being open, and that's

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a classic case where Hyponatraemia and Neurology both say things about being open, and we need to join those together, rather than seeing them as two separate enterprises. Obviously with whatever recommendations this Inquiry makes, we would look to follow the same sort of broad approach. You need to be able to demonstrate that you have, or haven't, fully implemented what the Inquiry asked for, but also that it's part of that wider view of what's being done in the space to make sure that, as I said, we are not just getting focused on individual aspects but we are seeing this as a systemic issue. 11:18 11:19

64 Q. It's clear from your statement that there were some confusions or uncertainties around where responsibility for MHPS lay. I think that was in the previous potential review in 2011? 11:19

A. Yes, that's been resolved. There's a clear lead within the Department, and it's also clear who will provide support to enable that work to be done.

65 Q. Do you have any view as to whether that confusion may have contributed to the delay in getting MHPS reviewed and changed as needed? 11:19

A. So far as I can assess, I think that it was much more a question of prioritisation. There were multiple things going on and inevitably an Inquiry looks at one particular thing, and so on, but there's always lots of other things going on, and the MHPS was seen, I think, as perhaps being a bit clunky but not fundamentally flawed, and, on that basis, the priority was to do some 11:20

of the other things. For example, I know there was quite substantial work done in the 2009 review, but then at the point when that was getting near to a conclusion, the Revalidation issue was being negotiated with the various medical associations, trade unions, for want of a better word, and it may well be that Revalidation was given priority as something that was new and additional. MHPS can't be done on its own. Even after the review it needs to be negotiated because it relates to the kind of terms and conditions of service for Clinicians. In 2018/2019, I think the challenges were more, there was a major industrial relations issue with the nursing strike, and then Covid came in, and those were things that kind of prevented that review from, I think that review was never as fully taken forward as the 2009 one. I think it was wider issues rather than the confusion that caused the problem. Confusion doesn't help, but I don't think that that was the fundamental problem. 11:20 11:20 11:21

66 Q. One of the other things, just before the break, I wanted to mention, was the current involvement of RQIA in looking at the Urology Services at the moment. If I could ask for WIT-85746, the letter from the Urology Services Inquiry to your Department. Following the RQIA review of the Urology structure case record review carried out by the Southern Trust, and in that they made a recommendation number 13: 11:21 11:22

"That the Department of Health should commission the

RQIA to undertake a review of governance arrangements within Urology Services in the Southern Trust and on terms the Chair of the Inquiry sought information from you to make sure that roles were clarified in relation to the" terms of this Inquiry and that recommendation. You wrote back, WIT-85748, by letter 9th November 2022.

A. I received a further letter this morning, I think indicating that this issue is resolved at this stage.

67 Q. Yes. It's just to indicate to the public that there is a current review being undertaken by the RQIA and the Terms of Reference have been set by the Department to look at the current systems in place. 11:22

A. Yes.

68 Q. I just wanted to acknowledge that in passing.

A. Okay, thank you. 11:23

MS. McMAHON: Perhaps this would be a convenient time?

CHAIR: Yes. Say 15 minutes, so, 20 to.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:30

69 Q. MS. McMAHON: Mr. May, I just have two other very brief areas to ask you about, and the first one is in relation to the Department's relationship or oversight or scrutiny of the Trust Board. As I understand it, the Chair of the Board, the appraisal is carried out, is that by the Department? 11:39

A. Yes.

70 Q. Is that done on an annual basis?

A. Yes.

71 Q. Is there a designated person in the Department who does that?

A. Yes.

72 Q. Who is that?

A. It depends on the arm's length body but I think for the health trusts, the appraisal is carried out by Jim Wilkinson, one of the grade 3s in the Department, and then I see all of the appraisals and sign them off or my predecessor would have done. Again, I'm not certain whether the appraisal process continued during Covid but it has restarted this year. 11:39 11:39

73 Q. When you look at those appraisals, if anything arises would it be your first port of call to speak to the Chair?

A. First port of call would be to speak to the person who had done the appraisal probably, and thereafter to the Chair. 11:39

74 Q. The other issue I just wanted to ask you about was in relation to Mr. O'Brien. In his counsel's opening address to the Inquiry he raised concerns generally around the funding of Urology and the way in which the Department has been organised. Specifically for you to consider, if you wouldn't mind, was the shortness of notice he received in relation to the calling of the public inquiry. Mr. O'Brien I think was given 30 minutes, roughly 30 minutes' warning in advance of the announcement. I think the Trust was told within the hour that the announcement was imminent. I wonder if you have any comment to make on that? 11:40 11:40

A. Maybe to start with the more general point you made about funding in relation to Urology Services. It's my understanding and belief that as need grows, so Commissioners are faced with decisions about how to apportion scarce resources accordingly. I think a number of steps have been taken over a number of years to try to increase the resource provided in relation to Urology Services more generally across Northern Ireland and for the Southern Trust, but we do face challenges in relation to demand outstripping capacity in a whole range of services at the moment, and there's no easy resolution to that in the absence of a substantial additional investment of money to Health in order to seek to manage that. We are looking at how we can maximise what we do with what we have got in terms of maintaining a core quality standard, but alongside that, maximising productivity and efficiency so that the system meets the needs of as many of the Health and Social Care needs of our population as possible. I think it's commonly understood that there are challenges and that those challenges have existed for a number of years. I understand, and we have made some specific investments to support the Service provision in the Southern Trust in the last couple of years, there have been some reductions in the level and extent of those waiting as a consequence. That's largely by supplementing the Southern Health Trust's own resources with the independent sector resources. Just to give some background to that. I know there

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have been challenges in terms of recruitment of Consultants to the Southern Trust Urology Department which I don't claim to be an expert on.

In relation to the calling of the Inquiry, the 2005 Act does not specify any time that needs to be provided for individuals. I think there are always competing challenges in relation to timing, because a Minister will always feel he or she needs to be accountable to their peers in the Assembly, and if news of what is being announced becomes known too far in advance, through whatever means, whether, you know, because there are a raft of different people who have an interest in an Inquiry, obviously Mr. O'Brien and the Trust, but patients and families also have an interest, so trying to define and decide precisely who gets told when is a judgment-call. I would just offer that there's a series of things to be thought about, not simply how much, you know, not simply the time scales, but how it all fits within the wider piece. 11:43 11:43 11:43 11:44

75 Q. Just finally, you have mentioned about the funding and structuring of the Health Service. We have had reports like the Bengoa Report delivering together initiatives from the Executive seeking to restructure Healthcare to try and optimise patient care and standards. Is that another stream of work or developments that can't be taken forward because of the absence of an Executive? 11:44

A. There are some aspects of the work that relates to the Bengoa Report which can be progressed and others which

are more challenging. There have already been a number of reviews of major Services in the areas of Stroke, Adult Social Care, Urgent Emergency Care, Cancer Strategy, and there's been a number of other things that have been done and can continue to be done. The area which is most difficult is that if there needs to be a reconfiguration, particularly of hospital services in order to deliver more efficiently and more effectively for the people of Northern Ireland, then the nature of those decisions they would definitely normally be taken by a Minister, and there would be a very high public profile and there would be a lot of public interest in relation to those, and it's not easy for me to see how those could be progressed in the absence of a Minister, save for the unfortunate circumstances where the Service can't be continued to be delivered safely, in which there's a inevitable need to make a change. In our past I would reflect we have seen pretty much all the changes have that have been forced rather than planned, and that's not a good way to manage services. 11:45 11:45 11:45 11:46

CHAIR: I have no further questions for you. I think the Panel may have some, so stay where you are, please.

THE WITNESS WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

76 Q. DR. SWART: I was interested in your comments about the proposed changes to the Regulatory Framework which you referenced in your statement and again today. Can you tell me what, in your view, the drivers for the need for change has been? 11:46

A. I think there's a number of drivers. I think that the changes would essentially involve both giving the RQIA, potentially giving them more teeth -- this is all subject to public consultation I should say -- but also broadening the scope. The Neurology Inquiry made a series of recommendations, for example, around the independent sector and the need for -- and while RQIA has the scope and the remit to do work in relation to the independent sector, it's a question about whether that's sufficient. One of the issues that I'm sure will come up in this Inquiry is around those employed by Health and Social Care who then see private patients, and that seems to be a lacuna in the RQIA's remit doesn't stretch to cover that. You know, it's one of those areas where obviously we would be interested to see the Panel's recommendations and observations. It will take some time to get to the point of legislative change, there's a question of whether something more immediate is needed in that space, but I would be very interested in whether you 11:46 11:47 11:47 11:47

have observations or views when you feel that you've done enough to reach them in that space because, you know, we are open to receiving suggestions before you reach your final report.

77 Q. Another thing that you have drawn attention to a couple of times this morning is the distinction between Corporate Governance and Clinical Governance. My experience in hospitals, for example, are very much concerned with measuring and providing safe quality care, and it's quite difficult to differentiate these because the Board, as a whole, has responsibility for everything? 11:48 11:48

A. Yeah.

78 Q. Do you think that ongoing separation is helpful, and, if so, how could that be resolved, do you think? 11:48

A. I mean, I think we always have to see the quality of the Service as intrinsic to the Service, and it comes down to who has the skills and the expertise to properly oversee that. I'm loathe to make suggestions that would require my Department to grow substantially in size when I'm not confident that that would necessarily be the right answer, so it may be there needs to be some way of better aligning the methods of governance, but I'm not just sure saying it's the Department's responsibility, and please create a big function to do it makes sense, if that's an answer to your question. 11:49 11:49

79 Q. I get that. Just finally, I wonder, having looked at the previous inquiries and the materials so far here,

and from my own experience, there's a huge value in involving patients and families, and you have referred to it already in the context of being open, and in the death reviews, both of which there's a lot of learning in England and Scotland, and so on. Has the Department given any thought to the greater involvement of patients in Northern Ireland in terms of things like copying them into clinical letters, and initiatives like that, which have been in place in other countries for some time, and to try to assess the value of that in the patient being, in effect, a monitor of their own quality of care through that mechanism? 11:50 11:50

A. Yeah, and I think the other thing, the RQIA review of SAIs also makes reference to patient involvement as well. 11:50

80 Q. It does.

A. I think strategically giving individuals a greater sense of agency over their own healthcare has to be a good thing and we should be looking at ways in which we can achieve that, so I can't claim to be over the detail of what those specifics might look like, but I think, in overall terms, that's the right way to go, and that might include, for example, allowing individuals to decide themselves whether they need a review appointment in some cases rather than it being on an automatic recall basis. So, there's a range of different ways, and again I'm interested in any observations you reach in that space. 11:50 11:51

81 Q. Thank you, that's all from me.

CHAIR: Do you have any questions, Mr. Hanbury?
MR. HANBURY: No questions.
CHAIR: One thought that occurs to me is that you talk about the Department being responsible for the policy, the Healthcare policy, and the fact that you would issue, we do know that you issue Circulars to the various Health Trusts periodically. I just wondered what level of training on that policy is available to the Leadership within the Trusts? Because it seems to me that a lot of the Leadership, current Leadership, for example, in the Southern Trust is someone who comes from a Clinical background but may not have the training in Corporate Governance that is required to put into effect some of the policies, and I just wondered does the Department provide Leadership training? If so, what level of Leadership training and, if not, has any consideration been given to doing so? 11:51 11:51 11:52 11:52 11:52

A. The Department doesn't directly provide training. There is a Leadership centre within Health and Social Care that does provide and contracts with each Trust for Services. Those Services, there may be some they provide to everybody, but there is certainly some that are specific. Each Trust senior team should be designed to have a range of different skills and expertise with, for example, the Finance Director and the HR Director being able to support whoever the Chief Executive is, whatever their background, whether it be a Clinical or a management background. I think your

wider point about whether we do enough in relation to Leadership training for our Service is a good one, and one that certainly I have begun to turn my mind to. I can't claim to have a complete answer yet, but I do think there is a need for us to think about that and there are different sorts of training. My version of Leadership training, yours might be more of a Corporate Governance training you were describing there, I don't know, but I know the two are linked, and it can be about what is reasonable to expect of an individual and what that individual ought to be looking out for in any given set of circumstances. I think another aspect to that is how do we encourage people to take a systemic view as opposed to merely an organisational view when they reach the most senior levels. Again we need to think about how we can do more, I think, in that space, so that there's a regional perspective being taken in relation to some issues, and the idea of regional learning becoming much more embedded as a result. 11:53 11:53 11:54 11:54

CHAIR: Thank you, Mr. May, I have nothing further I want to ask you today. Thank you very much for coming along on what I know is a very busy media-heavy day.

A. I would like to say that that's unusual, but it's not.

CHAIR: Thank you very much. We won't keep you any longer. Thank you. 11:54

I think then 2 o'clock, Ms. McMahon.

THE WITNESS THEN WITHDREW

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon everyone.

MS. McMAHON: Ryan Wilson, who is the Acting Director of Secondary Care within the Department of Health. 14:03

MR. RYAN WILSON, HAVING AFFIRMED, WAS EXAMINED BY MS. McMAHON AS FOLLOWS:

14:03

82 Q. MS. McMAHON: Mr. Wilson, you have provided a very detailed statement to the Inquiry. If I can ask that to be called up. WIT-50710, and it runs through to 50767. Do you have that on the screen in front of you?

A. Yes. 14:04

83 Q. If we just go to the last page of that statement, do you recognise that statement as yours, that's your signature on the last page?

A. Yes.

84 Q. It was made on 1st September 2022? 14:04

A. That's correct.

85 Q. Do you wish to adopt that statement as your evidence to the Inquiry?

A. Yes, please.

86 Q. At this stage, are they any corrections you wish to make or amendments, additions to the statement before we go to it in detail? 14:04

A. There is one, in fact. I would just like to draw the Inquiry's attention to paragraph 38, an update to the

position that I outlined in that statement around the Department's request for a project evaluation of a 2009 review of Urology Services. At the time of my statement I had stated that the Department didn't hold a record of a response from the Health and Social Care Board. I have since found out last week that the Health and Social Care Board did, in fact, submit a response to a request in 2019. It appears not to have been filed by the Department, but has now been received. So we may come to that later in the proceedings. 14:04 14:05

87 Q. I will take you through. What I propose to do with your statement is really to start off with your role, what that involves, and then take you through your statement and highlight the main points along the way as they are relevant to the Inquiry. Mr. May gave evidence this morning and we have covered quite a bit of ground with him. I don't intend to go over that with you, except where relevant to your role, or if you have anything to add in relation to any of that. If you do at the end feel we haven't covered anything, please just say and you will have an opportunity to fill in any gaps. 14:05 14:05

You indicate that you took up your role, in paragraph 1 of your statement, on 3rd August 2020 as Acting Director of Secondary Care. I wonder if you could just explain what Secondary Care is? 14:05

A. Secondary Care Directorate is a Policy Directorate

effectively within the Healthcare Policy Group of the Department of Health. It's one of a number of Policy Directorates which generally provides policy advice to the Health Minister and has policy oversight for the Clinical Services which underpin, broadly speaking, hospital services and ambulance services.

88 Q. You have been in the Healthcare Policy Group since 2013?

A. I have, yes. I have been in the Department since 2005 and in the Healthcare Policy Group since 2013. 14:06

89 Q. In paragraph 4 at WIT-50711, you say your role:

"As the Director of Secondary Care is an Assistant Secretary and the Department's Senior Adviser to the Minister of Health on Secondary Healthcare Policy with responsibility for developing and reviewing Departmental policies which underpin the delivery of Healthcare mainly within hospital settings and the Clinical specialties to which these services are delivered." 14:07

So in layperson's terms, is it possible to translate that into layperson's terms, Mr. Wilson?

A. I will make an attempt. The broad area of Secondary Healthcare Policy, as I said, covers almost every aspect of clinical services that take place within a hospital setting, so the agenda or the priorities for Secondary Care are generally set by the Health Minister. While we cover, broadly speaking, all areas

of Secondary Healthcare, there are, at any time, a number of high priorities within that Service which may be under review or which may be the subject of interest by the Assembly or by the media. For example, a number of areas, prior to my current position as Director, I have worked in and around Secondary Care on areas such as Paediatric Healthcare, Children's Heart Surgery, the establishment of a major trauma service centre, Organ Donation and Transplantation, Fertility Services, those type of broad clinical areas each have a policy position from the Department, or a policy statement of some kind. That is our role as Policy Leads within the Department to keep those policies under review in accordance with the priorities set by the Minister, or in accordance with the needs of the system at any time. 14:08 14:08 14:08

90 Q. When you talk about the agenda being set by the Minister, we don't have a Minister at the moment but, in the absence of that, is it the case that the policy work that was ongoing under that Minister continues until a new Minister is appointed and perhaps stays in that direction or takes a different direction; is that the way it works in real terms? 14:08

A. Yes. I can maybe illustrate that with an example. In 2016 when the previous Minister published what is currently the Department's ten year Healthcare Strategy "Delivering Together", that essentially set the policy agenda for the Department so while we had then a period of three years without any Minister or any Executive in 14:09

place, in effect the policy priorities in the strategic direction for the Department had been set, and that's what we worked to up until 2020 and continued thereafter, although we did have Covid then to contend with from early 2020. The policy position generally set by previous ministers, in the absence of any current Minister, are what we continue to work to.

91 Q. We have spoken to Mr. May this morning about that and the difficulty then of taking things any further, but it is the case that the Department is still working away, as it were, on what's considered priorities at the moment, even though there's no-one at the helm, as it were? 14:09

A. That's correct, yes.

92 Q. You speak about the Departmental policy in relation to the Urology Services at paragraph 11, WIT-50712. You have exhibited to your statement the standard policy brief in relation to Urology dated September 2019, and that's an internal brief that sets out the issues around Urology and for internal use giving, for example, the location of the Services, Clinical Guidelines and other information, sort of a one-stop-shop that if anybody wants to know within the Department about Urology I presume that's the function of that document? 14:10 14:10

A. That's right. There would have been a similar document in place across most or all of the Clinical Specialities that is covered by Secondary Care and, as you said, there's a reference document that gives

a high level easily accessible information for the purposes of being able to pull off-the-shelf, as it were, the key facts and current policy position around any of the Clinical Specialities, and that's used by us as officials for briefing requests or for Assembly questions as they arise.

93 Q. One of the things you have referred to is the regional review of Urology Services in 2009. I am not going to spend any great time on that, but that was a result of increasing demand and issues with capacity, and resulted effectively in three teams, a Team South with the Southern Trust being one of them. You have just said at the bottom of that page, at WIT-50713, you have quoted from the policy document that there was to be a Secondary Care Directorate for the next policy review of Urology Services was 2019. Do you see that? 14:11 14:11 14:11

A. I have it in front of me. It's not on my screen currently but I do have it in paper format.

94 Q. I will read over the page while you're looking for it:

14:12

"A further review has not been completed since policy brief document was revised in September 2019".

I know you weren't in post at the time, but do you have any information about, firstly, why that was planned and, secondly, why it didn't occur? 14:12

A. My understanding of that date is that it would have been an estimation of an appropriate timeframe in which to revisit a regional review of Urology Services on

account of the fact they had previously been reviewed ten years prior, but that estimation would have been subject to any number of factors, including what an incoming Minister might prioritise or what the Department was currently prioritising under the Delivering Together priorities in the absence of a Minister. It serves as an estimation of what we, as Secondary Care Officials, would have considered an appropriate timeframe, but doesn't represent the decision as such to prioritise that. 14:13

95 Q. I think an example of that you give later on is the interjection of Covid in healthcare plans, or you had to meet the demands at the time, and we will come on to that. 14:13

I just want to slightly jump ahead to point out some of the key features of why the 2009 Review was important for the Panel to note. If you go to WIT-50716, paragraph 21. You have said in paragraph 21 that the Department has been unable to locate any records in advance of the initiation of the review, but, nevertheless, at the end of that paragraph you quote from Michael McGimpsey who was then the Health Minister who stated that the rationale for the review was: 14:14

"This was in response to concerns regarding the ability of HSC Urology Service to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and

emergency services."

Then just over the page at WIT-50717, paragraph 24:

"The Terms of Reference set the overall purpose of the review to develop a modern, fit for purpose in the 21st century reformed service model for Adult Urology Services which takes account of relevant guidelines, NICE, good practice, Royal College, British Association of Urological Surgeons, British Association of Urological Nurses. The future model should ensure quality services are provided in the right place at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care". 14:14 14:15 14:15

The context of the review at paragraph 25 was:

"The evolution of the field of Urology from being the provenance of a general surgeon into a separate surgical speciality, and the growth in the number of urologist appointments in Northern Ireland hospitals from ten in 1999 to 17 in 2008 and 2009." 14:15

Paragraph 26 says: 14:15

"The review was completed in March 2009, it contained 26 recommendations."

If we jump forward again to WIT-50719 at paragraph 33, we see:

"Dr. Miriam McCarthy, then the Director of Secondary Care in the Department wrote to the HSCB on 2nd April 2010 to communicate the decision to request that the HSCB implement the recommendations as soon as possible." 14:16

That was the commencement of the Urological Service provision in Craigavon and in outlying areas. 14:16

I would just like to go back very briefly, because you have mentioned the guidelines, WIT-50714. The Inquiry will hear and has received evidence that there are quite a considerable number of guidelines, standards, policies, that are filtered through from various bodies. Firstly, can I ask do those guidelines emanate from your Department or come through you before eventually making their way down through each of the Trust? 14:16 14:17

A. Can I just clarify you're talking about NICE guidelines broadly?

96 Q. Yes, NICE guidelines broadly, generally, yes.

A. That process into which the Department entered into 2006 with NICE was the formalisation of a relationship between the Department and the National Institute. They don't come through my Directorate routinely. There's a branch within the Department which serves as 14:17

the host branch effectively for receiving and processing any new NICE guidelines. They will inform me as the Policy Lead where that NICE guideline is relevant to my policy area. Generally that process is one whereby the Chief Medical Officer would endorse any NICE guideline that's produced. That's the Policy position that the Department adopted in 2006 was that we looked to NICE as the body that provides us with the assurance around the cost-effectiveness and the clinical-effectiveness of any treatment or medication or any new technology. Once that has been through the robust process within NICE, that effectively is the assurance that the Department leans upon, and where the Chief Medical Officer's endorsement of that NICE guideline is based upon. It then undergoes a period of quality screening and consultation by colleagues in the Department who look after that, and then it's formally issued effectively to the Health Service via the former Health and Social Care Board and to Trusts for implementation. At that point, implementation is often subject to availability of funding, so it's not necessarily implemented automatically, but the Policy position will have been set by the endorsement by the Chief Medical Officer of any particular guideline. 14:17 14:18 14:18 14:18

97 Q. Just to clear it up for my understanding. When you say it's not always implemented because of perhaps funding or an issue like that, if a NICE guideline is in existence but not implemented are those standards to be adhered to anyway, or are you referring to guidelines 14:19

specifically in relation to technology or something new?

A. In relation to anything, it will be subject to availability of funding, so the standards may not be able to be applied. For example, just to try and illustrate that point, we have a policy position in effect in relation to Fertility Services where we agree in principle with the policy of providing up to three cycles of IVF, and that's been the policy position of the Department for a number of years, but as yet the funding and the capacity to provide that has not been in place, so it's not a standard to which Trusts can be held to account yet, although work is in progress in that example to get us to that point. I mention that by way of example to show that the endorsement of any NICE guideline doesn't automatically become the standard that Trusts can automatically implement. 14:19 14:19 14:20

98 Q. Yes, thank you for that. And once the guideline makes its way from, we will just call it the Department generally, and finds its way through to the Trust, the Trust then are responsible for implementing that. Do you have any or any of the Department bodies have any oversight of those guidelines; any review or any responsibility around assurance of them, to see if they have been implemented? Do you have any role in that? 14:20 14:20

A. Sorry, just to be clear, on the implementation of NICE guidelines?

99 Q. Yes.

A. Generally once the policy position has been established

and Trusts have been asked to implement it, provided that there is funding and capacity in the system, then that would be one of the functions of the former Health and Social Care Board, now the SPPG in the Department, to ensure that the Service is being delivered to that standard.

100 Q. That oversight role passes through to what we will call the HSCB for our purposes?

A. Yes. It's effectively delegated but as Policy Lead in any of those areas covered by NICE, we would have an interest in drawing assurance from the Commissioner that the Service is being implemented in accordance with NICE.

101 Q. If we just move on then. In paragraph 34, WIT-50719, again in relation to implementation, this is about the Urology Review Recommendations in a response to an Assembly question in 2010. There was a question about how many of the recommendations had been implemented, and just four lines from the bottom:

"The time scale for full implementation is being guided by the Health and Social Care Board and is subject to the approval of implementation plans by Commissioners to fully deliver all of the recommendations."

I suppose just to tie that up with the previous point I was making about the guidelines, does the Department have any role in oversight or seeking assurance or monitoring in any way any recommendations from a Review

such as that?

A. Effectively once a review has been completed on any service and a set of recommendations have been accepted by the Minister -- I will take you back to the previous paragraph, 33, where my predecessor Dr. McCarthy wrote to the Health and Social Care Board. That is the point at which the implementation responsibility is effectively handed over to the Health and Social Care Board to oversee, and then Trusts, as the delivery organisations, would work closely with the HSCB to deliver that in accordance with or in line with the allocation of additional funding. The Department, in effect, has handed that over to the Health and Social Care Board but will draw its assurance from the HSCB and now from the new SPPG group in the Department that there's structures in place to make sure that the implementation is being delivered. 14:23 14:23 14:23

102 Q. The only thing then the Department would have been involved in then would be if the HSCB came looking for funding to make good some of the recommendations? 14:23

A. Yes, the funding process or the funding that's associated with any new recommendations or any new service model effectively goes into a new process, and in the context of finance being extremely constrained as it is at the moment, it's always a constraining factor. Funding will have to be prioritised in normal circumstances where a policy has been set by the Department or by a Minister. There is an expectation that that funding would be prioritised to allow the 14:24

implementation of those recommendations to proceed, but that is in the context of an extremely constrained budget so it's not always automatic that funding is available.

103 Q. It's difficult to look back, and I know you weren't in post at the time, but just so we understand exactly how that works. Would it ever be the case that HSCB would come back to the Department and say we can't implementation that recommendation or the anticipation of the Department that we would meet this service can't be met because, for example, we can't secure the staff, we don't have the capacity? Do those things happen in real life? 14:24 14:25

A. Yes, they do. I can answer that generally and then maybe speak specifically about the Urology recommendations. That is a common constraint. I would say policy is formulated with those constraints in mind and policy generally isn't formulated by the Department in isolation. It's routinely clinically led. That means there's clinical representation from across Health and Social Care Trusts, from the Public Health Agency and from Commissioning within the former HSCB, so it's a collective effort to develop policy, and that will be informed by the relevant NICE guidelines, all of which is the context in which the policy is developed. So while any policy review or set of recommendations will attempt to raise the bar effectively for a service, it then, once that's accepted as a reasonable set of recommendations that 14:25 14:25 14:26

can feasibly be implemented, it goes into a process, as I referred earlier, of prioritisation and identification of funding. So, in reality, it can often be the case that either funding is not automatically available. For example, if the Executive collectively has set a priority for a particular initiative, it doesn't necessarily follow that additional funding has come into the Department's budget to deliver that, so effectively it creates a new pressure which means something else probably needs to be de-prioritised for that to happen. Setting aside the funding, there is, in many Specialities, a recruitment challenge whereby there is a relatively low number of qualified specialists for a particular role. So while there may be a desire to grow the workforce in a lot of areas, it isn't always the case that recruitment into any Speciality is successful. Those are the real life constraints to any policy being implemented once it's been set by the Department. 14:26 14:27 14:27

104 Q. That's very helpful. The Inquiry will hear evidence and suggestions that from the time of the Review there were existing problems that perhaps weren't grappled with, and they will want to look at whether there's any merit in that in light of what subsequently emerged, so that's useful background. Thank you. 14:27 14:28

I think we are close to the paragraph where you wanted to add something, paragraph 38, WIT-50721, just the next page. I think the preceding paragraph -- does it

follow on from that, Mr. Wilson? There was a stock-take. The paragraph you wanted to amend relates to January 2019? Okay. So you had indicated in that paragraph that you wrote to the HSCB asking them to update on the implementation of the Review recommendations, which was ten years post review. You had indicated at that time, as you said, you hadn't been aware there was a response and you said that there wasn't. You haven't yet provided that, because I think you have just received it, to the Inquiry, but I know you have a copy. Would you be able to give us just an idea of highlights from that, from the HSCB? 14:28 14:29

A. Yes, I can, and I apologise for the confusion. At the time of preparing my statement for the Inquiry, myself and colleagues performed a thorough search of the Department's records and, unfortunately, we don't appear to have filed the Post Project Evaluation when it was requested in 2019, but I did find out last week, and subsequently received a further copy, that the HSCB did, in fact, submit that to the Department in March 2019. I received that Post Project Evaluation last week. Essentially it confirms what the HSCB did following the receipt of Dr. McCarthy's letter at paragraph 33, and in line with what the Department would have expected at that time, the HSCB set up the necessary structures to oversee the implementation of the review recommendations, and that was an Implementation Board known as the Urology Review Project Implementation Board, and we will submit a copy 14:29 14:29 14:30

of this PPE to the Inquiry after today. It confirms that £3.5m of additional recurrent investment was made available through the HSCB to Trusts to establish the three team model. That was to, among other things, increase the Consultant workforce within Urology across the region from 19 whole time equivalent Consultants to 23. That was in recognition of the increasing projected demand for Urology Services and the pressures that the Service had been under. It goes on in the PPE just to describe how that funding was allocated across the three teams. There was Team East comprising the South-Eastern Trust and the Belfast Trust, Team South comprising the Southern Trust and a part of the Western Trust, and Team North comprising the Northern Trust. So the 3.5m was allocated across those three teams to increase the workforce and also to adopt the working model whereby there were more Clinical Nurse Specialists incorporated or recruited into those Urology teams to support the Consultant workforce.

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The PPE then goes on to summarise, and it's a fairly high level summary as you would get with PPEs generally, but there is a section asking about value for money. The purpose of the Implementation Board was to ensure that the Urology Service was designed to meet the needs of patients, to recommend to the Implementation Board how the £3.5m should be allocated and to establish appropriate performance indicators. It then goes on to summarise the problems that were

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encountered during implementation of the Review Recommendations, saying that:

"The main problems pertain to the vulnerability of the Consultant teams where sick leave, vacancies and recruitment challenges impacted upon service provision", and goes on to describe a few examples of that. 14:32

That's hopefully answered your question, just to give a flavour of what's in the PPE, and we will submit a copy of that after today. 14:32

105 Q. Thank you. There's mention of the Bengoa Report at paragraph 39 and we spoke to Mr. May about that this morning, that there is work behind the scenes, and you had mentioned yourself about the Delivering Together. Is there any part of that particular policy -- I think you had said that the Delivering Together, there was policy work continuing on that; is that correct? 14:33

A. On Delivering Together generally? 14:33

106 Q. Yes. Is that still a live project as it were?

A. Very much so. It remains the Department's ten-year strategy for Health and Social Care. I mentioned earlier that that was published in 2016. The Department, through the period of there being no Assembly between 2017 and 2020, the Department oversaw a programme of work to review what Delivering Together had identified as the top priority areas for review and progressed those as far as possible essentially without 14:33

a Minister being in place to take the necessary policy decisions at the end of that work. There was work initiated to review Urgent and Emergency Care, Stroke Services, Paediatric Services, Breast Assessment Services, and a number of other high priority areas. 14:34
So when I say "work initiated", what I mean by that is essentially those Services were reviewed with recommendations as to how those Services should be delivered and configured under the broad model that Delivering Together had recommended. 14:34

The core theme of Delivering Together, if you like, was that the Health and Social Care is being delivered on a burning platform and is in urgent need of reform in terms of how Services are configured and delivered. 14:34
When the Assembly was restored in 2020, I think it's fair to say that the plan would have been then to begin to bring these policy reviews and recommendations to the incoming Minister for consideration by him and, where necessary, by the Executive. Covid-19 did 14:35
obviously impact on the ability to do that, and essentially paused a lot of that work. To varying degrees, that work has been picked up, particularly in 2022, but it hasn't been possible to fully resource those through 2020 and 2021. In the last year, the 14:35
Department has concluded some of that work in terms of publishing the Cancer Strategy, the Elective Care Framework, the Review of Urgent and Emergency Care, for example, and a Stroke Implementation Plan, so the

direction that was set by Delivering Together still remains the overarching strategic direction for the Department. There will be further work taken forward under that, albeit that there is a rebuilding job to do in terms of the impact that Covid-19 has had on waiting lists and that is an additional challenge to what would have been the Delivering Together programme.

107 Q. In paragraph 41 you have talked about the priority 1 and priority 2, and we see at the top of page WIT-50722 that Urology Services would be among a number of priority 2 services for review. Later in your statement I think you indicate that post Covid you weren't going to reach Urology anyway, any time soon, I think. Perhaps if you explain what Priority 1 is and why Urology falls within Priority 2? 14:36 14:36 14:37

A. I'm not sure if I used the term post Covid, because I don't know if we are post Covid just yet. The prioritisation, my understanding it's not that Urology was de-prioritised, it's those areas that were listed as Priority 1 were regarded as essential, requiring urgent review. I am referring to urgent and emergency care, unscheduled care, in particular, and general surgery, and those areas where we have systemic problems that contribute to long waiting lists. 14:37

I think it was in the summer of 2021 that a further look was taken and a submission sent to the Minister just to check in on where the prioritisation of those reviews stood at that point in time. Effectively, there was no change to what had previously been 14:37

identified in terms of Urology. There wasn't a reason to elevate it to a Priority 1 status at that point.

108 Q. Just to go back slightly. When you spoke about Delivering Together, is there anything specific, the governance, in the plan in Delivering Together, is it anticipated that restructuring will impact in some way to bring about change to the way in which healthcare delivery is governed or overseen by the Department or the HSCB? 14:38

A. I have to confess that I would need to go back and study Delivering Together to see if that is specifically referenced. My area of interest in Delivering Together really is around the Service Model and the Delivery of Services and which ones ought to be prioritised for transformation. It doesn't spring to mind that there's anything particular around governance issues within that. 14:38 14:39

109 Q. Paragraph 44, WIT-50722, I have referred to post Covid but you were quite right in correcting me. There was a publication at that time in June by the then Minister, Robin Swann, when he published the Strategic Framework for Rebuilding Health and Social Care Services. Was that a document that was aimed specifically to address the state of the Health Service, as it were, in light of what had happened as a result of Covid? 14:39 14:39

A. Yes. At that time just to revisit what the context was. We had just emerged from the first wave or the first surge of high Covid admissions, and there was

a recognition of the impact that that had had. Effectively a lot of staff within Health and Social Care were redeployed to Critical Care roles or to supporting the Covid response and that meant their normal services were largely down turned or paused entirely, so that contributed to longer waiting lists for diagnosis, and for treatment, and for surgery. The Framework that was published by the Minister in June 2020 was a recognition of that impact. It was a snapshot of the impact at that time and a request for Trusts then to bring forward three-monthly rebuilding plans, subject to prevailing Covid-19 conditions. At that point, it was expected, I think it's fair to say, that there may be further waves of Covid-19, but while we were in a lull, as it were, there was a desire to ramp up as much activity as possible, so each Trust was asked to bring forward a set of rebuilding plans and to keep those under review in order to return, as far as possible, to activity levels. Those activity levels, it was acknowledged, could not return to pre-Covid levels at that time because we were still operating, or the Service was still operating with full social distancing and hygiene measures, so that impacted the number of patients that could come through Services. Also, there was an inevitable impact on staff absence due to Covid from that time, from early 2020 onwards. The capacity was not able to be restored to pre-Covid or to commissioned levels, but the aim of the Strategic Framework and the action plans that flowed from that

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was to maximise the activity that Trusts could deliver, and to keep that under review on a three-monthly basis.

110 Q. Would it be fair to say that that represented a landscape change in how things were approached because of the impact on Services, were the priorities moved down? 14:42

A. Yes. It may be worth saying from early 2020 until the summer of this year effectively the Department and the Health and Social Care system was in a business continuity mode and that meant that at any time the priority was to respond to the Covid-19 situation as it was at that time. Other Services inevitably had to be down turned or paused, but the landscape essentially was changed because of that for over two years. 14:42

111 Q. I think that's reflected in paragraph 47 where you have quoted the reference you made in your oral evidence that: 14:43

"No progress will be made on any of the extant planned projects between the 9th March and 30th June 2020. The HSC and all of Hospital Services Reform Directorate and Regional Health Service Transformation Directorate Resources have been redirected towards planning for and managing the impact of Covid". 14:43

Your evidence is that essentially that remains the position?

A. No, I'm not saying that that remains the position currently.

112 Q. Sorry, in relation to Urology. Sorry, I should have said the Priority 2 Urology, just at the beginning of that paragraph, it's not going to move at all and move up the list, as it were?

A. As things stand at the minute there hasn't been any decision to elevate it to a Priority 1 or to the next set of priorities for review. There's a lot of review work underway within the Department and that draws on the Health and Social Care system in terms of Public Health Leads and Clinical Leads from across the Service to provide their input and expertise to those reviews, so there is a limit to the amount of reviews that can be undertaken at any one time. As things stand, there isn't an intention to look at a regional review of Urology Services at this point in time. 14:44

113 Q. You cover that again in the proceeding paragraphs, paragraph 52, where you have already given evidence about the prioritisation of certain services at the moment. Paragraph 55, WIT-50726, we will move on from that background information to the Early Alert, which I think you were directly involved in that. Almost your first day in the office I think was the phone call. You have summarised the position that you found at that time, at paragraph 56, WIT-50727, and one of the first things you mentioned: 14:45

"My response will show that" -- and this is in response to the statement 21 that the Inquiry sent to you -- "that the Trust led Lookback Review was already

underway when the Department became aware of concerns relating to Urology Services in the Southern Trust, after which the Trust progress with the Lookback Review was guided by ongoing discussion with the Department, HSCB and PHA, both prior to and subsequent to the establishment of a Department led Urology Oversight Group in October 2020".

We will lead up to that in a moment. Can I just ask you generally had you been involved in anything to do with Lookback reviews before? 14:46

A. No.

114 Q. Had you been involved in Early Alert process?

A. Yes. Prior to taking up my current position on 3rd August 2020, as I said, previously I have worked either in Secondary Care in related roles within Healthcare Policy Group, so the normal protocol with Early Alerts is that a senior member of staff within the Department can receive a phone call from anybody within the Health and Social Care that meets the criteria. On occasions where a senior civil servant is not available, somebody of the next grade below, which I would have been prior to August 2020, can receive that call and pass on the necessary details to colleagues. I had some experience over several years of receiving Early Alert calls on a range of different issues, from across Health and Social Care Trusts. 14:46 14:46 14:47

115 Q. When you mention that the Lookback Review was already underway, is that merely just a factual statement or

was there an element of surprise for you that things had come so far before the alert to the Department?

A. It is a factual statement that the Early Alert, when reported on 31st July 2020, indicated that the Trust had begun to look back at issues that they had concerns around from early June of that year. As I said, I wasn't familiar with the Lookback Review process or guidance at that point, but I understood the rationale that the Trust had taken to try and quantify those concerns before raising an Early Alert with the Department. 14:47 14:48

116 Q. I'm going to take you through the dates of the Early Alert and the increasing knowledge. I think you talk about your information elevating as time went on. If I could just ask you in general terms, given what you now know about the information over that short window of time, would you have expected or do you think the Department should have been informed at an earlier stage about what was happening in Urology? 14:48

A. I think the Lookback Review guidance has subsequently been revised to provide more clarity in that regard, essentially saying that when a Trust recognises the need to even begin a lookback exercise, that they should definitively raise an Early Alert, even if it's not something that they can quantify at that point in time. I think the previous Lookback guidance left a bit of flexibility for Trusts to try and ascertain more information before raising the Early Alert with the Department. I mean, having reflected on this, 14:48 14:49

I think had the Trust raised an Early Alert sooner, i.e. in June 2020 when they first began to recognise that there were concerns, I think that the process would have been similar in that the Trusts still needed to undertake a large intelligence-gathering exercise in order to be able to quantify, and that obviously has continued on in the intervening period. 14:49

117 Q. I suppose that begs the question then: Why was the Lookback Review criteria changed to try and make things happen a bit sooner? 14:49

A. The purpose of the Early Alert is a notification essentially to make sure that senior members of the Department, senior officials and the Minister are aware that there's an issue, even if the issue can't be completely defined at that time. I think the purpose of tightening that part of the Lookback guidance is really just to ensure that the existence of an issue is known as early as possible. 14:50

118 Q. If you take the Lookback Review issue out of it, would you accept the proposition that if patient standards are in question or if there's a potential for patient risk, then really the earlier the Department know about that, the better? 14:50

A. That's the underlying purpose of the Early Alert system. I understand that the Early Alert process itself or the protocol is under review and will be revised to provide more clarification on the criteria or the process through which Trusts should notify the Department. 14:50

119 Q. Just again for my clarity, so it's not my misunderstanding. It's not the case that commencing a Lookback Review serves to, if I can put it in very general terms, give the Department more time before it has to notify, or give the Trust more time before it has to notify the Department? 14:51

A. Sorry, I'm not sure I picked that up.

120 Q. We were talking about the Early Alert and I said if you take the Lookback review out of it, and you agreed that the earlier the better, that under the criteria for a Lookback Review there are defined times when you inform the Department, so is it possible that the Trust instigating a Lookback Review can serve to extend the time for them to get their numbers together or to get their facts together, where if they didn't instigate that they might have to tell the Department a bit sooner? 14:51

A. My understanding of the revised lookback guidance is that it clarifies that, so the notification comes as early as possible, in effect as soon as the Trust has confirmed that there is something that meets the requirements for a Lookback. I'm not sure that it necessarily buys the Trust more time because in any instance a Lookback Review can be relatively small or it can grow in accordance with what the Trust determines. Whatever that period of time is, it's an intelligence-gathering exercise and it really needs to be assessed on a case-by-case basis, I believe, because it depends where the information is located or who 14:52 14:52

needs to be involved in ascertaining the full picture.

121 Q. Just while we are on this topic, was there any sense at all, at this time or any of your dealings with the Trust, that they were reluctant at all to escalate matters, or that they sought to not go public, that they wanted to delay things; was there any sense of that at all in your interactions with them or from anything anyone might have said to you? 14:53

A. My recollection of the period of time between the receipt of the Early Alert and the early establishment of the Urology Assurance Group, is that there would have been some debate or discussion around the timing of public communications around the issues. That is an issue that does require discussion and consensus because there is a need to get the balance right because if you're making any type of public announcement, the information needs to be well-informed to the extent that it answers any questions that might arise, and also assuages any concerns that might be from members of the public who are affected. I think that was a necessary discussion. 14:53 14:54 14:54

My recollection is that the Trust reported to the Assurance Group that this issue had been discussed internally within the Trust. I believe there may be some differences of view expressed as to whether the -- it was accepted that the Minister was going to have to make a statement to the Assembly at some point. Collectively between the Department, the HSCB and the 14:54

Trust, there was discussion with a view to reaching consensus as to when that date should be. My understanding was that the Trust was reporting some discussion within its ranks internally as to whether that should be sooner rather than later, or a desire to essentially continue the lookback exercise and acquire more information in order for the Minister's public statement to be more fully informed.

122 Q. I wonder just on that point, if you could go to WIT-50734, paragraph 78? I think I partially quoted this about the evolution of the picture, but I will just read out what you have actually said in your statement. This is a time when there were weekly Zoom calls before the establishment of the Urology Assurance Group. So that's the time frame. You have said: 14:55 14:55 14:56

"Over the course of these weekly calls, a clearer picture evolved of the full scope of issues needing to be investigated and the number of patients within different cohorts about whom the Trust had identified concerns and potential SAI cases. The Trust advised that it was developing a comprehensive communications plan for the purposes of handling communications and call-backs with any patients impacted, their families, GPs, elected representatives, and the media. Discussions took place over the course of these calls regarding the relative merits of making a public announcement while the Lookback exercise was ongoing, or alternatively endeavouring to make further progress 14:56 14:56

to fully understand the scope and scale of issues in order to make a more informed public announcement at an appropriate time in the near future. My recollection is that the Trust advised that the Trust Board had taken the view that there was insufficient information available for a public announcement to be made at that time, i.e. during September and into October, and that the Trust would need time to further establish facts, confirm the cohorts of patients potentially affected or who otherwise would be assured that there were no concerns about their care and prepare for the opening of public advice telephone lines." 14:57 14:57

Obviously the last sentence indicates operational things that needed to be put in place. If I can just ask you, you were obviously involved in these conversations at this time around that. Was there any risk assessment carried out by you and the others in the group, HSCB, PHA, into whether or not there was a potentially increased patient risk by delaying making the announcement? 14:57 14:57

A. To my knowledge, there wasn't a Risk Assessment carried out within the Department. It may have been something that the Trust undertook. I can't recall whether that came up in our discussions at that time. 14:58

123 Q. Did you have any discussions around risk and the potential between giving the Trust more time and people perhaps being exposed to sub-optimal care?

A. I think risk was at the heart of all of those

discussions, leading up to and after the establishment of the formal assurance group. Early on in that period, the Department was assured that the Consultant had retired essentially or had effectively left employment with the Trust, and the remaining consultant 14:58
body within the Trust had concerned or prioritised that they would seek to ensure that no patients had come to harm or would come to further harm, so there was certainly a priority coming from the Trust in their discussions with the Department that they would want to 14:59
identify any cohorts of patients and contact them as soon as possible. I think at that time, while there were a number of SAIs, serious adverse incidents, identified, and I believe that contact had been made with the patients with the families involved and those 14:59
individual SAIs, there had not been a public announcement, firstly, and there had not not been a confirmation given to those families that there were similar or related cases identified, so essentially each patient involved would have been contacted as 15:00
necessary or as deemed clinically necessary, but would not have been aware that there were wider issues being looked at or wider cohorts at that point in time. That essentially was what those discussions centred around, was: at what point or when would it be appropriate for 15:00
a fuller announcement to be made in the knowledge that there's always a chance that information could make its way into the public domain and cause further anxiety among patients and families. So there was a desire to

try and acquire as much information as possible in order for any public announcement and any patient communications to be as comprehensive as possible.

124 Q. The changes to the Early Alert system and the Lookback Review, the procedure I'm not sure if they do, but do you consider it might be helpful if they expressly import the requirement that a balance of risk is part of the assessment when considering the timing of such announcements? Do you think that would be something that would be a beneficial factor to include in that? 15:01

A. I personally think that it would be. I think in our discussions risk was a factor and it was a theme of the discussion. I am just not sure that a formal risk assessment was carried out.

125 Q. I am not sure we have them but are there notes of the discussions that took place around issues like risk? 15:01

A. Prior to the formal establishment of the assurance group in October 2020, the Department doesn't have any written records of those discussions. They were settled into a pattern of more or less weekly telephone calls or video conference calls, hosted by the Southern Trust, involving myself and other officials from the Department, the Health and Social Care Board and Public Health Agency along with the relevant Trust Leads. They were more or less weekly calls where the Trust provided a verbal update as to the emerging intelligence that it was gathering through its various strands of investigation or of Lookback. As that picture developed, that led to the decision then for 15:01 15:02

the formal establishment of the assurance group, but we don't have Departmental written records of those calls prior to the establishment of the formal group.

126 Q. I wonder if I could just ask you a little bit about that. The first meeting was on 10th September. Then I think the meetings were weekly up until 29th October, and the Urology Assurance Group then was set up on 30th October. Just for the Panel's note that's paragraph 76 of Mr. Wilson's evidence at WIT-50734. These meetings, were they set up at the behest of the senior officials from the Department or was it another one of the arm's length bodies that decided that this would be a good idea? What way what did that start, that process? 15:02 15:03

A. I can't say definitively whose decision it was or whose direction it was to establish those. To my recollection, the immediate days following the receipt of the Early Alert, as I said in my statement, I had a number of telephone conversations with relevant Leads from within Commissioning from the Health and Social Care Board and from the Trust. The purpose of that was, as I say, to try and ascertain what level of intelligence or knowledge there was around the Trust's concerns. Over that period, between August, September and into October, the Trust was still developing its knowledge around the concerns and attempting to quantify the number of patients in each of the cohorts around whom they may have concerns or need to look back at their care. I don't recall whether it was directed by the Department that we should have weekly calls. 15:03 15:03 15:04

I think there was a recognition that the picture was unfolding and emerging and that a weekly call would be beneficial. I think it's fair to say that there was consensus between the Department, the Health and Social Care Board, the Public Health Agency and the Trust Leads that a weekly call would be useful to check in and hear from the Trust what the current position was.

127 Q. For an audit of that decision-making if one were needed, were any notes taken of the telephone calls that you had with various individuals, apart from these weekly meetings? 15:05

A. No, I didn't retain a note other than my two submissions that were sent to the Minister around the Early Alert. While the intelligence picture was developing weekly, it wasn't until the Trust was asked to submit a formal report around the middle of October of its progress to date that I then sent a further update submission to the Minister in October. 15:05

128 Q. You have provided those submissions to the Inquiry. I suppose what I'm looking for is the information that forms the basis for those submissions, the notes and minutes that you might have used to take a view as to what way the Minister might want to look at the information that you were providing him so that he could be informed of that. If there are no notes or minutes leading up to that or available, then that's the way it is. I'm not going to keep asking you the same question. I'm just interested to know if there are any and where we might ask for them? 15:06 15:06

A. The information would have been formalised essentially when the Trust sent an updated version of the Early Alert notification and then submitted its report, its progress to date report. All of the information gleaned through the weekly calls was a changing picture. The report, as requested in mid-October, provided a further snapshot at that point in time of where the Trust had got to, so that formed the basis of a formal submission then to the Minister around which the decision, at that point, was taken to establish the formal oversight assurance structures. 15:06 15:07

129 Q. I just want to, because we will be hearing from other people who were likely at these meetings, just so we are clear, there wasn't a formal notetaker. These were informal conversations effectively set up to, if I can use the word react in a neutral way, react to the information that was coming from the Trust, in order to devise a plan and provide advices to the Minister by way of a submission. We don't have the information leading to the decision-making up to the submission, but we have the factual information provided by the Trust that informed that submission. Is that fair? 15:07 15:07

A. Yes.

130 Q. A fair reflection. Because from 1st October from the first Urology Assurance Group meeting, we have notes for every meeting since then, and I think more or less, bar one or two individuals, I think it's the same people involved in those meetings, so there will be, hopefully for the Panel, a corporate memory perhaps of 15:08

the decision-making that resulted in the Minister making the announcement?

A. I think there should be. The difference, I suppose, is the purpose of the weekly calls as the rhythm became was for the Department and Health and Social Care Board to agree what the appropriate assurance mechanism or oversight arrangements should be as this picture unfolded. Those calls were hosted by the Southern Trust, so I'm not sure, I don't believe that there has been a minute submitted by the Trust of those weekly calls. Once the Urology Assurance Group was established then from late October, with the Permanent Secretary as the Chair of that group, that's when the Department essentially assumed responsibility for the conduct of those meetings and would have had a formal minute taker in place from that point onwards. 15:08 15:09 15:09

131 Q. Because one of the issues raised by Mr. O'Brien, if we could just deal with it at this juncture, is that he questions the integrity of a strength, and the strength of the information that was relied on in order to commence a review of his practice effectively. He says that was an erroneous basis. That does lend itself to the question of, if at all, did you or anyone in the group seek to test the information that the Trust was providing you with, and which ultimately led to the ministerial submission? Did you seek to ask questions about it or interrogate it in any way so that you were assured that your response to it was based on a sound basis? 15:09 15:10

A. Can I clarify? Are you referring to the submission to the Minister that I sent in October or the subsequent submission around the --

132 Q. I think if we look at this as a chain of events. Everything led to that point, and certainly from the Trust on your actions -- your involvement from 3rd August, everything subsequent to that was layer upon layer which ultimately led to that. The information that Mr. O'Brien takes issue with was the information that subsequently triggered the Lookback and the SAIs, and he questions that. That was the start of what could be considered the particularly intense look at his practice, and he sees that as a sort of a false start. 15:10 15:10

A. Okay. 15:11

133 Q. The Inquiry will have to take their own view on that and hear evidence, but just from your perspective and your position in the Department and the other professionals you were working with, is it the case that you do question the robustness of information given to you or do you take the Trust at face value? 15:11

A. I think that my position, and the Department's position on that is fairly straightforward. The Trust raised concerns initially using the Early Alert process as the mechanism to raise those concerns, but at that point onwards any concern raised by a Trust then becomes a matter of judgement as to what the appropriate response to those concerns should be. The period of August, September, October that followed was very much, 15:11

from the Department's perspective, one of trying to build a full picture of the nature of those concerns and to have those quantified, which the Trust was doing through its various work streams and the cohorts of patients that were being looked at. Those concerns were escalated when the Trust submitted an update to the Early Alert in the middle of October, I can't recall the exact date, but when the Trust began to look at the prescribing practices, the nature of those concerns took on, from my perspective, a greater degree of seriousness. The Department does take what Trusts report at face value, there's no reason to doubt what Trusts report, especially when they are concerns around patient safety. Patient safety is paramount in everything that the Department does, especially when reacting and responding to an issue that arises. We do have to take what Trusts report to us through senior management and through medical directors very seriously, but the discussions that ensued leading to the more formal process were not designed to test the robustness of the Trust's information, but to seek assurances that the concerns were being investigated and that the appropriate interventions were being put in place, firstly, with regard to patient safety and, secondly, with regard to the Trust's overall response to those issues. 15:12 15:12 15:13 15:13 15:13

MS. McMAHON: I wonder if that's a convenient time, I am just about to move on to the last section?

CHAIR: 15 minutes, Ms. McMahon. We will take a short

break and we will come back at half past three.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

134 Q. Mr. Wilson, I just have a couple of other topics to discuss. I will discuss the learning bit at the end. There is a couple of mop-up bits that will come up in evidence and I want to give you the opportunity to comment on them. If I just ask, before asking the question I want to ask, what involvement do you have, or your Department have, in relation to targets that a Trust has to attain? Do you have any involvement in monitoring or overseeing any targets or liaising with the Trust about targets? 15:31 15:33

A. In a general sense, yes, but the function around the monitoring of Trust performance and the reporting of that was a function of the former HSCB, and has now come into the Department to colleagues in the Strategic Planing and Performance Group, so the function remains the same essentially. It is of interest and importance to me as a Policy Lead what waiting time targets are set and how Trusts are performing, because that, obviously, has a bearing on how patients experience it, and how they come through the Service. The Department generally sets those targets normally through a commissioning plan direction issued to the Commissioners, now to SPPG, and Trusts are expected then to deliver upon those. I don't have a direct role in the setting of those targets or in the monitoring of 15:34 15:34 15:34

them, but they are important and relevant to my work.

135 Q. I just want to read an extract from Section 21 Response from Martina Corrigan, who was the Head of Service of Urology. She refers to the word "Department", it may be she is referring to the Department or, having listened to your answer, she may be referring to the HSCB. Given that she makes this comment, I just want to give you the opportunity, if you have any comment, to make on it. There are just other names on this so I am just going to read it out rather than bring it up on the screen, I will just read the relevant part: 15:35 15:35

"It was apparent that the Trust was being held to account by the Department of Health and I am aware of the monthly meetings chaired where comparison with other Trusts on how well they were or were not doing was presented with all Trusts being present. I am aware, through others, of fractious conversations with the Department of Health personnel and feel this impacted on the operational teams as they didn't want the Trust to look bad in front of the other Trusts. While I believe this was introduced for the benefit of the patient, I also believe that the patient's needs were at risk of getting lost in the need for the Trust to be seen to be best performing in the eyes of the Department of Health. In short, it was all about figures and the patient needs, risk getting lost in the midst of these figures." 15:35 15:36 15:36

If you just hold on to that thought at the moment and just, out of balance, I will finish off the next part of the second paragraph on the next page. She also said:

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"In my opinion, the Urology Unit was not adequately staffed but I can confirm that was not due to funding from the Department of Health to implement the recommendations of the review."

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Those are the two particular references. Just in relation to the first reference where she talks about pressure for targets, the notion that Trusts were maybe being played off each over, first of all, is that anything you recognise at all?

15:37

A. Back to my previous comment, I don't have a direct role in the performance monitoring or in holding Trusts to account on how they perform against targets. I have to say I don't recognise that is what is being described as the Department's primary focus, and I want to be careful not to take those comments completely out of context. I would recognise that it's maybe a concern that's expressed at times, but ultimately I would say that from the Department's perspective the monitoring of Trust performance is a really fundamental and important function. The Service is provided through public funding, and there's a Statutory function upon the Commissioners where are now in the Department to monitor how that funding is used, and that is done

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primarily through the process that we generally call Performance Monitoring, so the performance targets are set by the Minister and they are what Trusts are measured against, among other indicators. It's not accurate, I think, to say that would be the sole focus and I would say in my almost 18 years in the Department, and nine years working in healthcare policy, I think that patient safety and patient experience would be paramount. I am saying that from the perspective of a policy maker rather than somebody who is tasked directly with performance management. But the focus really is across both; both are extremely important and fundamental parts of how the system operates. 15:38 15:38

136 Q. To be fair to Ms. Corrigan she will give evidence. The reason why I read that out is because there are other examples in the evidence before the Inquiry of other individuals in different levels, including more senior to Ms. Corrigan, who say the same thing effectively; that there was not so much the Department playing Trusts off, but there was an over-focus on outcomes and perhaps less of a focus on patient quality, the standard of care. Just on that point, I know you have said you are not directly involved in targets but you have quite a considerable experience in the Department. Are you aware of particular targets or assessments that relate to the quality of patient care rather than data, rather than just the numbers? 15:38 15:39 15:39

A. I can't say, it's not something that comes into my

direct responsibility. I think it's worth saying that whilst performance monitoring in general is really fundamentally important, there is probably a constant debate about the nature of how those metrics are set and whether the current performance indicators are the most appropriate, or whether they they can improved upon. I think that's something the Department is looking at, and will look through the work on the integrated care system. So there is ongoing work to look at how and what performance indicators should be set for the Health Service and maybe to relate that more to things like patient experience and overall population health outcomes. But the fundamental data as you describe around actual throughput, if you like, and again, I want to be careful not to make this completely about numbers, but that is still an important consideration. We need to know how is the system is performing, both internally within Northern Ireland across five delivery Trusts and also by comparison to other regions and countries. It's a really important means of assessing where our system is at and how it could be improved. 15:40 15:40 15:40 15:41

137 Q. Just before moving on to the last part in the learning, I just wanted to raise with you the issue of -- I'm not sure if you address it. I don't think you address it in your statement, I don't think you were directly involved but because you were part of the Early Alert process, Mr. O'Brien appears to have only got around half an hour's notice of the announcement by the 15:41

Minister, and I think the Trust got just under an hour. Do you have any view as to the appropriateness of that short period of notice, or was there a reason that those involved in the decision thought that that was appropriate? 15:41

A. I should clarify, I didn't have any direct involvement in the advice or the timing around the Minister's announcement about the Public Inquiry, so my view is a general one. I think it's probably fair to say that when a decision like that is taken that something is of 15:42 a seriousness or a magnitude that the Minister wants to make an announcement to the Assembly, that there's a certain degree of caution needs to be exercised around the handling of that announcement in order that members of the Assembly don't find out through another 15:42 means. It's an important part of giving the Minister his or her place in the making of that announcement. I am aware of the details around timings of who was informed about that just prior to the Minister's announcement, but I can't speak to the rationale other 15:42 than just to say generally that there's a reason to exercise some caution around the timing of that.

138 Q. If we move onto the learning part of your statement. It's WIT-50764, paragraph 168. A lot of these issues we discussed with Mr. May this morning so I'm not going 15:43 to go over them again. He has updated us as to the current position with the Department. You, in paragraph 170 at WIT-50766, have indicated that -- after referring to all of the various developments and

planned reviews:

"It is envisaged that the implementation of any learning identified through the various processes and reviews outlined in this statement include any recommendations from the USI itself will be taken forward at an appropriate juncture." 15:43

I think that last part of your sentence reflects your evidence today, that this is a fluid position for the Department and you have to prioritise. Certainly the issues that were discussed with Mr. May this morning would indicate that the reviews currently undertaken have a certain level of commitment, that they will be followed through once the recommendations are made. 15:43 15:44

Paragraph 171 where you were asked by the Inquiry:

"Does the Department consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?" 15:44

You have said:

"It is clear from the issues identified and actions underway to date that opportunities to improve processes and prevent or mitigate risks exist at a Policy and Oversight level for which the Department accepts it has direct responsibility as well as at an 15:44

operational level."

If I could just ask you, when you refer to the risks in that paragraph, what sort of risks are you referring to? 15:45

A. I think I'm referring to the risks around the concerns that the Trust raised in the first instance around patient safety.

139 Q. Reading that into the sentence then that: 15:45

"There is opportunities to improve the processes and prevent or mitigate patient safety risks at a policy and oversight level"?

A. Mm-hmm. I'm referring there to some of the processes that we have touched upon around primarily the SAI process, the Early Alert process and the Lookback Review process, all of which have been revised or are undergoing a revision at present. These are all essentially protocols and processes through which Trusts identify where there are potential risks or 15:45 15:46 improvements to be made or clinical learning that could be drawn from any incident as it arises and disseminated through the region, through relevant clinical specialities.

140 Q. You are referring to the systems by which you hear of patient safety risks rather than the patient safety risks themselves? 15:46

A. I think that's one aspect of it. I mean, I don't think there's an inherent risk in when the Department hears

about an incident; it's more about the timing of when it's identified in the first instance and the appropriateness of the response to that. Once the Department becomes aware that any Trust has identified concerns about any issue, as I mentioned earlier there then needs to be an assessment and a judgement taken as to the appropriate response to that. Quite often Trusts will have already taken the appropriate action or will have initiated at least the action that's needed to mitigate those risks. 15:47

141 Q. When you are looking at these issues it's sometimes quite difficult to distinguish between Clinical Governance and Corporate Governance whenever you are providing an oversight and ultimate accountability role which the Department has and the distinction between those types, there's certainly a point at which they almost crystallise. Would you accept that, that it can be difficult at times to separate those two notions of governance out? 15:47

A. I know the Permanent Secretary touched on this in his evidence earlier. It's not a question that comes up regularly in my role, so I haven't given that great consideration but I think they are two separate issues. The Corporate Governance to me relates to how the Trust management and its board functions and how it translates to assurance through the Department's Standard Assurance Process. Clinical Governance to me means more around how the medical side of the Service is delivered and the structures that exist and the 15:48

processes around individual clinicians and clinical teams and the role of Trust Medical Directors in providing an oversight to that. Essentially, you know, maybe the role of Trust Medical Directors and their teams is where those two functions essentially converge because you have a role that is part of the Trust's Corporate Governance structure as well as part of the Trust's Clinical Governance structure. They are both important and I'm not sure if I'm qualified to comment further on the importance or the convergence of those two functions. 15:48 15:49

142 Q. Just when you look at your statement in the round, it's clear that there's been significant work or effort put into looking at the Healthcare system and certainly in the systems of Governance that the Department rely on, it's also evident that there's quite a bit of work to be done to adjust those systems so they operate in a way that enhance patient care - the RQIA, the SAI, the Lookback Review, the Early Alert, all the things that are on the list for review. The Hyponatraemia Inquiry recommendations, the Neurology Inquiry, and then this Inquiry. Is it a source of frustration for you that you can take the work so far but in the absence of a Minister to take most of it over the line, then improvements may not take place as quickly as they might do? 15:49 15:49 15:50

A. In the time that I have been in this current role, as I said, we have been in a business continuity mode of operation essentially with the Minister until recently.

Prior to that, yes, we, I think, became accustomed to working as a Department without a Minister and with civil servants having limited decision-making powers, so, in a sense, there is a space in which to develop policy and to review policy and develop recommendations, but there is always a point at which ministerial decision will be needed to advance those. The main source of frustration that arises from that really is around the inability to set a budget for the Department, because inevitably any Policy that we review or any Service that we seek to transform will require some degree of additional investment and on a recurrent basis. Even with Ministers in place for the last eight or nine years, we have been living with a situation of single year budgets and often injections of nonrecurrent funding into the system which helps on a temporary basis, but I think the frustration from us as policy makers and I probably can speak on behalf of delivery organisations and Trusts and Clinicians, is that there, as yet, has not been a a multi-year budget that allows us to undertake any meaningful long term planning so it makes it difficult to put good policies into effect. 15:50 15:51 15:51 15:51

143 Q. I have no further questions, Mr. Wilson. The Panel may wish to ask you some questions, so if you would just wait there for a moment. 15:52

THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:

144 Q. DR. SWART: I just want to bring you back to your comments about Delivering Together and the prioritisation, and the work plan, and the current situation where there is a huge backlog of work, the fact that you have been operating under business continuity. On the one hand, you can regard that as a huge problem, but to what extent has the Policy Group looked at what has really been learned during Covid in terms of the ability to rapidly transform services with good Clinical Leadership, because surely that's an opportunity to actually do things differently. Has that been built into your current thinking? 15:52 15:52

A. Yes, and for the duration of the Covid response, I have been part of the Department's what we refer to as the Gold Command Structure, which has been stood up or met with increasing frequency during periods of high surge in Covid. Those structures would have brought together the leaders from across the Department's Arm's Length Bodies, including Trust Chief Executives. There's very much a sense that it is possible to introduce rapid changes to the way of working and to break down I think what were previously perceived as organisational barriers or silos across the five regional Trusts, and my sense -- as we have continued and hopefully are now emerging from the height of the pandemic -- my sense is that the leaders from right across the system want to capitalise on that sense and there seems to be, from my perspective, a very good spirit and determination to do 15:53 15:53

that. There are, as I said previously, constraints to do that, because it still takes time to develop policy and when we do it properly there is a need to fully involve stakeholders and that inevitably slows things down a little bit. I don't think the system can 15:54
constantly react in a rapid sense. I think the proof of concept has been delivered by Covid in lots of ways that a lot of services could be stood up rapidly and the extent of cross-Trust collaboration, seeing Services as Regional Services where they previously 15:54
weren't maybe perceived in that way, and a centralisation of waiting lists becomes much more of a reality that people can work towards, so I think there is an opportunity in that that has begun to be capitalised upon, but I think there's possibly scope 15:55
for more of that.

145 Q. Within the Trust, they will no doubt be embarking or are embarking on a huge programme of work to improve things in Urology, and there will be quite a cost attached to all that in terms of the transformation 15:55
work. Does the Department recognise and sponsor that or does the funding for that come through another vehicle?

A. Can I just ask you to clarify what type of funding or what type of initiative? 15:55

146 Q. I'm talking about people to oversee improvement projects, additional managerial support, expertise, and so on, which the Trust will incur on a practical way on the ground, I imagine, in order to transform things at

the Southern Health care Trust?

A. Yes.

147 Q. How does the Department's Policy Group assist with that?

A. I think the Department will be open to any requests and discussion around additional funding that's required. It's obvious that funding is extremely constrained this year, and looking into the next one or two financial years, with the budget as it currently is. So there isn't a guarantee. Quite often when Trusts want to initiate a programme or a project within their Trust locality, it will be funded or the additional resource to put in place the core programme team will be identified from within the Trust's own baseline, so there isn't necessarily a need for additional investment on top of that, and that might be a result of other projects coming to an end and project managers becoming available, and there are other projects and programmes that take place at a regional level and that are sponsored by the Department in any case because they are recognised as regional priorities. I'm involved in some of those around the regional approach to transforming Pathology Services, for example, or Imaging Services where you do need need a regional approach of all Trusts working together as a system. In the past we have been fortunate that initiatives like that have been able to attract additional admin funding, and it's not often a huge amount of funding but putting together a core team of three to four

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people to manage and run projects and programmes, in my experience, makes a huge amount of difference for relatively small investment.

148 Q. It's really a question about whether you recognise the pressure this puts on cultures and the need for investment to support the Trust in whatever they think needs to be done as part of your Department Policy role and a part of these big Inquiries? 15:57

A. To bring it back to my role, if that is something that, in this case the Southern Trust or if any Trust identifies a clear need to have or to identify additional investment, my role as a Policy Lead overseeing that particular service would be to, I would often be asked for policy support for a bid to go forward to the relevant Finance Leads. It would be a matter of myself and my team assessing the proposal and getting an understanding of what it seeks to achieve. If that's in line with what the Department would see as a Policy priority we would usually support that, and then the bid or the proposal might go forward for consideration by the relevant Finance Or Economy Leads. 15:58 15:58 15:58

DR. SWART: Thank you.

CHAIR: Mr. Hanbury have you any questions?

MR. HANBURY: No. 15:59

CHAIR: Just one left field question perhaps. One of the issues that there seems to have been certainly in the Urology Department and in the Neurology Inquiry, I think identified this also, there's an issue with

recruitment in Northern Ireland. It may be not just particular to Northern Ireland, but I wondered had the Department any policy initiatives, if I can put it that way, to help to recruit more bodies for our healthcare system here? 15:59

A. The Department has an overarching workforce strategy and the responsibility for that sits with one of my neighbouring Directorates under Healthcare Policy and Workforce Directorate, and it essentially sets a framework for the future planning for the workforce 15:59 needs within clinical specialties looking at projected future demand and demographic change. The purpose of those workforce plans is to prepare in advance or to begin to identify the training needs and the succession planning that's needed to sustain and grow those 16:00 services in line with demand. But inevitably there is always, and across most of the areas where we face long waiting lists, we have a recognised gap between growing demand and the system's current capacity. Often that comes down to recruitment difficulties or workforce 16:00 shortages and Services, by and large, try to address that gap by adopting different models of care or identifying opportunities to work more efficiently, but inevitably there is a need across most Services to grow the workforce. One of the areas I oversee is in the 16:00 Imaging Service, the overall provision of Radiology and Radiography Workforce, so there's an exponentially growing demand across all Specialties for Imaging. We have an initiative underway to radically try to grow

the amount of trainees coming through as radiologists and radiographers recognising what the future demand is likely to be, that needs to be met with the appropriate investment, and it comes back to the point that I made about multi-year budgets and issues like that. Part of my role is to lobby effectively, or to ensure that those types of needs are prioritised because across most of the long waiting lists, one of the underlying factors is workforce, and the succession planning and the growth of the workforce. It's recognised as a major constraint and a major factor in the current waiting list situation that we face. The response to that is being taken forward at the level of individual Clinical Specialties regionally and also within individual Trusts with the Department's oversight. It's definitely not a quick fix, but there is an eye on the future, to the extent that it's possible with our current budget, trying to put in place the necessary resource and training places to address that.

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Another aspect of that, it's not my area of expertise, is the Nursing workforce, which I think was exposed during the Covid crisis, that we simply aren't training and producing enough nurses. Although there were decisions taken immediately prior to Covid to increase the number of trainee places for nurses, it will obviously take a few years for those changes to come into effect.

16:02

149 Q. I mean I can understand the need to plan long term

about that, but one of the points that my colleague was making was in relation to the agility that was shown when there is a will among the medical workforce and the Commissioners and the Department and the Trusts to work agilely, if I can put it that way. I am just wondering is there learning from that that can be applied to this long term planning? Is it possible to cut out some of the fat, as it were, in order to be more agile? 16:03

A. I think in relation to the training and growth of the workforce, I think that is a difficult one because it's accepted it's going to take time to firstly increase the number of training places that are funded and available, and then for the trainees to come through those programmes in order for there to be more feet on the ground, effectively. The notion of agile working, I maybe want to clarify if you are talking about the ability to deploy resources across the region as they are required using the staff resource that's currently in place, is that more the sense? 16:03 16:04 16:04

150 Q. That would be part of it, yes.

A. Yes. I think it's maybe a question that the Trusts can address more directly, but I think there's a desire to do that, and essentially to map the current workforce to where it's needed. I think during Covid it was done in a crisis, and staff responded to that, but I think it probably has to be recognised that staff who were involved in that response were stretched. I probably can't speak on behalf of different sections of the 16:04

workforce as a whole, but that's my sense that, yes, there's a will to do that where it's possible and where there's enough resilience in the system, but I think the first challenge is to build the resilience, and that's not a quick fix. 16:05

CHAIR: Thank you very much, Mr. Wilson.

MS. McMAHON: That's the end of today's evidence.

CHAIR: Thank you very much, Mr. Wilson, ladies and gentlemen. We will reconvene in the morning at 10.00. Mr. Wilson, I think you were scheduled for tomorrow morning to continue on, so our next witness doesn't come until 2:00 then. See you all tomorrow at 2:00. 16:05

THE WITNESS THEN WITHDREW

16:06

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 16TH NOVEMBER 2022 AT 2.00PM