MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 4TH APRIL 2023 - DAY 32

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

_____

GWEN MALONE STENOGRAPHY SERVICES

32

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY BL MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MR. JAMES TOAL BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES
FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL

INSTRUCTED BY:	MRS. SARA ERWIN MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

THE INQUIRY RESUMED AS FOLLOWS ON TUESDAY, 4TH APRIL 2023

CHAIRPERSON: Thank you very much.

MS. TANG: Good afternoon, Panel. Can I check you can hear me okay? Good afternoon, Panel. This afternoon the Inquiry is going to be hearing from June Champion, who is appearing on behalf of Belfast Health and Social Care Trust. 13:57

DR. MAXWELL: You are a bit quiet, actually. 13:57

PROF. MURPHY: You are a bit quiet.

CHAIRPERSON: Yes, and it won't be picked up on the livestream.

MS. TANG: I see. Okay, I'll try again.

13:57

This afternoon the Inquiry is going to be hearing evidence from June Champion, who appears on behalf of Belfast Health and Social Care Trust. The evidence is in a witness statement which begins at page 0881.

CHAIRPERSON: Yes. 13:58

MS. TANG: If the witness could be called, please.

CHAIRPERSON: Got that, thank you very much.

As with the previous witnesses in this section, if you can call out the page number if you're highlighting a 13:58 particular paragraph, it will help the production team to find it.

MS. TANG: Yes, I will. Thank you, Chair.

MS. JUNE CHAMPION, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: Can I just welcome you to the Inquiry. We met very briefly in the little room. We're very grateful to you for your very long statement and many exhibits, and for coming to assist us now. If you want a break at any stage, as I said to you before, please just let me know and we'll stop immediately. 13:59

It is possible, I suppose, the electricity might go. It hasn't happened to us yet, but if it does, then we'll just pause. In the meantime, I'll hand you over to Ms. Tang.

THE WITNESS: Thank you, Chair. 13:59

THE WITNESS WAS EXAMINED BY MS. TANG AS FOLLOWS:

MS. TANG: Good afternoon, Ms. Champion. I am Shirley Tang and I am one of the counsel to the Inquiry. I am going to be taking you through your statement this afternoon and asking you some questions on it. As you know, at this stage in the Inquiry we are focusing on healthcare structures and governance in Belfast Health and Social Care Trust and the things that would have applied to Muckamore Abbey during that time. 13:59

Thank you very much for providing your statement and your exhibits. There should be a copy of it in front

of you. I see that you have paperwork with you.

A. (Witness Nods).

1 Q. You are free to refer to that at any point if you need to. Where an exhibit is going to be opened up, that will be brought up on screen. We'll be using page reference numbers to identify that. 14:00

I'm not going to read your statement into evidence but I may ask for sections of it to be put up on screen. You will be able to see that on the screen in front of you. 14:00

Can I start by asking you to confirm to the Inquiry that you are content to adopt your statement as your evidence? 14:00

A. I am content to adopt the statement, thank you.

2 Q. Thank you. The way I'm going to structure the examination this afternoon is that I'm going to focus in on the questions as they were asked in the broad headings in the letter that was sent to the Trust. 14:00 That letter is found at page 08878. If that could be brought up on the screen, please. Thank you.

As you can see from that, that will define our focus today. It's the module 2 questions, sections 2E to 2I, 14:01 in particular a historical overview looking at the development of the Trust and arrangements for MAH and placement of patients. It will also look at the account of the management and governance structures,

explaining directorates, divisions etc., and the flows of information between them. It will look at interrelationships between the Trusts regarding patients admitted to MAH, the key mechanisms to promote quality of care at MAH and then, finally, the provision of community-based services, so use of learning disability teams etc. I note from your statement that a number of people have assisted you in preparing your statement. 14:01

A. (Witness Nods). 14:02

3 Q. And I'm mindful that there will be some elements of your statement that you will be able to speak more to than others. So, what I would say is if there's any question that I put to you that you feel you aren't able to furnish the Inquiry with a response on, you may not know some of the responses, let me know that. The Inquiry will be calling other witnesses on behalf of the Trust in due course, so it may be that it's more appropriate to put some questions to those witnesses. 14:02

A. Thank you. 14:02

4 Q. So tell me what you can tell me. If you need me to repeat any question or anything isn't clear, do please say so and I can do that.

The only other thing - and I may be just as guilty of this myself - is that as we have a stenographer present, can I ask you to try and speak up and not too quickly. Okay? 14:02

A. Thank you.

5 Q. Can we turn to page 3 of your statement, if that could be brought up, please. Looking at paragraphs 5 and 6 in particular, you provide some introductory information to yourself. You qualified as a nurse in 1980. What kind of clinical roles did you undertake as a nurse? 14:03

A. So, as a staff nurse for the first five years of my career, I was in the Burns Unit in the Royal.

CHAIRPERSON: I'm going to find it difficult hearing you, I'm really sorry. You do need to speak a little bit louder. I mean, these microphones are pretty good, but they're not that good. 14:03

A. All right. Thank you.

CHAIRPERSON: So I need you to speak directly into the microphone and just a bit louder. 14:03

MS. TANG: If you need to pull the microphone closer to you, as I had to, please do. It will be just fine.

A. I'll just test one more time then.

CHAIRPERSON: That's better. Thank you very much.

A. So, yeah, qualified in the Royal Hospitals Trust here in Belfast, worked for five years in the Burns Unit. Moved to theatres. Got a sister's post in 1988. Then, as clinical governance started to evolve in the Trusts in Northern Ireland, I applied for the first Clinical Risk Manager's post within the Royal. I took that up on April Fool's Day 1999 and stayed in that job until Belfast was created, and at that stage became a Co-Director for Risk and Governance. 14:03 14:04

MS. TANG: Thank you. And did you always work in the

Belfast hospitals area or did you ever work in hospitals outside of Belfast?

A. I have never worked anywhere else --

6 Q. Always in Belfast?

A. -- other than Belfast Trust. 14:04

7 Q. You mentioned taking on the Co-Director of Risk and Governance role in 2007. That was at page 3 of your statement at paragraph 7 that we see in front of us. Can you tell us what that post involved?

A. So, that post came in at the time when Belfast was created. Risk and Governance fell under the executive director leadership of the Medical Director at that time. Initially, and for the first probably two years of that role, we were merging the former six legacy Trusts that formed Belfast. So, bringing together the 14:04 14:05 staff from those areas, relocating them, creating Belfast Trust identity for many, many policies and procedures; risk management strategies; working around what would probably be traditional clinical governance roles, which was around incident reporting, complaints 14:05 management, coroners, litigation, clinical audit.

Initially, and I would say probably for the first two years, it was getting everything together. It was a time of huge change for Belfast, so I had teams coming 14:05 from all parts of Belfast, all with their different backgrounds, and it was a time of formulation of new teams and new structures.

8 Q. You've mentioned a couple of phrases there, including

risk management, that I'm going to come back to further on in my questioning.

At the point in time whenever you took up that post, were you conscious of that role relating in any way to Muckamore Abbey Hospital? Or how did that connection -- 14:06

A. Initially we were given information around all the various units. Well, because in risk management and with the use of Datix, we had to know the various spread, geographical spread. We met with all of the new directors as part of that role. There were a lot of areas to take on board. So yes, I knew that Muckamore was now part of the Belfast Trust and geographically disparate for us as well. 14:06 14:07

9 Q. But would it be fair to say it was very much within your remit?

A. It was not only within my remit, I think we had probably got two or three members of the Risk and Governance team from the old North and West Trust who worked with us. As I say, we would have had round the table at that time representatives from all of the directorates to try and help us formulate the policies and procedures and strategies. 14:07

10 Q. Did you report to a Trust director in that role, or what was your reporting arrangement? 14:07

A. Initially I reported to the Medical Director, who is the executive lead for Risk and Governance. Then in 2009, one of the previous directors who was in a Head

of Office/Board Secretary role retired and I took that on as an additional role. In that respect, I was a member of the executive team and serviced the committees, the board and the board committees. From 2009 until I retired, that was an additional role that I held.

11 Q. Okay. You've made some reference to some of the legacy arrangements, the likes of North and West Belfast Trust. I want to drill into that a bit more now,if we can talk about some questions in relation to the historical overview of what this module wants to focus on. 14:08

If I could refer the Panel to page 19 and paragraph 72 of that. It should be on screen now for you. I just want to clarify with you, MAH came in under Eastern Health and Social Services Board from 1972 onwards. Is it correct to say that MAH has been, in some shape or form, under the auspices of either a Belfast Health Board or subsequent Trust structures ever since? 14:08 14:09

A. I wouldn't be aware or recollect that initial structure under the Eastern Health and Social Services Board. It is just my recollection that when it was under North and West from whenever Trusts were formulated here back in the early 1990s, and then moved to Belfast Trust in 2007. But that's as much as I probably can provide you with. 14:09

12 Q. I see. In terms of the Trusts, as they formed where they moved in under Eastern Health and Social Services

Board and later Belfast Health and Social Care Trust emerged, how did Belfast Health and Social Care Trusts interact with the health boards, the likes of Eastern Health association, are you able to comment on that?

A. I'm sorry, I couldn't comment on that. 14:09

13 Q. Okay.

A. But I certainly can find out information for you if, you know, you want to follow that one through.

14 Q. Okay. That's fine. I want to move on and bring up some questions about funding and financial 14:10 arrangements. Again, if that's something you can comment on, please do. Let me know if you can't. I'm looking there at page 8 of your statement and paragraph 20 onwards. I'm looking to paragraph 26, if that could be scrolled down to, please. There's reference there 14:10 to the levels of recurrent funding provided, the financial needs of the Belfast Trust and the various ways of funding, annual funding coming in and nonrecurrent funding growing.

14:11

Then moving down to paragraph 30, please, which is on page 10.

"Each year Belfast Trust works with SPPG, formerly the Health and Social Care Board, to agree the Belfast 14:11 Trust's annual budget."

That whole process of agreeing that budget, is that something that you've had any exposure to or that you

are able to comment on?

A. No. Forgive me, that would have to go back to Mrs. Edwards, in one of the financial teams.

15 Q. That's noted. Can we then move on to focusing in on management and governance structures. I want to start looking at page 39, paragraph 147, please. This is a section where you begin to talk about Belfast Health and Social Care management structures. Moving down through that, if we could go down to page 43 and paragraph 158, please. You have given us some detail there about the different layers of management and I wanted to focus in on, initially, on the directorate structure. Can you describe what a directorate is in Belfast Trust for a start? 14:11 14:12

A. At the time that the Trusts were formed back in 1991 and they were separate identities, I think it's fair to say across the NHS, business units, for want of a better word, were formed called directorates. They were largely around programmes of care. So, for example, you might have a clinical area, such as mental health and learning disability, or trauma and orthopedics, and then for some of the corporates or support services, you would have directorates being formed around specialty areas such as human resources or estates, or indeed my own area, corporate risk and governance. 14:12 14:13 14:13

Each of the directorates had a management team lead. And I know this has all evolved, Ms. Tang, since I

retired, but it would have been a director who sat on the executive team. If it was an executive director, then they sat on Trust Board. They were supported by a senior nurse and a business manager. Within Belfast Trust, there would have been an association or a 14:13
partnership with one of the corporate teams. So, the clinical management team would have had a business partner relationship with somebody in HR to provide them services of that specialty. There would have been a directorate accountant working within finance that 14:14
wasn't part of the directorate structure but provided support and advice and information. From my recollection, there was a risk and governance manager within each of the directorates. Again, that might not have been a full-time post, it might have been a post 14:14
that was combined with nursing.

They were largely formed around programmes of care. And over my period of time in the Belfast Trust from 2007 to 2014, there were a few reconfigurations as, I 14:14
suppose, things were tested and maybe reformed, or directors retired and an opportunity was taken, you know, to re-jig the service.

16 Q. Is it correct to say that the directorate management team, did they report in to the Trust Executive Board 14:15
to an individual on that board, or did they report to the Chief Executive or...

A. So again, if it's a director, there was an executive team. I'm wondering if it's possible maybe to use one

of the structure diagrams?

17 Q. Yes. Do you have the page number to hand?

A. If we pulled up page 1555.

18 Q. Oh there, it's made a bit bigger now. Yes, we see there -- 14:15

A. This is an early iteration of the Trust structure. If you could take it down from my perspective to the bottom of the page. There, you have the service group. It says "Assurance Committees" there, but if we take that as a service group or a directorate, as it was 14:16 then, each of the directors reported to the executive team - coming up the page a bit - and the executive team was led by the Chief Executive. And the executive team reported to the Trust Board.

DR. MAXWELL: Can I just clarify, there's quite a lot 14:16 of matrix management in the NHS, isn't there?

A. Yes.

DR. MAXWELL: Would there have been an operational group that the directorates reported through to senior management, as well as assurance groups? 14:16

A. Yes. I mean --

DR. MAXWELL: So there are a number of different ways in which the directorates report up to the board, not just one single way?

A. Not just one single one. This probably isn't the most 14:17 effective flow chart to demonstrate that.

DR. MAXWELL: This demonstrates risk and governance, your area?

A. Yes.

DR. MAXWELL: But there would be other flow charts operations?

A. Yes. So the directorates -- the directors managerially report to the executive team and the executive team is led by the Chief Executive as the accounting officer. 14:17
Within the executive team - and this would be similar to most NHS Trusts - there are executive director members who are members of the board. So, they are all given the vote under the standing orders and scheme of delegation. 14:17

The executive team in Belfast would have been executive directors, Chief Executive Director of Nursing, Director of Finance, Medical Director, Social Care and also the service group directors. So this is where all 14:17
of the sort of the information came through executive team up to Trust board, and through various committees.

Now, I appreciate Belfast has actually completely rejigged, for want of a better word, the committee 14:18
structure above executive team, but the same flow kind of, everything comes up through the executive team. There would be one or two committees. Social Care's not there in this iteration but it is in one of the documents later on. I think it's probably tab 20. 14:18
There's been some changes around the committee structure more recently, but that's how it was back in 2007.

CHAIRPERSON: I'm so sorry, Ms. Tang, but I just need

to understand this. Dr. Maxwell knows this stuff fairly well but I don't, and others may not. If I have a look at this diagram again, the Assurance Group which sits underneath the executive team, is it populated by different people? 14:19

A. It's actually exactly the same.

CHAIRPERSON: Right. Okay, that helps.

A. It's just, you know, once every quarter, the executive team sat purely as an assurance group looking at all of the papers that had to go up through to the assurance committee. But it was the same team. 14:19

CHAIRPERSON: So it would be the same bodies, as it were?

A. Yeah.

CHAIRPERSON: But they will sit as a committee at different times? 14:19

A. Yes.

CHAIRPERSON: But then they're effectively reporting -- all of this material is effectively being reported at the same time to the executive team. These various committees are reporting up to the Assurance Group? 14:19

A. Yes.

CHAIRPERSON: Which is made up of the same bodies as actually are on the executive team.

DR. MAXWELL: Would the Assurance Group not have had some additional people from Risk and Governance that aren't part of the executive team attending? 14:19

A. That would have been myself as a co-director --

DR. MAXWELL: Yes, so it's not quite the same.

CHAIRPERSON: We need it from the witness, sorry.

A. The Assurance Group was supported by the corporate governance team.

CHAIRPERSON: Right.

A. They weren't members of the -- they would have been in attendance to provide the secretariat. 14:20

CHAIRPERSON: Right.

A. I think potentially it's probably better to go to the more recent one.

CHAIRPERSON: Okay. 14:20

A. If that's... if I can find it. 1699.

CHAIRPERSON: 1699?

A. 1669, I beg your pardon.

MS. TANG: 1669?

A. Yes. 14:20

19 Q. Okay.

CHAIRPERSON: Right.

20 Q. MS. TANG: And in that structure we see the Trust Board, the audit committee, the assurance committees, and then the various directorate and divisional groups that feed up into that. 14:21

A. The boxes immediately below the Trust Board are those committees that are delegated by Trust Board to undertake certain functions, whether it's around charitable funds or remuneration, assurance committee, audit committee, and they've always been in existence. They are all led by nonexecutive directors. In attendance at each of those committees on that second level, directors will be called in to provide 14:21

particular reports.

The executive team then reports through, particularly to the assurance committee. Could we go down to the next page? It then shows, the next layer down, the board subcommittees, who meet on a schedule throughout the year, normally quarterly. They don't all have the same representation, so certain directors or executive directors may chair various subcommittees along here. For example, the Director of Social Care chairing the Social Care Steering Group, et cetera. 14:22 14:22

Within each of those subcommittees there will be representatives from the directorates as well as from the -- at directorate level, there will be senior managers and support services. So, all that information is going up through this very busy matrix to Trust Board. 14:22

21 Q. Can I clarify with you then, if there was an issue raised, for instance, about Muckamore Abbey - MAH as I will probably find myself referring to it - would it potentially have been addressed through any of these committees, depending on what the issue was? 14:23

A. Depending on the particular circumstance that it might have been. So if it was something around recruitment and selection, it might have gone up through the people in Culture Steering Group. If it was something that had come in as a serious adverse incident or a complaint, it would come in through the Safety and 14:23

Quality Improvement Steering Group. I should say, these steering groups offer a second level of assurance. They are independent to the directorate where the incident or the complaint; Muckamore is the point in question. It would also possibly have been reported directly through to the executive team, and they met on a weekly basis. So, there might be emerging issues in any of the directorates, and the first point of call would probably have been through to the executive team as a whole. 14:24

22 Q. Is there a logic behind having that double reporting potentially, that, you know, it could go through one structure but it could also go straight to executive team?

A. Well, the executive team, I suppose, if I could put it this way, is the managerial structure lines. This committee structure level is offering a second level of assurance or independence. I suppose if I could put it as a layer of additional scrutiny and challenge for the people within the directorates. 14:24

23 Q. Thank you. Bringing you back to the directorate structure, you made reference to the number of senior people that would be in that. Could you just remind me who would be the senior leaders in the directorates, the service directorates, so those looking after a clinical area? 14:25

A. This has changed quite recently, Ms. Tang, so I'm not entirely confident in saying how the new collective leadership model works within the Belfast Trust now.

If you take it to from when I can recollect it, there would be a director, supported by a senior nurse, a business manager/co-director.

24 Q. Yes.

A. They have a discrete team. Whenever the leadership model was introduced, what that did was try to increase the clinical input into that. I believe they have a Chair of Division. This is something where I think, you know, if you wanted to explore directorates and divisions, we would probably have to take that back to the Trust because the creation of divisions came after I retired. 14:25 14:26

25 Q. I see. That's certainly something we can pick up with witnesses who are still in the Trust; potentially they could maybe give us a bit more detail on the way it's organised. I. 14:26

Think rather than spend too much time talking about those structures in detail with you just now, given what you've said, I would like to clarify one thing. You've referred to directorates in paragraph 158. On page 44 at paragraph 162, you mention divisions. Then coming down to page 46, paragraph 170, you make reference to care delivery units. Can I just check, is a care delivery unit something new or is that something that would have been in place when you were in the Trust? 14:26 14:26

A. It's new to me.

26 Q. New to you?

A. When I worked in the Trust, they would have been specialties rather than care delivery units. But it's new terminology since I have retired.

27 Q. For clarity, would you be able to say, as a result of that, whether MAH, to your knowledge, would be deemed a care delivery unit? 14:27

A. I would have to take that back and check for you, sorry.

28 Q. That's noted. Okay, thank you. Can I turn to the governance structures in particular? I'm conscious that you've helpfully referred to some of the structures in that. I would like to go to page 24, looking at paragraph 91 onwards. Just to go back to basics almost and thinking about the terms of governance. In clinical governance -- I'll give you a minute just to find. Has it come up in front of you all right? 14:27 14:27

A. Where are we?

29 Q. It's page 24, paragraph 93.

A. Yes.

30 Q. You have it. All right. In your recollection from your time in the Trust, what did Clinical Governance actually cover? What kind of issues would have been dealt with under that heading? 14:28

A. 93 is referring to corporate governance. So it would have been -- that would have been more around finance and the audit committee, but not the Clinical Governance. 14:28

31 Q. So Clinical Governance wouldn't have been captured under corporate governance at that stage at all?

A. No.

32 Q. Can I take it that Social Care Governance would have been the same then, that Corporate Governance was dealing with something different? Are you able to speak to what Corporate Governance would have covered or is that something... 14:28

A. Corporate Governance. I mean, again the Cadbury Report was something that came from private industry. But from the initiation of Trusts, even that Cadbury systems by which organisations are directed and controlled would be very much still in vogue, and it's a definition we would still use. 14:29

I mean, from my recollection, the corporate governance at that time was more things around board effectiveness, the audit committee, the role of internal audit. In the later 1990s and probably even into 2001 was when Clinical Governance started to be introduced within the Trusts here. I think it's further on down in the paragraphs. 14:29 14:30

33 Q. Yes, we're going to come on to that actually. Looking at page 29 and paragraph 112, where it begins, your statement refers to

"... the expectation that organisations would establish a plan for developing and maintaining clinical and social care governance arrangements." 14:30

Then going to paragraph 115, there is reference to

"Clinical and social care governance appearing to signal a new approach to a more integrated model."

Given that your mention of corporate governance, that it was perhaps slanted more at the managerial and financial running of an organisation, what do you understand by the term "integrated governance"? 14:30

A. Integrated governance. I think the example is probably going back to one of those flow charts where we were trying to pull together the elements of... It could be -- I guess it was trying to stop them having individual silos. So a Trust Board just concentrating on the corporate governance function, it was also looking at social care, it was looking at clinical governance around clinical effectiveness, around SAIs. So, a merging of the various strands that had been quite separate up until 2003/4. 14:31 14:31

So, the reporting arrangements, the structures that the Trust Board had formulated, was looking at that broader range, you know, from health and safety to the management of drugs to, you know, other clinical elements of care. 14:31

34 Q. In practical terms, if an issue had emerged in a directorate, for instance, that they were significantly short of staff, is that the kind of issue that might have been discussed by the Trust Board as an overarching governance issue, that it wasn't just 14:32

perhaps a clinical risk that there was insufficient staff, would it actually have been considered as a Trust-wide governance issue?

A. I think that that might well have come through from two different routes. It could well have been identified as a risk and on a risk register and escalated through as a risk that way. Or it could have been a report through to the Director of Nursing, and she brought that to the attention, first of all, of the executive team and then through the reporting structures to Trust Board. So, there were various routes for identifying or communicating those kinds of issues. 14:32 14:32

Staffing. From my personal experience, on an executive team you may well have seen it coming through in various routes. It may have been from a direct report from the Director, saying, folks, this is the issue that I have. That then might have been backed up by the fact it was on a risk register or a different report. It might have come through following an investigation into a serious adverse incident and it was flagged in that route in that way. So, there were various ways of that kind of information coming through to executive team. 14:33 14:33

35 Q. Thank you. Thinking about Learning Disability Services particularly, how did the governance function interact with Learning Disability Services, in your recollection? 14:33

A. And by governance function?

36 Q. The risk and governance function that you were involved in, that you led.

A. Okay. There were, like -- there were formal and informal routes. The governance leads within Learning Disability reported through the directorate line, so their accountability was through to the director in that route. There was an informal or a dotted line between the governance leads or the governance function within Learning Disability and my team, so there was a regular meeting. There were also -- obviously, my team supported the directorate teams in the provision of information. Because as Datix evolved, not everybody had access to it at directorate level. 14:34 14:34

So, there were formal and informal ways of communicating between the corporate team and the directorate teams. 14:34

37 Q. Can I clarify, was there a specific individual who always dealt with learning disability or might that have been picked up by different people in your team? 14:35

A. Within my team, there wasn't a business partner relationship, so it would really depend on the particular information that that governance lead was looking for. So if it was incident reporting, it would have been a nominated person. If it was complaints, it would have been a different member of my team. It was the same person, so to speak, within the directorate. 14:35

38 Q. Can you see any issue where there might have been a benefit in building up a specialist knowledge within

the risk and governance function of learning disability and mental health particularly, and effectively carving out a risk and governance specialist for that function, or do you feel it worked?

A. I suppose I have not really reflected on that. The expert at local level was the governance lead within that particular directorate. I suppose we were more generic in the centre, with more general advice. But the expertise was within the directorates, for whatever that specialty might have been. That was where the local knowledge, particularly in an organisation the size that Belfast is ... 14:35 14:36

CHAIRPERSON: Are you able to assist as to how the filter was set in relation to information going up eventually to the board? Because all of these committees, your Clinical Governance committees, would obviously receive quite a considerable amount, presumably, of information, some of which the board would need to know about and some of which they wouldn't. Who would set the filter? Do you understand the question, first of all? 14:36 14:37

A. I might have to reflect on that a little more. I'm not sure really what the filter... I mean, prioritisation and more strategic things might have been brought to the full board. As things were, you know - I won't say less important because it's very hard to attribute an importance to something. 14:37

CHAIRPERSON: Quite.

A. But higher risks, strategic risks, would have been what

the Trust Board would traditionally have looked at. From my own personal memory, they did like to get operational at times, so they may well have wanted more detail around particular things.

14:38

I probably would have to reflect a little bit more on how that might look.

CHAIRPERSON: Sure. No, I understand that. But would that come down from the Chief Executive as to how much information the board wanted to receive, or at a lower level than that? 14:38

A. Probably it was between the Chair and the Chief Executive, that they would agree the reporting arrangement -- the reporting schedule. Certainly for the first four or five years of Belfast, you know, it was test and see. Was this the right level? The nonexecutives would be very quick to come in and ask for more information if they wanted it, or indeed less information. I think there are some, probably, reports that are prescribed how they might look, and statutory functions would be one of those. There is a template, for want of a better word, for those. The rest, some of it was just up to a little bit of see how things are and what information's there. 14:38 14:38

CHAIRPERSON: Okay. Sorry, Ms. Tang. 14:39

MS. TANG: I think some of those issues may come out in the next section, thinking about risk management and the different tiers of risk register and things like that that are mentioned.

I wanted to take you to page 49 of your statement and, in particular, to paragraph 183. You've referenced there three levels of risk register. Can you tell us what those are? And I want to just try and understand what kind of things would have went on to each.

A. If I start at the lower level?

39 Q. Yes, of course.

A. If that's okay? A risk register at the lower level would be based on information coming from a variety of sources. It could be risk assessments; it might be something that has come through from a report or from an incident or a complaint. I mean, I understand this is always going to be brought up in module 3 where the risk assessment process and risk management process might be in more detail.

40 Q. Yes. Yes.

A. At service level, they are now all entered onto a Datix web risk register, and they use standard regional agreed matrix to evaluate each of the risks. At a service level, you will have all levels of risk from low to extreme.

41 Q. Can I ask, when you refer to service level, are you thinking of a directorate, a division, something of that nature?

A. I'm thinking of below a directorate level. This service level register would be -- could be wards and departments.

42 Q. Yes. Yes.

A. Then the directorates, they do have access. Through Datix web, they can see every level of risk from yellow right up to red, low to high. But they will concentrate - and I guess this is maybe perhaps down to that filter again - they will concentrate on the more significant risks. 14:41

They also make a decision more locally around, you know, the monitoring, the action plans. In fact, there are four levels of risk register here, as I look at it. 14:41

The next level up is the corporate risk register, which takes all of the risks from across the entire Trust in Datix. I don't know, I would need to go back to ask how many hundreds that would be because it literally could be everything from, you know, health and safety risk assessment up to something more clinical. 14:42

43 Q. So, do I understand you correctly that is a compilation of every single risk?

A. It's a compilation, yes. 14:42

44 Q. And it's not that it's only above a certain level of severity, it's everything?

A. It's the whole lot, and this is a bottom-up approach.

Then for Trust Board, what they would traditionally see is what Belfast initially called a principal risk register. That was purely, maybe I think usually about 12 to 14 strategic risks. This is at the higher level, so these would be all having evaluated at around 25, or 14:42

a red on the matrix.

45 Q. So, just to try and give everyone examples in practical terms, what kind of thing might be considered a strategic risk?

A. Well, I do have -- we do have a sample of that, if I can actually read, on page 1731. 14:43

46 Q. 1731.

A. And the next page down, please. At that point in time -- and I should also say that there's been a variation in titles used by Belfast to describe the strategic risk or the principal risk, and that's largely around some of the difficulties that we had. It would now have been called -- from 2001, the principal risk register in NHS Trusts in England would be called a Board Assurance Framework. The guidance came in to Northern Ireland; it wasn't mandatory to have a principal risk register or a board assurance framework until, I believe, around 2009. 14:43 14:43

Having spoken to colleagues in all of the Trusts, the terminology "Board Assurance Framework" to us didn't really mean, you know, it didn't sound like what it was, a risk register. Now, they're all sort of moving to the model that England has used, and two or three of the Trusts here in Northern Ireland refer to this principal risk register as their board assurance framework now. 14:44 14:44

So you can see on that page that there are a number of

principal risks.

DR. MAXWELL: Can I just clarify, the second column is the Trust's strategic objectives?

A. The second column, SQ01, etc.

DR. MAXWELL: Does that relate to the strategic objectives? 14:45

A. It does, possibly further on in the document. Each of the risks on this register have to be mirrored against one of the corporate objectives. You can see that predominantly all of them are against the safety and quality element. There's only a couple at the bottom which are resources, and one is people. 14:45

DR. MAXWELL: So, the starting point is the strategic objectives, and what the board is doing is looking at the risks against its pre-defined strategic objectives? 14:45

A. That is correct.

DR. MAXWELL: Rather than a bottom-up approach?

A. So this is where the bottom-up meets the top-down. So the difference fundamentally between the risk registers at service level up to corporate level are that they are that bottom up approach being brought to the table through from frontline staff. This is where the board are looking at their strategic objectives and identifying what the potential threats to reaching those objectives are. 14:45 14:46

Now, there is a link. As you can see from the reference numbers, the SQ34 or SQ36 means that that is somewhere on either a server - well, its probably on a

directorate or a corporate risk register somewhere, and that is how it has filtered itself up through the system.

If we go to the next page down, it takes you through an example. What is different about this principal risks register, or board assurance framework, to the Datix risk register is that in this document you get some of the gaps in assurance and gaps in controls. There's more information here that is more relevant to a board member than somebody working down at, you know, ward level. 14:46 14:46

This is where the Trust Board are looking at -- this went quarterly to them so that they could check to see, well, what have you got in place, folks, that is trying to mitigate that risk? Who are you reporting to? What's your actions? And, you know, at what committee or -- can you bring that down just slightly so that I can see the top of the page to remind me? 14:47 14:47

Yeah. So you can see across the top the existing controls, the gaps in controls or assurance that have been identified by the directors, and the actions and time scales for that. The column that is entitled "Assurance Internal or External" is where we would have been looking for a form of independent assurance that those controls were actually working. 14:47

Now, when you see this particular example, it's quite primitive considering what I've seen Belfast and worked with them over the last couple of years. We've taken examples from NHS Trusts in England, and this principal risk register looks very much more -- it looks much better now because it has the direction of travel for the risks, it's got much more detail. So this is, I think, one of the early -- earlier principal risk documents but it does kind of demonstrate the difference between the various levels. 14:48

MS. TANG: Thank you. So, we have looked at the corporate risk register. The sense that I have from the headings that you have used is that these are very much high level Trust Wide issues for the most part. There are some specific service areas, like ED referred to there. 14:48

Moving down then to the level below that, Directorate Risk Register?

A. So this is a principal risk register. 14:49

47 Q. Yes.

A. The Corporate Risk Register is something which contains -- it is in Datix format, and occasionally the nonexecutive directors in particular would want to see the both of these together. So, they would want to see the high level principal risk, but they would also want to see, if you want, the next level of risk down that was being identified by all of the directorates. They could have looked at that, you know, once a quarter as 14:49

well.

48 Q. When you say risks identified by all of the directorate, was that a compilation of every single directorate in the Trust, what they identified?

A. Yes. 14:49

49 Q. So it would have had serious risks, relatively minor risks, the whole lot?

A. (Witness Nods).

50 Q. Is that correct?

A. (Witness Nods). 14:49

51 Q. Okay. How did something go from, say, a service level risk register, how did it find its way up into the next one? Was there a severity index that had to be used before it would be escalated up to the next level?

A. Well, yeah, it's the 5 by 5 matrix. I'm sorry, we don't have, I don't think, any of the documentation to support it in this module because I think it was being provided for module 3. It is, in effect, well, it's a semi-quantitative, it's a 5 x 5 matrix that is used, severity against likelihood. You get a level of, you know, risk. Generally speaking, a 15, an amber, is something that goes up onto the Corporate Risk Register. 14:50 14:50

52 Q. So is it a score?

A. Yes, it's a scoring. Although that's always up for challenge. So from risks, from my memory, we looked at risk registers. Each of the directorate governance leads came to a quarterly meet -- no, it was probably more regular than that - meeting with me as a risk 14:50

register group. Then the assurance group, if we take our minds back to the flow chart, they looked at the risks at a particular level there, and then Trust Board looked at the more -- at the risks, at the principal risk level. 14:51

53 Q. Okay.

A. Gosh, it's all very convoluted, sorry.

54 Q. Thank you. I know we are going to speak to that in later modules, so I think that will be picked up in more detail there. 14:51

Can I ask you to focus in on MAH and the risk reporting there, and, in very practical terms, what the methods of reporting risk would have been on-site in MAH? At a ward level, for instance, if someone had observed a 14:51 risk - a risk of injury, perhaps - physically what would a member of staff who noticing something that they felt was a risk, what would they physically do?

A. Speaking generically around wards and departments, the risk would have been reported up through the line 14:52 management structure, so to ward sister, department manager and taken through the directorate structure.

From my recollection, it was the risk and governance leads who actually populated, took the risk as it was 14:52 articulated by the frontline member of staff and populated it on to Datix. I don't know, and we would need to find out, whether you can directly go on as a ward manager and populate a risk from there.

55 Q. That is something I wanted to just come on to straight after, actually. It's the method of capturing the detail of the risk as it happened. So, someone notices a faulty bit of equipment that they think harm could result from; would there have been a standard template form, or is risk reporting something that was quite often done verbally between staff? 14:53

A. Do you know, I can't recollect. I know there are risk register templates that are completed but I'm not sure whether they were used until everybody had access to Datix. I can't -- I can't -- I would have to find that out for you. I can't remember. 14:53

DR. MAXWELL: Did you have a policy of reporting near misses?

A. Yes. 14:53

DR. MAXWELL: So that would have been potentially a way of picking up risks that weren't instanced?

A. (Witness Nods). I mean, it was something that we always, you know, sought to improve because people tended to report -- well, bizarrely, tended to report the incidents that actually happened quicker than the ones that -- you know, taking time to think through as a near miss, if I report it now, it could prevent the incident from happening. But it was something we were always striving to improve, that near miss, lower level reporting. 14:53 14:54

56 Q. MS. TANG: You've made reference to Datix a number of times.

A. Yeah.

57 Q. Can you remember when Datix was rolled out to Muckamore Abbey?

A. I can't, no.

58 Q. You can't?

A. It was... 2007 not everybody even was using Datix, but regionally we started to adopt it. No, we'd need to find that out for you. 14:54

59 Q. Okay.

A. Because it's used for a number of different clinical governance functions. It's used to capture complaints, incidents, risk registers. I think it's used now for alerts around standards and guidelines. It's a commercial software package that is used in all -- by all of the Trusts in Northern Ireland. 14:54

60 Q. Can you clarify with Datix - just in case anyone is unsure - Datix, am I correct in saying, is an on-line, a computer-based -- 14:55

A. Yes.

61 Q. -- capturing system? So for someone who perhaps didn't access to a computer work station, for instance maybe worked in a clinical area where they couldn't routinely access one, would they have had to report an incident through Datix, or not at all? 14:55

A. It was paper forms for quite a long time. I'm not sure when the capability... possibly around the time I retired. But we had books. People completed an incident form, it came back to the corporate centre, and it was the corporate centre who populated it through Datix electronically. I'm pretty sure they all 14:55

have access to it now.

But we had to keep -- thinking about the community-based organisations, not everybody can access a computer there and then, so forms had to be kept going as a second process.

CHAIRPERSON: Sorry, do you mean even when Datix came in, you continued using forms for a while?

A. For a while, yes.

CHAIRPERSON: Right. 14:56

A. So, out in the community, I'm not sure how they now capture those, you know, for people that can't. Or maybe they can all now use tablets, I don't know.

62 Q. MS. TANG: Do you recall if there was any kind of monitoring within your team to look at the numbers of incident reports that were coming in from different areas, whether on hard copy or via Datix? Would you have looked at that via directorate to see how much was being recorded? 14:56

A. I think trend reporting is probably in one of the later modules. 14:56

63 Q. Yes.

A. But statistics and trends and themes and numbers were something that we reported both -- we collated the reports for the directorates and service areas because they couldn't create their own, initially, and also created the reports for those various committees that you saw on the flow chart. 14:56

64 Q. Yes. You're quite correct, we will be going through

that in more detail later on. I just wanted to clarify if there was some kind of collation, an overview of the numbers coming through, and, in particular, if you noticed an area where you thought they don't appear to be reporting very much, I wonder why that is? Would you have had facility to pick that up and potentially follow that up with areas that didn't report very much?

A. Yeah, the numbers -- yes, the ability to interrogate the data would have been there, yes.

65 Q. Have you any recollection of following up on... 14:57

A. On particularly --

66 Q. On particular; if you noticed there was a variation in the amount of incidents being reported across areas that were in other ways fairly similar?

A. Probably followed up on, you know, even lower level trends of data rather than whether there was a historic gap or how to identify, you know, what that was. I think I probably need to reflect on that, from my memory, how we looked at that. 14:58

But at directorate level also, you know, they would be looking at their data against the directorate team. So, there were various ways that you could have reviewed that information.

67 Q. I want to ask you about staff training. There's a little section on that on page 58, paragraph 216. 14:58

CHAIRPERSON: Shall we take a break after that?

MS. TANG: Yes.

CHAIRPERSON: If that's short?

MS. TANG: Of course.

It was really just to try and clarify with you -- if you have that paragraph. It was page 58 and it's paragraph 216. Thank you. I want to clarify with you in terms of training for staff, was that built into the overall risk management process so that staff actually understood what was counted as a risk and what to do about it when they found one? 14:59

A. Can you just -- which paragraph are we looking at? 14:59

68 Q. I have 216. Forgive me, it doesn't use the word "training" particularly but I think that paragraph was what prompted me to ask about training.

DR. MAXWELL: It says "training" at the end of the sentence. 14:59

A. So the Trust has -- well, risk and governance had various training programmes, incident reporting, complaints training. There is a training policy within the Trust, and there was also a training matrix which was developed by Human Resources based on what was mandatory and what was statutory, and then some of the other elements might have been, you know, wider. There were certain elements of risk and governance training that was mandated, so you had to attend it. The risk matrix told each group of staff, whether they were nursing or allied health professionals or security officers, what training they had to have on induction, and thereafter when it needed to be updated and refreshed. 15:00 15:00

We did induction training for all grades of staff on risk and governance at a relatively high level, and then there were various programmes within the suite of risk and governance information that was available.

69 Q. MS. TANG: In terms of what was mandatory, was there mandatory training for staff, i.e. that every single member of staff had to go on that told them how to use the risk reporting system?

A. Yes. 15:01

70 Q. Did that include clinical risk reporting or is it more about fire safety and things?

A. No, it would have been the incident. The incident reporting was integrated so it was one system, whether it was a health and safety issue, building, land and planned, or a clinical incident or a social care incident. 15:01

71 Q. Okay. Thank you.

A. But, Ms. Tang, the detail of, you know, who had what training, again we can certainly provide that for you. 15:01

MS. TANG: Okay. Thank you. I'm happy to break there, Chair, if that's appropriate?

CHAIRPERSON: Sure, okay. Do you think you're about halfway through or not quite?

MS. TANG: I think almost finished. Probably about another 15 minutes. 15:02

CHAIRPERSON: Oh, I see. Okay. All right. Well, we'll take ten minutes. Thank you very much.

THE WITNESS: Thank you.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

MS. TANG: Thank you. Ms. Champion, I want to return, just very quickly, to some of the questions that we were dealing with in terms of risk. I want to get some further information from you in terms of a serious adverse incident. How would you define that?

A. The Health and Social Care Board have guidance. There's quite a significant definition of an SAI. 15:16

72 Q. In relation to somewhere like MAH and learning disability, is there any kind of reference that staff could use to know what an SAI would be?

A. I think there are about 14 -- this might be -- I'm not sure on how many individual criterion there are, but at the highest level they would be applicable to whatever area within a health and social care trust you would be working to. But the definition was developed back in 2003/4 and has evolved since then. They're currently, because of the Hyponatremia Inquiry and the work at that, they are looking at the whole process again. 15:17

There is a definition, regional definition, regional policy, and all of the Trusts use that regional policy. Significant harm or significant injury, or it could be in relation to cyber security. There's a range of criteria that -- 15:18

CHAIRPERSON: But it includes risk as well, doesn't it? Does it not include serious risk?

A. No. It would be more around an actual harm occurring.

CHAIRPERSON: Right. Okay.

DR. MAXWELL: Can I just clarify there. The staff would report the incident and a manager would determine whether it was a serious adverse event, it would be the staff who would make that decision, would it? 15:18

A. The staff are entitled to grade an incident within Datix. They will use a formula within the policy which will, you know, give you an indication of what level of harm that is. Each member of staff's incident form is signed off by the next line manager, who will review it in terms of, well, you know, what immediate action needs taken, does it need to be escalated to an SAI. It's frequently the director of the service area who makes the decision if it's a serious adverse incident. 15:18 15:19

The risk and governance team, because they're overseeing all of the incidents coming in, in Belfast they've evolved a weekly teleconference call which they might challenge. So yes, it's the director's decision but they might, you know, come back to them and say, well, look, you've got this red incident, somebody who died, you know, in ED overnight and we think that meets the criterion. But generally, it's the director who makes the decision. 15:19 15:19

The Executive Director of Medicine Or Nursing can -- could overturn that, if necessary. It's generally the director who makes the decision rather than the member

of staff.

73 Q. MS. TANG: We spoke briefly about training before we took a break. Is the definitions and some practical examples of what would constitute the likes of a serious adverse incident, is that part of the training? 15:20

A. It would be part of the training. You know, for various staff groups, my personal experience would have been doing case studies, particularly with clinicians, to work through a particular example of an incident or a complaint - because complaints can meet the 15:20 parameters of an SAI as well - so also we would have, you know, talked through that, yes.

74 Q. Would the training, or would the feedback from the incident reporting system have gone to staff to show them where incidents were upgraded or downgraded 15:20 compared to how they initially assessed them? Would the feedback that they got have told them that?

A. The feedback, certainly in my time, would have gone back through directorate reports and through learning events in particular. The team in Belfast had created 15:21 safety newsletters and various ways to feed back to staff what had happened to their incidents, or, you know, what learning had been taken out of them. They do try to catch that in annual reports as well.

75 Q. So, if a serious adverse incident was reported through 15:21 to a directorate structure, what typically would have happened to that?

A. Well, again that's very much within the policy, which I understand is coming through for the next module as

well. Depending on the level of -- because even within an SAI, you have three levels of investigation. The decision is made, given the grade, the nature, the type of incident, as to whether it's a local investigation. If it's something more significant and maybe with more regional learning to be taken out of it, you might decide to have that upped to a level 2, which has somebody independent to the directorate area where the incident took place, either as a panel member of the investigation team or chairing that. Then at the highest level, a level 3 would be an SAI where you require an independent team, independent quite often to the Trust as well, which can be difficult. Sometimes, you know, you have to approach clinical experts from other jurisdictions to help you investigate a particular incident. 15:21 15:22 15:22

If you wanted that level of independence because, you know, obviously it gives the carers or the family members more confidence if an incident is investigated by independent people. It's all based on the levels of injury, the levels of significant harm to the person. 15:22

76 Q. So, if something satisfies the threshold for serious adverse incident, regardless of where it forms in those three hierarchies, was there a Trust-wide review of everything that was counted as a serious adverse incident? Did that all go via the Trust Board at some point? 15:23

A. Yes. It was through -- there was one at a level of the

steering group, so that was a subcommittee to the Board committee, and then ultimately they were all seen in the Assurance Committee of Trust Board.

At the beginning of each of Trust Board meetings, during the confidential session, in my entire time there was a session which was called Emerging Issues. So, serious adverse incidents that had occurred in the interval would have been raised in that particular forum. 15:23 15:24

77 Q. Would you have expected something such as staff shortages to be raised as an incident in itself, or might that have been raised through some other mechanism?

A. Staff shortages, I would say, have been on the risk register since I first encountered risk registers. I think perhaps even in the example that we looked at, staff shortages were, you know, escalated up through the various levels. I've certainly seen staff shortages on most Board assurance frameworks. I review them for other trusts as well. So, you know, they would be a fairly frequent entry. 15:24 15:24

78 Q. Have you any recollection of seeing staff shortages flagged as a serious adverse incident, or would that not meet the criteria? 15:25

A. It might meet the criteria for it to be a strategic risk. As an SAI, that might be one of the root causes of the actual SAI as opposed to it being the SAI in itself, if that makes sense?

79 Q. Yes.
A. It might be a contributory factor to what caused the incident.
80 Q. Is there a risk in that approach that the underlying cause might not be fully brought out because the focus is on the incident itself? If there is a staff shortage, for instance, that had led to the serious adverse incident? 15:25
A. Not in my experience. You know, as an SAI investigator, you know, it's one of the areas that you look to in your investigation, all of the contributory factors because you can never be sure what, yeah, what one of the root causes is. 15:25
81 Q. That investigation, who sees that, where an SAI has occurred and an investigation happens? We mentioned earlier that the Trust Board would be made aware of all SAIs, but would they also see the investigations in every case? 15:26
A. They probably wouldn't see the entire report; they might see an executive summary. They would be particularly interested in the learning, what learning did you -- rather than the minutiae of the investigation. What's your learning? What's the action plan? And looking for -- because all of the action plans were reviewed by one of the steering groups, in particular, to monitor whether things had been closed off or action taken. 15:26

So, the SAI full report this time went to, well,

obviously the directorate. It was kept in-house. It was shared with the families, if the families wanted access to it.

In the case of a coroner's inquest, the SAI requests were shared with corners as well. They are, of course, all anonymised to enable that sharing of information to take place. 15:27

82 Q. I'm almost at the end of my questions. I have a couple I want to just run past you in terms of Section G of the structure that we're following, the interrelationship between Trusts and patients admitted to Muckamore. I don't know if that's an area that you're able to comment on but I would like to at least check that with you. I do have some questions that relate to how the care of patients in Muckamore was funded, depending where they came from. Is that an area -- 15:27 15:27

A. I'm sorry. Forgive me, I can't address that, no.

83 Q. I have some questions in relation to resettlement and that agenda. Is that -- 15:28

A. Sorry, no.

84 Q. That's not yours. I had some questions on the explanation of structures that promote quality of care at MAH but in our questioning earlier, you've actually dealt with all of those. So, certainly from my perspective, those are all my questions, unless the Panel have any further? 15:28

CHAIRPERSON: Yes, Dr. Maxwell does.

JUNE CHAMPION WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

DR. MAXWELL: Yes, I have a couple and, luckily, I think they are in your area and your time period.

15:28

You talk a little bit on page 59 of your statement about safety huddles. Could you tell us a little bit about safety huddles?

A. Safety huddles were more in vogue after I retired. I am aware of them because of my IHI training, but more from a theoretical perspective, but they weren't in vogue and used in Belfast the way they are now. 15:28

DR. MAXWELL: You actually say -- I think you say they were introduced in 2007?

A. Yeah, but really through, just through the Safer Patient Initiative rather -- 15:29

DR. MAXWELL: So this wasn't part of the risk and governance structure in the Trust?

A. It was part of the quality -- quality improvement was within -- there was support for it within Risk and Governance but the initiatives were taken forward more with the directorates themselves. 15:29

DR. MAXWELL: Okay. Then in one of your appendices, on page 2927 you give an example of the MAH weekly safety report. Can we get that; page 2927. I wonder, would this safety report go through Risk and Governance, do you think? 15:30

A. No. The date on that is -- is that 2019?

DR. MAXWELL: It is, 2019.

A. What they have introduced is a much more robust quality management system within Belfast over the last -- I think from probably about '16/'17. And they take very detailed infomatic reports. They're created by a number of corporate sources, so I couldn't safely say whether one of the Risk and Governance team supplied this information. But the directorate then present this level of data to the Executive Director Group for scrutiny and challenge. Again, I'm not sure of the regularity of that but we could find that out for you. 15:30 15:31

DR. MAXWELL: So maybe for the next module when we'll talk more about risk management in detail, perhaps we can explore that.

A. Yeah. Because just looking at that, I'm not sure if that's something that the Risk and Governance team itself produces -- 15:31

DR. MAXWELL: Okay.

A. -- for the Trust.

DR. MAXWELL: It's something we can explore with other people from the Trust. 15:31

A. I'm sorry. Forgive me.

DR. MAXWELL: It's okay. The other question I wanted to ask you, you tried to make sense of this very complex matrix management which, in my experience, is common in all NHS Trusts. But what I wanted to ask you 15:31 is the divisions and directorates had this tripartite management that had a general manager and people from professions. You talk in your statement about how the professional leads have meetings with their heads of

professions. So, the senior nurse at Muckamore Abbey would have a meeting with the Director of Nursing, with other senior nurses. Do you know if those meetings were minuted during your time there?

A. I can't answer that, no, sorry. 15:32

DR. MAXWELL: Okay.

A. No.

DR. MAXWELL: Okay.

CHAIRPERSON: Again, these may be things you can't answer but I'm going to ask them anyway to see if you 15:32 can assist.

Can we just go to page 934? This should be a capital investment plan. Just at the bottom. This is, I think, in the period when you were a Director of Risk 15:32 and Governance, so this may not have come across your desk, as it were, but it is an exhibit you've produced. If we just look, it's just right at the bottom of the screen. This is obviously post Bamford: "Muckamore design fees, 2.878 million". Then if we go to the next 15:33 page, we will see that there was a capital project spend - if we go on down, I think - of 4.8 million. Do you have any recollection what was going on at this time?

A. No. I would take that back to Mrs. Edwards. 15:33

CHAIRPERSON: Your role from 2007 to 2014 was Co-Director of Risk and Governance?

A. (Witness Nods).

CHAIRPERSON: I understand that you obviously weren't

therefore in post in 2017 when certain revelations came out about Muckamore, but do you remember during those seven years Muckamore Abbey Hospital being on your radar as a risk?

A. No, I don't recall. I mean, we could go back through, for example, risk registers to see if any risks were escalated but nothing is jumping to my mind, Chair. One of the things that would have been on, in terms of perform -- resettlement would have come up in terms of, you know, where were we at board meetings being asked that, because that was reported. 15:34 15:34

No, I can't recollect anything in particular.

CHAIRPERSON: So, I mean, if there had been an abnormal number of incidents, for instance, being reported out at Muckamore, is that something you'd have expected to have been on your risk register? 15:35

A. Yes.

CHAIRPERSON: As Co-Director for Risk and Governance of the Trust? 15:35

A. Although the risk registers are owned, you know. I'm overview, but they are, at each level, owned by that directorate.

CHAIRPERSON: Sure. No, I understand that. But at Board level, if you see a spike in a particular hospital of things appearing to go wrong, then that becomes potentially a corporate risk, doesn't it? 15:35

A. Yeah. Well, I mean, if you looked at the example we had earlier of emergency departments, that was flagged

up through --

CHAIRPERSON: Quite.

A. -- incidents that were reported, and it appeared on the risk register.

CHAIRPERSON: So in the seven years that you were there up to 2014, you don't remember Muckamore, as it were, being a red flag institution? 15:35

A. Not through the reporting mechanisms that I over -- you know, that I saw or reports that I produced. To my memory, no. 15:36

CHAIRPERSON: All right. Finally this. I don't expect you to recall this at all, but right tend of the exhibits there's a patient satisfaction survey from, I think, Muckamore. Were patient surveys brought before the board on a regular basis that you remember? 15:36

A. Yeah. One of the steering groups, Patient Experience, would have seen the reports of that and then they would have been in the annual reports for sure. So yes, there was a reporting mechanism for that sort of feedback. 15:36

CHAIRPERSON: Yes, okay. Do you know if those would have been retained? The actual core documentation, would they have been kept?

A. I will endeavour to find that out for you.

CHAIRPERSON: Okay. Well, the Trust are her and I'm sure they've heard that, so I'm sure that's registered. 15:37

Okay. That is all that I ask. Unless there are any other questions? No. Can I thank you very much indeed

for coming to assist us. Are you coming back? I don't think you are coming back as a witness, are you?

A. (Shakes head).

CHAIRPERSON: All right. Well, thank you very much so far as the extent to which you have tried to help us, and I'm sure you have tried your best. Thank you also for the very extensive statement that you have written and we will take into account. You can go with Jaclyn. Thank you. 15:37

THE WITNESS: Thank you very much, Chair. 15:37

CHAIRPERSON: We're sitting tomorrow at ten o'clock. I think we've got two witnesses.

MS. TANG: Yes, Chair.

CHAIRPERSON: We may be able to conclude in the morning, but we'll see. 15:38

MS. TANG: Yes, Chair. Tomorrow morning at 10:00 a.m. is Dr. Petra Corr of Northern Health and Social Care Trust and Jan McGall of Southern Social Care Trust at 11:30.

CHAIRPERSON: Okay. Look, if we finish those in the morning, we won't be sitting tomorrow afternoon, but we will obviously have to take the time that we need with those two witnesses. Thank you very much indeed for today. Thank you, everybody. See you tomorrow. 15:38 15:38

THE INQUIRY WAS THEN ADJOURNED UNTIL WEDNESDAY, 5TH APRIL 2023 AT 10:00 A.M.