MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY 21ST JUNE 2023 - DAY 52

52

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

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 MR. SEAN MULLAN 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 AT 10:00 A.M. ON WEDNESDAY, 21ST JUNE 2023 AS FOLLOWS:

MS. TANG: Good morning, Chair; good morning, Panel.

This morning the Inquiry will hear evidence from Ms. Clare Cairns on behalf of the Belfast Trust regarding Module 2, topic (f), and that is:

"Belfast Health and Social Care Trust and MAH management and governance structure, specifically risk and governance arrangements of the Belfast Trust since 2014."

She will be speaking to June Champion's statement. The reference for that is 0881. She will be dealing with some of the issues that Ms. Champion was unable to provide further details about when she gave oral evidence. Ms. Cairns will be asked to focus on paragraphs 130 to 194 primarily, and those are on pages 35 to 52.

CHAIRPERSON: Hang on, sorry. 35 to 52. Yes.

MS. TANG: Chair, unless there is anything further, the witness can be called.

CLAIRE CAIRNS, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:

CHAIRPERSON: Good morning, Ms. Cairns. Thank you very

much indeed for coming along to assist the Panel.

1 Q. MS. TANG: Good morning, Ms. Cairns. You and I met a short time ago. I am Shirley Tang, I am one of the counsel team for the Inquiry. You have been put forward by Belfast Trust to speak to the topic that was previously dealt with in the statement of June Champion. Can I check that you have a copy of that statement in front of you, please? 10:07

A. Yes.

2 Q. I am going to be focussing for this section of evidence on paragraphs 130 to 194, and those are on pages 35 to 52 of the statement. Can I check that you have had an opportunity to read through those paragraphs, please? 10:07

A. Yes, I have.

3 Q. Thank you. I am not going to ask you to formally adopt that into evidence because Ms. Champion has already done that, but rather to confirm that you agree with the contents of those paragraphs in the statement? 10:08

A. Yes, I do.

4 Q. I am going to ask you a general question or two first. Can you tell me what your current role is, please? 10:08

A. My current role is Co-director For Risk and Governance for the Belfast Trust.

5 Q. How long have you been in that role?

A. I have been in that role since July 2014. 10:08

CHAIRPERSON: Can I ask you to keep your voice up a little bit because this is being live streamed and I know that sometimes people can't hear what is being said.

6 Q. MS. TANG: Can you tell me how long you have worked for Belfast Trust?
A. I have worked for Belfast Trust since its beginning, as a senior manager within the Risk and Governance Department; and prior to that to the Legacy Trust, Royal Victoria Hospital. 10:08
7 Q. So, always in the Belfast hospitals?
A. Yes.
8 Q. Whenever you were previously a senior manager in Risk and Governance, did that cover general areas in the hospital or was that on a specific clinical service area? 10:09
A. It was a corporate role.
9 Q. A corporate role?
A. It was the central team. 10:09
10 Q. Would you have focused on any particular area like Acute Services Or Mental Health, or was it any of the Trust service?
A. No. It was more the corporate function of the structures that the various clinical teams would have used to create their governance structures within their own areas. So it wasn't directly with any particular clinical area, it was a totally corporate function. 10:09
11 Q. So a very generic --
A. Yes. 10:09
12 Q. I understand. You've told us that you commenced in your co-director role in 2014; is that correct?
A. Correct.
13 Q. Can you outline what the Trust governance structures

looked like at that point in time for us, please?

A. So, they continued on as they had done really from the beginning of Belfast Trust. The Medical Director's office had corporate governance -- well, a risk and governance team that covered various strands of risk and governance from incidents, complaints, claims in terms of clinical negligence claims, EL claims and OL claims.

14 Q. Sorry, EL and OL?

A. Employers' liability and occupiers liability. And Coroner's inquests, along with risk management in terms of the development of risk registers, risk assessment, and the Standards and Guidelines Department that hosted the receipt of standards and guidelines and dissemination and would follow it up with the implementation of those standards and guidelines across the Trust.

We had medical devices in our remit. Not that we managed every medical device in the Belfast Trust but we would have been charged with the policy for that, maintaining it, et cetera, and assisting staff in reporting incidents specific to medical devices, and safety alerts that come into the organisation in relation to medical devices.

15 Q. Okay. You mentioned guidelines and things like that. Would that have included things like NICE guidelines or anything like that?

A. Yes.

16 Q. So am I right in understanding that those might have been sent in to the Medical Director; your team would then have disseminated those to whoever needed them?

A. That's correct. They generally -- they can come in a variety of reasons -- routes. Ideally, we like them to come to a specific mailbox today so that we have a grasp that they have come into the organisation. But inevitably they can come into a variety of people, and people will be dealing with them in their own world, not down the route that the Trust expects them to be dealt with. 10:11 10:12

But in theory, yes, they come through us. Then, one of the deputy medical directors will assist with agreeing where that guideline needs to go to in the organisation, because they can be a very vast range of topics that come in and it's important, therefore, that they are directed at the right speciality who need to deal with it. Some of them will affect all specialties; one will be particular to one specific speciality. 10:12 10:12

17 Q. In general if a set of guidelines came in and they applied to a particular service area, obviously you've told us that you would be disseminating them to that area. In terms of how compliant that service area is with those guidelines, does your team have any role in assessing that and trying to work out whether the Trust is actually on the mark with those or whether something needs to change to be compliant? 10:12

A. So, it has changed over time. Back in 2014, the team would have -- the team in particular that was dealing with that guideline would have done an audit of their compliance with the guideline, and they would have made a statement in relation to that. NICE actually advocates the completion of a baseline audit tool, which Belfast Trust at a point in time was not completing. In the last few years, we have introduced that and insisted on that baseline audit tool being completed and submitted back to us. Then, there is a nominated individual or individuals within a specialist team who are charged with actually then taking steps to address any gaps that there might be, and we would expect to see that come back through to us. 10:13 10:13

18 Q. Sorry to interrupt. I just want to clarify. When you talk about an assessment and the specialist team, is that within the clinical area that the guidelines relate to? 10:13

A. Yes.

19 Q. If I understand you right, that team assesses how far off the compliance we are, if at all, in reference to yourselves? 10:14

A. Yes. So, it could be a clinical director in Learning Disability, for example, who would receive the guideline and assess how the Trust met it or didn't meet it, and what action is needed to be taken to address it. 10:14

20 Q. That is then reported back through to yourselves as an action plan, or what does it look like?

A. Yes, it looks like an action plan. So all of the item -- it is all itemised and referenced, and there would be an action against each piece. The Health and Social Care Board monitors this, and actually they monitor -- it's not monitored through my offices, it has always been monitored through the Planning and Performance Office.

21 Q. Okay.

A. So there would be a status report go to the Health and Social Care Board on a regular basis to inform on progress. 10:15

22 Q. Am I right in thinking it's mostly clinical people or people from a clinical background in your team who will be doing the assessment, or who will be looking at --

A. Sorry, it isn't my team that do the assessment. 10:15

23 Q. Yes, I know but in terms of looking at what is sent?

A. It would a team in the directorate or the division who would do that assessment.

24 Q. Yes. They have done their assessment, they send it back to you. Is it mostly clinical people within your team who look at what they send back? 10:15

A. It would be a deputy medical director who would have sight of it.

DR. MAXWELL: Can I just clarify that point? I think you said the clinical area assesses their compliance with the NICE guideline and produces an action plan and that then goes to the performance monitoring team. Have I got that wrong? 10:15

A. No. The action plan doesn't go back to the performance

monitoring team, it would come back into the central team in Risk and Governance, but the monitoring of it is done from the Board through the Planning and Performance Team; so the request for updates on. If, in a six-month period, we have 10 NICE guidelines that are active, there will be a status report go back through the Planning and Performance Team.

DR. MAXWELL: So, what's the relationship between the central risk and governance team and the performance team. 10:16

A. It's, I suppose, a partnership working. It's not that we report to planning and performance, they are another directorate within the organisation that we would work alongside. The Assurance Framework is closely linked to our corporate management plan, which again is led by the planning and performance director. So we would work almost in partnership to create that environment. 10:16

DR. MAXWELL: Is that an executive director post?

A. The Planning and Performance Director is not an executive director. 10:17

DR. MAXWELL: But attends Board?

A. Yes. Absolutely.

DR. MAXWELL: The action plan comes to you. Is it copied to them --

A. No. 10:17

DR. MAXWELL: -- or do you alert them to things that need to be monitored? How do they know they need to monitor it?

A. They don't. They get their queries coming in from the

Health and Social Care Board as to what they want an update. The Health and Social Care Board have had, up until recently, regular meetings with key people, key directors within the organisation, so almost an accountability meeting. Responses to NICE guidelines might be picked up at those meetings as well.

DR. MAXWELL: The baseline audit, when a new guidance comes out, is done clinically, it is sent to the Risk and Governance Team. Do you then send that to the HSCB or SPPG? 10:17

A. When a NICE guideline comes in, it generally will have timeframes that they expect actions to be completed by. There could be different timeframes in the one guideline. There could be elements they seek immediately or there could be elements that are longer. 10:18 So, we would be monitoring those timeframes in seeking answers to progress at specific points within the guideline.

DR. MAXWELL: That would be the Risk and Governance Team, not the Performance Team. 10:18

A. No, no. They are just simply the conduit from the Trust, out of the Trust to the Health and Social Care Board. Now, I would have to caveat that in that very recently, in the last year since the Board has become part of the Department as SPPG, what we are finding now 10:18 is there is a shift, and so there will be quarterly performance meetings. I, as Co-director For Risk and Governance will deal with, today in a guideline coming in, I will be asked about the position of a particular

guideline. If there is a delay in responding within timeframes, it will come through my team, which historically it didn't do, it really came through the Planning and Performance Team. Outside of that, there were regular meetings in the region where all of the standards and guidelines staff in all of the Trusts would have met regularly. There may have been discussions at that about guidelines but it wasn't an accountability forum as such. 10:19

DR. MAXWELL: Thank you. 10:19

25 Q. MS. TANG: Can I just probe something a wee bit in terms of what comes back into your team from the areas. I am just trying to think about the assurance side of that. Hypothetically, if an area is asked to implement a detail of a guideline, say ensure that there is a certain number of staff trained in a particular method of working and they have to have that done by the end of the year, whenever you are looking at that with clinical eyes on it, are there circumstances when you would look at the directorate or whatever's report and say, yes, we are on track with that, and you, with your clinical head on, would say you are never going to have done by then. Do you push back on things that they tell you or is it very much that you receive it and you send it on? 10:19 10:20 10:20

A. It really would be a receipt and sending on. I wouldn't -- from a clinical perspective, I personally wouldn't be very close to the day-to-day operational management of this. It would more be the deputy

medical director who also chairs the Standards and Guidelines Committee in the organisation would be more hands-on in the clinical assessment.

26 Q. Are you aware of times when they might have pushed back and said, look, folks, we're concerned you might not achieve that target on time? 10:20

A. I can't say. I would need to check that. I mean, I think it's probably something I could check but I couldn't say off the top of my head, I'm sorry.

27 Q. That's okay. Thank you. 10:21

I want to look at the statement now. If we could go to paragraph 130, which is on page 136. Okay. That should be coming up on the screen in front of you as well there, Ms. Cairns. Sorry, it's page 36, and it's paragraph 130. My apologies. 10:21

CHAIRPERSON: Paragraph 130?

MS. TANG: It is on page 35, my apologies.

Okay, that's in front of you there. That statement refers to organisational objectives that the Trust set out in its corporate plan. I can see, if we went down the page further to 133 - I think that's just over the page - that by 2013, the corporate values of the Trust are being streamlined, the words used there: 10:21 10:22

"Treating everyone with respect and dignity, displaying openness and trust, being leading edge, and maximising learning and development."

Would it be fair to say that there are a number of different strategic plans and structures that the Trust has to work to at any given time?

A. The corporate plan will be the main one but there will be -- for example, at a point in time there was a quality improvement strategy introduced, and it had a plan associated with it. 10:22

28 Q. Was that something that your team played a key role in?

A. We were involved with it. It would have been led by the Medical Director, the quality improvement plan, yes. 10:22

29 Q. Okay. Was that specific to individual areas, quality improvements that, for instance Learning Disability Services should achieve, or would it have been more general? 10:23

A. It was broad themes, so improving safety of medications. I can't remember. Sorry, I apologise, I can't remember the exact wording of it. For example, it would be improving the safety around medication, so it could have applied to anywhere where there were medications in use, for example. 10:23

30 Q. Okay. In terms of how that worked its way down through the organisation, high level themes as you've mentioned, is it the case that divisions, directorates underneath would have been expected to respond to those themes or how did that filter down? 10:23

A. Yes. Certainly with the corporate plan, absolutely the objectives that are in each directorate would devise

how they would contribute to that and what they would be doing in that year in relation to that. The quality improvement plan was slightly different in that it was led, and reps from all of the directorates would have been involved in agreeing what the key themes were and then would have taken them away and would have been working with them.

31 Q. Okay. Did they report back on how they were delivering against anything they had committed to, via yourselves?

A. Yes. The monitoring of the quality improvement plan would have been done through one of the steering groups of the Assurance Framework. So it would have been the safety and quality steering group at a point in time.

32 Q. What way did your team link in with that group?

A. Our team would have supported that group in an administrative role, and our team also would have been involved in collating some of the data that might have been used at that steering group.

33 Q. Would you have played a role in flagging up risk areas, for instance, there is somebody who has not managed to meet their targets or here's somebody else who is struggling? Would your team have picked that up?

A. Well, the ethos of the Trust really would be, and it is laid out in the assurance frameworks, that the directors for each directorate are responsible for being over their risks and driving that forward at directorate level. So, we have designed a structure that they operate within.

34 Q. From that perspective, am I right in understanding the

directors of the individual areas would be expected to flag areas of pressures, challenges --

A. Yes.

35 Q. -- non-compliance; it wouldn't have been yourselves?

A. Yes. 10:25

36 Q. Can we go down to paragraph 136, which is I believe is further down that page. Thank you. Reference to the concept of assurance there. Would it be fair to say that this was about the Trust making sure it was achieving what it was meant to be doing; checking that 10:25 what it was supposed to be doing was actually happening?

A. Yes. Being assured --

37 Q. Being assured.

A. -- that what it thought was happening is happening. 10:26

38 Q. Can I clarify, whenever you are talking about assurance and risk and governance, are you thinking purely about clinical risk and governance or would your team have had any link across into the other areas, managerial risks or financial risks? 10:26

A. So not financial risks; that sits within the Finance Directorate. It is not just clinical risks, I suppose. You know, we would have a health and safety team sitting within our remit so we would be interested in those types of risks as well. 10:26

39 Q. Can I ask you about operational risks, so an area that was struggling to staff rotas. Is that something that would be brought through to your team?

A. No. That would be dealt with at directorate level.

40 Q. Directorate level.
A. The Assurance Framework seeks to delegate responsibility for the risks, incidents, complaints, et cetera. So, it is laid out and hasn't really changed from the beginning of the Belfast Trust. How the Assurance Framework materially works and functions has remained the same. Yes, directorates have changed and some of the external drivers have changed, and the Assurance Framework has been adapted to accommodate those changes, but actually the roles and responsibilities within the framework have remained fairly constant throughout. 10:27 10:27
41 Q. Okay. Thank you. I want to move down to paragraph 143, which is on page 38, please. I see mention there of the Board Assurance Framework. Is that a document that your team would have contributed to or played a role in developing? 10:28
A. So, we play a role in the development of that document. It is a document formally known as the Principle Risk Document, and I know the terminologies can cause confusion. It is a list of the risks that our executive team and Board believe to be the risks that involve us actually achieving our objectives, so they would be at a strategic level. 10:28 10:28

My role in that would be coordinating the quarterly update to that document; liaising with the various directors to make sure that they did update it. However, the knowledge of their service and the detail

behind the risk would come from the directorate themselves, wherever that risk might sit. We would then keep a record of the update. We would, for Trust Board's benefit, highlight where the changes where each quarter that it came to them for their consideration. 10:29
So, it is an administrative role as well as the actual development of the document at the beginning of the Belfast Trust. The format of it remained very similar right throughout the Trust up until 2021. At that point, we were looking at really revamping both the 10:29
Assurance Framework Committee structure and the roles and responsibilities within it, plus this risk document, which is the highest level risk register that the Trust has and that the Board considers on a quarterly basis. We, at that stage, horizon-scanned 10:29
examples of other Board assurance frameworks across the UK and what the latest thinking was. So, it looks different today than it did up until 2021.

From my mind, it is clearer. The way it's laid out, 10:30
the Board can see at a glance whether a particular risk is increasing or improving. They can see clearly where the controls are and what the gaps in control are; what the assurances are against those controls. We've introduced three lines of assurance. So, it clearly 10:30
articulates whether the assurances are coming from the first line of assurance, which is the assurance that you would find at a department level, a self-audit that a department is doing on something to confirm how

things are. Or, as its second line, perhaps someone more senior in the organisation committee within the Assurance Framework is seeking assurances, have asked for an audit of something. Or whether it's a third line assurance, where there is an external body coming in and assessing how we are performing.

We use, as all Trusts in Northern Ireland do, we use an internal audit, who sit in the Business Services Organisation, to come in. Although they say internal audit, they are an external body who regularly audits us.

42 Q. You have preempted where I was going to go next, which was talking about audit actually. In thinking about the assessments, say if a department does a self-assessment of how they are getting on against a risk area, how does the Trust assure itself that that audit is robust and that that department hasn't had a bit of a false sense of security that they are doing much better than they actually are?

A. I believe -- well, there is a certain amount of trust in terms of a director being confident that the audit is accurate. We have certain mechanisms where you would check that. So, if there was any doubt that there wasn't a satisfaction that that assurance wasn't robust, you would go to the next level up and perhaps seek a second line of assurance. Or, indeed, use something like internal audit. Regular RQIA reviews are ongoing all of the time and will find issues. You

can link that back to what the Trust is saying about -- what the directorate is saying about a risk.

We also have in the Belfast Trust, which was unique to Belfast Trust, the Belfast Risk Assessment and Audit Tool, within an acronym of BRAAT. It really is a tool that articulates a series of standards. It is a self-assessment, but we have introduced a verification. So at random, the corporate team would go out and verify that a ward sister who had completed the tool was accurate in what they said; they would cross-reference. It wouldn't be done in every area, we simply wouldn't have the resource for that, but there would be some picked at random that would check that verification. That is just an example of how that might happen. 10:32 10:32 10:33

43 Q. You've mentioned the BRAAT mechanism that you have. Is that generic, in other words, it could be applied to any area, or is it tweaked for individual clinical areas, like mental health for instance? 10:33

A. In total it's a generic tool. There will be standards within that that might not apply to everyone and they will, for that section, rule it out as not applicable. But it is a generic tool that can be used across the organisation, both in clinical settings and in non-clinical settings. 10:33

44 Q. Is it tracked who has used it and reported against it? Is everybody expected to fill it in for their areas?

A. Yes. There are an agreed number of assessments that

are expected to be submitted. It's a tool that runs for a three-year period, and it is monitored by the Trust's joint Health and Safety Committee. So, there are regular updates from each of the reps of each of the directorates who would provide that committee with an update as to how it's going.

45 Q. Would Learning Disability Services be expected to complete that as well?

A. Yes.

46 Q. Are you aware of them completing it in the last few cycles in the last years? 10:34

A. They will have completed. I'd need to check the records but I would be surprised if they hadn't.

47 Q. Okay. Just thinking about Learning Disability Services, are you familiar with the term "risk appetite"? 10:34

A. Yes.

48 Q. In terms of how that works, can you explain that to us, please?

A. So, risk appetite is tied in with our assessment of risk. It's referenced in our risk management strategy. It will direct our staff across the organisation to understand what our appetite for risk is. In that I mean when they assess a risk, depending on what level or grade that risk comes out as, it will direct who can be delegated to have oversight of that risk. If it comes out at a particular level - above 15, for example - then that would be considered a corporate risk and Trust Board would want to have sight of that 10:34 10:35

risk. So, our appetite would be that that has to be monitored very closely and that Trust Board have to have ongoing oversight in it.

We have had quite a rudimentary understanding of risk appetite over the years. If I'm honest, it is something that we still are developing and improving at the moment. In the next iteration of a risk management strategy, which is undergoing fairly radical revision, we are looking at risk appetite and how that can be better explained and understood by staff on the ground, because I think it's an area that we all struggle with at times as to how to explain it clearly. 10:35 10:36

49 Q. Can you help me understand what kind of risks might attract a score of over 15 within that? 10:36

A. It's hard to give you a generic answer to that. It basically will be on the risk matrix and what the most probable outcome from a risk materialising is going to be against the likelihood. So, if the most probable outcome of a risk is that there is going to be a catastrophic outcome, that a patient may die, and then the likelihood of that actually materialising is rare, then it will be calculated as an amber risk; it won't make it onto the corporate risk register as such. It really depends on the scoring. Each risk is individual. It depends on the person assessing the risk as to what they think the most likely outcome is. They have a matrix that has a series of domains, so they will pick the most relevant domain. I have picked 10:36 10:37

patient safety there but it could be compliance with standards. There is a list of them. We always recommend that if a risk actually fits with more than one domain, then you would pick the most serious domain and use that as your scoring mechanism, and then the likelihood is more straightforward in terms of how likely that person thinks it is going to material -- it will occur. 10:37

CHAIRPERSON: Forgive my ignorance, but is there an exhibit which deals with the scoring mechanism that we can actually see? 10:37

A. Yes. The risk management strategy.

CHAIRPERSON: Sorry, I just wanted so we have an understanding.

A. I'll just need to check which page that is on. 10:38

CHAIRPERSON: If we can't find immediately, please don't worry, we can come back to it. I need to sort of have an understanding of...

A. I think it's much easier to talk through the tables than me trying to describe it. 10:38

CHAIRPERSON: Right.

MS. TANG: We can find that, Chair.

CHAIRPERSON: If we can't find it straightaway, I don't want to disrupt things, but at some stage I would like to sort of look at it so I have a real understanding of what 15 means. 10:38

A. It will be a three times five.

CHAIRPERSON: Sorry?

A. It will be a three times five, so it could be a

likelihood --

CHAIRPERSON: If that helps me.

A. I think I'm testing my memory here. You have almost certain, possible, likely, unlikely and rare. I think those are the words. So, a three is in the middle there, it is maybe around possible. Then you have your severity; so it has an insignificance severity, a minor severity. By that we mean the outcome, how much harm there would be if we stick to patient safety. 10:39

CHAIRPERSON: I understand broadly how it works but it would just help me to see what the number actually means. But we can come back to it. 10:39

50 Q. MS. TANG: Thank you. Can I move down to paragraph 147, please, which is on page 39. At that point, you make reference to organisational structures and how they have changed several times over the course of the Trust's existence. The directorates and the divisions under them, obviously it presents as a hierarchical structure that reports up to the Trust Board; is that a fair comment? 10:39 10:40

A. Yes.

51 Q. Looking down to paragraph 161 then, which is on page 43, I want to pick up on some of the specific posts that are referenced there. You've made reference to the governance manager, governance group, and risk governance staff. Are those staff within your team or are those staff within divisions or directorate teams? 10:40

A. So, those are staff within directorate teams. Each directorate in the Belfast Trust had a governance

manager allocated to them who reported to the director of the directorate concerned.

52 Q. What kind of issues would they have dealt with then within their structures?

A. They would deal with the wide range of issues that we would deal with corporately, but they would be dealing with those issues very specifically for their directorate. 10:40

53 Q. Did they have to report anything across to yourselves if it got above a certain level, or how much of what they were dealing with were they telling you about? 10:41

A. The reporting structure would have been very much the division making would have been by the director of that. Having said that, the governance managers work very closely with my team in terms of incident reporting, complaints, et cetera. Not that they report to us or are accountable to us, but sharing expertise and knowledge and supporting would have been that kind of relationship with the governance managers. 10:41

54 Q. Would it be fair to say they dealt then with the incident reports, any SAIs, et cetera, or did your team deal with those as well? 10:41

A. So, our team are a central conduit for all information in relation to SAIs, for example. They would be the first people hands-on who may be dealing with the incident and the reporting of an incident. The information would all be held centrally, and we would have oversight of the information for the entire organisation. It would be my team who would, for 10:42

example, run the information and provide quarterly reports to the Assurance Committee of Trust Board on incidents across the entire organisation. It would be my team that would have all of the information on all of the SAIs that happen everywhere in the organisation, so we would have a central oversight of everything. But the hands-on operational workings of governance in the directorate would have sat with the governance manager who was sitting in a particular directorate.

10:42

55 Q. If I understand you correctly in terms of recording these things and dealing with them, whatever needed to be done, directorate level; but keeping track on them administratively, is that correct, for the Trust was our own team?

10:43

A. Yes.

10:43

56 Q. Was there anybody who was taking a Trust-wide overview that said here is an area that seems to be generating a lot of these things, maybe we need to be looking a bit closer at it? Whose job was that?

A. So, really that would be coming through the Assurance Framework Committee structure, ultimately the Assurance Committee itself. I had mentioned there a quarterly incident report. There would be a clarity in terms of if there was a trend in incident reporting, for example, and an area we are seeing a spike in a particular type of incident, Trust Board - or Assurance Committee who is effectively Trust Board - would have that data and would be able to make a comment. The director would be at that meeting. So, if it was in

10:43

10:43

one particular area, that director may well be asked to speak to that at the meeting.

We would also, though, follow up. If my team are pulling together all of the data for a quarterly incident report, for example, and we're going through it and we're looking at it and we are seeing a trend ourselves, we would go directly back to our colleagues in the directorate and ask them can you give us a comment on this, what is going on here. You know, from Trust Board's perspective, it is much better to have a trend identified and actually have some understanding of what that is, rather than going back and trying to find out retrospectively after the meeting. 10:44 10:44

57 Q. I understand. In terms of the trends that you might pick up on, what kind of things are you likely to pick up on as a trend? Is it a statistical thing or might it be the type of incidents? 10:45

A. It will be statistical. It can be the -- you know, it will be statistical in perhaps a particular type of incident is increasing. It may be statistical that, in general, incident reporting has increased over a period of time. You know, we have found that. In Belfast Trust, we started off with around 26,000 incidents per year and we are now up to around 40 plus incidents, 40,000 incidents per year. To me, that's not a bad thing. That's a reflection of staff understanding about reporting incidents and feeling comfortable to do so. Our reports would show that the vast majority of 10:45 10:45

our incidents sit at that level of insignificant incident where there has been no harm, which is a real opportunity for teams to actually learn from things before something more serious happens.

58 Q. If an area, for instance, was struggling to staff their rotas, would that sometimes be reported as an incident? 10:46

A. It may be, yes.

59 Q. To your recollection, might it be a significant, a serious adverse incident?

A. I would need to check that. I don't think it's ringing a bell with me in that way. It may be part of a serious adverse incident. You could have a serious adverse incident reported and in the review of the incident, there may be an issue in our systems in terms of staffing as contributing to that. As a standalone incident, I'm not sure but I can double-check that for you. 10:46 10:46

DR. MAXWELL: Do you encourage staff to report near misses?

A. Absolutely. 10:47

DR. MAXWELL: People may report staffing issues and, by the grace of God, there was no consequence?

A. Yes. Absolutely.

DR. MAXWELL: How would you assess the severity of the near miss? 10:47

A. It would be a risk rate. It wouldn't be -- a near miss is there has been no harm. That in itself would remain insignificant. But the potential -- we risk grade incidents not just for the severity but also the risk

associated with it. So, if it was something very serious - for example, Emergency Department is something that's very high profile - that may well -- that would come out as a red incident because of staffing issues in an ED, so it would be there as a very high level incident.

DR. MAXWELL: Another example is during Covid, intensive cares across the world didn't have the right staffing.

A. Yes. 10:47 10:48

DR. MAXWELL: If they are assessed as red but they are not serious adverse events because there is no associated harm, how do they get discussed, escalated?

A. Okay. So we have, for the last number of years, probably from around 2017, introduced a weekly teleconference call. It's hosted by my team on behalf of the Medical Director. Actually, for the last few years, myself and the Deputy Medical Director have jointly chaired the teleconference. On a weekly basis, my team extract all of the key governance information that has happened in the previous seven days. That will be incidents, high risk complaints, any confirmed SAIs, any new high corporate risks. There will be some information there about our claims, any serious claims coming in, any coroner's cases that are coming up. We actually have a news letter where we issue to everyone that's on the call all of the recent NICE guidelines that have come in in the previous seven days as well so that everyone knows that this is in. But if there is a 10:48 10:48 10:49

serious incident on that, it will be picked up on that call, it will be discussed on that call. The discussion may well be does this meet SAI criteria, if it hasn't already been identified as an SAI.

10:49

The point I am making is that information goes -- it happens on a Thursday at lunchtime. The report from those discussions and the list of all of those incidents goes to executive team on the Friday morning, and it also goes to the full Trust Board. It's copied 10:50
to the full Trust Board. The Trust Board know when they receive it, they can query or follow up with any of the directors that those issues are against if they have any queries or concerns about what's in the report. 10:50

DR. MAXWELL: So, a red risk near miss, which isn't an incident because there was no obvious associated harm, would that be discussed at this Thursday meeting?

A. Yes.

DR. MAXWELL: That would then be escalated to the 10:50
Board?

A. It would be, yes, the Board would get a full list of those incidents. The Emergency Department is quite a good example actually at this particular period of time because the report will have a number of incidents in 10:50
the Emergency Department, for example, where there hasn't been any harm to a patient but there are serious risks associated with the position in the ED. So, there will be a number of incidents. Actually, we

theme them. The section that deals with those incidents at the moment, because there are a number, they will have themes - NIAS hand-over times, ambulances delayed, et cetera, et cetera.

CHAIRPERSON: Sorry, who is on the tele call? Your team hosts it. 10:51

A. Myself and the Deputy Medical Director chair it, and it would be the governance representatives from each of the directorates would be the key people on that meeting. Central Nursing are represented, Pharmacy, our governance folks are represented, and a social care governance person is also on that call. 10:51

CHAIRPERSON: Right. Thank you.

60 Q. MS. TANG: I want to go back to a statistic that you mentioned a few minutes ago I was interested in. You said, I think, 25,000 incidents a year initially reported. 10:52

A. Roughly.

61 Q. And it has increased to 40,000 or so?

A. Yes. 10:52

62 Q. Who is it who is responsible for training staff in what counts as an incident, how to report it, et cetera? Who does that?

A. It is my team would do that. It is a mandatory training for anyone in the organisation, and everyone joining the organisation is expected to undergo that training. It's now mainly delivered within an e-learning package but we can facilitate bespoke training as well on request. 10:52

63 Q. The increase in the incidents reported, is there any tracking as to whether there were some areas who reported very few incidents in the past who are now reporting more, or is that just a Trust-wide number?

A. It is possible to drill down and do that. I don't have it to hand. Some of the increase will be our inclusion of independent sector incidents now in our incident data. But, in general, there has been a steady increase in incident reporting across the piece throughout the life of the Belfast Trust. 10:53

64 Q. Are you able to comment on the level of incident reporting in respect of Muckamore in the time that you've been in post? Has there been any change?

A. I haven't checked that data. I mean, I can absolutely give that to you. I would be speculating. 10:53

65 Q. Okay.

CHAIRPERSON: I'm sorry to interrupt again. When you talk about the independent sector which will have increased that number, is that the independent sector obviously only in relation to matters commissioned by the Trust? 10:54

A. Yes.

66 Q. MS. TANG: Okay. I'm just thinking about risk management more generally now. How confident would you be that the staff at Muckamore were clear what should be reported as incidents or risks? 10:54

A. I believe the structures are there and have always been there to support the staff in that knowledge. They will have had access to a governance manager in that

area. So, I believe they should have been well equipped to do that.

67 Q. So, if a member of staff or a patient, or a relative of a patient for instance, had had some concerns, say, about ill-treatment or neglect of a Muckamore patient, what would their options have been? Thinking pre-2017, for instance, what could they have done about that? 10:55

A. A relative of a patient is most likely to make a complaint in relation to that. Staff have incident reporting as an option. They can simply raise a concern with their line manager. If they don't feel comfortable to do that, we do have a whistle-blowing policy in place to support them through other routes to raise such concerns. So, those would have been the main ways. 10:55

Obviously, the nursing profession has a code of conduct, as do medical profession have a code of conduct. In that, there is a requirement on them about raising concerns, perhaps through a professional lead rather than a line manager. 10:56

68 Q. In a scenario, a hypothetical scenario, where a relative makes a complaint perhaps to a member of ward staff, saying I am not happy about how my loved one is being looked after in here, is that recorded anywhere, and will your team see that or how do they know about these things? 10:56

A. So, it will depend. If the complaint is made to a local team and they are able to deal with the complaint

there and then to the satisfaction of the complainant, then that is frontline resolution. We would like to have a copy so that we have a full record, but historically we know that there is a lot of frontline resolution goes on, staff move on quickly and perhaps they don't remember to inform the Complaints Department. So, we wouldn't have full sight of frontline resolutions. 10:56

If a complainant is not happy or the member of staff is not able to assist them, they are all trained, all staff are trained in complaints awareness. Again, it's another mandatory type of training for all staff. They can direct that member of the public to the Complaints Department to make a formal complaint. At that stage then, we should have -- they will come through to us and that will be recorded on our central system. 10:57 10:57

If a complainant wants to go onto the internet for the Belfast Trust, our site, there is guidance there as to how they can make a complaint. Actually in recent times, we have an electronic form that they can actually fill out online and submit that through to us automatically. Also, there would be leaflets on all wards and departments throughout the Trust for members of the public to lift to understand how they can make a complaint. 10:57 10:58

69 Q. Am I right in understanding those are fairly recent things, or how long would those arrangements have been

in place?

A. The leaflets.

70 Q. The leaflets or website access.

A. The leaflets have been a fairly longstanding entity. The website is something that improved probably around six years ago. I would need to plot back to see what was there at a particular point of time. 10:58

71 Q. I understand. Am I also picking you up correctly then that there isn't a central -- I'm sorry, there isn't a database that individual areas of the Trust, if they get a complaint, they deal with it, it doesn't need to go to yourselves? Am I right in thinking there is no official way of recording that if it's being dealt with at frontline level? 10:59

A. They will have - they should have - files, and we train staff to make records of all conversations and all actions taken, and they should be holding that locally. Ideally, we would like them to inform us that that has happened. What I am saying to you is that has not always been consistent across the entire organisation. I am not saying this is a particular issue with intellectual disability. 10:59 10:59

When a complaint come into us, again our team manage and support the support the dealing with the complaint, but it is the service who will be contacted and asked to investigate the matter. We will keep sight of progress of that complaint investigation. The final response to the complaint, the Director will have 10:59

responsibility for signing off that complaint.

72 Q. Thank you.

DR. MAXWELL: Can I just ask, do you use a software database of complaints? There are a number on the market, I think, part Datix has got -- 11:00

A. We have a module in Datix.

DR. MAXWELL: You have a module in Datix where individual about complaints is logged. Potentially, local areas could log local complaints on that Datix module? 11:00

A. They will be once we introduce the web version of the Datix module. At the moment, complaints are still on what's called the Rich Client, which is a corporately held module. At the moment, they have to send the information to us to put it onto the Datix system. 11:00

DR. MAXWELL: So, they are using paper records about local management of complaints at the moment, are they?

A. They will be, although I --

DR. MAXWELL: Until you move onto the new system?

A. Yes. 11:01

73 Q. MS. TANG: Is there a risk in that from your perspective that if an organisation is getting perhaps a verbal complaint, they think they have dealt with it at local level, whether or not the complaint is actually dealt with properly; that nobody outside of 11:01 that individual bit of the service knows about that complaint and there is no way of tracking the kinds of things people are complaining about unless someone at that local area tells somebody?

A. I think it is a risk, and we are working to improve the position so that there is full sight of that. But complaints isn't the only way of understanding what a service looks like. We have introduced in recent years the real-time patient feedback process, which again has a number of domains. There are a team of patient experience officers who visit clinical areas and have an interview with their service users and get feedback directly from those service users. That information is turned round within 24 hours, and the ward that it happens in or the area it happens in have an opportunity to address those concerns. That process has been rolled out across the Trust over the last number of years since 2017 really, and has gone, in the last year or so, into Muckamore Abbey and been adapted for the service users with intellectual disability to make it easy for them to respond to the types of questions. So, we will have sight of that as well as the complaints process. 11:02 11:02 11:02

74 Q. To be clear, that's in the last year has been available to Muckamore? 11:03

A. Yes. The other piece of work that's really been taken forward - again, it's a fairly recent development - but it is this term "triangulation of data". It is not just comparing complaints information in isolation but also looking at it alongside incident information, and claim information, and, where appropriate, coroner's information, so that you are getting the whole picture of what sort of governance issues are going on in an 11:03

area.

75 Q. Is that triangulation something that has been happening for a while, or how long have you been doing that?

A. Well, we have, over the last few years - it would be post 2017 - been pulling together graphics reports on behalf of all of the directorates. They will get all of that information delivered back to them in the one package on a quarterly basis. 11:03

76 Q. Just so that I'm clear, was there any Trust-wide work of that nature done before 2017 in previous years in your time? 11:04

A. I think, no. Well, I would need to check the timeline. Perhaps it started to be introduced around 2016. But it is an enormous complex organisation, and you tend to go with early adopters, people who are keen to really do something, and then role it out as a success, roll it on. So, whilst there may have been moves in 2016, it wouldn't necessarily have hit all areas at that time. 11:04

77 Q. Yes. Are you able to say at what point, if at all, it reached Muckamore? 11:04

A. It would be in Muckamore. I couldn't -- I would need to double-check the actual timeframe.

78 Q. That would be helpful. Okay, right. I want to go down now to paragraph 175, which is on page 47, please. The paragraph begins to describe various committee structures. What I wanted to pick up on is further down the page, there is mention of an assurance committee. You've made some reference to that already 11:05

in your evidence. Can you tell me how that Assurance Committee would have related to Muckamore in particular and the standards of care for intellectual disability patients?

A. So, Assurance Committee is effectively Trust Board. It is chaired by the Trust chairman currently, with all of the non-executive directors on it. Then, we have our Chief Executive and all of our directors, including our executive directors and operational directors in attendance. So, therefore, it would deal with all topics, anything that is on the Board Assurance Framework risk document would be dealt with at the committee. If there was an emerging issue - and each committee has a section at the start of the committee called "Emerging Issues" - so the executive team, prior to the committee time - I am talking in the run-in to the committee, maybe a week beforehand - would be confirming if there were any emerging issues that needed to be brought to the attention of the Assurance Committee. So that's an opportunity, regardless of the standard governance reports that are considered at that committee, an opportunity to bring anything that is emerging in the organisation to the attention of the committee.

11:05 11:06 11:06 11:07 11:07

There is the same principle applied to Trust Board meetings on a monthly basis. The issues in Muckamore, for example, could be brought at that section of the committee.

79 Q. In your recollection, were issues in Muckamore brought in that section of the committee? Do you recall instances of that?

A. Pre-2017 I couldn't confirm.

80 Q. And since 2017? 11:07

A. Yes. Absolutely.

81 Q. Can I take you down to paragraph 186, which is on page 50, please. You'll see there there is reference to a number of reports that the Trust Board produced. Can I take it that those are essentially for supply to 11:08 outside organisations, be it Health Board, et cetera?

A. Yes.

82 Q. In terms of the information that the Trust Board got from yourselves, would it have been fed into any of these reports? 11:08

A. Yes. There will be governance information in the annual report and there will be a lot of governance information in the quality report.

83 Q. How did the Board interrogate that information? Did you have to talk them through it, or was there a formal 11:08 reporting process that you and them would have had?

A. It would be presented. The quality report would be presented to the Board and there would be a discussion about it with the Board.

84 Q. When you say the Board, do you mean the Health Board or 11:09 the Trust Board?

A. I mean the Trust Board, sorry.

85 Q. Yes, I understand. How did you decide what to tell the Board in terms of the main issues?

A. In terms of the quality report - and I wouldn't want to confuse the quality report, which is an annual report - the layout and format of that is driven externally by the Trust, by the Department of Health. My understanding of the thinking behind that is that the quality reports are all published at the same time across the region, so all quality reports in format will look the same regardless of which organisation the quality report belongs to. 11:09

Aside from the quality report, there are regular reports going to Assurance Committee on incidents, complaints, claims, as I'd said. There are also the Board Assurance Framework Risk document which routinely goes to them. I am trying to think of the other agenda. 11:10

Each of the steering groups within the Assurance Framework report to the Assurance Committee. So, they are giving an assurance report to Assurance Committee on all of the work that they and the subcommittees beneath them have carried out in the last quarter. There is an element of escalation of risk in that stream. So, if there is a committee sitting under the Safety Quality Steering Group that is escalating a risk and the Safety Quality Steering Group - which is generally a very senior group, it's chaired by a director - if they believe that that risk needs to be escalated on to Assurance Committee, then that will be 11:10 11:11

included in that report as well.

86 Q. Those are the formal structures you've described, presumably regular interfaces with the Board and various folks. If there was something that came up, is there a mechanism to raise something informally or more urgently with the Board? Say, an issue that emerges that can't wait for the next quarterly meeting, for instance, what would happen there? 11:11

A. Our Trust Board meets every month and Assurance Committee meet every quarter. If it is more urgent than that, there is informal mechanisms. If I give you an example, we have an early alert process in Northern Ireland where Trusts raise an early alert with the Department of Health about urgent issues that may be emerging on a day-to-day basis. Those are also dealt with on the weekly teleconference, which I think I didn't mention when I was describing that to you. As I say, that's copied to Board members. 11:11 11:12

But a director raising an early alert about an emerging and serious matter, will, as I understand it, make contact with the chairman of the Board, if necessary, and he would have an opportunity to convene the Board if it was required as an extraordinary meeting of the Board. 11:12 11:12

87 Q. Okay. Thank you. We've discussed a number of structures. I think it would be fair to say the Trust have a lot of structures, a lot of policies, a lot of arrangements around governance. From your perspective,

the issues that emerged, for instance in the CCTV footage in relation to Muckamore, how did the systems miss those?

A. I'm not 100% sure I know what you mean by that.

88 Q. What I mean is that -- 11:13

MR. AIKEN: Can I just --

CHAIRPERSON: Could I suggest that if there is an issue about this, we are coming up to the break, it might be sensible to take the break, you can raise it with counsel to the Inquiry rather than address me across 11:13 the floor, as it were. Would that be better?

MR. AIKEN: Happy to do that.

CHAIRPERSON: All right. Okay. I didn't realise there was an issue. Can I just see where we were; hold on a second. Well, look, it is not a perfect time to take a 11:13 break by any means. It is now 11.15 so we will take a short break now. You can discuss with Mr. Aiken whether your question is acceptable. If I need to be addressed about it, then I can be addressed about it.

MS. TANG: Thank you, Chair. 11:14

CHAIRPERSON: Can I thank you very much for your evidence so far. You're obviously very knowledgeable and it has been very helpful so far. Thank you.

<u>THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:</u> 11:14

CHAIRPERSON: Thank you very much.

MS. TANG: Good morning again, Panel. Good morning again, Ms. Cairns.

CHAIRPERSON: Do we have resolution?
MS. TANG: We do, yes. We do, Chair. Really, just to say we've dealt with the issues in relation to the systems before the break and I have no further questions on that particular topic. 11:34

There was an issue raised by the Chair in relation to the risk management strategy. It was just to confirm it wasn't actually exhibited with June Champion's statement which you have been assisting us with, but my 11:35
colleague, Ms. Kiley is going to be picking that up in her examination which will follow this.
CHAIRPERSON: I see, okay. That's great. I missed that.
MS. TANG: I have no further questions for 11:35
Ms. Cairns unless the Panel have any questions they would like to ask.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 11:35

DR. MAXWELL: I just want to ask you about clinical negligence indemnity schemes. I am aware that in England, Scotland and Wales there is a risk pooling system. I'm not going to ask you about that, I am just 11:35
going to ask you what happens in Northern Ireland. In those schemes, in the English scheme, the clinical negligence scheme for Trusts, there are a number of standards that Trusts are assessed against, and their

performance relates to the fee they contribute to the risk pooling scheme. I have two questions really: Is there a risk pooling indemnity scheme in Northern Ireland, and if there is, what are the standards? If there isn't, are there any standards like the standards that Scotland, Wales and England have looking at clinical practice? 11:36

A. The first part of your question, we do not have the system that is in England in relation to that. I would need to check with my colleagues just to double-check to make sure I am giving you an accurate answer to the second part of that. I don't believe there is anything like that. We use internal audit to come in and audit our performance and management of clinical negligence cases. They would also perform similar audits to DLS, which is the Directorate of Legal Services that supports the organisation. I am not 100% sure of what standards they use to carry out that audit. 11:36

DR. MAXWELL: I suppose the thing in England, Scotland and Wales is there is a common set of standards so Trusts can be compared with other Trusts in terms of their clinical controls assurance. Is there any scheme in Northern Ireland that would allow people to compare the different Trusts on their clinical controls assurance? 11:37

A. There is. There is a regional overview of Trust performance. That is dealt with through the Director of Legal Services and their monitoring of cases, time to completion of cases, and meeting the requirements of 11:37

the courts in submission of statements, et cetera, et cetera, and costs associated with all of that. But rather than speculating --

DR. MAXWELL: Schemes.

A. Oh, okay. So, you're... 11:38

DR. MAXWELL: In the schemes in the other three countries in the UK, Trusts are assessed on the controls assurance of clinical risks.

A. Okay.

DR. MAXWELL: That then determines what they pay into 11:38
the indemnity scheme but it's not about their claim. Well, the standards are not about their claims. I suppose my question really was you have described in a very comprehensive way, and thank you for that, the processes within the Belfast Trust, and my question is 11:38
is there a way of comparing that with other Trusts in Northern Ireland?

A. I'm not 100% sure and I would need to check that, sorry.

DR. MAXWELL: That's fine. Thank you. 11:38

CHAIRPERSON: I suppose just a follow up to that for my elucidation. Is there any organisation like the NHS LA here in Northern Ireland? Is there an overarching, as it were, assurance system?

A. No. 11:39

CHAIRPERSON: So each Trust deals with its own negligence claims?

A. It is dealt with through the Department of Health Central Fund.

CHAIRPERSON: Right. Okay. Thank you very much.
MS. TANG: Thank you, Chair.
CHAIRPERSON: Does that conclude that part?
MS. TANG: It does, yes, Chair. This concludes this element of the witness's evidence. I understand a short break would be preferred before Ms. Kiley -- 11:39
CHAIRPERSON: Who is coming back after the break?
MS. TANG: Ms. Cairns and Mr. Hagan.
CHAIRPERSON: Okay. Thank you very much indeed. How long do we need? It is 11:40 now; would 20 minutes be enough? 11:39
A. That's okay with me.
CHAIRPERSON: All right, Mr. Hagan? Okay, thank you very much. 20 minutes; we'll start again at 12:00.
11:39
THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIRPERSON: Ms. Kiley.
MS. KILEY: Chair, as you can see, Ms. Cairns has returned to address some topics in the Inquiry's Module 3, and is accompanied by Mr. Chris Hagan. You will recall the Inquiry has previously heard from Mr. Hagan, but in order to keep ourselves right procedurally, Mr. Hagan is going to affirm once again. 12:08
CHAIRPERSON: That's fine. Thank you very much. 12:08

MR. CHRIS HAGAN, HAVING BEEN REAFFIRMED, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Which of Mr. Hagan's statements? Is it the first, the main one, that we need in front of us? 12:08
MS. KILEY: Yes. I will identify the relevant paragraphs with the witnesses, Chair.

Firstly, Ms. Cairns, thank you for returning. We are now moving on to a different module to that which you 12:08
addressed this morning. You have returned to address some issues which arise in respect of the Inquiry's Module 3, which is broadly looking at policies and procedures. You're accompanied by Mr. Chris Hagan, who is the Medical Director. You haven't, in fact, made a 12:09
statement yourself about these particulars issues but, given your role, you have been identified by the Trust as someone who may be able to speak to some of the issues raised in Mr. Hagan's statement; is that right?
MS. CAIRNS: Yes. 12:09
MS. KILEY: Mr. Hagan, welcome back. Thank you for returning. To remind everyone, you are the Medical Director of the Belfast Trust; isn't that right?
MR. HAGAN: That's correct.
MS. KILEY: I think the last time we heard you've held 12:09
that position since 2020?
MR. HAGAN: That's correct.
MS. KILEY: Having held the Deputy Director position since 2018 and 2020?

MR. HAGAN: That's right.
MS. KILEY: You have made two statements to the Inquiry. Today we are going to deal with some issues arising from your first statement. I'll shortly bring up those topics so we can identify the relevant paragraphs and orientate ourselves. 12:10

As you know, Ms. Cairns has been identified by the Trust as someone who will be able to assist the Inquiry with the particular topics that we are dealing with today. Of course, you may also be able to. As I explained earlier, the way this is going to work is I will primarily address my questions to Ms. Cairns, but if, Mr. Hagan, you do have something that you feel can assist, you're welcome to intervene and to give us that evidence. I would just ask, as you know, it's important that our transcript record carefully who is giving evidence, so it is important obviously that we don't talk over the top of each other. If you have something to add, Mr. Hagan, if I have directed a question primarily to Ms. Cairns, if you would wait until she is finished and then let us know. Okay. 12:10 12:10 12:10
CHAIRPERSON: Also perhaps just say "Chris Hagan" at the beginning, if you could. Thank you.
MS. KILEY: So I am going just to orientate us to bring up the modules document on the screen so we can identify the issues in Module 3 we are addressing today. You'll recall, Mr. Hagan, that your statement was a voluminous one and dealt with all of the various 12:10

subtopics in Module 3. We are not going to deal with all of those today, we are dealing with a specific number. If that document could be brought up on screen, please. If we could scroll down to Module 3, please. Just pause there. 12:11

You can see Module 3 has a number of topics, but today we are focusing on Module 3(i), complaints and whistle-blowing policies and procedures. This is dealt with at paragraphs 208 to 231 of Mr. Hagan's first statement. 12:11

The next topic is Module 3(j), overview of mechanisms for identifying and responding to concerns. That is dealt with at paragraphs 232 to 260 of Mr. Hagan's first statement. 12:11

The next topic is Module 3(k), risk assessments and planning regarding changes of policy, which is dealt at paragraphs 261 to 301 of Mr. Hagan's first statement. 12:12

Finally, Module 3(l), procedures to provide assurance regarding adherence to policies. That's dealt with at 302 to 319 of Mr. Hagan's first statement. 12:12

Ms. Cairns, can I ask you first of all have you had an opportunity to read those sections of Mr. Hagan's statement?

MS. CAIRNS: Yes.

MS KILEY: Do you agree with their content?
MS. CAIRNS: Yes.
MS. KILEY: Thank you. If we move then to the first topic, please, which is 3(i), complaints and whistle-blowing. We're on paragraphs 208 to 231 of Mr. Hagan's first statement. I want to break that down, Ms. Cairns, and deal with complaints, first of all, and then to look at whistle-blowing. 12:12

Mr. Hagan provides some context on complaints in the statement itself, so I am going to read two short paragraphs on that, paragraphs 209 to 210. This is page 98, please. Scroll down so we can see 209 and 210, please. That's it, thank you. 12:13

We can see it is said: 12:13

"The complaints process in the Northern Ireland Health and Social Care system is a Northern Ireland-wide or regional system. It is centrally designed, arises from legislation, and is imposed on HSC bodies, including the Belfast Trust. It is the responsibility of the DoH. 12:13

"Belfast Trust policies have reflected, and kept pace with, emerging regional guidance. Following the formation of the Belfast Trust in 2006 and becoming operational in 2007, it was considered that the development of the first Belfast Trust policy and 12:13

procedure in this area should await expected regional direction. The regional directions were provided by DHSSPS in April 2009. Legacy Trust policies continued to govern the complaints process until that time. Each of the Legacy Trust policies were based on the prevailing regional guidance which I identify below."

I just want to pause there, Ms. Cairns, to properly orientate us in time because, as you know, the Inquiry's terms of reference span from 1999 and 2021, and we know that the Belfast Trust wasn't an entity for that entire period. In the list of Belfast Trust policies that have been provided in respect of complaints, the earliest policy is dated April 2010. Is it correct then that for complaints in respect of Muckamore pre-April 2010, it was the North and West Belfast Health and Social Services Trust policies which applied?

MS. CAIRNS: Yes, that's my understanding.

MS. KILEY: Are such documents still available to the Belfast Trust as that Trust's predecessor.

MS. CAIRNS: So, I'm sorry but I'm not able to confirm that. I would need to return to the Trust and see if we can locate it.

MS. KILEY: Okay. Well, focussing just on the Belfast Trust specific policies, there have been various versions. They are listed at paragraph 211, if we could bring that up, please. Paragraph 211 refers to a number of relevant documents, so it contains a list

which refers to documents which are wider than the Trust complaints policies but I just want to identify the complaints policies in this list. If we scroll down to (f), please. That's the April 2010 Belfast Trust complaints policy. You can see that that is entitled "Policy and Procedure for the Management of Complaints and Compliments." 12:16

MS. CAIRNS: Yes.

MS. KILEY: Then it was followed up in 2012, it seems, if we look at (g) by an appendix to the complaints policy entitled "Guidance For Investigation and Escalation Protocol For Complaints." Then if we turn to the next page, please, there is a further iteration of the policy in September 2013, entitled "Policy and Procedure For the Management of Complaints and Compliments." And then at (i), March 2017, "Policy and Procedure For the Management of Comments, Concerns, Complaints and Compliments." Then at the bottom finally on (k), there is an April 2020 version with the same name. 12:16 12:17 12:17

Those are Trust-wide policies; is that correct, Ms. Cairns?

MS. CAIRNS: That's correct.

MS. KILEY: Is there any specific complaints policy that is tailored to the learning disability sector. 12:17

MS. CAIRNS: Not that I'm aware of.

MS. KILEY: I want to look at some of the detail of the policies. I am going to use the 2010 policy as an

example, if we could turn that up, please, at page 15552. You should see that on your screen. If we could scroll out just to see the entirety first page, please. You may recall, Chair, from the previous evidence sessions that this is a huge file electronically and so whenever we scroll out, it jumps a little on the screen. We will focus in the best we can, which seems to rectify the problem. 12:18

You can see there hopefully, Ms. Cairns, this is the 2010 policy which we identified in the list. I want to take you down please to page 15570. This is an appendix to that policy, Appendix 10 as you can see there. It is a flow chart which summarises the process for staff to follow when dealing with complaints. We can see there that there are two limbs, one on the left-hand side and one on the right-hand side. The first question that is asked is "Can this" - presumably there should be a "be" there - "Can this be resolved locally to the satisfaction of the person raising the issues." 12:18 12:19

Is local resolution always the first port of call in respect of a complaint, Ms. Cairns?

MS. CAIRNS: Yes. Frontline resolution is the most desirable. In fact, the latest thinking from the Northern Ireland Ombudsman's office is one of the key principle of good complaints management is to deal with a complaint as early as possible to resolve it. 12:19

MS. KILEY: When you refer to frontline in the context of Muckamore Abbey Hospital, who is that frontline? Is that the ward staff.
MS. CAIRNS: It could be or it could involve more senior staff within Muckamore Abbey Hospital, but it would be within the facility itself, it wouldn't involve the Complaints Department. 12:19
MS. KILEY: Okay. I think that's where the two limbs come in.
MS. CAIRNS: Yes. 12:19
MS. KILEY: If we can see the left-hand limb, if the question is answered yes, that it can be resolved locally, there are a number of steps there that we can see in the box on the left-hand side. You can see there is: 12:20

"Listen to the complainant. Record the issue accurately. Agree a plan of action with the complainant and document. Inform relevant staff including line manager. Carry out actions. Feedback to complainant and document. If complainant is happy with the outcome, record on the complaints form which can be found on the internet site. Send a form to complaint managers for your service group." 12:20 12:20

I wanted to ask you about the recordkeeping element of that. It appears there that at the local stage of frontline resolution, as you have referred to it as, there are requirements, even if it can be resolved via

that method, for whoever has dealt with it to keep a record; is that right?

MS. CAIRNS: That's correct.

MS. KILEY: And the 2010 policy that we're looking at here refers to a complaints record form which can be found on the internet site. Can you tell the Panel any more about how staff would access that and what type of information they would record on that. 12:21

MS. CAIRNS: I can answer how they would access it. All staff in the Belfast Trust would have access to the Trust intranet site, and so they would be able to go on there and access it. The detail of the information that it would contain, I would need to confirm exactly what that looks like. I can't remember off the top of my head. I think maybe it says there is a copy enclosed which, if you scroll down, it might be. 12:21

MS. KILEY: I have done that but it's not actually enclosed, as far as I could find.

MS. CAIRNS: Okay.

MS. KILEY: But it may be something that we can return to. If a staff member goes onto the intranet and populates that form, was that something that then became recorded on Datix. 12:21

MS. CAIRNS: Only if it was submitted to the Central Complaints Department. I believe it isn't an electronic automatic populating it and it goes straight to the Complaints Department, I think the staff member had to download it, manually fill it in and, back in 2010 and that era, it probably came in via post into 12:22

the Complaints Department to be uploaded then onto the Datix system. If the staff member did not do that, if they populated it and held it locally, the Complaints Department would not see it. It would need to come through to the Complaints Department for it to go on to Datix.

MS. KILEY: There is reference in the final bullet point there to "send form to complaints manager". You referred earlier in your evidence this morning to there not always being consistency in your directorate receiving forms; was it those forms that you are referring to.

MS. CAIRNS: Yes.

MS. KILEY: But certainly under the policy, is it right that the Trust's expectation is that if there is a frontline resolution, that that form be filled in and sent to complaints managers.

MS. CAIRNS: That's correct.

DR. MAXWELL: Can I just clarify that? It says "Send the form to the complaints manager for your service group", so the local staff would send it to the service manager within the directorate, not directly to your department; is that correct?

MS. CAIRNS: So, this dates 2010 to 2013 which predates my close involvement with complaints. I was a manager in the area in a different field. Complaints managers have been partnered with the various directorates, so there would be specific complaint managers within our central Complaints Department who would work

consistently with a group of directorates. I am speculating a little but I suspect that's what that bullet point means. I'd need to go back and confirm to be sure.

DR. MAXWELL: Thank you. 12:24

MS. KILEY: That's at the local complaint stage, or frontline as you have also described it.

Can you tell the Panel more about the role of the complaints manager at that stage, so just at this local 12:24 stage? Is it just about receiving the forms or do they have any analytical role?

MS. CAIRNS: It is just about receiving the forms.

MS. KILEY: Okay. But am I right in saying the role of the complaints manager is a little different if it 12:24 can't be resolved locally, and then they are involved at the next stage; is that right.

MS. CAIRNS: That's correct, yes.

MS. KILEY: If we look at that, then this is the process on the right-hand side. You see it says there: 12:24

"If a complaint can't be resolved locally, you must advise the complainant of the Complaints Department or assist the complainant to make a complaint to the Complaints Department or give complaints leaflet." 12:25

If we could scroll down to the next page, please, we'll see the process for that. Can I ask you just, first of all, about the position of the Complaints Department.

Where was that positioned within the Trust's structures? Was it attached to a directorate or is it a wider, more broad, system?

MS. CAIRNS: The Complaints Department sits corporately within the Medical Director's office and has always done so. 12:25

MS. KILEY: We can see the various stages there. I won't read them all out but we can see there that it appears that if there is this more formal process, then in turn it results in an investigation report and then a draft outcome report; is that right. 12:25

MS. CAIRNS: That's correct, yes. Well, it's a draft response.

MS. KILEY: Yes. Now, that is kind of the flow chart which summarises the various procedures. Of course, the policies themselves go into the roles in more detail. I don't need to open all of that with you. We're looking at the 2010 policy. There have been various updates to that, as we have seen. Is it right to say that those two limbs, so the idea of an informal process and then the more formal process via the Complaints Department, have remained the same throughout the period of those policies. 12:26 12:26

MS. CAIRNS: I would say it is fair to say that, yes.

MS. KILEY: So, in terms of records then, the policy expectation would be that there were records of both locally resolved complaints and more formally resolved complaints. 12:26

MS. CAIRNS: That's correct.

MS. KILEY: If a complaint was raised with ward staff, how would that record now be found? If, for example, a complaint was raised with ward staff and the ward staff were following that policy and had completed a form - I asked you earlier about the Datix system and you had said it's not necessarily on Datix - how would that form be held by the Trust. 12:27

MS. CAIRNS: So, there will be one of two ways. It will either have been submitted to the Central Complaints Department and they will have uploaded it on to Datix, or it will have been held locally. I'm not responsible for the management at that frontline, that would be within the management of that directorate, but I would expect that they would have a manual folder that would contain that form. 12:27 12:28

MS. KILEY: Just thinking of the local resolution side again, we know that there is a requirement under the policies in the various iterations to send the record to the complaints manager. Whose role in the Trust is it to check that that's actually happening. 12:28

MS. CAIRNS: So, the Director -- and it is articulated within the Assurance Framework of the director's, service directors rules and responsibilities. The management of complaints is incorporated within that. There has also been throughout the life of the Trust, albeit a committee under different names at a point, and at that point I imagine it was referred to as the Complaints Review Group, which would have, for quite some time, had a non-Executive Director sitting on that 12:28

group. More recently its name has changed and it is now a wider title called the Service User Experience Feedback Group. There is more information goes forward to that group than just complaints.

12:29

But we would keep information -- we would present data that we would have centrally on the number of frontline resolutions, for example, over the years. I can't speak with authority as to how far back that information would go, but at whatever point it started, 12:29
then that group, which sits within the Assurance Framework, would have had oversight of the rate, at least of frontline resolutions. They mightn't have had the detail behind it. At a point in time a number of years ago, we did produce KPIs to try and improve the 12:29
efficiency and effectiveness of frontline resolution to try and drive the numbers up, in keeping with the national guidance and the ombudsman principles of management of complaints.

MS. KILEY: But that corporate knowledge could only be 12:30
achieved if there is notification to the complaints manager; is that right.

MS. CAIRNS: That's correct, yes.

MS. KILEY: And you have referred to some of the challenges in ensuring consistency of notification. 12:30
Are you able to tell the Panel, have the Trust taken any steps to try and address that challenge.

MS. CAIRNS: I can't think of any particular steps, sorry.

MS. KILEY: Okay. You mentioned, I think, reports in respect of complaints and they might contain, for example, numbers but not particular information. Would the Trust Board regularly have received reports on complaints. 12:31

MS. CAIRNS: Yes, yes. In the Assurance Committee format.

MS. KILEY: So that's how it feeds up. It starts at Muckamore Abbey Hospital level, and then it goes to the Assurance Framework level, and then feeds up to the 12:31 Board through that.

MS. CAIRNS: There would be another step in there because Muckamore Abbey Hospital sits within a directorate. So, the directorate will have had its own governance arrangements in place and it would be 12:31 expected that in their governance meetings, they would deal with complaints at that level. Running in parallel then, the information that we would have corporately would feed in through the Assurance Framework in the first instance to a group called the 12:31 Complaints Review Group - more recently, it has been called the Service User Experience Feedback Group - through one of the steering groups of the Assurance Framework, and ultimately being presented and included in routine quarterly reports to Assurance Committee. 12:32

MS. KILEY: In terms of the expectation of the directorate, is it expected that they simply collate information about numbers of complaints, so statistics, or is it expected that they have a more analytical role

in analysing trends, for example, of complaints.
MS. CAIRNS: It would be my view that it would be more analytical; constantly trying to improve and make things better from the information that they have.
MS. KILEY: Is the expectation then that that sort of product of an analytical exercise will make its way up to the Board via the structures that you have described. 12:32
MS. CAIRNS: I think that's reasonable, yes.
MS. KILEY: In terms of the information the Board receive, that's more than just statistics on the number of complaints; is that right. 12:33
MS. CAIRNS: It is. It's quite a fulsome report and it gives information about the types of complaints. It gives information about the effectiveness of the area's response to a complaint in terms of how long it has taken to investigate a complaint and provide a response. It will give information about the numbers of reopened complaints in an area. There will be some information about high risk complaints and a little bit more detail. There will be information in relation to complaints that have proceeded to ombudsman processes. If the complainant has remained dissatisfied to the Trust efforts to resolve their issues, they would have the option to go to the ombudsman to do an independent review of the issue. So, all of that would be included. 12:33 12:33 12:34

Over time, we have improved our work in the area of

actually identifying learning from complaints to make services better. So, there would be information go to the Board on where learning has been identified from complaints and what that looks like.

MS. KILEY: Is that part of the annual report? 12:34

MS. CAIRNS: It is part of the quarterly and annual.

MS. KILEY: So complaints are taken to the Board both quarterly and annually.

MS. CAIRNS: That's correct.

DR. MAXWELL: Can I just ask? You said there would be more information about high risk complaints. How do you grade complaints? 12:34

MS. CAIRNS: The same risk matrix is used.

DR. MAXWELL: Five five five; frequency by consequence?

MS. CAIRNS: The likelihood, yes. The first grading will be carried out by the complaints manager when it is received in the Complaints Department. That is then discussed with the service manager in the directorate to agree that that grading is correct. This is people sitting remote from the service who may not have a full understanding of the issues. The director will have oversight, if necessary, of that grading as well. 12:35 12:35

DR. MAXWELL: Do you use the same criteria for escalating to the Board anything above a 15?

MS. CAIRNS: Yes. Yes. 12:35

MS. KILEY: How were the policies we have looked at, and the various iterations of them, communicated to patients and their family members so they could understand when they could make a complaint and how do

that?
MS. CAIRNS: So, the policy in itself wouldn't be communicated in the form that it is in that very wordy detailed document, but certainly our intranet site would have had for many years - again, I am not quite sure how far back this would go - but there would be a description of how a service user or family carer could make a complaint, and assistance there with contact details et cetera. There would have been information leaflets. In fact, it refers to a leaflet, I think, in that earlier page. The expectation is those are readily available on all wards and departments for sharing with families, patients and carers, et cetera. All staff in the Trust are required to attend the complaints awareness training as a mandatory, so they are equipped to help inform users of the service at that frontline about the complaints and how to go about it. 12:36 12:36 12:36
MS. KILEY: Do you know when that complaints awareness training became mandatory. 12:37
MS. CAIRNS: I believe it has always been mandatory but I would need to just double-check that.
MS. KILEY: Is that as part of the induction training or is that something separate.
MS. CAIRNS: It is, yes. 12:37
MS. KILEY: I want to move back to the statement, please. If we could bring up page 100, and paragraph 213. You can see there, Ms. Cairns, that this paragraph refers to a new process that was introduced

after the investigation into a former consultant neurologist. The process is described as "Clinical Record Review". We can see there it was implemented in May 2022. The process, as it exists now, only applies to medical staff; is that right. 12:38

MS. CAIRNS: That's correct.

MS. KILEY: It says that it operates where a complaint includes a clinical component relating to the quality of treatment and care or staff attitude. Would that include things like complaints about overmedication of 12:38 patients.

MS. CAIRNS: Yes. I believe that would be a problem with treatment in care, so yes.

MS. KILEY: I can see Mr. Hagan nodding. Do you want to come in on that, Mr. Hagan. 12:38

MR. HAGAN: So, clinical record review was based on the structured judgment review process devised by the Royal College of Physicians. We adapted that so that if there was a complaint about the quality of treatment, care and staff attitude in respect to medical staff, it 12:38 would give that extra level of assurance, and independent review of the care and treatment within the care delivery unit. Then, if there was a concern in respect of the treatment of care, or the attitude borne out in the CRR, then that would be escalated up to the 12:39 divisional team and even to myself, if necessary. We are now embarking on a process where we are going to roll this out in nursing staff.

MS. KILEY: Yes.

MR. HAGAN: Now, that's pilot stage at the minute. I think there is with the 2000 doctors in Belfast, 6,000 nurses; it is going to be potentially be a substantial undertaking.

MS. KILEY: Has that pilot commenced, Mr. Hagan. 12:39

MR. HAGAN: The Director of Nursing is leading on that at the moment. We have a plan in place. That hasn't -- I don't believe that has started as yet.

MS. KILEY: Do you know if it is part of the plan to pilot this in Muckamore. 12:39

MR. HAGAN: It will be across all of nursing.

MS. KILEY: Across all nursing areas?

MR. HAGAN: Yes.

MS. KILEY: In terms of how it exists now, it involves an equivalently qualified doctor making an assessment 12:39 of the care provided; is that right?

MR. HAGAN: That's correct.

MS. KILEY: Are all the doctors involved employees of the Belfast Trust?

MR. HAGAN: Yes. We do it as an internal mechanism 12:40 now. Very occasionally we would ask for an independent review from the Royal College, for instance. If it was a very serious complaint that we would -- we might make a determination on or a serious incident, we might ask for an external review by the college. We do grade 12:40 these in terms of severity, you know.

MS. KILEY: How does that grading take place? Is that the matrix we have heard about?

MR. HAGAN: That might be a discussion with myself, for

instance. Because we meet with the divisional teams regularly. They have they have a process that Claire has talked about, where they do a live governance meeting once a week where they review complaints, incidents, deaths et cetera in their area. If there is something that requires escalation, then it goes up to the weekly governance report that comes to the executive team. If there was something in that that we felt needed an external review, we could ask for that. Now that is unusual, but it can happen. 12:40 12:41

MS. KILEY: Given the internal nature of it, are there any additional steps that the Trust have taken to ensure that that process can be independent; the process of peer review, I am thinking, where people are potentially colleagues and how can that be independent? 12:41

MR. HAGAN: The way the CRR, the structure judgment, is designed is it statements about the quality and treatment of care, and it is given a number scale from zero to five. It is a validated independent way of doing it. The Royal College of Physicians have validated that tool and have demonstrated it can be replicated irrespective of the person who is doing it. It does provide that level of independence within the team. Then if there is a concern, then that's escalated further. 12:41 12:42

MS. KILEY: In terms of the carry-over to nursing then, is that Royal College of Physician's tool replaced by something else or is it being used in the nursing scheme too?

MR. HAGAN: No, it's the same tool; it's the clinical record review tool. I think we have attached... There is a document on that, actually.
MS. KILEY: Yes, you have provided --
MR. HAGAN: If you look at page 15728, that gives you the process for clinical record review. 12:42
MS. KILEY: Yes. In terms of just sticking with this statement, at paragraph 214, Mr. Hagan, you do refer to the Trust having encountered some challenges in implementing and improving the CRR process. Can you explain a little bit more about what those challenges have been? 12:42
MR. HAGAN: I think the first challenge was we tried to introduce it, or we did introduce it, during Covid. So you have a very -- you have a workforce under extreme pressure with Covid and you are bringing in a new policy and procedure. But I would have to say that like all new things, it can take sometimes to bed in. We listen to feedback from teams as to how it could be best implemented. Some teams found it very useful as a learning exercise to actually do it with a few doctors doing the review rather than just one and then that learning was shared back in with the team. But we have now got a really good pick-up for this across the organisation at the minute. Like all new things, it takes a little bit of time to bed in. 12:43 12:43
MS. KILEY: I want to move on now and look at whistle-blowing policies and procedures. I am going to come back primarily to you, Ms. Cairns.

Whistle-blowing policies and procedures are dealt with at paragraph 218 of the statement. Page 102, please. The statement provides a background about the structures of national documents and regional documents on whistle-blowing. Is it fair to say this, Ms. Cairns, that there are a number of high level national and regional documents in respect of whistle-blowing but then, underneath that, the Belfast Trust has created its own whistle-blowing policies? 12:44

MS. CAIRNS: That's correct. I suppose just to add a little bit of clarity, at the beginning the Trust through to 2018, the Trust policy on whistle-blowing would have been a standalone Trust policy on whistle-blowing. In 2018, following the RQIA regional review of whistle-blowing arrangements in Northern Ireland, the Department of Health created a regional template for a whistle-blow policy. At that point, Belfast Trust was aligned with all other Trusts in terms of how the policy was laid out in its content. It is in effect, from that time forward, a regional policy. 12:44 12:45

MS. KILEY: Yes. Prior to that then, we see the specific policies listed at paragraph 220. Scroll down to page 104. You can see there is reference to a September 2008 policy, a June 2013 policy, and then a 2018 policy, it says there following the September 2016 RQIA review. Is that the policy change that you have just been referring us to, Ms. Cairns? 12:45

MS. CAIRNS: That's correct, yes.
MS. KILEY: We can see in terms of date that the first in time there is September 2008. Before then, what were the policies in respect of whistle-blowing?
MS. CAIRNS: I'm sorry, I would need to check that and come back to you on that one. I'm not sure. 12:46
MS. KILEY: They would have been, of course - if there were any - they would have been Legacy Trust policies; is that right?
MS. CAIRNS: Yes, they would have been. 12:46
MS. KILEY: I want to look then at the 2018. Well, before we look at the policy, I wonder if I could ask you, in fact, Ms. Cairns, to just address the Panel generally on the procedure for raising an issue under whistle-blowing procedures. Three policies have been provided. Rather than open it all, I think it's fair to say that all of them have in common that there are two processes, essentially. There is an informal process by which a concern can be raised in the whistle-blowing policies, and then there is a more formal process; is that right? 12:46 12:47
MS. CAIRNS: Correct.
MS. KILEY: Can you tell the Panel more about each of those in turn? First of all, thinking about the informal process, how that works, please? 12:47
MS. CAIRNS: So, the policy guides staff and encourages staff that in the first instance, they raise a concern in their normal day-to-day working with their line manager in an informal way, with the intention that

many times a concern can be addressed readily by their manager and very quickly resolved and moved on. Then, where that hasn't been possible, either because it hasn't been resolved to the whistle-blower's satisfaction or they feel unable to do that with the line manager in their own world, they do have the opportunity to come through under a formal - it's referred to as formal process - by coming directly to the designated officer for whistle-blowing, who is in the head of office role in the organisation. 12:47 12:48

The 2018 policy and the year leading up to that, we introduced -- other Trusts, other areas, call them Speak Up Guardian; our individuals were called advocates. We asked directors to nominate individuals from their service who spanned various professions and backgrounds, and trained them to be advocates sitting out in the directorate so that staff mightn't feel quite so daunted to go to someone in, if they were a doctor, a medical colleague to raise their concern, or a nurse to a nurse colleague et cetera, without coming through to the person sitting in Trust headquarters as that formal designated officer. 12:48 12:49

MS. KILEY: So, whilst that role was an introduction, it remains within the informal limb of the process; is that right? 12:49

MS. CAIRNS: The advocates will deal with a lot of issues informally, without them being reported formally through to the head of office. Having said that, we

are keeping a record of all of those, so they would -- even if they have been dealt with by an advocate and closed down, we would ask that we get a copy of what the concern was and what the outcome was to resolve the issue, so that we have a full picture of those concerns across the organisation. 12:49

MS. KILEY: Is an advocate attached to a division or directorate?

MS. CAIRNS: They would be within a directorate primarily for the purposes of identifying X number of advocates per directorate. It was really left down to the director to identify those individuals and how they sat in the directorate. 12:50

MS. KILEY: Thinking, for example, of learning disability, how many advocates are within each directorate, or does it vary? 12:50

MS. CAIRNS: It can vary. I would need to check to give you a correct answer, but there were approximately 40 in total for the entire organisation. So, you would be talking about single figures probably in each directorate. 12:50

MS. KILEY: Thinking then about the processes with that informal type of route to raise a concern, if something had been raised with a line manager or an advocate under that procedure and had been resolved to the line manager or the advocate's satisfaction, what happens then? Is there a document or record of the concern having been raised? 12:51

MS. CAIRNS: To the best of my knowledge, unless the

manager has kept a record - and I think the policy encourages them to keep a record - there wouldn't be. I certainly, as head of office in my time from 2014 onward, wouldn't have received information about those concerns.

MS. KILEY: Is there a reason for that? Is there a reason why those types of informally resolved concerns aren't notified upwards?

MS. CAIRNS: It is my view that if you think about the day-to-day working environment, there can be concerns raised day in day out that are a misunderstanding, or easily addressed. There would be quite a lot of additional resource in maintaining and recording that, so I think it may be that issue. Whistle-blowing isn't the only way that concerns -- without giving it the title of whistle-blowing. Concerns can come through the incident system as well and be registered that way.

MS. KILEY: You've referred to there being encouragement to record issues but is it right to say then there is no requirement on the line manager or the advocate to make a formal record at that informal stage?

MS. CAIRNS: No, there is no requirement as such.

MS. KILEY: Moving then to the formal channel. Can you tell the Panel a little bit more about how that process works?

MS. CAIRNS: So, if a formal whistle-blow is coming through to the designated officer, it would either be by contact by the whistle-blower directly themselves.

They may call, telephone. My contact details would have been in the policy; there may have been a call come straight through to me to seek to share their concern. Or it could come through via email or there could be a letter come through to headquarters. 12:53

The other way that the concern may come through would be via a line manager, who is perhaps not able to cope with whatever it is at that level and they want to escalate it to the head of office. 12:53

MS. KILEY: You've given us an example there of a line manager escalating something. Aside from that, in more general terms, who decides which route the concern should take formal or informal?

MS. CAIRNS: So, initially the whistle-blower will have that choice. If the whistle-blower is raising a concern and it is not resolving, it can be either the whistle-blower or the line manager may wish to escalate it. 12:54

MS. KILEY: If something has proceeded on the informal route and essentially it is the line manager that closes that then, is that right, is there any mechanism of review of those sorts of decisions and a facility to escalate those? 12:54

MS. CAIRNS: So for the time period, there would be bits of it that there wouldn't have been a system to support that. In more recent years, we have become much more equipped to deal with whistle-blow concerns. In the latter years, we would have much more 12:55

information held centrally where that could be recorded.

MS. KILEY: Thinking then back to the formal side of things, you have described how something might reach the formal stage. Once it reaches that stage, who decides what level of investigation should take place? 12:55

MS. CAIRNS: So, my role as head of office would have been to meet with the whistle-blower if they were coming through in a confidential manner. Quite often you get whistle-blows that are anonymous so you don't know who is raising the concern. But if they came through in person, they would meet with me. There would be -- I would arrange to meet them wherever they wanted to reassure them that they are okay. One of the first things I would do is whether they are wanting to raise this confidentially, so that we can ensure their confidentiality is protected throughout the process if that is what they are coming under the whistle-blow policy as. Their concern would be assessed as to whether it met the criteria of the whistle-blow policy. Then I would take a record of what that whistle-blow concern entailed. 12:56 12:56 12:56

I would have the opportunity as head of office to speak to the Chief Executive and/or the Director of HR and/or the chairman to decide at what level that should be investigated. Some are straightforward and it can be investigated out with the service that its occurring in by someone internally to the Trust. Some are more 12:56

complex and we may need to go out with the organisation entirely. We quite often use the Leadership Centre associates to carry out external investigations in terms of whistle-blowing.

MS. KILEY: If an investigation does take place either using internal or external people, is a formal record made of that -- 12:57

MS. CAIRNS: Yes.

MS. KILEY: -- at that stage?

MS. CAIRNS: Yes. 12:57

89 Q. Who is that record shared with?

MS. CAIRNS: That record would come back to the head of office.

MS. KILEY: What about the Trust Board, how do they become aware of instances of whistle-blowing that have been raised. 12:58

MS. CAIRNS: So, today the Trust Board have nominated a nonexecutive director to have a special interest in whistle-blow concerns. Prior to that, there would have been a very high level report go to Trust Board to just outline the number of whistle-blows that had come in in a period of time. 12:58

MS. KILEY: So prior to the introduction of the nonexecutive director, it was more statistical; is that right? 12:58

MS. CAIRNS: Well, it's one of these things that has evolved over time. In the early days it would have been very high level information; the area, the director that was responsible for the area and perhaps

a very brief description of what the concern was. Today, it is still reported and there is a report goes to Trust Board. Well, it is the Assurance Committee it goes to on a quarterly basis and it would be more detailed. There would be much more detail in the report as to what the concern was than there would have been in the early days. 12:59

I think the numbers of whistle-blows have grown over the years. When I took up post, if there were two a year, that was the maximum, that was the number that were coming through under the formal process. Whereas now we are getting dozens of. We would be in the twenties, thirties of whistle-blow concerns coming through to the whistle-blow manager. 12:59

MS. KILEY: So through that formal process then?

MS. CAIRNS: Yep.

MS. KILEY: In paragraph 225 of the statement - page 106, please - there is reference to what happens after an investigation. You will see at the final sentence of the first paragraph, it says: 13:00

"In order to ensure and implement learning (A) the final outcome of the investigation report and lessons learned will be documented and approved as final by the responsible director." And B: "The findings will be independently assessed by a professional executive director for assurance that the matter has been appropriately addressed." 13:00

Just pausing there. Are those steps that can only take place when there has been a formal investigation? They don't take place when it has been informal; is that right? 13:00

MS. CAIRNS: That's correct.

MS. KILEY: The Lessons Learned document, how is that shared throughout the Trust?

MS. CAIRNS: So, the director would share it with their immediate area. If it is an appropriate lesson to be 13:01 shared widely, we have a shared learning policy and a model to allow those types of learning to be shared widely in like a newsletter or a safety alert where it gives a brief outline of issues and what's been learnt and changed, what needs to change, et cetera. 13:01

MS. KILEY: There is reference at B there, we've heard, to an independent assessment by a professional executive director. Is that someone outside the Belfast Trust or within?

MS. CAIRNS: That would be within the Belfast Trust. 13:02

MS. KILEY: Okay. Then moving on to point C. In terms of other steps to ensure implementation and learning, it is said:

"High level information about all concerns raised 13:02 through the procedures and action taken to address any issues is shared with both the Belfast Trust Board and DoH as well as in the Belfast Trust's annual report. Further, a nonexecutive director is tasked with the

responsibility for the oversight of the culture of raising concerns."

Is that the executive director role that you were speaking about just a few minutes ago? 13:02

MS. CAIRNS: Yes. Nonexecutive director.

MS. KILEY: When did that role commence?

MS. CAIRNS: I would need to check that for you but I would say about two years ago.

MS. KILEY: Okay. Then we see at point D: 13:02

"Regular reports as to the whistle-blowing case load are provided to the Belfast Trust senior management and Audit Committee."

13:03

E: "An annual return is shared with the DoH setting out actions and outcomes."

In terms of those procedures, there is reference at D to the Audit Committee. What is their role in 13:03 assessing trends and information received in respect of whistle-blowing?

MS. CAIRNS: So, the whistle-blowing policy covers both whistle-blows relating to fraud and those whistle-blows that are more in the safety quality type arena. The 13:03 Audit Committee have oversight of the fraud whistle-blows. In fact, the head of office's designated review officer for whistle-blows does not deal with the fraud whistle-blows. Those go to a

separate senior manager in the organisation sitting within finance to commission investigations and reports on those. So, the report is almost split in two in that the concerns about fraud go through to audit committee to have oversight, and the others come through the Assurance Committee line. When I spoke to you about the numbers, that wasn't including those issues in relation to fraud. I was thinking of what I dealt with personally in the formal procedure. 13:04

MS. KILEY: I commenced those questions by summarising the policies and saying that common to all policies, it appeared there was this formal and informal channel, which you agreed with and you have helpfully elaborated on that. 13:04

From a review of the policies, another issue that is common to all three Trust policies is they contain a requirement for the Trust to promote a culture of openness and honesty, and to ensure that all issues are dealt with responsibly and taken seriously. That is a big task in a big organisation. How does the Trust do that? 13:05

MS. CAIRNS: It is engrained, I would say, in all of the training that we deliver out with whistle-blowing itself, in incident reporting, in complaints management, in general governance. It would be addressed at induction. There would be a session in induction where there is a talk about those issues as well. 13:05

So with respect to whistle-blowing, certainly again from around 2016, we engaged in regional programs to have awareness weeks for whistle-blowing. The Trust also runs a week in September, which is referred to as Safetember, which is a real focus on safety, and openness would be engrained in all of that. We have a March to Safety session as well, and again being open would be a part of that. We have a Being Open policy as well which relates to all of these areas, and an attached e-learning package, which was really taken from the MPSA learning and guidance across the water. 13:06 13:06

MS. KILEY: What type of guidance do staff receive on what type of issues they should raise under whistle-blowing policies? 13:06

MS. CAIRNS: I think I would need to just take that away and come back to you on that, I think. It's hard for me to pinpoint one particular piece of training that deals with that; I think it's ingrained in everything. It will be in medical induction, it will be in nursing induction, it will come in lots of formats. I think I would need to tap into those so that I can give you a full answer as to what that looks like. 13:07

MS. KILEY: But are you saying there is no specific training directed to whistle-blowing or are you saying that you don't know if that's the case? 13:07

MS. CAIRNS: There is now specific training to whistle-blowing. In the beginning of the Belfast

Trust, it would have been limited to fraud, whistle-blowing in the context of fraud and not the wider picture of whistle-blowing.

MS. KILEY: Okay. The wider picture is something that has evolved then. Can you say how recently that has emerged? 13:07

MS. CAIRNS: It has evolved over time. I think it really it started to evolve and grow from 2016 onwards, when the RQIA regional review came in and looked in at the whole region in terms of our processes for whistle-blowing. I think it's fair to say that that probably goes beyond Northern Ireland, that this is a topic that has become more to the fore in recent years than it had been at the beginning of Belfast Trust. 13:08

MS. KILEY: In fact, there is reference to a recent appointment in the Trust in respect of whistle-blowing. If you turn to page 108, please, paragraph 230. You can see there that there is reference to the appointment in April '22 by the Belfast Trust of a manager for whistle-blowing. It says: 13:08

"This recognises the advantage of bespoke electronic system for the recording and management of whistle-blowing concerns. The introduction of the new system is a priority focus of the new manager and is expected to be operational in the course of 2023. The new manager has given presentations on whistle-blowing within all directorates and has developed an e-learning package which has recently gone live for all staff. 13:09

She was also working with HR Operational Development colleagues to ensure the inclusion of whistle-blowing within induction training for all staff and new manager training."

13:09

Does that person then, the whistle-blowing manager, have a remit across all directorates within the Trust?

MS. CAIRNS: Yes.

MS. KILEY: Does that person have a professional background?

13:09

MS. CAIRNS: They are a manager with experience in investigative training. They are not a nurse or a doctor.

MS. KILEY: Okay. Those are all my questions on this topic. It might be an appropriate time.

13:09

DR. MAXWELL: Can I just ask one question?

CHAIRPERSON: Yes, and I have a few as well.

THE WITNESSES WERE QUESTIONED BY THE PANEL AS FOLLOWS:

13:09

DR. MAXWELL: Does the Belfast Trust take part in the annual NHS staff survey?

MS. CAIRNS: Yes.

DR. MAXWELL: Question 31 of that survey -sorry, I'll tell what you it is - asks staff whether they had confidence in the security of reporting unsafe clinical practice. Does the Trust Board receive the feedback on that by division and unit, or just at a global level?

13:10

MS. CAIRNS: So, HR take the lead on that survey and,

yes, it's very detailed.
DR. MAXWELL: So, if the Inquiry wished, we could track over a number of years the responses from different divisions to that question, the staff confidence?
MS. CAIRNS: I believe you could. I would need to double check with my HR colleagues but yes, I think potentially, yes. 13:10
DR. MAXWELL: Staff confidence on reporting unsafe practice?
MS. CAIRNS: Yes. 13:11
CHAIRPERSON: Could I just ask a few questions because you have spoken generally about whistle-blowers. Do I take it you are not confining yourself to people who are using PIDA, the Public Interest Disclosure Act, you are referring to whistle-blowers in the more general term? 13:11
MS. CAIRNS: Yes.
CHAIRPERSON: You mentioned the guardians that are being appointed, and you mentioned there has been more of a focus, perhaps, on whistle-blowing since 2016. Are you aware of the report by Sir Robert Francis in 2015 -- 13:11
MS. CAIRNS: Yes.
CHAIRPERSON: -- about speaking. I imagine that is where that has come from. Do you have a national guardian, somebody who over sees the guardians within each Trust, or is that your manager that you have just been referring to? 13:11
MS. CAIRNS: They don't... So, the guardians, or the

advocates as we call them, would have looked to me as head of office. So I didn't have line management responsibility for them in their role as an advocate, but in terms of sharing information and organising training to equip them to do the role, that all came through me as head of office at that time. 13:12

CHAIRPERSON: But obviously you have a wide range of responsibilities?

MS. CAIRNS: I do. This is was one of the difficulties with this because I'm Co-director For Risk and Governance, as you see, with the bundles of information for these two modules alone, plus I was fulfilling the role as head of office, which was supporting the Trust Board in all of its workings in terms of committee structures and running of the Trust headquarters facility and the staff therein. Plus I was the identified designated officer for whistle-blowing. As we have discovered in the years that have passed now as whistle-blowing has become more and more to the fore and staff are engaging with, as one individual with no support in that role, I had not the capacity to fulfil it effectively. 13:12 13:13 13:13

CHAIRPERSON: This isn't a criticism at all of you, but I suppose it's possible you might not be seen as independent? 13:13

MS. CAIRNS: Possibly.

CHAIRPERSON: There was also, I think, a recommendation that the guardians should be at different levels and cover the different disciplines or professions. You

might have a NED, a nonexecutive director, who had responsibility for whistle-blowing or for the guardians. Do you know if that has come in here?
MS. CAIRNS: It hasn't come in in the way you describe. When we trained our advocates, we also provided -- and 13:14
we brought Public Concern At Work at the time in to deliver that training. They also delivered training to the nonexecutive director at the time. They also delivered training to our Trust Board and our directors at the time so that staff at all levels had the benefit 13:14
of their expertise in that field.
CHAIRPERSON: Finally this: Is there a common networking system for those guardians, or once they have been trained and they go off to their individual hospitals, are they rather left to their own devices? 13:14
MS. CAIRNS: Initially, no. I ran a forum on a six-monthly basis where we brought them all back together, and we together developed things like training packages for them to take to their staff meetings and raise the profile of whistle-blowing 13:15
routinely. We did get hit by Covid in the middle of all of this so I can't say that that has continued to the present day.

We have a very capable manager now appointed who is 13:15
taking the communication and support to a whole other level now because it's her sole focus. So, today things are much improved in that. There also is a regional group. Again, following the RQIA review and

their findings, there was a regional group who had representatives from each the Trusts in Northern Ireland who would have met regularly and contributed to the Department of Health's development of the regional policy on whistle-blowing. 13:15

CHAIRPERSON: Right. Thank you.

MS. KILEY: There are three more topics to deal with with these witnesses after lunch. I think in total it will take around an hour.

CHAIRPERSON: If we take an hour for lunch now. We have a bit of an extended morning but it was useful, I think, to finish that topic. We will come back at approximately 2:20. Thank you very much indeed. 13:16

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:16

CHAIRPERSON: Thank you.

MS. KILEY: Ms. Cairns and Mr. Hagan, thank you for returning. We are moving on to our next topic, which is 3(j), the overview of mechanisms for identifying and responding to concerns. I am going to primarily direct my questions to you, Ms. Cairns. This is dealt with from paragraphs 232 onwards of Mr. Hagan's statement. If we could bring that up, please, at page 109. You can see 233, it says there: 14:26 14:27

"The main mechanism for service users to raise concerns is through the complaints process."

We've already discussed that this morning, Ms. Cairns so I am not going to take you through that again.

If we scroll down to paragraph 235, please, we can see that there commences a list of references to certain other mechanisms which are also important in the context of this topic of identifying and responding to concerns. Starting at 235, there is reference to patient experience mechanisms. It is said that they proactively obtain and respond to feedback which can be used to improve services. 14:27 14:28

Those various mechanisms are then explained in turn at paragraphs 236, I think, if we can turn to those, please. You can see one of the first things -- I am not going to go through all of these, Ms. Cairns, the Panel have the various what are described as mechanisms set out but I just want to alight on some particular issues and ask you a bit more about them. You will see there that there is reference at, first of all 239, if we could go to first, there is reference to safety thermometer's. In fairness, Mr. Hagan referenced these whenever he last gave evidence. 14:28 14:28

Are you able to say, Ms. Cairns, first of all are you familiar with the patient safety thermometer? 14:29

MS. CAIRNS: Yes.

MS. KILEY: When were they introduced?

MS. CAIRNS: To give you an exact date, I would have to

go and check exactly. They have been around for quite some time. I just can't remember the exact year. Apologies.

MS. KILEY: Okay. Can you explain to the Panel a little more about how they work? 14:29

MS. CAIRNS: They have a range of areas that are audited, and the results of that are published and included now in the responses of the Patient Safety Experience Audit. So our patient safety experience -- our patient experience officers check for things like 14:29 medication compliance and various topics that would fit in with the patient -- with the safety thermometer.

MS. KILEY: There is reference there to the patient experience officers?

MS. CAIRNS: Yes. 14:30

MS. KILEY: Was that a role that existed before the thermometer came in or was that something that --

MS. CAIRNS: That's a later addition.

MS. KILEY: Okay. Who carries out that sort of role?

MS. CAIRNS: Those are individuals who are at Band 4 14:30 level. They are trained to go out and carry out the -- I'm calling it an interview with the service user, but also check the data in the files to get the answers to the items that are contained within the safety thermometer. 14:30

MS. KILEY: Are they attached to a particular directorate or how do they work?

MS. CAIRNS: They are currently in the central Medical Director's office.

MS. KILEY: How many of them are there?
MS. CAIRNS: We have around 13 posts.
MS. KILEY: You refer to them going out and interviewing; they are described as undertaking audits in the statement. How often does that take place? 14:31
MS. CAIRNS: So they are aiming to -- I have to, sorry, I'll have to double-check how often they do a repeat audit in an area, but it is on ongoing process on a daily basis.
MS. KILEY: How is the particular area identified for audit? 14:31
MS. CAIRNS: We really aim to reach all clinical areas, ultimately. Again, it has been a project that has started in one area and been rolled out gradually over a period of time. There are some areas such as Outpatients, or children's wards, or intellectual disability, where the standard audit template has to be adapted to fit in with those areas. So, it is a work in progress. I think we are now, from memory, at around 80 areas at the moment across the entirety of the Belfast Trust, which includes areas in Muckamore Abbey Hospital. 14:31 14:32
MS. KILEY: Who decides which areas are selected for audit and when?
MS. CAIRNS: So, it has been rolled out on a principle of -- clinical teams really have been very engaged and wanting to engage with this. It is a really good way of getting realtime feedback back to services and allowing them to respond to that very quickly. So, 14:32

there hasn't been a difficulty in getting volunteers to roll it out. The constraining factor in rolling it out is actually the capacity to move on and have patient experience officers who have the capacity to actually carry out the audits. It is being spread across the organisation as quickly as possible. Once you're in the process, it happens automatically. The audits will continue and they continue at a regular interval. The same for everyone, if you know what I mean. 14:32

MS. KILEY: If you turn back to paragraph 239, there you'll see that there is reference to the safety thermometer. It is said in the second sentence: 14:33

"They are used to measure the level of "harm-free care" be patients are experiencing whilst receiving treatment." 14:33

What does that phrase "harm-free care" mean?

MS. CAIRNS: Care where there has not been any -- there is no indication in the information that harm has occurred. 14:33

MS. KILEY: Is that harm of any kind, taking a very broad definition of harm?

MS. CAIRNS: If we take medications, there may be specific things that are considered, whether it is omitted doses of medication. If there is an omitted dose, they will assess whether or not there has been an omitted dose. If a person is on a particular medication regime that is supposed to be delivered four 14:33

times a day and there is a dose omitted, then that would be registered as an omitted dose. So, they are checking for those sort of things.

MS. KILEY: Yes. They, being the patient experience officers -- 14:34

MS. CAIRNS: Yes.

MS. KILEY: -- whenever they are carrying out their audits?

MS. CAIRNS: Yes.

PROFESSOR MURPHY: Can I ask, does that include things like restraint, seclusion, as harm? 14:34

MS. CAIRNS: I don't believe that's on that.

MS. KILEY: I can see actually Mr. Hagan shaking his head. Maybe if you can assist, Mr. Hagan.

MR. HAGAN: That information was collected in the sitrep report that we talked about the last time. 14:34

DR. MAXWELL: The patient thermometer is fairly universal across the UK, and it identifies five avoidable harms. It's usually pressure, damage, infection, falls, medication, and I can't remember the fifth. It focused largely on acute care on general surgical and medical wards. 14:35

MS. KILEY: Does that correlate with your understanding, Ms. Cairns.

MS. CAIRNS: I believe in Muckamore it is the medications element that they would be checking for, primarily. To be honest with you, I would need to check the documentation to be sure I am giving you the absolutely accurate answer to that. 14:35

DR. MAXWELL: But I think we did discuss it last time, as you said. I think the answer given was that there weren't any learning disability specific modifications to the patient safety thermometer.

MS. KILEY: So, moving to the next mechanism that's described as being able to proactively obtain feedback. It is the care opinion online user forum. It is mentioned at paragraph 240. Can you tell the Inquiry more about that tool? 14:35

MS. CAIRNS: Unfortunately, that tool does not sit within the Medical Director's office remit, and my knowledge of it is not very deep. 14:36

MS. KILEY: Okay.

MS. CAIRNS: It is a tool, as I understand it, where members of the public can provide an experience and that will be delivered directly to the manager responsible for that service, and they will have an opportunity to come back very quickly to that service user. The management of it is operated within another team in the organisation so I don't know the nuts and bolts of how it works. 14:36 14:36

MS. KILEY: Which team is it?

MS. CAIRNS: The Central Nursing team.

DR. MAXWELL: Is it through nursing? Because Care Opinion is a commercial website and anybody can enter anything about any hospital and any healthcare professional, but some Trusts have a contract which they pay for to receive aggregated feedback. Presumably somebody in Belfast Trust has got a contract 14:36

with Care Opinion to do that?
MR. HAGAN: I would need to double-check that it's a regional initiative that not all Trusts signed up to through the Department. This was brought in after we had started our own realtime patient feedback and we run the two in parallel. 14:37
DR. MAXWELL: Okay.
MS. KILEY: Just the paragraph below then, another tool is described as "The patient client experience team within Central Nursing." 14:37

I appreciate that Central Nursing isn't your domain, Ms. Cairns, but can you tell the Panel any more about what that team does?
MS. CAIRNS: I'm really sorry but I would need to go back to the Trust to get that information for you. 14:38
MS. KILEY: Mr. Hagan, do you have any additional knowledge that you could help us with on that?
MR. HAGAN: So, that team administer Care Opinion.
MS. KILEY: Right. Okay. 14:38
MR. HAGAN: So they collect and collate the data from that. Then, that is brought to the Service User Experience Feedback Group or committee that we also bring complaints to in realtime feedback. That's how we gather feedback around the organisation, both from complaints and compliments. 14:38
MS. KILEY: So it's connected to the Care Opinion.
MR. HAGAN: They administer the Care Opinion.
MS. KILEY: Okay. The remainder of Mr. Hagan's

statement on this topic refers to the various referrals can be made to a professional regulator. I am not going to read through each one. I just want to ask a question about something that's referred to at paragraph 260. Page 117, please. 14:39

Mr. Hagan, I'll address this to you first, I think, and if necessary, Ms. Cairns, you can come in. Mr. Hagan, you can see there there is reference to this. 14:39

"Between 2010 and 2022, the Belfast Trust was also subject to the DHSSPS scheme for the issue of alert notices for health and social care professionals in Northern Ireland." You provide a copy. "The scheme was designed to ensure that HSC bodies and professional organisations were made aware of registered healthcare professionals whose performance or conduct gave rise to concern that patients, staff or the public may in future be at risk of harm either from inadequate or unsafe clinical practice or from inappropriate personal behaviour. This scheme was revoked in 2022." 14:39 14:39

The Inquiry has heard from the Department of Health about that scheme and its revocation. The position now, so since 2022 whenever it has been revoked, if the Trust has a concern about a healthcare professional giving rise to an issue of patient safety, setting aside the referral that one can make to a regulatory body, what mechanism exists now for the Trust to bring 14:40

that to the attention of the Department?
MR. HAGAN: If a doctor is -- I mean, I can talk about doctors. If a doctor, for whatever reason, is restricted or excluded, then the General Medical Counsel will be notified of that, and we have a duty to notify the Department as well. 14:40
MS. KILEY: But that's only if it gets to the stage of a restriction from the GMC; is that right?
MR. HAGAN: Well, predominately an exclusion. Healthcare professionals can have restrictions on practice that still lets them work, and there can be a whole variation on those things that may require some supervision. What we do ensure, if they are working in another facility, that that other facility is aware of the restriction that's on that individual. So, if you had a doctor that was working in HSC but then was also working in independent practice, we would inform the place where they practised independently of the restrictions. 14:41 14:41
MS. KILEY: But the DHSSPS scheme was about notifying the Department of Health; isn't that right? 14:41
CHAIRPERSON: Wasn't it for unregulated? It was used across the water but was it not used for unregulated practitioners?
MR. HAGAN: Primarily, in my experience, it was related to doctors working elsewhere who had lost their licence to practice. So usually related to, but not exclusively, GPs, and we would be notified of that list. 14:41

CHAIRPERSON: Anyway, that's now gone and there is no replacement?
MR. HAGAN: Yes.
MS. KILEY: It hasn't been replaced, is that right; there is no equivalent? 14:42
MR. HAGAN: Not to my knowledge.
MS. KILEY: I am going to move on to the next topic, 3(k) risk assessments and planning regarding changes of policy. This is addressed in your statement, Mr. Hagan, as you can see there commencing at paragraph 261. 14:42

In respect of risk assessments, Ms. Cairns, you dealt with that a little this morning in your questioning on Module 2, and the Inquiry has also heard some other evidence from June Champion about risk. I am not going to take you through all of that again, but you may recall this morning that the Chair asked you about the risk rating matrix and you referred to the risk management strategy, which you thought it was an exhibit. It is, it is exhibited to Mr. Hagan's statement, so I want to look at that now with you. Page 17403, please. Mr. Hagan's statement provides various versions of the risk management strategy from 2008 to 2021 but I am going to have brought up the one that is entitled 2008 to 2011, just to aid this discussion. 14:42 14:43 14:43

Can you just tell the Panel what the purpose of this

document is?
MS. CAIRNS: So, this strategy really lays out for the organisation how we manage risk. It sits alongside the Assurance Framework and is integral to the Assurance Framework. It has behind it also a policy or a 14:44
procedure for the development of risk registers and management of risk registers, which is more useful to staff on the ground when they are creating their risk registers and populating it. There is a lot of
information in the risk management strategy that is 14:44
carried through to the procedure, so there is a lot of similarity in the two documents. It makes a policy statement about risk management; it defines roles and responsibilities within the strategy; it sets out
expectations in relation to risk management et cetera. 14:44
At the back of it then, which we referred to this morning, it has that appendix.
MS. KILEY: Yes. I wanted to turn to that. Appendix 1 deals with the risk evaluation system, page 17417,
please. Can we scroll out so we can see that whole 14:44
page, please? You can see the risk evaluation system is set out in narrative form there, Ms. Cairns. I'm not going to read it all but is it right that it follows a coloured system? So, risks are evaluated as
red, amber, yellow or green; is that right? 14:45
MS. CAIRNS: That's correct.
MS. KILEY: You can see there paragraph 2 deals with a red risk, and that is described as one which is considered to be unacceptable as there is an extreme

risk of harm to an individual or the organisation. I am going to come and look at the chart in due course but I just want to establish the different levels.

The next level is dealt with at paragraph 5; that's amber. 14:45

"Amber coded risks have a high potential to cause harm to an individual or the organisation."

14:46

Then paragraph 6 refers to yellow coded risks, which have a medium potential to cause harm to an individual or the organisation. Then finally at paragraph 7, green coded risks are described as having a low potential to cause harm to an individual or the 14:46 organisation.

There is some further detail on that. I haven't gone through it all because I want to ask you to tell us how it works in practice. If we can scroll down to look at 14:46 that system as it appears on the next page. This is entitled "The Risk Evaluation System and Their Instructions For Use". Can we pause there and look at those three instructions? The instructions are (1), identify the risk; (2) using table 1, identify the 14:46 consequence should the risk occur. Select a number from scale 1 to 5. (3) using table 2, identify the 1 likelihood and immediacy of the risk occurring; scale 1 to 5. If we scroll out there, we can see table 1

appears on that page and table 2 on the next page.

Ms. Cairns, if you can, can you explain to us how that works in practice? What does someone have to do if they are assessing a risk and applying this document? With reference to table 1 and 2, can you tell us practically what happens?

MS. CAIRNS: Okay. So the first table - if you could scroll, thank you very much - the extreme left-hand side of the table as you are looking at it has descriptors. If you were assessing a risk, you would be picking one of those descriptors to best describe what area that risk is in. For example, if it is injury or harm to a patient, they might go across that. In the more -- in the later versions and regional table, the language has changed; I think we now talk about domains.

In terms of injury there, if, for example, they are picking something that is going to be reportable or requiring a member of staff to have time off work, between four or 14 days, or there is some semi-permanent, physical, emotional injury, trauma or harm, then the person would pick 3, moderate, as the most probable outcome if that risk was to materialise. They will then move onto the next table.

MS. KILEY: Could we scroll down to the next page?

MS. CAIRNS: Okay. They are going to be thinking about how often is that likely to happen. So again, it's 1

to 5, and the least likely is "rare", which would be a 1, or if they think it's almost certain to happen, then they would be going to pick a 5. Say they believe that that is a possible risk and they pick a 3, if they then move onto the third table, they will cross-reference the consequence of 3 against the likelihood of 3 and they will come out with a yellow risk, which is moderate. 14:49

If you scroll on down, and I'm not sure in this very earlier version - I think it is there - there will be direction then as to who should oversight of that particular risk. So, a yellow risk -- 14:49

MS. KILEY: Table 6, if we move down a little bit.

MS. CAIRNS: Table 6 there describes that remedial action would be expected to be taken by a ward or department manager. The decision to accept that risk would rest with the service manager or co-director. The level of that risk, it would remain as an operational risk in the service area. 14:50

If they were, for example, to pick a risk that had a consequence of 5, that they expected, if the risk materialised, the most probably outcome would be death, then they would pick 5. Could I ask you to scroll up slightly again there? In terms of likelihood, say they thought that was very rare and they were picking 1, that risk would still remain as an amber risk. If you scroll back down again. In this version, it would have 14:50

oversight by a co-director or director within that service, so it would be a very senior member of staff and it would be considered at the directorate level, risk register groups et cetera.

In the procedure that goes along with the later versions of this, it will describe how a co-director/director could say that that has to be on a corporate risk register. If they feel it can be managed operationally, they can take the decision that it doesn't go onto the corporate risk register, but if they feel it does need to be on there, they can add that onto the corporate risk register, which is included on a quarterly basis to Trust Board at the Assurance Committee meeting. 14:51

MS. KILEY: Can we scroll down a little bit because there is reference here at point 7 to priority levels. How does that fit in with the assessment?

MS. CAIRNS: So, you had read earlier about unacceptable risks. That means that if you have a red risk, there is an expectation that there would be actions taken to at least mitigate that risk to a more acceptable level. It might not remove the risk entirely. In fact, in reality we're in a very risky environment, it's very difficult to completely remove a risk. But you are wanting to bring that risk down to a level where you are content that it is less likely to happen, so the expectation is that there will be actions starting immediately. As you go down the level

of risk, you can see that the timeframes there are less demanding, I suppose, is how I would describe it.

MS. KILEY: There are various updates to this risk management strategy, which have been provided as exhibits to Mr. Hagan's statement. Is it right, however, that the mechanism of assessing risk remains broadly the same throughout those, so the mechanism of having the graded red, amber, yellow, green system; is that right? 14:52

MS. CAIRNS: That's correct. Very minor changes to maybe some terminologies but in principle the methodology has remained unchanged. It is in keeping with the regional risk matrix because at a point in time, the region agreed these tables, so it should look the same in any Trust that you look at. 14:53

MS. KILEY: Yes, okay. I am not going to ask you more about risk, I am conscious that you have already addressed that this morning. We'll leave risk there and move on to the related area, which is planning regarding the changes of policy. This is dealt with at paragraph 289 of the statement, which is page 131, please. If we could scroll down to paragraph 290, please. Just pause there. Thank you. 14:53

I want to ask you about the committees mentioned there, Ms. Cairns. You can see it is said as to structures: 14:54

"The development and ongoing review and planning in relation to policies and procedures has been overseen

and supported by two committees."

Those committees are listed there, (A) the Belfast Trust Policy Committee, and (B) the Standards and Guidelines (S&G) Committee. 14:54

Taking each of those in turn. Firstly, the Belfast Trust Policy Committee, if we look at A. It is said that it was formed in 2007 and 2008. If we look at the bottom sentence there, you can see that what are 14:55 provided are terms of reference for the Policy Committee. They are exhibited to the statement. It's noted there that those terms of reference are dated 2008, 2009, 2010, 2020 and 2021. You can see there is a gap there between 2010 and 2020. Was the Belfast 14:55 Trust Policy Committee still in operation at that time?

MS. CAIRNS: Absolutely.

MS. KILEY: So whilst the terms of reference might not have been updated, it was still operating.

14:55

Then scrolling down to B, the Standards and Guidelines Committee. I want to just look at its role in the context of this topic. It is said:

"This committee was responsible for the review and 14:56 approval of all new and revised clinical Trust-wide policies for noting all directorates' specific policies and for the dissemination, progression and implementation of external clinical guidance such as

safety and quality alerts and NICE guidance. It was also responsible for advising on a programme of work for the Audit Department to review internal guidelines and to work to ensure that audits to support the implementation of guidelines are prioritised in the relevant service areas."

Again, the terms of reference are provided.

There is no reference there to when that committee was established; are you able to assist with that? 14:56

MS. CAIRNS: I believe it was established in and around the same time as the Policy Committee. I don't remember a time when it wasn't there.

MS. KILEY: It says there that the role of the committee was responsible for advising on a programme of work for the Audit Department. Was it practice to conduct an audit after the introduction of a new policy? 14:56

MS. CAIRNS: I would need -- I'm sorry, I would need to check that. I'm not sure. 14:57

MS. KILEY: Are you able to say any more generally about how the audit process works? So, who decides what's being audited and when; is it this committee?

MS. CAIRNS: This committee may have done and may have done up until recently. I'm not aware. I don't attend the committee, to be honest with you, and I haven't checked the terms of reference so I am not 100% sure that it was as clearcut as that. I'm happy to go away 14:57

and find out for you and come back to you on that, if that's okay.

MS. KILEY: Thank you. Finally, if you can, I wanted to just direct you - you needn't turn to it - at paragraph 303 of the statement, it is clarified that it wasn't actually a function of the Policy Committee to monitor and oversee the adherence to policies. Are you aware of another body within the Trust that does carry out that function of overseeing adherence to policies? 14:58

MS. CAIRNS: So, each policy will have a section within the template entitled "Monitoring", and the author of the policy, along with the lead director - all policies will have a lead director that they sit under - will have agreed and stated in that section as to how that policy is to be monitored going forward. Each policy, dependant on its nature, might have a very different way of auditing how the policy is working. So, the complaints policy that we looked at earlier has quite a detailed monitoring section in it, and part of the effectiveness is by looking at the information about complaints and how they are managed and our effectiveness of managing them. The Complaints Review Group initially, followed on by the Service User Experience Feedback Group within the Assurance Framework, would have a role in overseeing that policy. 14:58 14:58 14:59 14:59

There are some clinical policies that there would be traditional clinical audits that may well look at the effectiveness, and it may well have been directed at a

point in time by the Standards and Guidelines. I'm just not sure how that worked.

We also have mentioned earlier this morning about the Belfast Risk Assessment and Audit Tool which monitors a number of standards. For example, it may look at management of trips, slips and falls risk assessment, which would be part of a policy. It will go into each and every ward and it will ask the question have you completed the assessment; has an action plan against that been completed; do all of your staff know where that is? So, the outcome of that will be scored and that will be reported on into the Assurance Framework. 14:59 15:00

It is monitoring it in a general way and not with us taking 700 policies in a year and having a schedule of audit for each and every one of those. There will be differences dependant on the type of policy, if that makes sense. 15:00

MS. KILEY: Yes, it does. Does it follow then that there is no single body that is performing a task of looking to see whether the quality has been good? 15:00

MS. CAIRNS: No, that's correct.

MS. KILEY: In fact, we have referred to those two committees but the statement then goes on to describe how that has now changed and those two committees have merged. I think, in fact, you referred to that earlier in your evidence. 15:01

MS. CAIRNS: Yes.

MS. KILEY: The single committee is entitled The Policy and External Guidance (PEG) Assurance Committee. It says that the new committees is still in development and terms of reference have not yet been finalised. Does that mean that whilst there is a merger, those two individual committees are still in operation, or what's the transitional arrangement? 15:01

MS. CAIRNS: So, the transitional arrangement is that the PEG Committee is up and running. It has three chairs: The former chair of the Policy Committee, which is me, and the chairs of the Standards and Guidelines Committee, which is the Deputy Medical Director and the Deputy Director for Nursing. 15:01

When we say the terms of reference are not quite finalised, they are in draft form and are almost there, and we are operating and fulfilling what the individual committees would have fulfilled historically. I would imagine that those will be finalised in the very near future going forward. 15:02

MS. KILEY: Was there a reason behind the merger?

MS. CAIRNS: It was the last review of the Assurance Framework and the very complex number of committees, and the demands on staff in the organisation to attend lots of committees, and an effort to try and streamline that a bit whilst not losing anything in terms of the function of those committees. 15:02

MS. KILEY: I want to move on then to our final topic, which is 3(l), procedures to provide assurance

regarding adherence to policies. We have touched on this a little bit during our exchanges.

This commences at paragraph 302 at page 137, if we could bring that up, please. If we look at paragraph 303, it is recognised there that there is some overlap between procedures to provide assurance regarding adherence to policies, and matters which have already been addressed in earlier topics of the statement and which we have in turn addressed already this morning. 15:03

If we look down to paragraph 305, please.

CHAIRPERSON: Sorry, 305?

MS. KILEY: 305. A number of sources of assurance are identified. I want to read that. It says: 15:04

"One source of assurance is the investigation, monitoring, review and analysis of incidents, serious adverse incidents, complaints, claims, inquests, and patient service user feedback through the various patient experience mechanisms. These aspects are addressed in more detail elsewhere in the statement." Indeed, you have spoken to us about those just recently. 15:04

The paragraph continues:

"They are central processes in highlighting issues of non-compliance with policies, procedures and clinical

standards and guidelines. They potentially lead, depending on the circumstances, to review and changes to an existing policy or to the development and introduction of a new one."

15:04

Then paragraph 306 continues:

"Other important sources of assurance includes the staffing structure and HR processes."

15:05

Moving down to look at paragraph 307. It is said:

"HR investigations and procedures including grievance and disciplinary procedures are an information source as to compliance with policy."

15:05

The statement goes on in the next paragraphs to refer to staff training, morbidity and mortality rates. I am not going to read them all out but those types of mechanisms which we have just looked at and described appear to be reactive in nature. I just wondered does the Trust have any proactive procedures in place that can help it be assured that policies are being adhered to?

15:05

MS. CAIRNS: I think they are largely reactive but not totally. Certainly the incidents policies and procedures, and the encouragement of staff to raise incidents, even if it is a near miss, is an opportunity to proactively seek to address things before something

15:05

happens.

The Belfast Risk Assessment and Audit Tool is another proactive way of looking at a series of standards and, again, perhaps identifying where things aren't as they should be in an area, and an opportunity to address that before something happens against that. 15:06

Clinical audit is another way that may well identify an issue where something may not have happened but they uncover something that is not as it should be. So, a lot of what we do is reactive but there are elements of proactive examples as well. 15:06

MS. KILEY: Does the Trust gather statistics on adherence to policies? Would it, for example, conduct an analysis of whether policies are being adhered to with reference to complaints processes or other tools that may feed into that? 15:07

MS. CAIRNS: I'm not sure about the statistical, how statistical it is. For example, I have mentioned Internal Audit, who have a schedule of reviews that they come in and do over a period of time. They would have risk management audits that they do in directorates, and will very much drill down into the policy side and give findings and recommendations that are an opportunity for the Trust to respond and react before things go wrong. They also look at the corporate side and would go into great detail and provide us with findings where we can make things 15:07

better.

The Trust's quality improvement, training and encouraging staff to look at the services they are providing and how they can make those better is another example of where the Trust is striving to really improve the safety and quality of our services out with anything perhaps going wrong, but looking to how we can absolutely do it better in the future. 15:08

MS. KILEY: You referred there to the Internal Audit and the schedule of reviews that they carry out. Who drafts that schedule, so who decides? 15:08

MS. CAIRNS: The head of Internal Audit. She will draft that schedule based on our latest risk, corporate Board assurance risk register, and will then meet with senior directors in the organisation to agree that she is going in the right direction in that what she is proposing to audit over the next year is the most useful audits to help us be better; safer for the organisation. 15:08 15:09

DR. MAXWELL: Is that plan taken to the Board and signed off by the Board?

MS. CAIRNS: Audit Committee, so yes.

DR. MAXWELL: Is there an opportunity for the Board through the Audit Committee to influence that plan? 15:09

MS. CAIRNS: Absolutely.

MS. KILEY: Can we turn to page 140, please, paragraph 316. You see there is reference to the response to the report on the Inquiry into hyponatraemia-related

deaths, which was published in January 2018. It says there:

"The DoH established an implementation programme to take forward 120 actions relating to 96 recommendations arising from the report of that Inquiry." 15:10

There is reference to a number of work streams and subgroups. Picking up halfway through that paragraph, it says: 15:10

"This highlighted the role of audit within the Board Assurance Framework arrangements and, specifically, the need to focus on rebuilding and improving the programme of clinical audit which stakeholders advised have been diluted over time in favour of quality improvement." 15:10

A number of examples are given. Example A is recommendation 40: "Learning and trends identified in SAI investigations should inform programs of clinical audit." 15:10

Thinking about Muckamore specifically, does the Trust undertake a process of identifying trends in SAIs, and then does it use that process to feed into programmes of audit? 15:11

MS. CAIRNS: We do identify trends in SAIs. I can't think directly of where that has informed an audit within that environment. I would need to take that

away and check it.
MS. KILEY: Okay. That is something, if it exists, in order to form a part of the process, there would have to be some interaction with the Audit Committee, is that right, to create those programmes? 15:11
MS. CAIRNS: There is a difference between clinical audit and the Audit Committee.
MS. KILEY: Yes.
MS. CAIRNS: The Audit Committee is a very financial-based committee, which has an element of 15:12
external audit in terms of the internal audit team and the external audit team who do a variety of audits; some of them safety and quality type audits.

Clinical audit is something that sits within the 15:12
Assurance Framework and under the auspices of the Outcome Review Group, which is chaired by the Medical Director. Perhaps the Medical Director is better placed to speak about that work. It would come through the regular audit meetings that occur out in the 15:12
directorates and clinical areas on a monthly basis, where they will discuss and agreed what audits they need to do, and they will report back within their teams. If there is something that needs to be escalated up through the organisation, it will come 15:12
through the Outcome Review Group through to Assurance Committee.
MS. KILEY: Mr. Hagan, as Ms. Cairns has referenced your role there, are you able to help with that

question? Does the Belfast Trust analyse trends in SAIs and use that to inform programmes of clinical audit?

MR. HAGAN: We have the SAI Review Group that does exactly that, that's review SAIs and that reviews learning from that and tries to identify trends. For instance, we had an instance with never events around wrong side surgery. That was a persistent theme. So, we did a bespoke and specific piece of work around that. 15:13

One of the difficulties with SAIs is around the time it takes to complete them. I think that there is a real need to look at how the SAI process works. I'm involved in the work stream of that actually, where we try and get rapid reviews completed and we get learning out quickly, so we can change and get that built in as sort of almost like a quality improvement piece within the team where the SAI has happened. The Patient Safety Incident Response Framework in NHS England is a very good tool that actually describes that piece of work really clearly, with different ways of running investigations depending on the seriousness of it and the complexity of it. That is an ongoing piece of work. 15:13 15:14 15:14

Claire has talked about the Outcome Review Group, which originally started as a mechanism to review mortalities. Every three months, I think, we get

information from the Department that tells us where we are in terms of our mortality, which is benchmarked both regionally and nationally, so we have an idea of our mortality rates. We consistently sit below peer. We have expanded the Outcome Review Group now to look where we have an external report on a service, like the NICOR database for cardiac surgery and cardiac procedures. We bring that Outcome Review Group and look at our outcomes for that. 15:14

15:15

We have really embraced benchmarking. Because Belfast Trust is very big and there is not really a local peer for a lot of the stuff we do, so we benchmark against NHS England primarily. We pay a fee to benchmark against NHS England and we get our data compared. That's the way we compare ourselves. 15:15

MS. KILEY: I think that partly answers my question. Forgive me if I am going to ask you to go over something you have already explained. You have described how SAI trends there are analysed and that's the role of the SAI committee. How then does that feed into the programme of clinical audit? 15:15

MR. HAGAN: I think the clinical audit -- the clinical governance first started in around 2003, 2004. Audit was a big part of that. Latterly in 2016, '17, '18, we focused a lot of our resource more on quality improvement, and clinical audit tended to take a bit of a back seat. But with bringing in the quality management system that we have now, clinical audit is a 15:16

big part of that, both internally and using internal audit from BSO. So, we are building up our clinical audit again. I don't think we have at the moment a clear link with SAI investigations and clinical audit.

MS. KILEY: Okay. Thank you to you both. Those are all my questions on all the topics that we have this morning. Thank you for answering them. If you remain where you are, the Panel may have some more questions for you. 15:16

15:16

THE WITNESSES WERE QUESTION BY THE PANEL AS FOLLOWS:

PROFESSOR MURPHY: Can I just ask you a little bit more about the patients experience officers? As I understand it, you were saying that they are part of checking out the safety thermometer, but it sounded like the safety thermometer didn't apply to anything apart from medication and falls and some very medical things. I am wondering to what extent they would be interviewing people in Muckamore, for example? 15:17

15:17

MS. CAIRNS: So, there is a mixture here. They are interviewing -- interacting with folks in Muckamore to ask questions about noise at night, and how they found staff, have they been treated respectfully. It has been adapted so that if I am not able to communicate effectively, they have pictures that they can point to, smiley faces and things, so that we can get some feedback as to how they are finding the doctors treat them, the nurses treat them, is it noisy at night. But 15:18

then the team also will have access to the Kardex that maybe in place to give medications. So, they are checking for things like omitted doses on the Kardex. So it is not feedback -- that element is not feedback from the patient.

PROFESSOR MURPHY: They are not expecting the patient to know what dose they are on or whatever?

MS. CAIRNS: No.

PROFESSOR MURPHY: Are they using talking mats to do that?

MS. CAIRNS: Yes.

PROFESSOR MURPHY: Okay. Thank you.

CHAIRPERSON: I am just going to come back to the guardians. I just want to understand if they have the same role here in Northern Ireland as they might be thought to have in England. Here, are they really advocates for staff? Will staff go to the guardian, and do the guardians make their presence felt, as it were, on the wards to ensure that members of staff know to come to them? Or do they actually fulfil really a managerial role to funnel any concerns through to the right committee? Does that make sense as a question, first of all.

MS. CAIRNS: Yes. It is a little bit of both. When we started of with the advocates, we were involved in a regional awareness week. For that week, all of the advocates were out and about on the sites; we had pop up posters. They were also taking it forward in their own service areas, bringing the topic of

whistle-blowing to staff meetings at various levels and in their day-to-day role, because this role is on top -- this isn't a bespoke role, that they are only doing this.

CHAIRPERSON: No, no, of course not. 15:20

MS. CAIRNS: They are a lead nurse in a division, a doctor, a manager. They will be out and about with staff all of the time anyway. They become known and identified to staff on the ground so that they know they can go to them in the first instance if they are 15:20 not happy coming through to the central team in Trust headquarters, or they don't feel they can go to their manager.

A big part of their role is that awareness thing and 15:20 making it real for folks on the ground, and more accessible for folks on the ground. I think I have a -- which may not have been put into evidence, I would need to check with the whistle-blowing manager. We have sort of a one-pager that describes the expectation 15:21 of the advocates which may be helpful to you.

CHAIRPERSON: If, among the thousands of documents that we have, that isn't there, we would like it. That's all from me. 15:21

Can I thank you both very much for coming back to assist the Panel. I think, Ms. Cairns, you've probably done most of the heavy lifting today but you have both been helpful. I am very grateful for the preparation

that you obviously put in for today's session. Thank you both very much indeed.

We are next sitting on Tuesday? Yes, Tuesday of next week at ten o'clock. We will be sitting on Wednesday, and that will complete the current session. 15:22

MS. KILEY: Yes.

CHAIRPERSON: All right. I thank everybody very much for their attendance and we will reconvene next Tuesday. 15:22

THE INQUIRY ADJOURNED UNTIL 10:00 A.M. ON TUESDAY, 27TH JUNE 2023