Friday, 15 November 2013

(10.30 am)

(Delay in proceedings)

(10.38 am)

DR MICHAEL McBRIDE

DR ANDREW McCORMICK

MISS CHARLOTTE McARDLE

THE CHAIRMAN: Good morning. It's day 148. It's time for the department. This is the last day, ladies and gentlemen, and as you'll remember from what we said before, the idea at the end of the public hearings, of taking evidence, the original plan was that we would have a small number of public seminars and conferences. But because it takes time, quite a lot of time, to organise those and because the inquiry's timetable was shifting, the planning of those became impossible, so the alternative route was the route we've taken this week, which is to have a series of individuals and bodies coming before us to probe the National Health Service as it now is and what progress has been made and what more might be done in the future. It makes sense, in the sequence that we've done things, to end with today's panel from the department.

Therefore, I am pleased the welcome the panel of three who are sitting to my right. In the middle is

Dr Andrew McCormick. Dr McCormick joined the Northern Ireland Civil Service in 1980, but for the purposes of this inquiry, his central importance is that he succeeded Clive Gowdy in 2005 as Permanent Secretary in the Department of Health Social Services and Public Safety. He is therefore the most senior civil servant in the field of health in Northern Ireland answerable to the Minister and, among others, to the public accounts committee.

To Dr McCormick's right is Dr Michael McBride, who some of you may remember gave evidence to this inquiry about his involvement in late 2004 and early 2005 in referring the death of Claire Roberts to the coroner after meeting Mr and Mrs Roberts. At that time Dr McBride was the medical director in the Royal Group of Hospitals Trust, a position he had held from August 2002. In September 2006, Dr McBride was then appointed as the Chief Medical Officer for Northern Ireland, in which capacity he attends today.

To Dr McCormick's left is Charlotte McArdle. Miss McArdle has been the Chief Nursing Officer in Northern Ireland since March 2013. She qualified as a nurse in 1991 and, after working in Dublin, she moved to Belfast, initially to Musgrave Park Hospital, then to the Royal Victoria and moving into senior management in

the Royal Group of Hospitals in 1999. Miss McArdle's career progressed so that she was appointed deputy director of nursing at the Royal Group in 2004. She was made acting director of nursing in 2006 and then, in 2007, she became executive director of nursing and director of primary care and older people in the South-eastern Trust in 2007. She was with the South-eastern Trust until her appointment as Chief Nursing Officer earlier this year.

Thank you very much, everybody, for coming. I think Dr McCormick, you wanted to make an opening statement on behalf of the department. Please feel free to do so now.

Opening address by DR ANDREW McCORMICK

ANDREW McCORMICK: Thank you, Mr Chairman. I'm grateful for the opportunity to participate, as you described, in this stage of the work of the inquiry. First and foremost, Mr Chairman, I want to express sympathy and support to the families of the children who died.

I know that the present Minister, like Minister Smith who set up this inquiry, and like the other Ministers in the intervening years, would want to underline that his sympathy is strongly with the families.

THE CHAIRMAN: Thank you.

ANDREW McCORMICK: The mMinister's remit to the department,

as to this inquiry, is to promote quality and safety in all aspects of health and social care, and he would hope that these hearings -- and in due course your report, Mr Chairman -- will provide some degree of explanation for the pain that the families have had to face over the years, and I would want to emphasise, both personally and on behalf of the department, my commitment to seeking the best possible application of the painful lessons that we have learned from these deaths and I have no doubt that, as the Minister has made clear very many times, the goal of safe, high-quality service is served by openness and transparency, by a willingness of all parts of the system to learn and a culture of fair accountability. I don't in any way want to pre-empt the conclusions you will reach on the evidence you have heard, but I do want to underline, on my own behalf as well as the Minister's, that some of the events and actions that have come to light were deeply disturbing and unacceptable.

I hope I can draw out today some of the differences that already apply between the time when these tragic and avoidable deaths occurred and now, but with my colleagues I have a responsibility to provide leadership to the HSC system that does all we possibly and reasonably can to prevent incidents and failings such as

these.

Also I want to thank the inquiry for the very thorough, thoughtful and penetrating approach you have taken to fulfilling your terms of reference. This is very important to the Minister. It is so important for the future that no one can say there was any hindrance or obstacle to the quest for truth and explanations in relation to these deaths. I'm conscious I'm speaking partly in the role of the organisation which, on behalf of the MMinister, is the sponsor and commissioner of the Inquiry and that leads me to want to take the opportunity to underline that the issues that gave rise to this inquiry are of a different order to most of even the most serious incidents we've faced over the years.

Successive Ministers have recognised that it's important for the nature of the investigative process to be proportionate to the degree of concern. So for example, some very serious issues have been investigated through special RQIA reviews, sometimes led by external experts -- including, for example, the Troop review following the deaths from pseudomonas. Where Ministers have judged that stronger means of investigation are necessary, then they've used various forms of inquiry, for example the dental inquiry which was led by Brian Fee QC and the C. diff public inquiry.

Now obviously it is not for me to comment on whether there was any cover-up. I'm saying all this to emphasise that this inquiry was commissioned because Minister Angela Smith and my predecessor, Clive Gowdy, recognised the particular significance of credible allegations that the truth of what happened in relation to at least one of these deaths had not come to light. That was seen as an issue of a different order to more general concerns about a closed culture or some lack of openness and transparency.

It is now for you, chairman, to reach your conclusions on the evidence you have seen and heard, but Minister Poots wants to ensure that the truth emerges and that all concerned in the HSC respond appropriately. This is an unusual inquiry, but there should be no doubt that the department will use its powers to convene inquiries on this kind of basis if there are incidents that warrant this type of scrutiny.

I believe very strongly that the future of safe and high-quality care depends fundamentally on having a cadre of clinicians across all aspects of the service in Northern Ireland who are willing and able to play their part in managing all the complex risks that arise in modern day healthcare -- and I'm using the term "clinician" to embrace all qualified health

professionals, not only doctors.

Our submission quoted Cyril Chandler and the quotation is well worth emphasis:

"Medicine used to be simple, ineffective and relatively safe; it's now complex, effective and potentially dangerous."

It's essential that there is an increasing understanding of this reality in that society -- including politicians, commentators and patients -- support and recognise the challenges we expect clinicians to manage on our behalf. It would be very detrimental if clinicians, in the face of an uninformed approach to scrutiny, react by playing safe and, if they hesitate to act when they need courageous, confident action, to allow everyone to get the best care available. It's also a concern that there could be a perception that some leadership roles in clinical management as well as executive roles are so subject to scrutiny and jeopardy that the risks are not worth taking. Society needs courageous leaders and that, in turn, requires confidence that the process of accountability is fair.

To be clear, I'm sure there are cases when it is fair for leaders to be subject to sanction. I simply want to ask that all those commenting on the inquiry

recognise that sensationalism is not a neutral phenomenon and that there is a risk that the best leaders will avoid the crucial roles in the HSC if they do not feel supported in managing really difficult risks.

I want to say a little bit in this opening about the approach we take in the department to our oversight of the HSC and how we seek, through systems and leadership, to promote a culture that is open, responsive, always learning and with good and effective communication. The balance we seek is that we aspire to a culture of fair accountability. All that we do and say about clinical governance and the particular aspect in dealing with serious adverse incidents, all that emphasises the fundamental reason for these systems is so there can be timely and effective learning from all that happens in our risky and complex systems. They are not designed as means of enforcing corrective action.

That said, I have set my face against the so-called no-blame culture and I would stress that that is not our approach. There must be clear, individual accountability when the reason for some adverse outcome is an unacceptable standard of care by an individual. It is, in the first instance, for employers to act in relation to substandard care as part of their fulfilment

of their statutory duty of quality. Where individual deficiencies in practice are identified employers should take the appropriate remedial action. This may range from a period of retraining to termination of contract depending on the nature and extent of the deficiency identified. And where deficiencies are so severe that an individual's fitness to practise is in question, the involvement of the professional regulator is mandated. Michael will be able to say more about this if you would find that helpful, but I would emphasise that the public can take confidence from the fact that these steps are applied in a significant number of cases in the HSC every year.

More often, the issues are more complex than the practice of one clinician. The training arrangements provide clear checks and balances designed to ensure that clinicians are only given the responsibilities that match their standard of training, experience, competence and aptitude. So we've, in effect, designed a system where harm should only arise if more than a few individual failures coincide. That's the so-called "swiss cheese" metaphor. There are and must be fail-safes and opportunities for checking that should -- and in the vast majority of cases do -- prevent harm when things begin to go wrong. So it follows that in my

view, systems failure is much more serious than individual failure and also much more harder to prevent, and systems failure is an issue of corporate organisational accountability because the responsibility of the system is at the level of the governing board, the chair, chief executive and directors of each organisation. And clearly, different responses are required at regional level, depending on the context.

I want to take two extremes. There can be a single complex incident that might have severe consequences, but that might not merit any sanction against management if it could not reasonably have been foreseen. At the other extreme, a persistent failure of standards, a persistent pattern, as was unfortunately seen in Mid Staffs, does rightly require a robust intervention from the responsible authorities. So in light of all that, I think there are a couple of key questions that may be of interest to explore today, and those will include "What can we and what should we do as the department to promote patient safety and good effective clinical governance?" and "How can we know if arm's length bodies are actually fulfilling the guidance and directions issued by the department?"

On the first of these, we see a need for both systematic interventions and cultural interventions.

Both of these reflect the fact that quality and safety depend fundamentally on human behaviour. So first of all we need to ensure that the right people are in the right jobs, that they have and maintain the relevant skills. This does not prevent things from ever going wrong, but it maximises the possibility that at least one member of a balanced, well trained team will see a problem before harm arises. So all the paraphernalia of governance structures, reporting arrangements, accountability meetings mean nothing if the front line deployment of staff is inappropriate and I would want both my colleagues to comment on the approach taken by professional leaders to keep this fresh and focused and effective, and I hope there will be that opportunity.

The governance arrangements are very important and I'm happy to elaborate on them if that would help, but I do want to make the key point that all the twice-yearly accountability meetings that I chair with trusts focus on the triangle of quality, performance and finance, with structured questioning to secure assurance that the procedures for implementing departmental guidance and other good practice is in place and that there is systematic learning from SAIs and so on. There are clear obligations to disclose governance issues, that is risks that are known and which are difficult to

manage.

I don't rely solely on the direct line accountability of the HSC bodies to the department, we're also sensitive to other sources of information knowing that they could contain warning signals we need to act on. So as well as requiring that there are strong and effective internal complaints processes, we have strong working relationships with RQIA, as the regulator and inspector, and PCC, as a very important voice on behalf of the patient. So we're currently exploring how we can go further in ensuring that patients' views are more easily heard and understood by management teams and Charlotte will be able to elaborate on that if you wish.

The Minister wrote to all staff across all of our arm's length bodies last year to underline his support and authorisation of whistle-blowing and his commitment to protect those who draw attention to possible failings in the public interest. He said that:

"The aspiration must be that whistle-blowing shouldn't be necessary because in a good-learning culture teams will all be open to mutual challenge and scrutiny, but we support whistle-blowing and all HSC bodies have clear procedures to protect whistle-blowers."

So we're have clear that the system should be candid and responsive, engaging effectively with patients and families when things go wrong and that concealment of information or evidence has to be anathema. There are clear duties in this regard already in the key professions and the department is considering carefully the implications of the Francis recommendations in relation to a statutory duty of candour.

We'd be happy to discuss this further today, but we do not have a specific remit on this point from the Minister. In reflecting on the proposal, our view is that the key question is whether a legislative approach will actually achieve the goal of candour if behaviour adjusts to fit the letter of the law rather than -- in a culture of openness that might not be the case.

I think its well worth noting that information is inherently much more open and available than even five years ago and, whether or not the Assembly introduces a statutory duty, we should make sure that we're acting to promote the behaviours we want and need in the HSC.

Mr Chairman, I know that systems and procedures can be undermined by the wrong statements or actions from senior leadership level, so I regard consistency of message and the reinforcement of appropriate behaviours

as critically important in promoting safety and quality. Michael will be able to expand on the section on culture in the "Quality 2020" strategy, but I would want to take the opportunity to say here two things that I have said many times in HSC meetings and events.

First, that the triangle I mentioned earlier of quality, performance and finance means that each organisation -- and I include here the department -- must take a balanced approach to all three obligations. Our message is that trusts must never use difficulty with one of the three to excuse failure in another, and patient safety is paramount in all cases and contexts.

The second point is a subset of that. What I say is it's never acceptable to do the wrong thing to meet a target. Performance targets on, for example, access times for elective care are very important, but they are a means to the end of providing care, not an end in themselves.

Mr Chairman, the way we do things now is, of course, built on the lessons from many difficult issues and previous failings and on the progress achieved by the departmental and HSC leaders who have gone before us. It is a combination of systems informed by worldwide good practice, people trained and equipped to manage risk and leadership that aspires to always put the

patient first.

We know we'll always have to be ready to adapt and change the way we work because risk increases with familiarity and because best practice is always evolving, but for today's purposes I hope this introduction shows that some very important lessons have been learned from the circumstances of the deaths that the inquiry has been investigating and we look to you, chairman, to provide wise insight and recommendations from the evidence you have heard.

Thank you very much.

Questions from THE CHAIRMAN

THE CHAIRMAN: Thank you, Dr McCormick. We have a number of areas to discuss today, but can I raise this one to start with? If Raychel or Claire died tomorrow in any hospital in Northern Ireland, how does your team expect that they would find out about that and how quickly would they expect to find out about that?

ANDREW McCORMICK: I think we probably expect three things to happen very quickly. The formal processes are as have been described very clearly yesterday so the responsibility is on the trust concerned to report a serious adverse incident, to provide the early alert notification to the department, but the more important and the more severe the issue, the more likely is that

I would expect a personal phone call from the Chief Executive. That happens quite regularly. I do get phone calls when something happens, that's normal practice now, and I'm very clear that that's simply because an incident has happened. There's sometimes a tendency to report things when the issue is about to go to the media. My clear advice to leaders is: let's talk about issues just when the issue is about the patient and the concern is quality and safety. We'll only learn if we continue to work in that way. But undoubtedly media handling tends to come into it. Maybe Michael would want to expand more on that issue.

THE CHAIRMAN: I can understand -- you'll know that we've explored over the last couple of weeks that whatever system was supposed to be in place in the mid-1990s to early 2000s really didn't work. The suggestion was that the expected route was through Dr Campbell as the then Chief Medical Officer. Would you expect it to come to you, Dr McBride, now?

MICHAEL McBRIDE: I think that -- there's absolutely no doubt that the inquiry's had an opportunity to review quite a lot of documentation around the evolution of adverse incidents and how those are managed within the Health Service in Northern Ireland, and that certainly has been a journey here in Northern Ireland as it has

been in the rest of the United Kingdom and indeed as it has been globally as increasingly it was recognised that quite apart from doing real, good healthcare, the provision of it sometimes causes real and very serious harm, including death. So in terms of the situation that you describe, certainly what I would expect now -- and indeed what does happen now -- is that when an event such as this would occur, clearly there is an adverse event that's reported within the organisation itself. That goes through the appropriate governance arrangements in the hospital so that the appropriate staff -- nursing and medical staff -- are advised of what has occurred and indeed the whole chain of executive directors, director of nursing, medical director, Chief Executive is advised accordingly.

As Andrew as said, in such circumstances, the protocols which are in place, which have been refined and have developed over time, would require the organisation to submit a serious adverse incident report to the Health & Social Care Board. And I know, Mr Chairman, you had an opportunity to hear evidence from colleagues there yesterday.

THE CHAIRMAN: Yes.

MICHAEL McBRIDE: Obviously, on many occasions at the early stages of an investigation, there's uncertainty in terms

of what has gone wrong, how it has happened and why it has happened. And I think yesterday, again, colleagues took you through the categories that would be assigned particular SAIs when they're notified and obviously, dependent on that, the approach in terms of investigation and indeed the role of the designated review officer, the degree of independence of panel, et cetera, in the terms of Category 3 incidents is determined.

But certainly in parallel with that, we would -- certainly the department would receive an early alert. Many adverse incidents, serious adverse incidents, may not necessarily become early alerts, but certainly a significant event such as this would become an early alert and, as Andrew's said, not only would we have an early alert form, but we would have contact and a phone call made into the department.

THE CHAIRMAN: Does it come through the nursing end too, Miss McArdle?

CHARLOTTE McARDLE: Yes, my colleagues would and have alerted me as a matter of professional concern. It's not to take away from the responsibility to inform the department, it would be as a back-up to that. We would talk about some of the professional nursing issues that we would need to deal with as a result of that.

THE CHAIRMAN: Okay. I was given a couple of examples yesterday, including for instance a fire in Altnagelvin, which would be an early alert because it's going to have potentially a knock-on effect on the way services are provided. Can you, without naming names, give us any examples of events closer to the inquiry's scenario where you have received an early alert that something has gone wrong in the treatment of a patient, a patient has died or has suffered serious harm? Are there examples of that?

MICHAEL McBRIDE: I can give you a practical example which is very close to the area the inquiry is considering at present, but it did not result in a patient death, but nonetheless was advised to the department as an early alert. I'll try and recall an episode of actual death to a patient, but for instance, in recent --

THE CHAIRMAN: I have to say, it'd be even more reassuring if it isn't a death that's reported because that shows the system doesn't depend on a catastrophic event for you to be notified. If you give me your example.

MICHAEL McBRIDE: In the last number of weeks, we had, as part of the work from the learning in terms of fluid balance and the prescription of intravenous fluids, there has been a significant amount of work going on in Northern Ireland and indeed across the United Kingdom on

this whole issue. But we had a serious adverse incident, it was reported for instance in one of our trusts. It was initially reported within the organisation as a Category 1 event, so it was investigated locally as a failure to measure urea and electrolytes in a male, an adult patient, who was being treated for diabetic ketoacidosis, which is a complication that occurs in diabetes.

The individual did not have his U&Es checked as per the guidance at the required time. That was flagged and captured within the adverse incident reporting system within the individual hospital. It was subsequently considered by the director of nursing, and indeed the medical director within the hospital, who then decided that on the basis of the -- despite no harm had occurred, felt this required to be escalated as a serious adverse incident, given the fact that there were extant guidance and procedures in relation to his -- as you're familiar with the treatment of hyponatraemia and the management of fluid balance in adults as well as in children.

So that early alert came into the department and what happens when an early alert comes into the department is, as Charlotte has said, it's circulated to all the professional leads in the department -- and also

all the policy leads -- in terms of what has happened within the system, whether or not we are assured in terms of the actions that the board and Public Health Agency are taking, whether we are assured in relation to the actions that the individual trust is taking.

Now, on considering that and on that discussion, we then may make contact, and often do -- and in this case did make contact -- with the board and the agency to seek further clarification in terms of the significance of this, and on this occasion both of us communicated with the trust in terms of seeking further assurance around other aspects of fluid and electrolyte management and prescription of IV fluids in the trust.

That's an example which I think is very close to the area of --

THE CHAIRMAN: It is. And just to get it clear, that's an incident in which the adult guidance on hyponatraemia had not been followed, there was no harm caused to the patient as it turned out, but it still made its way to the department as an early alert?

MICHAEL McBRIDE: It did, because again it reflects the priority and focus that we have in relation to the risks associated with the prescription of IV fluids and indeed the importance of adhering to established protocols, guidance and indeed training that has been provided

in the HSC. And I think it's an example, if I might suggest, of the system flagging an omission which occurred. Obviously the circumstances of all of that we'll know in full in due course as to why that happened.

THE CHAIRMAN: Yes.

MICHAEL McBRIDE: I don't know the full details at this stage because obviously that SAI is being investigated and it's part of a live and current investigation. And obviously, in due course, there may be a range of factors which come out of this in terms of learning. There may be human factors in terms of staff or in terms of staff training, there may be a range of environmental factors, there may be some patient-specific factors, there may be issues in terms of the correlation of laboratory tests and how they made their way back to the treating team. So at this stage we don't know, but clearly it was sufficiently concerning for us to flag to the system that there may be a problem here, we need to know more.

THE CHAIRMAN: Right. During the opening address there, there was a reference made to the need for individual -- it's not just a systems failing sometimes, but there are occasions on which there's a need for clear, individual accountability where there's an unacceptable standard of

care. One of the things I know from the questions which have come from the floor in this inquiry is a concern that in all the events that we've looked at, the only person to have had serious disciplinary action taken against them ... Sorry, there are two. There's Dr O'Donohoe in the Erne, but then Nurse Bullas in Craigavon who was struck off by the Nursing and Midwifery Council. I have heard from the floor from the various lawyers that there was certainly a culture in the mid-1990s that trusts did not report their own employees to the GMC or NMC and I was told there has been some change in that and there is now a greater readiness on the part of employers to report errant doctors and nurses. Is that correct in your experience?

ANDREW McCORMICK: Michael can fill in and Charlotte as well from the nursing point of view, but as I said in the opening address, the professional regulators come in towards the end of a process. The first thing is for the employer to intervene and take responsibility because it's their statutory duty of quality that's at risk. We are well aware of some strong interventions in relation to areas where individual care is not of the required standard.

MICHAEL McBRIDE: Yes. Just to say to that -- and again the inquiry's had an opportunity to consider previous

documentation and hear evidence on this -- I think there are a number of aspects to that. Firstly, in the past -- and certainly in the mid to late 90s -- the emphasis was that when things of this nature happen in terms of a failure in the care of a patient, our focus -- and again it was on the back of the Bristol Inquiry -- at that time was that it's bad doctors doing things that shouldn't be done, and the whole emphasis at that time was ensuring that we addressed the issue of underperformance in doctors and indeed other staff at that time.

You saw two key documents which were published, one in England by Sir Liam Donaldson, "Protecting patients supporting doctors", and also here "Confidence in the Future" published by Etta Campbell. Those basically said that the systems we have in place within organisations and within our overall healthcare system are not sufficiently robust in terms of monitoring and detecting underperformance, for whatever reason that might be. It may be issues in relation to training, it may be issues in relation to other behavioural issues or health problems.

THE CHAIRMAN: Yes.

MICHAEL McBRIDE: So there were very fundamental pieces of work taken forward at that time and indeed the General

Medical Council, as Andrew has alluded to, gave an undertaking at that stage to introduce what was called revalidation for doctors. Obviously there were a number of public inquiries which came in the intervening period which delayed progress on that. It was planned to introduce revalidation in 2001. We then had Bristol and that delayed things and we had Shipman and Dame Janet Smith's series of five reports. We are now just in 2012 at the stage where revalidation for doctors has been introduced.

But the fundamental point that I would make in relation to the point that Andrew's made about the primary responsibility being with the employer and within organisations is one of the key recommendations in "Confidence in the Future". I think it was recommendation 14 within that which was that there would be the introduction of appraisal for all doctors on an annual basis. And that was introduced in Northern Ireland in 2001. So from 2001 it has been a contractual responsibility of all doctors to undergo an annual appraisal.

To that annual appraisal they must bring evidence in relation to their involvement in quality improvement initiatives, their involvement in clinical audit and a range of activities in terms of how they benchmark

against their peers within their team or indeed, in many organisations, how they benchmark against a similar sized organisation and a similar skill mix.

That has been further enhanced -- and there's a long intervening period of work and I don't want to take up too much time this morning with it, but obviously that annual appraisal has been copper fastened in terms that it forms now the basis of doctors' revalidation. All doctors in the UK require to be revalidated every five years.

To emphasise the point, it used to be that passing -- getting your professional qualifications, getting your name on the medical register was sufficient to continue to practice. That clearly wasn't sufficient, it wasn't sufficient then and it certainly isn't sufficient now. And revalidation is a process whereby individual doctors and/or organisations -- and indeed the GMC as the regulator -- assures itself of doctors' continued fitness to practise.

THE CHAIRMAN: In the revalidation process, if I as a doctor have been involved in one or two serious adverse incidents over the previous two or three years, is that a factor which is taken into consideration when it's being decided whether I am revalidated?

MICHAEL McBRIDE: Yes. The GMC has very clear guidance in

"Good Medical Practice", the latest version of which was in 2013 across the four domains. Two of the domains are in relation to quality and involved in quality in improvement work such as audit. Another area within that is also within adverse events. So doctors are required to bring to their appraisal documentation, evidence that they're actively involved in clinical audit and efforts to improve service, but also to bring to their appraisal documentation in relation to adverse incidents that they have been involved in.

Basically, what it is to do is to encourage reflective practice, but also to ensure that individuals -- you know, the individual who's carrying out the appraisal and in due course the responsible officer within the organisation, it's usually the medical director, is sufficiently confident in relation to sign off that doctor's continued fitness to practise.

I'm a responsible officer, I've been revalidated, all doctors in the UK will be revalidated by 2016. When I sign off another doctor as fit to continue practise on the basis of the evidence that's before me, I have to document that, I have to consider the evidence in front of me, and I have to make a professional determination on the basis of the evidence that I have in front of me, whether I do so or not.

THE CHAIRMAN: If I'm the doctor who's applying for revalidation, I can't just keep quiet about some serious adverse incident in which I was involved because you as the medical director signing off will know that I was involved in that incident?

MICHAEL McBRIDE: Yes. And the other thing is, if -- I suppose the ultimate -- I am putting my registration at risk as a doctor if I sign off, as a responsible officer, another doctor as being fit to continue practice. So not only is appraisal now -- as it always has been since 2001, a contractual responsibility, it's also a statutory responsibility. So it is now, since 2012, a statutory responsibility that every doctor undergoes an annual appraisal, every doctor relates to a responsible officer, every doctor is appraised on the basis of the GMC four domains that I've outlined and brings to that appraisal meeting a range of information, including -- and I think this is important -- including also feedback from colleagues and including feedback from patients.

So all doctors are required to bring to their appraisal the feedback from their colleagues who work with them in the team -- who perhaps, in certain circumstances, may be the first individuals to note if there is a problem -- and that includes nursing

colleagues as well as medical colleagues, and also to bring information in relation to input from patients.

So again, in terms of ensuring that there's a comprehensive picture in terms of a doctor's clinical skills and knowledge, but also his -- behavioural aspects of his or her work, interaction with the patients, communication skills, empathy, teamworking, et cetera.

THE CHAIRMAN: Two points about that. If you hadn't moved on to be Chief Medical Officer, if you were still the medical director in the Royal Trust, or as it now is the Belfast Trust, would you, as the medical director, have to sign off on each revalidation application by a doctor employed by the Belfast Trust?

MICHAEL McBRIDE: Yes, and the current medical director there, who I believe you met previously, does that on behalf of the organisation. He revalidates.

I revalidate those doctors -- and as Dr Carolyn Harper, I think, explained the process to you yesterday -- I sign off or not or defer. If there's insufficient information there, I defer until I get the information and then ask for further information and I have had occasion to do that where the information has not been sufficiently robust in my opinion -- or there have been gaps -- for me to make a recommendation to the GMC.

It's the GMC that ultimately then, on reviewing my comments and the evidence, will determine or not whether to revalidate a doctor. Also, I was revalidated in April of this year, so I'm -- Chief Medical Officer or not, as a requirement to remain on the medical director, I'm am still required to be revalidated every five years. And again there are similar proposals and work under way in relation to the nurses.

THE CHAIRMAN: I will turn to Miss McArdle in a moment. The second point on the doctor's revalidation -- and let me put it bluntly: some of the evidence I heard, particularly if I take Adam's case as an example, was of doctors knowing that another doctor had made the critical error which contributed hugely to Adam's death. There was perhaps a reluctance or unwillingness to face up to this. That may be protective of a man who's otherwise a very good colleague, but who had made a terrible mistake on this occasion, but if that was the attitude then, how are the public and the families in this inquiry reassured that when you have to bring feedback from your colleagues as part of the revalidation process that your colleagues might not take the same approach?

MICHAEL McBRIDE: I hear the point you're making and it's a very valid question. I suppose there are two aspects

to that. Firstly, it isn't dependent on a once a year annual appraisal. If an incident occurs, as we described earlier, there's investigation into that incident. If indeed there are factors in relation to the performance or actions of an individual doctor, then those clearly merit investigation. That root-cause analysis, the methodology that's used, will be provided to the medical director, and if there are issues in relation to the practice or performance of an individual doctor then there would be recommendations within that.

Now, that may require, for instance, a -- if the circumstances are such that there is a question around the doctor's performance, then indeed it may well be that the medical director in the organisation requests the doctor to refrain from certain procedures or practices until such time as there has been a further investigation of that or remedial training or whatever else is required.

What the department did in 2004 when it introduced appraisal was it put in place a service level agreement with the National Clinical Assessment Service, which is a UK-wide organisation, which has been modified and is now relocated within the revised structures in England, who will independently assess either the clinical

practice, the behaviour -- cognitive testing, psychological profiling, a range of tools that they have at their disposal to ascertain a doctor's continued ability to practise.

It often and can -- depending on the severity of the concerns, it can also result in a period of observed practice. So for instance, NCAS assessors, who are trained, will assess the doctor in their normal interactions at their normal place of work doing their normal procedures and will form a view and will provide advice to the employer, because it's primarily a matter for the employer in terms of what their assessment is in relation to whether there's a need for further training or whether indeed this doctor is fit to continue practise.

Now, if there's a question at all in relation to his fitness to practise, we have in place -- and again it was alluded to yesterday, I think -- the maintaining of high professional standards in relation to procedures, which were previously difficult, I think, in the 90s for organisations to navigate their way through, which are much more streamlined, much more clear, and will require, for instance, an independent board member to oversee the investigation of any concerns of that nature within the organisation, which will oversee any NCAS

assessment and will determine whether there's a need to restrict the doctor's practise, exclude him from practice, or refer him to the GMC.

THE CHAIRMAN: Has NCAS been involved in assessing doctors in Northern Ireland?

MICHAEL McBRIDE: Yes, and indeed we can provide details in terms of that.

THE CHAIRMAN: One final point before I turn to Miss McArdle. In terms of revalidation, is revalidation either a straight "yes" or "no" or can you be revalidated on condition, for instance, that you get further training in a certain area or you attend certain courses, or is it just you either get revalidated for the next five years or you don't?

MICHAEL McBRIDE: There's, I suppose, an underlying question there which I would answer. You're either fit to practise or you're not fit to practise. You're either safe to practise or you're not safe to practise, or indeed you're safe to practise, but not in certain areas or with certain conditions upon your practice. But in terms of are you revalidated or are you not, it is a simple yes/no. However, revalidation can be deferred, for instance, if there are legitimate reasons. Individuals may be on maternity leave, they may not have had an opportunity to get all the correct documentation,

or indeed, as responsible officer I may say, "Actually, I have no significant concerns in relation to your continued ability to practise, but quite frankly at this point in time you haven't supplied me all of the relevant information to enable me to make an informed judgment and as signing-off as a responsible officer I have a responsibility to ensure that I make a fully informed assessment and I make a fully informed recommendation to the General Medical Council".

THE CHAIRMAN: Okay.

On the nursing side, do I pick up from Dr McBride that some equivalent system is being developed or is there an equivalent system in place?

CHARLOTTE McARDLE: In terms of the regulation element of revalidation, medicine was the first of the professions to go forward with revalidation. So NMC have a plan to commence revalidation from 2015 and that will include a self-assessment -- a self-assessment by the nurse, potentially the organisation, and potentially by patients and users. It will be out for consultation post-Christmas from the NMC in that regard.

But what I would say in terms of some of the other core components in terms of regulation, nurses, under Agenda for Change, which would have been the review of the employer's contract with the staff and the HSC, with

the exception of doctors or dentists, put in a process for appraisal known as KSF, the knowledge and skills framework. There are component parts that will be key attributes that you would expect for any professional providing healthcare around quality and safety and, in particular, communication. So that annual appraisal process takes place, obviously, on a yearly basis.

On top of that, the previous CNO had issued guidance to the system to say that every nurse in Northern Ireland had to have two professional supervision sessions a year. And the directors of nursing provided an annual report back to myself in relation to that.

THE CHAIRMAN: Just pause there. Two professional supervision sessions? Does that mean for a day in May and a day in November, for instance, that the nurse is effectively monitored or followed when on duty?

CHARLOTTE McARDLE: What that would mean is they would have a supervision session. It may be their line manager, it may be a colleague, it may be a group supervision, but they have the opportunity to reflect on their practice to learn from experiences and to talk about issues and concerns that may be on their mind. So for example, if they dealt with a particular difficult situation or it was the first time maybe a new graduate nurse

experienced caring for a dying patient, you might want that to bring to your supervision session to talk through the issues, how you felt, how you performed, how you dealt with the family, and talk through that with a more senior colleague. So that system is in place. Equally, if they had concerns about their own or other people's practice, the opportunity to raise that would be provided in that supervision session.

So that is in place. In terms of the regulation, the NMC obviously, we have the code, which is the Bible in terms of the standards for nursing and midwifery practice. And that sets the standards that we expect our nurses and midwives to perform to. You will know too that the NMC have just recently republished guidance on raising concerns and there's very clear guidance on that for everyone in terms of how they might take that forward and up the line and chain of command if they don't get a satisfactory resolution to that.

THE CHAIRMAN: And part of that is emphasising the duty on nurses to raise concerns and providing a mechanism for doing that?

CHARLOTTE McARDLE: Absolutely. It actually goes through the stages of -- if you are a registered nurse providing care in a ward, your first point of contact is your ward sister. If you don't get a successful outcome, you take

it to the next level, all the way up to the director of nursing and, indeed, the chief executive if you need to do that. The same system is in place for our students, students of nursing at our universities, where they have provided guidance on raising and escalating concerns for them.

THE CHAIRMAN: Does that actually happen in practice? Are there instances of nurses raising concerns and not getting the response which they think is appropriate and taking it further up the line?

CHARLOTTE McARDLE: I was reflecting on that as you were speaking to Dr McBride. In relation to my -- both in my current role, which I haven't been in for a significant length of time, but my previous role as director in the South-eastern Trust, there have been many occasions when that has happened, where people have sought to raise an issue.

One in particular that I can recall would be in relation to the ED environment where the nurses on the ground were concerned about the quality and treatment that patients were getting because of the busyness of the department and they were raising that. And although management were trying to address the issue, they didn't feel that they were getting a satisfactory resolution to their professional concerns

and that actually did escalate all the way up to me and because of that then it became a corporate issue and dealt with in a different way. And there are many examples of that that I could point to.

THE CHAIRMAN: That's in the emergency department in the South-eastern?

CHARLOTTE McARDLE: Mm-hm. I'm trying to, in trying to reassure you that it does work, thinking about how many. We have a process of an alert system in place where the organisation has completed their investigation and where there's a significant concern about an individual's practice and they are awaiting the outcome of the NMC investigation, many the directors of nursing would formally ask me by letter to issue an alert letter, should that person employ -- be offered or have the opportunity to work elsewhere, that that employer would know the circumstances in which that nurse is currently in, awaiting that investigation to take part -- by the NMC. At the moment we have 28 people in Northern Ireland who have alert letters issued against their names.

So that's not a direct correlation with the number of referrals to NMC, but it means there are 28 people in the system that have cases ongoing with the NMC where there's significant concern.

THE CHAIRMAN: Does that alert letter apply to other trusts in Northern Ireland or does it extend beyond Northern Ireland?

CHARLOTTE McARDLE: It extends across the UK and it is for all healthcare professionals and in fact in Northern Ireland it extends into the independent sector as well.

THE CHAIRMAN: So it's a mechanism for avoiding a situation where a nurse who's under serious investigation in the Western Trust, who then sees a vacancy in the Eastern Trust or Southern Trust and applies for that and the new employing trust isn't aware that there's potentially an issue coming with that nurse?

CHARLOTTE McARDLE: Yes.

THE CHAIRMAN: Okay.

MICHAEL McBRIDE: Mr Chairman, if it's helpful, a similar arrangement applies on the medical side as well, and there is -- what we're attempting to do is actually make that an automated system in terms of an actual electronic system because at the moment it is a sharing of letters and information and obviously there are other challenges with that and, at a UK level, myself and other UK CMOs are seeking to progress it as an electronic system.

THE CHAIRMAN: Are these recent developments in the last

couple of years or have they been there for longer?

MICHAEL McBRIDE: I can't tell you exactly at what time those arrangements began, but they have been long-standing arrangements.

THE CHAIRMAN: Okay. In terms of the serious adverse incidents, we have explored quite a lot about those this week starting on Monday with the Patient and Client Council and Action Against Medical Accidents, through the Belfast Trust, through the Health & Social Care Board. I don't want to suggest that non-clinical serious adverse incidents aren't important, of course they are, but this inquiry is focusing on clinical events, but how do you know at departmental level, apart from the early alert system, how do you know what the picture is generally about the number of clinically related serious adverse incidents? If the ultimate report is completed by the trust and signed off by the Health & Social Care Board, I presume that each adverse incident does not come to the department, does it, because you'd be swamped if it did?

ANDREW McCORMICK: No, it doesn't.

THE CHAIRMAN: How do you then have an overview of areas of concern or particularly clinical areas where there's a run of serious adverse incidents?

ANDREW McCORMICK: A few things from my point of view, and

then I'll ask Charlotte to add to that. We would expect each trust, because they will be looking at the range of issues they are facing, if there's any pattern, any issue consistently, they should be raising that. That's an area that should come out in our twice-yearly accountability meetings. Those have the domain of -- governance in relation to quality and safety is top of the agenda in those meetings, so that's an opportunity to --

THE CHAIRMAN: Sorry, do you take those meetings?

ANDREW McCORMICK: Yes.

THE CHAIRMAN: Maybe this is a bit easier because there are fewer trusts now, but each trust has a twice-yearly accountability meeting with a team which you lead?

ANDREW McCORMICK: That's right, and full representation across the professions and the managerial side and we're looking at, as I said earlier, the domains of quality, finance and performance in a balanced way. Then personally, to supplement the information I'm receiving, I would meet regularly with RQIA and PCC to ensure that there's an opportunity for them to say to me -- draw my attention to any patterns that they see from the culmination of the work on regulation and inspection on the one hand and what the patient voice is saying on the other. So that's again me saying, "I want to hear",

I want them to take a view, not looking at detail, but any general pictures and patterns that are emerging.

So that's the tip of an iceberg. The iceberg is extensive and complicated, but it is very, very important that in all that detail we stand back and think "What's actually happening here? Are there connections, are there patterns, are there root-cause issues that are more subtle?", but we have to be actively thinking about it all the time.

THE CHAIRMAN: So that's your overview, but the direct responsibility for this lies initially with each trust --

ANDREW McCORMICK: Yes.

THE CHAIRMAN: -- and then with the HSCB and the Public Health Agency?

ANDREW McCORMICK: HSCB provides its overview to the department. That's again part of the system. Their overview of SAIs comes in to the department.

MICHAEL McBRIDE: Andrew's described the oversight, checks and balances, the overall system governance of this in terms of: what are the systems and processes in place, are they working? That sort of obviously biannual assurance is one mechanism. But obviously it needs to be more real time than that, as well as the system-wide governance which obviously Andrew's described. For

instance, whether there are learning letters -- and I think again that HSCB colleagues covered that yesterday -- whether there are workshops, which are trained events which would be carried out on the back of those, or indeed the six-monthly reports and summaries in terms of identification of trends and themes, those are shared with the department. Those are then shared again with professional colleagues and policy colleagues right across the department in a multidisciplinary way. We look at those and annualise those.

Our question at that point is: are we sufficiently satisfied in relation to the actions that have been taken? We also look at it from the policy perspective in terms of are there other aspects around policy which, for us, we need to consider in terms of are there changes in policies that we need to give consideration, how does it feed into strategic approach in relation to configuration of services, et cetera? So there's that wider aspect to it.

And indeed we'll also consider whether there are aspects and elements of this which we will wish to share with other jurisdictions. Because again in Northern Ireland, one of the advantages, paradoxically, of our scale -- and I am very mindful of the circumstances of this inquiry -- is that we often do identify system

problems and we do often identify them at an earlier point in time because of the shorter lines of communication because, again, it is possible, as Andrew said, to get all the individuals across all the trusts in a room.

I mean, I personally meet with all of the medical directors -- and Charlotte has similar meetings with directors of nursing -- medical directors, the medical director and Director of Public Health, who you met yesterday, Dr Carolyn Harper, the medical director within HSCB/PHA, the undergraduate dean, the medical director of GAIN, that's the Guidelines Audit and Improvement Network, the undergraduate representatives in terms of training on an alternate-month basis.

For instance, if there are issues of this nature then we would have all of the key individuals at that Medical Leaders' Forum, which I chair, where we can discuss whether there's training aspects of this, either undergraduate or postgraduate, because both postgraduate and undergraduate deans are there, whether there are aspects which are relevant in terms of other trusts that need to be taken forward, were we sufficiently satisfied that the action of Board and agency -- the Public Health Agency are sufficiently robust ... Similarly --

THE CHAIRMAN: I understand that. It inevitably sounds like

a system which has been developed and enhanced and made more demanding. Again, can you demonstrate a practical example of something which, if something springs to mind pretty quickly, has emerged from a medical leaders' forum in recent times as a result of this collective input of brains and experience?

MICHAEL McBRIDE: Yes. One in the last number of weeks which was in the media, the reports of death of a patient in an intraoperative period. Obviously, we have, you know, regular liaison on an ongoing basis and there's the coroner's liaison officer. We have regular liaison with the Coroner's Office in the department. We were aware of the circumstances of that particular inquest, we were aware of the emergent issues within that, that's a matter which myself and the Chief Nursing Officer discussed in terms of the implications, potentially wider implications for the HSC, the implications in terms of liaison and sharing of information between the respective organisations and bodies, whether there was specific guidance at a national level in relation to the particular circumstances that had occurred, whether there were aspects in terms of individual actions by individual healthcare professionals which needed to be considered.

And that -- following our discussion and liaison on

that we discussed it again also at the medical leaders' forum and we agreed a particular course of actions, certain assurances that needed to be sought, further work that needed to be commissioned and undertaken. So that's a very -- that's a real-time example of something which --

THE CHAIRMAN: Exactly what I'm looking for.

MICHAEL McBRIDE: -- is under way.

THE CHAIRMAN: I'm right in thinking that's an event in a private hospital?

MICHAEL McBRIDE: Yes.

THE CHAIRMAN: So the fact that it happens in a private hospital doesn't make any difference --

MICHAEL McBRIDE: No.

THE CHAIRMAN: -- it's part of the service?

MICHAEL McBRIDE: It doesn't matter. The case in question involved doctors who are also working in the Health Service across the independent sector, it involved procedures which are carried out in the Health Service as well as the independent sector, and therefore we have to ask ourselves as a system, you know, as organisations, as trusts, as commissioners, as a department, is there learning here which is of wider application here in Northern Ireland, but also further afield in terms of other jurisdictions? Charlotte,

I don't know if you want to --

CHARLOTTE McARDLE: Only to say that's a good example of a multi-disciplinary approach because many of these things are more complicated than just a uni-professional strand. And I also think that while there are issues for the individual practitioners in various different professional groups, there is a system issue which complicates things even further and that's why it's important that we're all together thinking about and making sure that the processes and systems are there to support the doctors and nurses and others on the ground to be able to provide the level of care that we expect them to do.

I mean, that example that Michael has shared with you, I've worked very closely with him and his team on that one, and in fact I have it on my agenda for my next CNO meetings with the directors and in the meantime, because I didn't have a meeting at the same time as Michael had scheduled his, I have written to them and they're aware of what they need to do in the meantime and I expect feedback on 6 December when we meet.

THE CHAIRMAN: That helpfully leads me into another area we wanted to discuss, to see how things have moved on. In 2002 when the department moved ahead of other regions and introduced hyponatraemia guidelines. They were sent

out with a covering letter from Dr Campbell to say that these should be implemented, their implementation should be monitored and audited. Now, disappointingly it turns out that that didn't very happen very well at all, at least in some areas. And I think it was Dr Harper yesterday who was saying there is more defined follow-up and there's more -- and some of the stuff that we've seen through the NPSA alert was that there's a pro forma now, which tries to make sure that the follow-up actually works and that the implementation occurs.

In the sort of event you have just been talking about or in other events, it's important, I think, for the families at this inquiry and for the public generally to know that there is some mechanism for ensuring that the lessons which have been learned are actually put in place in the various hospitals and elsewhere. Can you give that reassurance?

ANDREW McCORMICK: Yes.

MICHAEL McBRIDE: Yes, I think the lessons you described are at two levels. They're lessons in relation to -- prescribing IV fluids is like providing any other drug. It has a benefit and there are hazards and risks. I don't think that was perhaps fully and comprehensively understood as it ought to have been at points in time -- and I say that across the United Kingdom. In terms of

the other aspect in terms of assurance, we assume nothing in relation to our issuing of guidance to the HSC. We seek assurance and Andrew's alluded to the ultimate assurance in terms of his accountability reviews, which he chairs with the chief executives and their respective organisations on a twice-yearly basis and the assurances that are sought there.

But certainly, I think the NPSA Alert No. 22 of April 2007 is a very good example. Obviously, as a result of the learning that was identified here in a small system. NPSA Alert No. 22 went out in 2007. It alluded to the fact that of the three deaths that had been reported in Northern Ireland, it alluded to the fact that there were probably other deaths that had gone unreported in the United Kingdom and it alluded to the fact that there were 50 deaths reported in the world literature. I suspect, I don't know, but there may be many other deaths which were not attributed to the use of No. 18 Solution, which had not been associated or not understood to be necessarily directly related.

You're quite right that when that circular went out, out with it went an audit pro forma, a template to be completed, a learning aid and out with it went also a requirement for chief executives to sign, within a required timescale, their assurance that an action

plan had been developed within their organisation in terms of what steps now needed to be taken, that they'd completed the audit and any actions identified in the audit had been taken. We then subsequently followed that up, as you know, chairman, requesting RQIA to go in and audit compliance, so we asked the organisation -- back to Andrew's point, the organisation has a primary responsibility for monitoring adherence, compliance to departmental guidance and that's a responsibility at a corporate level. We then independently, over and above, asked RQIA to review that in 2008. They made some 15, I think, recommendations at that time and then again in 2010 we sent them back again and they made a further eight recommendations. And indeed I think you can see now that, as of last year, all of the recommendations had been completed and we have taken further steps in terms -- saying it's all very well having a wallchart and training in place, but we've actually gone a stage further with the roll-out of the IV fluid prescription and balance chart, which is basically saying, well, having a wallchart is one thing, but actually putting it down in a pro forma which is used hour by hour, day by day, in relation to nursing and medical staff in a range of settings prescribing IV fluids actually embeds it in terms of the processes

of care and again that roll-out is underway at present and we're going to be auditing that in February.

THE CHAIRMAN: The basic lessons which are on the wallchart are now being incorporated into the prescription records?

MICHAEL McBRIDE: They are.

THE CHAIRMAN: So for instance, the prescription records and the nursing records, I think now include on their face the method on which fluids should be calculated so that it's there right in front of you all the time, there's no mystery to it?

MICHAEL McBRIDE: It is, and Charlotte might want to comment on this. But not only that it's there, but there's a training package associated with it. Individuals have to be signed off as competent and completed the training. And as I say, we will be -- and we're very conscious of this, that this is something which we've introduced in Northern Ireland. I've written, in 2011, to NICE to ask that similar approaches be taken right across the UK in a unified approach.

Obviously the work here in 2002 by Dr Campbell informed the NPSA alert in 2007, but also the work that we've continued to develop perhaps may seek to inform work across the UK and actually make the prescription of IV fluids in children even safer again. But as I say,

we will be auditing this in February, both in terms of a quantitative audit in terms of how well it has been adhered to and also a qualitative audit in terms of actually -- sorry, a quantitative audit in terms of actually how well it's actually working in practice and a qualitative audit as well. And as I say, it's so important that we get the audit right so that we're asking the right questions and we're -- so we're actually piloting that audit in December of this year in two organisations who have already fully implemented the new IV prescription and balance chart.

CHARLOTTE McARDLE: I would just take that up a bit further. That training and education has now been brought into the undergraduate programmes of both professional groups, and I have asked for assurances through my Central Nursing and Midwifery Advisory Committee to provide assurances that the universities confirm that they have actually done that and that is in place so that when the students come out into practice for their clinical placements, they're familiar with and see that new chart working well in practice.

And as a bolt-on to that, I have asked that NIPEC, in their quality assurance role, take forward their review of the fluid management course for children next year to provide further assurances to us that that

training is embedded into practice.

MICHAEL McBRIDE: And the same would apply on the medical side, Mr Chairman, just in terms of both the undergraduate curriculum and also in the F1 foundation programme. All doctors are mandated to complete the e-learning module on IV fluid prescription. You will also see that within the special registrar module they are required to complete it again at that stage in their career progression. It's also now, at a UK level embedded, in section -- I believe it's section 4 and section 7 of the UK-wide curriculum for foundation programme. That's the first two years for doctors post-qualification whereby they're able to identify an acutely ill individual, able to administer safely an IV fluid challenge, and they're aware about how to safely prescribe intravenous fluids. So I think the profile and the understanding of the risks associated with this has certainly developed much more significantly at a national level and actions have been taken.

ANDREW McCORMICK: The detail provided by my colleagues is, I think, very good evidence in the way that's been followed through. The question in my mind is: well, the next big problem might be something completely different. So the general point I make, because there's

a host of guidance going out from a range of sources and that triggers professional letters giving guidance to the system all the time and the requirement we have in terms of overview is that each organisation has a system to receive, understand and distribute incoming guidance. So there's a corporate responsibility to deal with each and every piece of guidance which may or may not look important on its arrival, may look very technical, but it needs to be understood and recognised by each organisation and it needs to get to those at the front line who are most directly concerned, and that has to be dealt with case by case.

Again, our regular interaction at corporate level would ask that question: is your system working, is it being disseminated in each and every case?

THE CHAIRMAN: Is it then part of the problem that you'd have to control the quantity of guidance which goes out?

ANDREW McCORMICK: We can never hold back guidance because it is --

THE CHAIRMAN: I understand. Is there a risk that people can be swamped? How do you control or manage that risk to ensure that you get out the necessary guidance and that it does actually become something which is acted upon?

ANDREW McCORMICK: Yes, it is a risk, it's a very important

risk, but we're aware of it and require it to be managed. And the means of managing -- I've started to explain already -- are the internal system within each organisation and actually then coming back to the cultural side. Because, as I said in the opening, systems and culture go hand-in-hand here and the cultural point is thoughtful awareness to make the right connections.

MICHAEL McBRIDE: Chairman, it is something which we are very alert to. Dr Harper, in her evidence yesterday, advised of the new process that was introduced in relation to the communication of safety alerts.

THE CHAIRMAN: Yes.

MICHAEL McBRIDE: That was a piece of work which we had issued under "Quality 2020" and a number of work streams that Andrew referred to earlier, which was recognising that we must do our level best to ensure that we streamline systems and provide a coherence to the information messages we're getting out to ensure that we facilitate organisations in identifying the major priorities, those major risks, and taking actions to address those. And again I think you heard about that yesterday.

The other aspect that feeds into Andrew's comment around the assurance that we seek -- if for instance

there's a piece of guidance that goes out to the HSC to trusts or to the boards or to the agency, obviously that which has a legislative basis or statutory basis, we require and we have RQIA to independently assess against that, but again the primary line of sight -- our line of sight is through the normal accountability arrangements.

But if there's a piece of the guidance that goes out that we require assurance that it's been implemented, we send that out and we advise the trusts that we require them to provide assurance to the Health and Social Care Board, who are the commissioners of care and have a statutory duty of quality as indeed do the organisations -- to provide assurances within a certain timescale to the commissioners. The commissioners then will ascertain whether they're sufficiently satisfied or not with that assurance that's provided and then will advise us accordingly whether they're satisfied in relation to the assurances that have been provided. And there will often be a toing and froing within the organisations in terms of ensuring that the commissioners are sufficiently content because ultimately then they're providing, as the commissioner, that assurance to us in the department.

We will then, as Andrew has said, revisit that at each and every accountability review when we consider

safety and quality in relation to the assurances that are given to us by the trusts in relation to a range of guidance -- that can be NICE guidance, it can be in relation to social care, it can be a range of other guidance -- and also when we meet with the Health & Social Care Boards.

In between times, the trusts and the Health & Social Care Board and Public Health Agency have bi-monthly meetings and updates are sought at those bi-monthly meetings in terms of progress against -- progress against guidelines and alerts that have gone out from the department. And obviously that sort of regularity and formalisation of the meetings informs the ultimate assurances.

THE CHAIRMAN: And at those bi-monthly meetings, if there's any twists or hiccups in the way that the guidance is being implemented, they can be discussed or debated or drawn to your attention at those meetings? Is that right?

MICHAEL McBRIDE: They can, and those discussions are sometimes -- you know, those discussions are often quite engaging in terms of -- for instance, an example of sending out NICE guidance which requires implementation in relation to -- a technology appraisal about the introduction of a new drug, which will have real

benefits for patients and potential savings in terms of health -- you know, consequences of not having access to the drug. And we have required timescales for the Health & Social Care Board and Public Health Agency to have that guidance in place. They -- we ask them to provide assurances and we often will have discussions in terms of competing priorities and range of priorities.

But as Andrew has said, you know -- you know, there is absolutely nothing that trumps the quality and safety of patient care, you know, back to his analogy around that iron triangle. There are a range of risks that we manage in health and social care. Doctors, nurses, managers in the Health Service manage those risks on a day and daily basis. It is not risk-free. We often manage those risks in the absence of complete information and knowledge. And what -- apart from ensuring that we have the right people in place with the right set of values and principles and behaviours, we need to make sure that we have a system and process in place which provides us assurances, identifies when things aren't happening that should be happening and that we engage, as we do on a regular basis, with our colleagues in -- when they are the commissioners or indeed with trusts and seek further assurances if that's not forthcoming, and those sometimes are challenging

conversations.

THE CHAIRMAN: Yes. Can I ask, Miss McArdle, one specific issue about nursing now? In the paper that you provided the inquiry with there was reference to the development of, or maybe the reintroduction, of a nursing ward manager. And I understand that the idea there is that sometimes nursing managers or senior sisters have had managerial issues to focus on and perhaps sometimes at the cost of clinical issues. Do I understand it correctly that what you're exploring is the notion of reintroducing or adapting the system so that you have a nursing manager who will focus on clinical issues rather than managerial issues? Maybe you could develop that paper.

CHARLOTTE McARDLE: Certainly, Mr Chairman. I think that the role of the ward sister is absolutely key and fundamental to the running of HSC in terms of the organisation. Not only is the ward sister responsible for the standards of nursing care and midwifery care on their ward, but they are also responsible for coordinating the multidisciplinary team and for ensuring that the needs of the patients, whatever they might be, are met by whomever in the team is required to do that. So they have a very pivotal role.

They are in charge of their ward and they need to be

recognised as being in charge of their ward. And over the last --

THE CHAIRMAN: Sorry, when you say that, you mean by that more than they're in charge of the nurses on the ward?

CHARLOTTE McARDLE: They're in charge of the ward environment and everything that happens in the ward environment. And that's why I believe that they're pivotal to the quality and safety and the standard of care that the patients receive from all of the healthcare interactions that they have.

Over the last 30 years that role hasn't really changed. You know, the principles are still the same, there are three key parts of the ward sister's role. They are clinical leaders, teachers, and they're managers. And as part of the clinical leader role they have a clinical expert role to undertake and that requires them to be on the ward working with the staff, observing the standards of care, role modelling good practice, being able to talk to patients and their families when they need so. And in fact they are the linchpin in the complaints process on many occasions because it's in that role that they can deal with concerns early on when a family or a patient has a concern, and if it's dealt with and dealt with appropriately at a time, it often not only averts the

complaints process, but it means that the experience that the patient and family have is much more satisfactory. So they have a key role in that.

I think, as a profession, we felt that the ward sister role was being eroded into a managerial post where they were doing a lot more number crunching, office-type work, attending meetings, responsible for things that other people, in essence, could do for them and not focused on the clinical expertise and the clinical leadership role that they have, which is why the previous CNO asked NIPEC to undertake this piece of work around that time. The title of the post was "ward manager" and we've agreed to change that back to "ward sister" or "charge nurse" on the basis that that refocuses and reemphasises the importance of the things that I have described.

So that has happened. As part of that, they also -- we have developed a regional jobs description, which is applicable to every ward sister in Northern Ireland. We've developed a set of competencies and an induction programme to support them in that role. Interestingly, the PCC have provided feedback for us on the public's perception and they were part of this project around the ward sister's role and the feedback from the public is that they don't believe the ward sister is still

visible enough and the reason for that is mainly, I think, because we've changed the uniforms of the nursing staff in all our HSC organisations and the sister will have been traditionally associated with wearing a red uniform and they now don't wear that red uniform, so they're not immediately visible. So as a result of the feedback we've had from the PCC -- and this is an example of how we do all work together in our various roles -- we've undertaken a review of that to change that uniform.

THE CHAIRMAN: Over and above the colour of the uniform issue, will the effect of this be that the ward sister will spend more time with the patients on the ward than has been the practice in recent years because there were managerial issues to spend perhaps too much time on?

CHARLOTTE McARDLE: Absolutely. I think that in -- previous to my appointment, the previous Minister had allocated a sum of money to the wards so that they could have some personal assistant support to offload some of the admin roles that they were undertaking, which has been very helpful.

I have an expectation that the ward sisters will be out on the floor 80 per cent of the time that they are on duty and that they will employ the skills of the rest of their team to carry out some of the task that need to

be done. Off-duty rosters are very important and they need to be done, but they don't necessarily need to be done by the ward sister. So that is in place now. And there is definitely a refocus back on clinical leadership and person-centred practice and ensuring that the care I or you or any of us would like for our families is what's actually delivered in our wards and departments in the hospitals.

THE CHAIRMAN: So in a sense she becomes an additional nurse, but she becomes the visible nurse in charge of the ward?

CHARLOTTE McARDLE: She is the nurse in charge of the ward and there will be times when the ward sister has to have a hands-on approach to providing patient care for one of two reasons: one, there may be unexpected absence and the nursing component for that day is short and the sister will do that; but more importantly she has a role as a clinical expert to teach and support and role-model good practice, particularly for our student nurses and new graduates and that she would use her expertise in caring directly for patients to role-model that good practice for the staff.

MICHAEL McBRIDE: Mr Chairman, there is a very practical example of that, under "Quality 2020", the mechanism of the ward level review, which might be helpful in terms

of how that expanded time might be put to best use.

CHARLOTTE McARDLE: Yes, and thank you for that. The ward sister and one of the senior consultants in each ward, under "Quality 2020", have been asked to consider how best they can utilise time to ensure themselves and their staff that the standards that we expect to be met in terms of patient care are being met and -- we've borrowed some tools from the Institute of Healthcare Improvement, IHI, in Boston which is called the global trigger tool and it's a process that they can use to, I suppose, audit at a local level the care that's provided through the notes, through speaking to staff, through speaking to patients, through reviewing the patient experience, and then we expect that they will instigate action, where required, to make changes either on a small scale within the ward or on a larger scale within the hospital as a result of that and that is happening through Quality 2020. It's in pilot at the moment, but we would anticipate developing a model that is used widely across all wards and departments in Northern Ireland.

THE CHAIRMAN: And is your aspiration that you have that in place over the next year or two years?

CHARLOTTE McARDLE: Certainly within the next year. The pilot has been undertaken. There are many other strands to this work in relation to patient experience and there

are many other pieces of work ongoing, and what we're trying to do at the moment is to draw on all those to make sure we're getting a really strong voice from the patient because I believe, and I think we all believe, that the patient's voice has to be front and centre in everything that we do.

THE CHAIRMAN: It's relevant to this inquiry because there have been at least two instances of families not really feeling that there was anybody in charge and not really knowing who to turn to or feeling that their concerns were not being taken up or recognised by anybody who was there. And if there is now to be an improved system whereby there is an identifiable sister in charge or ward sister or charge nurse on each ward, that would help to respond to that problem which has emerged here and which I assume, from what you have said, has emerged elsewhere many times over.

CHARLOTTE McARDLE: Absolutely. I fully accepted that was the experience of the families in those very traumatic situations. My attempt today is to provide assurance that we as a profession have taken that on board and are keen to ensure that that situation, where we can improve that standard of care, that we do so and that we listen very carefully to what the families have told us in terms of their experience and we build that in to the

changes that we make, particularly to that role.

I think the other thing that I would just like to say is that one of the Francis recommendations was -- there were many in relation to ward sister's role, but there was one specific role around the sister's ability to be free to oversee the standards of care that have been provided and what I have done since I've come into post is that there was a piece of work ongoing, reviewing the nurse staffing levels and into that piece of work we have written that the ward sister is supervisory and should be there in a supervisory capacity, which should eliminate, with the exception of an emergency, the need for the sister to be counted as one of the nurses providing direct care on the ward.

THE CHAIRMAN: Right. So if the identified need is for three nurses, the ward sister does not count as one of the three, it's three plus the ward sister?

CHARLOTTE McARDLE: Yes.

THE CHAIRMAN: Where do you get the resources for that because I presume that's an issue?

CHARLOTTE McARDLE: That absolutely is an issue and we are in the process of agreeing how we might best take that forward. It will have to be done on a phased approach, but there's a commitment and the department have agreed that that is an approach that we will be taking forward.

THE CHAIRMAN: Okay. Let me move on. I have covered with a number of groups this week the issues about the involvement of families in complaints and in serious adverse incidents, and I'm not sure that I need to go over that again today with you unless there's any point that you've picked up from the discussions earlier this week about it. I think the only slight concern I had was about the extent to which the Belfast Trust's written complaints procedure put the families or the complainant as a part of the complaint. But I understand from what I've heard that the way that their complaint system works is slightly ahead of the written procedure.

MICHAEL McBRIDE: Maybe I could comment on that.

THE CHAIRMAN: Yes.

MICHAEL McBRIDE: I think, as Michael Bloomfield made clear yesterday, the department's guidance of 2009 is very explicit and clear in terms of the eight standards within it, in terms of access to the complaints process, involvement of families and complainants from the get-go, and facilitation in terms of either formulating the complaint and indeed ensuring that there's ongoing liaison and feedback. It's very clear in relation to the role of advocacy and support. I note the comments, we will be seeking further assurances in relation to the

trust in relation to -- that their policy is consistent with the 2009 guidance.

As you know, chairman, we're also -- we had commissioned a review from health a social care board, as a department, on the implementation of that policy and I know Mr Compton spoke to that yesterday in terms of its 14 recommendations. I think two in particular are important, and that is to enhance local resolution, but local resolution is a responsibility for trusts to facilitate and support that, and we will ensure, through the mechanism that Andrew's already outlined, that that happens.

And I think the other aspect, which was clear in the 14 recommendations, was the fact that we were not very good at providing, as yet, as a system, feedback to complainants and also to staff. What has changed as a result of the action on those complaints, that clearly is an area for improvement. Now the department, as a regional group -- the board is the regional group where they analyse the learning from complaints. We have a regional group, which includes the Patient and Client Council, Regulation and Quality Improvment Authority, the trusts, the board, the agency, and it meets on a six-monthly basis. And if there are elements in terms of further refinements, or indeed development of the

guidance that needs to be taken forward, we as a department have a mechanism and a vehicle a process of engagement to ensure that happens and, indeed as Andrew said, to ensure there's consistent application of the department's guidance across the HSC.

We've also asked RQIA to do a review of the complaints process in 2013 as part of their thematic reviews and they'll be reviewing the SAI system across Northern Ireland in 2014.

THE CHAIRMAN: We have a practical example in this inquiry of something, which is that in Raychel's case, which was the one which actually was followed up significantly internally in Altnagelvin and where some lessons were very quickly identified, changes were put in place and everybody in Altnagelvin knew that and the only people who didn't know about it were the Ferguson family, and that seems to me specifically what you want to avoid. Because as I understand it from Mr and Mrs Ferguson and Mrs Ferguson's sister, if they had been told that, they would have had some reassurance that what went wrong was recognised, steps were being taken to correct it, and their impression inevitably was "This was withheld from us because it made Altnagelvin look guilty or blameworthy in some way". It's hugely frustrating because in some ways what Altnagelvin did after Raychel

died was admirable. But the value of it is grossly undermined by the fact that the Fergusons are excluded from the people who are informed.

MICHAEL McBRIDE: I agree and accept that and we have much more to do there. I accept -- and I heard those comments. We're very keen not just to involve that patient voice at that level in terms of an individual complainant, but right across the system, whether it is in terms of, you know, the statutory duty of patient involvement which we have, the establishment of the Patient and Client Council to give voice to, to support through their advocacy role. But also, as we alluded to earlier and Charlotte took you through some examples of the works that we're talking forward through Quality 2020. We have -- I'm sure she won't mind me sharing her name -- Margaret Murphy, who may be known by some of the room, and Margaret was asked, in 2004, by Sir Liam Donaldson to sit on the WHO Patient Safety Alliance. She is a member of the Patients for Safer Care subgroup of that. Margaret sits on our Quality 2020 Steering Group, so she has oversight.

Along with us, she's a member -- like everyone else who is within the department -- along with other representations from the HSC in Northern Ireland and indeed from the Health Foundation in the UK. The

important thing there is that Margaret keeps it real, Margaret tells a very compelling story. I mean, she informs our undergraduate training programme and our postgraduate training programme about her son, Kevin -- and I'm not disclosing information that's not in the public domain -- who, at age 21, died of an undiagnosed, but easily diagnosable complication of a parathyroid problem. So he died of hypercalcaemia. It was missed. There were a series of missed opportunities and Kevin died. And she describes her experience of how it took, from 1999 to 2005, for the system to actually admit the failings. She describes her experience in terms of feeling that she was kept at a distance, the system closed ranks, the professionals closed ranks, organisations closed ranks, nobody was listening.

She sits on our steering group and she's a remarkably courageous individual who's used her experience in a very positive way to ensure that we, you know, keep sight of why we're doing what we're doing and the consequences, not just in terms of individual patients, but for their families, in terms of coming to terms with the aftermath of a healthcare system that's set up and established to provide care, but ultimately caused harm, something I know that we're very attuned to and I know the same involvement occurs in the training

of undergraduate nurses as well.

ANDREW McCORMICK: I think this is really, really important in terms of the whole way forward here. Michael and Charlotte and I have talked about this a lot in relation to the follow-up to Francis and so on. I would believe very strongly that the best chance we have of securing sustained improvement is through very open involvement, through making it easy for patients and families to be -- first of all, to be aware, secondly to feedback back views, and we want to explore ways to facilitate that process, to make that actually the norm, and I think that has great potential in terms of the impact on the service.

One thing that I think will come out of that is that there will be a lot of positive feedback, so it's something that all the organisations, trusts, should welcome because they will -- if we can create a way of doing this that's straightforward and effective and very open, then there will be -- that can be captured as well, but also then for organisations to see, at senior management team level, at board level, regular information as to what people are saying about them. It's just vital and strong.

THE CHAIRMAN: And the feedback -- I mean, sometimes it will raise morale because your staff are told they're doing

a really good job. So feedback is not necessarily negative, is it?

CHARLOTTE McARDLE: We have in Northern Ireland standards for patient and client experience around dignity and respect, privacy and dignity, attitude, behaviour, communication, five standards. And we have been monitoring those across the five trusts over the last year or two. And the feedback from that is, both, as you say, very positive in some aspects, but also areas of concern that patients tell us they want us to improve. So in terms of positive feedback, 95 per cent feedback on "treating me with dignity and respect", very high feedback on "willingness to help and being professional".

Some concerns about constant interruptions, communication, the availability of hot drinks, time to eat your meal while you're in hospital, mixed-sex accommodation. So having had that feedback, what happens now with that is that the PHA lead on the implementation of the feedback and the action plan on behalf of the department. The minister has, as a matter of priority, put in his commissioning plan directions and his indicators of performance. Some of the issues that have come back from the feedback that patients want improvement on, which we expect the service to deliver

on then next year.

That's just one mechanism that we have for doing that. I think there are many others. In relation to the Patient and Client Council, they have an absolutely developing role and I see that becoming a much more prominent -- as we move forward with, I think, our priority of putting the patient front and centre of everything that we do. And the department has asked the Patient and Client Council to take forward a business case in relation to real-time feedback so that patients and their families have some mechanism that on the day, no matter where they are, if they want to raise a concern they can do it by the Internet and that that will be acted on and that we will use that to generate more information around themes. And there are systems like that available elsewhere. We've had a workshop in September with many of the leaders in health and social care and we have spent time looking at what systems are available, looking at what we are doing currently and how we put these things together to create a much more systematic and joined-up approach to the patients' experience and the patients' voice.

THE CHAIRMAN: And when you say "systems elsewhere", is this an example of bringing in more advanced and more developed practice from outside Northern Ireland and

bringing it in here?

CHARLOTTE McARDLE: I think it's looking to see what leaders in health and social care, with regard to PPI and patient experience, are doing. For example, there are some companies that have already developed some systems, which are readily available, that are easy to use and which people can simply look at and easily give their feedback to. Some of which have been described akin to the Tripadvisor system that you would use for holidays. Now, not by any means is that the be all and end all, that is just one tool and one indicator in a series of tools that we need to use to gather patient experience. It's only an indicator. We also need to really work at developing the individual experience and getting the patient's story because the patient's story is where we get the depth of the information and the real-time feedback is the breath and we need to put those two things together in order to inform us.

There are many of our trusts now that are starting their trust boards with patient stories in the open trust meeting where the non-executive and the executive directors with the senior nurse and the senior doctor, the senior social worker, all sitting at that table and what that does is not only describe the experience, but also the trust will be expected to share the action plan

and the learning that has come out of that and how that has changed practice.

THE CHAIRMAN: Okay.

CHARLOTTE McARDLE: So they're just some examples, but there's definitely more work that we need to do.

THE CHAIRMAN: Thank you.

Let me move on to the area of litigation and inquests. There are two issues here. One is about the use of the claim for legal professional privilege, so that when an expert report is obtained by a trust for something like an inquest, as happened in Raychel's case, the report is not then provided to the coroner or was not, in Raychel's case, provided to the coroner, apparently because it was not supportive of the trust position and effectively confirmed what the coroner's own expert had said.

We've discussed at previous sessions, as I'm sure you're aware, that the trust, like any other individual or any other body, is allowed to claim privilege for such a document. The concern, however, is that since the trust is supposed to be acting in the public interest rather than protecting people within the hospital, why should a trust decide to exercise its discretion to claim privilege for a document like that? Mr Donaghy told us on Tuesday that the Belfast Trust

does not claim privilege for expert reports at inquests. I presume you agree with that development.

ANDREW McCORMICK: Yes. We said so in our response, that we have a presumption in favour of disclosure and it would support what Colm Donaghy said on that case. There's a phrase you could use, which is "We only protect patients" --

THE CHAIRMAN: Yes.

ANDREW McCORMICK: -- and I think that's a very, very important principle. There are different kinds of reports that come in at different stages and there are sometimes issues in relation to litigation, so I wouldn't make this an absolute black-and-white because we have to look at the context, but I agree with your point entirely that we're all obliged to work in the public interest.

THE CHAIRMAN: Similarly, there was, I think, a rather unhappy issue in relation to Claire's inquest, when Dr Webb, who had come along and treated her and, to some degree, had gone out of his way to treat her and had come back and looked at Claire a second time and perhaps a third time. When her inquest eventually came round many years later he included in his draft statement to the coroner a sentence to the effect that he regrets now that he had not referred Claire to the paediatric

intensive care unit before he finished his duties on a particular evening. And a suggestion was made to him, which he followed, that he should remove that sentence from his witness statement. The basis for that was that he should only tell the coroner facts, he shouldn't express a view or express regret in that way. I have to say, that seems to me to be rather unhelpful because part of the function of the inquest is not only to establish what happened, but also to do that with a view to avoiding the same sort of thing happening in the future.

So if a doctor says on reflection, "I wish I had referred Claire to PICU earlier", is that not the sort of thing that you should want doctors or nurses to include in their statements? It doesn't mean in a medical negligence context that they were wrong not to do so, but it means they're reflecting on what happens and, in effect, suggesting how something might be done better in the future.

ANDREW McCORMICK: I think that's the learning culture we're trying to promote.

MICHAEL McBRIDE: There should never be any Faustian bargain, which undermines, as Andrew said, or compromises potential learning from such incidents, whether that's learning in terms of -- arising out of

litigation or learning arising out of a coroner's inquest. I feel that very strongly. I'm no expert in the law and there may be certain nuances in an around that, but the primary purpose of any such process like a root-cause analysis carried out on an organisation, that should be shared fully and frankly on all occasions with a subsequent coroner's inquest.

As a medical director in an organisation at a point in time myself, I remember sharing -- and indeed I think I previous gave evidence to that effect -- previously sharing back in 2003 our very first root-cause analysis in relation to the death of a patient in the Royal with the then coroner for Belfast, John Leckey. So that should always be the case. It should never be the case that we have information in relation to the circumstances and death of a patient which is not shared fully, frankly and openly with the coroner to inform and assist him in his investigation and determination of the cause of death.

THE CHAIRMAN: I understand, from what I was told on Tuesday by the Belfast Trust, the point about confidential settlements of negligence claims, that there's a departmental direction to the effect that settlement should only be confidential at the request of the plaintiff; is that correct?

ANDREW McCORMICK: Yes, that's right. There are quite significant tests in the accounting system that require a presumption against confidentiality, but there has to be sensitivity to the circumstances, as you say, of the plaintiff.

THE CHAIRMAN: And for instance, there might be a family which gets in -- in an awful case, gets a £2-million or £3-million award because there are catastrophic injuries at birth and that family, for very good reason, might not want everyone to know they have got £2 million or £3 million because it creates entirely the wrong impression. The family aren't suddenly millionaires; that money is only awarded because that's what the care of the child will require for many years to come.

So the department, whether it does it by way of a direction or by way of encouragement, can show the way in which trusts might exercise their discretion to claim privilege or the way in which people should complete or volunteer information to the coroner?

ANDREW McCORMICK: I'm conscious that we haven't actually set that out in the form of any direct communication to the system on that basis and it's something we need to act on, I think.

THE CHAIRMAN: That's something that I will look at, Dr McCormick, in the report.

MICHAEL McBRIDE: Mr Chairman, you'll be more familiar than I am, but there are clear statutory and professional obligations on doctors in relation to disclosure of information to the coroner's court in terms of section 7 of the 1959 Coroner's Act. There are clear obligations on organisations within the Coroner's Act. There is clear professional guidance from the GMC in terms of assisting coroner's inquests and other inquiries and doctors are professionally accountable, both to their organisation, but also to their professional regulator in relation to assisting coroner's inquests and any other such inquiry such as this one.

THE CHAIRMAN: Just to finalise this point, there was a pretty stark and very uncomfortable moment for the Roberts at this inquiry when Mr Walby gave evidence that in effect, as he left Claire's inquest, in light of what he'd heard, he took the view that if the Roberts sued, it would be a case for admitting liability and getting the case settled. Now, as it happened at that time, the Roberts hadn't sued at all and they hadn't considered suing. But that's a pretty unhappy way for a family to learn that the trust view of what happened to their child was that the trust itself was culpable. I take that as an example. I don't know how typical or atypical it is, but surely that's the sort of situation

that you absolutely want to avoid and that feeds into the issue which the Francis report has developed -- and I know which is still being considered in the department -- about candour and openness.

MICHAEL McBRIDE: Absolutely. If I could refer back to Margaret Murphy for a moment, who I mentioned earlier. She fought for five years through the High Court ultimately to get answers to the questions that she wanted and to get compensation. She never wanted to pursue litigation, but it was the only way she could get answers to the questions. Then she donated the money she was awarded to charity. In my experience, it is never about -- no amount of money can compensate for the loss of a child or anything of that nature. So I think that my personal view, my professional view is that the process of litigation and the adversarial nature of that process does not lend itself well to getting answers to reasonable questions that individuals wish in relation to when harm occurs or indeed when there's a perception that something has gone wrong. Obviously, what you want to avoid at all is it getting to litigation in the first place, and that's why the feedback from patients -- we talked about public and patient involvement, about why the complaints process is so critical to that because the ultimate end result, if that and those systems don't

work well and effectively, is someone feels no other recourse than to take this down the course of litigation.

I think we need to look to more alternatives to litigation. Certainly something which we are looking at and very actively looking at is mechanisms which have been employed in other jurisdictions in relation to redress. Obviously, there is variability in the experience in terms of our jurisdictions, but clearly we need also to look at all alternative dispute resolution mechanisms, which are not within a judicial system, which may range from anything from mediation to conciliation to a range of other alternatives.

Some work which is being developed here by the Law Society and the Northern Ireland Ombudsman, you know, in terms of how -- there are alternatives and we need to get better and more effective at directing and supporting and facilitating people through those mechanisms, because I don't think, Mr Chairman, that the current mechanisms around litigation deliver what we would all reasonably expect in such circumstances.

THE CHAIRMAN: You don't have to comment, but I'm not sure how much insurers and lawyers help the process modernise.

MICHAEL McBRIDE: I could comment, but I won't, Mr Chairman.

THE CHAIRMAN: Perhaps allow your team to consider if there's any ground that you want to cover that we haven't covered and I will see if there are any questions from the floor.

(12.32 pm)

(A short break)

(12.50 pm)

THE CHAIRMAN: I have been asked to tidy up a few points we discussed earlier. There are two questions about the revalidation exercise which has been introduced for doctors and is to be introduced for nurses.

The first is this: once somebody graduates with a medical degree, the new system is foundation year 1 and 2; is that right?

MICHAEL McBRIDE: Yes.

THE CHAIRMAN: And then registrar?

MICHAEL McBRIDE: We then go into a training programme, whether it is into primary care as a general practitioner or a specialist training programme, which would be defined by a curriculum and a competency-based process. So basically a doctor's progress and assessment through their training is assessed on an annual competency-based assessment against the curriculum and the standards set out within that.

THE CHAIRMAN: Okay. Let's suppose there's a young medical

graduate who has done foundation year 1 and 2 and wants to go into paediatrics. So foundation year 1 and 2, will be spent covering a number of areas?

MICHAEL McBRIDE: Yes.

THE CHAIRMAN: If that doctor is successful in starting in paediatrics, how many more years of training are there before he or she is eligible to be -- sorry, what is that person called after the foundation years?

MICHAEL McBRIDE: They would be a specialist trainee in whatever the particular specialty is. The training can last from anywhere between four and seven years. Thereafter, depending on the specialty, some years might be taken out of training to be involved in research and then they get a certificate of completion of their training, which then entitles them to apply for a consultant post. But as I say, every doctor, every year is assessed on an annual basis before they progress through to the next stage of their training. And it also, I would add -- as they're appraised on an annual basis, as all doctors are, and they have a responsible officer, who is the postgraduate dean, who is their RO, who signs off their revalidation or not.

THE CHAIRMAN: And in terms of the five-year revalidation, do the foundation years 1 and 2 count as the first two of the five years for that, so that if you have, say,

a 25 year-old medical graduate, would their first revalidation come by the time they're about 30?

MICHAEL McBRIDE: No. It would be after their five -- post the time of their qualification. Doctors at present now -- as I say, the current system is under review, the Greenaway review, which is currently being considered by Minister in terms of the review of training. Doctors are currently registered with the GMC, so have a licence to practice from the point of completion of the F1 year, and then their revalidation is on five-year annual cycles thereafter and will be dependent on progression through their competency-based so-called RITA assessment -- Record of In-year Training Assessment -- plus again their completion of an annual appraisal and all of that will have to inform the decisions around their revalidation at the end of the five-year cycle.

THE CHAIRMAN: What I'm getting to is -- I think the question was raised is really this: if then I'm a junior doctor training towards being eligible to be a consultant and my five-year validation comes up during that time, as it will, is there anybody, apart from the medical director, who signs off on the revalidation exercise? Is there anybody from outside the paediatric department who's involved in assessing me for that

validation or is it done through the paediatric hierarchy?

MICHAEL McBRIDE: No, it's not done through the paediatric hierarchy at all; it's basically a portfolio of evidence in terms of -- based on the doctor's appraisal with his appraisee, and indeed that information is then objectively assessed by the medical director. The medical director then makes a recommendation or not. The General Medical Council ultimately determines whether or not they are satisfied on the basis of the recommendation and the information that is supplied or not. And as I said in my answer earlier, as a responsible officer my continuing registration as a doctor is dependent on the fact that I execute my professional responsibilities in that regard, contractual and statutory responsibilities, wisely and with due diligence.

THE CHAIRMAN: The second point raised was: are there doctors in our hospital system who have not been revalidated?

MICHAEL McBRIDE: Revalidation was only introduced -- the legislation only went -- the responsible officer legislation only went live in 2010. The legislation in relation to licensing and revalidation only went live a number of months ago. We're in the process of

revalidation right across the UK and obviously, you know, there is a capacity -- I mean we have 6,500 doctors employed in Northern Ireland, we have 252,000 doctors on the medical register across the UK. But by 2016, all doctors across the UK will be re-validated, but that's a phased and incremental process.

THE CHAIRMAN: So it's too early to see what the effect of the revalidation system is in terms of doctors who will not be revalidated?

MICHAEL McBRIDE: That is fair to say, chairman. In terms of the Confidence in Care programme board, which implemented the revalidation of doctors here in Northern Ireland -- we worked right across the UK with the other administrations and with the regulator, GMC, we ran a series of stakeholder events assisted by PCC and others in terms of engaging with public users of service and a range -- wide range of stakeholders in terms of consulting about the process that we were taking forward and actually how we were going to provide assurances to the public. Because ultimately, this is about providing assurance to the public about the robustness or otherwise of the process of revalidation. It's about using that same mechanism so employers can be assured of the continued fitness to practise of doctors, but ultimately it's providing assurance that the public

that doctors just don't pass a set of exams at a historical point and thereafter are deemed fit to continue to practise in their chosen area of specialism.

THE CHAIRMAN: Your mention a few moments ago of the GMC leads me on to a query raised from the floor about -- we looked the other day with the Belfast Trust at the number of complaints which have been made against doctors to the GMC as opposed to the number of complaints made against nurses to the NMC. Part of the explanation was the fact that there are many, many more nurses than there are doctors. Within the GMC, do you have any observation on the extent to which the GMC disciplinary procedure works effectively to protect the public from doctors who are underperforming in different ways?

MICHAEL McBRIDE: Well, I mean, I mentioned to you a number of high-profile scandals in healthcare which undermined the confidence of both the public, the system and indeed professionals themselves in terms of the system of regulation. I mean, Bristol was but one, but there are many others: Ayling, Neale and Kerr, et cetera, right cross the UK, Shipman. And on the basis of that, there was work undertaken following publication of a White Paper to ensure that there were more robust mechanisms in relation to providing assurances to the

public about doctors' continuing to fitness to practise, but also, as Charlotte said earlier, in relation to nurses. At one point in time we were taking forward -- because myself and the former CNO were formerly jointly chairing that work in Northern Ireland because it had been determined that that validation/revalidation, would be produced for doctors and nurses but the government changed its view and now proceeded with doctors, but again we're revisiting that and progressing that with nurses.

Just to assure you, the GMC thoroughly and comprehensively reviewed its own internal processes in terms of the membership its board, in terms of the number of lay representatives on its board, its entire processes in terms of fitness to practise hearings, the lay representation within those. If we look at how effective or otherwise the system is working, the GMC publishes annually reports, which are on the website, in relation to the state of training and the state of the service provided by doctors who are on the register.

As I say, there's some a quarter of a million on the register. If we look at complaints against doctors, the complaints have risen by some 24 per cent since, I think, the last couple of years. I think from 2007, some 104 per cent. Does that mean we are dealing -- are

doctors getting worse? I would suggest, Mr Chairman, no it doesn't; it suggests the system is working and there are mechanisms which are effective in identifying and providing opportunities for a range of individuals/patients, to make complaints about doctors, because 68 per cent of complaints to the GMC are from patients themselves, from organisations, employers, but also from fellow doctors.

So I think obviously, as Andrew said earlier, the first port of call is actually within the organisation using the mechanism of maintaining high professional standards. But if there's a question of severe inability or a performance issue which questions a doctor's fitness to practice which puts patients at risk, then obviously the GMC will seek to intervene.

If we look at the figures for Northern Ireland last year, my recollection -- and I can provide these is that there were some 170 complaints to the GMC in relation to doctors and I think the vast majority of these were from members of the public. Many will not progress into the final stages of a hearing or fitness-to-practise panel, many will be resolved at an earlier stage. I think somewhere in the region of 17 of those -- and I can check the numbers -- were from fellow doctors about their colleagues and my recollection is also that 15 of

those were actually from employing organisations.

So there is a system. Certainly the level of complaints in relation to doctors has risen. I don't think we should say the inference being doctors are less safe, less committed. Many complaints will not transpire into subsequent enquiries, but there's a mechanism.

THE CHAIRMAN: People are more questioning and challenging now?

MICHAEL McBRIDE: And rightly so. We live in a less deferential society. The era of doctor or nurse knows best has long since passed.

THE CHAIRMAN: Okay. I think, Dr McCormick, there was an issue which was raised on Wednesday this week with Dr Carson that I think you wanted to come back on. It's a point where I was discussing with him the accountability framework and we looked briefly at the example of the Northern Trust and what had happened there last year. Was there something you wanted to correct on that?

ANDREW McCORMICK: I'm a bit concerned to look out for any unfair reputational damage given that what was said understandably reflected some media reports, but those media reports were in fact inaccurate. There were a couple of inaccuracies that lie in the transcript and

that's why I'm grateful to you for allowing me to just deal with these points. I'm not saying anything new, it's all already public. But just to make it clear that at no stage did the Minister ask the chairman of the Northern Trust to dismiss the chief executive. And indeed, the chairman acknowledged -- and it's on the record -- that he was never asked to do that.

The second point is that the chairman himself did not resign, he was dismissed. There was a clear difference of view between the chairman and the Minister as to the expectations in relation to improving the performance of the trust. And then subsequently, the chief executive did leave the organisation, but that was by mutual agreement and accompanied by a supportive statement by the Minister in relation to the former chief executive's standing.

I think the point you were on, actually, the point of your discussion with Dr Carson -- there was nothing wrong with that. It's Ministers who appoint chairs and non-executives. The chief executives are employees of the organisation and cannot be dismissed by Ministers. The other person they have to maintain confidence from is myself as accounting officer because there's a separate chain of appointment in that sense as accounting officer. While that's well understood,

there's nothing that isn't familiar in --

THE CHAIRMAN: Thank you very much. I'm sorry if my contribution contributed to misinformation on Wednesday.

There's nothing more I wanted to raise with you, there are no other issues from the floor, so you don't have to make any concluding comments, but you're free to do so if you wish.

ANDREW McCORMICK: I would like to take the opportunity to ask my colleagues at this stage ...

MICHAEL McBRIDE: If I might, Mr Chairman. I think there's an important point here which we've discussed and I think it's through many of the sessions over the last number of months, but "First, do no harm" isn't a slogan in the Health Service, it's not a strapline; it's a fundamental requirement on all of us as professionals and all organisations that provide healthcare. That a system that is designed to treat and care for the sick should cause harm is almost inconceivable, but that it actually should fail to learn is unconscionable.

I trust, Mr Chairman, in terms of the evidence you've heard over the latter part of this inquiry and indeed the further evidence that you have heard today, that you will understand that we have been on a journey and that we have had, both as professionals and as organisations -- much progress has been made. We have

much more to do if we are to get to a point where we achieve, as far as we can, the situation where tragic events such as this never happen again. It's my earnest hope that this perhaps brings some small comfort to the families, however -- and I say "however" -- inadequate that is.

I'm also acutely aware that at times like this, words appear only too hollow, too little and too late, and a sense of wrongs that can never be put right. I think certainly what I would add is that all of us, at whatever level who have been affected by or dealt with the consequences of the matters under your inquiry, have been both personally and professionally diminished by the deaths of Adam, Claire, Lucy and Raychel. And certainly as Chief Medical Officer for Northern Ireland, I would want to apologise for the failings of the past, the questions that have remained unanswered and the pain that clearly still persists and we have heard recounted during the course of this inquiry.

THE CHAIRMAN: Thank you very much.

Ms McArdle, you don't have to, but --

CHARLOTTE McARDLE: Chairman, if I may, I would like the opportunity to reassure the inquiry and, more importantly, the families that nursing is in a different place. Over the last 10 years there have been a huge

amount of changes that have happened, primarily the establishment of the nursing as a degree programme, which means that nursing is on a par with all other professions and the nurses on the ground feel and believe that they're competent practitioners, they're able to analyse and interpret information, they use critical enquiry, they're trained in research and they have the skills to challenge a practice when it needs to be challenged and that they have the ability to raise those concerns.

Particularly in relation to paediatric nursing and in recognition of this inquiry and the work that it has done and answers that it has sought to gain, nursing as a profession has already learnt lessons from it, and I wanted to point to a small number of things that we have taken forward: recognising the sick child, record keeping, which was identified as an issue in this inquiry. There has been a very big piece of work done on record keeping in Northern Ireland and that work will continue through the auspices of my office and NIPEC. There is a paediatric collaborative, which is not nursing-led, which is multidisciplinary, initiated by the safety forum and looking specifically at communication issues and safety huddles in order to learn the lessons as they arise.

The introduction of the fluid balance chart was a significant issue, and in terms of the patient experience I would point to learning from international experience in paediatric nursing. Two of our paediatric units in Northern Ireland are in a research project with Sydney in Australia, looking specifically at the unique contribution that paediatric nursing brings to the care environment, and they're looking at the measurement of performance indicators around consistently delivering against the standard that's set, the patients', and the families' in this case, sense of safety, the families' confidence and competence in the nurse to be able to provide that care, and really understanding what's important to the patient and their family. And I think that indicates that as a profession we want to learn those lessons, and for any part that nursing had in the experience of these families on behalf of my profession that is with great regret.

THE CHAIRMAN: Thank you very much.

Dr McCormick?

ANDREW McCORMICK: I think I would like to echo and underline the combination of regret and hope that my colleagues have just expressed. I think their passion as professional leaders is very, very clear and I depend personally immensely on these two and other leaders

in the department and across the service for the future. And I do think we can have hope, but it's very, very important to regret and consider as well what has happened in the past. I'm confident we can secure progress and I just in closing would like to suggest that that does depend on the three things together, the professionalism and commitment of staff at all levels. I see that everywhere I go in the service. If I visit a trust facility and engage with front line staff, that's what I pick up. It's palpable in my engagement with leadership teams across the service and I would want to leave no doubt that I include professional managers as well as clinicians in the scope of that. It's vital that we hold on to that and support that.

We do need governance in systems. There's a lot talked about systems and procedures and that's all very, very important, but it's not a textbook system that runs like clockwork. We always have to be ready for the unexpected, always challenging and thinking and making sure that the oversight is active and engaged, truly open and transparent in its processes.

Third, and I think actually most important, is leadership, and I'm not thinking here of Henry V style heroic, visionary leadership, it's the consistent living of the values and behaviours that are at the heart of

what health and social care is all about. It's about always acting in the best interests of patients, families, clients, doing what we would all want for our families. One of my first encounters in the service in the front line back in the summer of 2005, somebody said, "Is it good enough for your family?" And it's always the yardstick. Leadership is not about position, it's about attitude, it's about behaviours that drive each individual to do the right thing all the time consistently and to work in a culture of openness where the concerns that have been expressed throughout this inquiry can be raised without fear or without any hindrance.

Henry Ford has been quoted already in this inquiry. Quality is doing the right thing when no-one is looking. We should be grateful that is the culture and ethos of the vast majority of HSC staff, they demonstrate that day in and day out, and I have a great sense of privilege in being associated with these two leaders here today and with the people who work, recognising that that's the issue all the time. That sense of privilege is tempered by the very serious issues that this inquiry has had to address and I want to commend to you the evidence you have heard and look to you, Mr Chairman, to help us to improve, to help us develop

further, to help us develop the right cultural change and leadership to secure a safe and high quality system of health and social care in Northern Ireland.

Thank you.

THE CHAIRMAN: Thank you very much.

MS RAMSEY: Mr Chairman, can I just raise one short matter? I, as you know, represent Conor Mitchell's family, and I know that Mr McBride didn't allude to Conor's death in his closing remarks, but insofar as Conor's family are concerned, they are very hopeful that lessons will be learned from his death.

THE CHAIRMAN: Yes, and I'm sure that was an inadvertent exclusion of Conor rather than anything else.

MICHAEL McBRIDE: My sincere apologies.

THE CHAIRMAN: Of course, thank you. Thank you very much to the panel from the department for coming.

Closing remarks by THE CHAIRMAN

That brings an end to the public hearings. This isn't a day for speeches, never mind long speeches, but please bear with me for just a few minutes while I make some closing remarks and say a few thank yous.

My role after today is to draw together the evidence which we've all heard over 148 days in a final report to the Minister. The Minister will have that report in January next year. Some of the evidence which will

be reflected in the report has been disturbing and upsetting. It has been especially disturbing and upsetting for the families, but also for everyone else who believes in and supports the National Health Service, which is one of the jewels in our system.

I hope and expect that the very fact of exploring and exposing what went wrong will itself make it less likely that similar failings will be repeated in the future. I think it is clear that there has been improvement and progress, particularly in recent years; for example, in terms of the ways in which complaints and serious adverse incidents are dealt with. It seems to me that the challenge is to maintain these improvements on a consistent basis across the service. This week, the term "patchy" has been used more than once. The aim of everyone involved in the Health Service must be to make progress uniform rather than patchy, and I hope that my report can contribute to that.

Having said that, let me move on to some acknowledgments. I was appointed to chair this inquiry a long time ago, in 2004. At that time, Mr Clive Gowdy was the Permanent Secretary. By the time he resumed in 2008, after the police and the public prosecution service had completed their work, Dr Andrew McCormick

had succeeded Mr Gowdy. I want to place on public record my gratitude for the support which I have received from successive Ministers and from both Permanent Secretaries, but especially from Dr McCormick. Not once has there been any interference with the work of the inquiry. On the contrary, every time I went to Dr McCormick and asked for more time or even more time, resources, or help with staff, staffing issues and staffing resources, he found a way to help me. The department through him has recognised and maintained my independence from the department.

Here in Banbridge, I want to thank our two expert stenographers and the whole technical team for their professionalism and achievement. Calling up documents and producing an accurate transcript quickly are both difficult tasks. We have been very lucky to have enjoyed such a high quality service, provided with good humour by everyone involved.

I thank the wonderful inquiry secretariat for all that they have done, both here and in Belfast. Without them, the inquiry simply would not have reached this point, and I am indebted to them.

I also thank the inquiry legal team for the same thing. I'm indebted to them all for their dedication, their professionalism and their energy. I also thank

the various lawyers for the families and the interested parties, those who hesitated to rise and even those who didn't.

I pay tribute to the families for their contribution, their patience and their remarkable endurance, and indeed I thank all the witnesses who came to the inquiry. Some found it hugely more difficult than others and sometimes witnesses came more than once to give their evidence and help the investigation.

Finally, and happily on a lighter note, I thank three people here in Banbridge who have surpassed themselves in making everyone feel welcome. Robin, Roberta and Margaret have been here day in, day out since early last year. They've helped people who have become upset, they've made tea for those who have arrived early from Derry in the mornings, even people who didn't particularly want to be in Banbridge to start with, Mr Doherty, if I remember. They have been just wonderful and they have made this whole difficult, rather up and down experience much easier for everyone involved. We all wish Robin, Roberta and Margaret the very best for the future and hope that the next inquiry that is due to start here in the New Year is wise enough to take advantage of their services. Thank you very much.

MS RAMSEY: Mr Chairman, I would like to perhaps respond on behalf of the families. I'll be very brief. This inquiry has been thorough, though at times it has been very arduous and emotional for everyone involved, none more so than for the families. The assistance to the smooth running of the inquiry has been down to a number of people, and the families just wish to thank people that you've already thanked, but we would wish to do it also: the stenographers; the IT support staff; the security staff; Robin, Roberta and Margaret; the inquiry staff, senior counsel, junior counsel and solicitors; Bernie Conlon, Denise Devlin and Leanne Ross. And finally, Mr Chairman, we would like to thank you, who throughout the inquiry have conducted it in a courteous, efficient and sensitive manner. Thank you.

THE CHAIRMAN: Thank you very much.

(1.20 pm)

(The inquiry adjourned)

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