Independent Neurology Inquiry

BELFAST TRUST INITIAL RESPONSE TO INI REPORT

1. I want to begin by speaking directly to our patients and particularly to the patients of Dr Watt and their families. The Belfast Trust let you down and many of you have suffered avoidable and unnecessary harm as a result. Whether that was through being given a diagnosis that was not correct, receiving an incorrect treatment or medication, or having a procedure you did not need. For that I am truly sorry.

2. That is not what the Belfast Trust wants for its hundreds of thousands of patients, cared for in a wide variety of ways by a dedicated staff. It is why that I, and my executive team, are determined to continue to work to improve the governance systems that we have in place to reduce, as far as we possibly can, the risk of something like this happening again. I will say something shortly about some of the steps we have already taken.

3. The report of the Inquiry, even at this early stage of our consideration, makes sobering reading. I want to acknowledge that the Inquiry's work has shown that, when we were making decisions about Dr Watt's practice, we did not have access to all the information that the Inquiry has found existed about Dr Watt in various locations across the health and social care system.

4. If that information had been known by various previous Medical Directors then I believe that more significant action would have been taken in respect of Dr Watt, and that he may have been stopped sooner as a result.

5. The Inquiry has established that when information reached me in 2016, which caused me to restrict Dr Watt for the protection of his patients, there was still much relevant information that I couldn't have known and didn't know. Some of the actions that we have already taken, and about which I am going to take some time to explain, are designed to reduce the likelihood of that being the case in the future.

6. Having fully restricted Dr Watt by the summer of 2017 we asked the Royal College of Physicians to independently consider his practice. When the Royal College reported on its work in April 2018 we swiftly organised and announced the largest ever patient recall in Northern Ireland. That was not a decision I took lightly, but it was a decision I had no hesitation in taking. Through the recall process nearly 5,000 neurology patients were seen and almost 1,000 patients had a change in diagnosis and change in treatment. The total cost of the recall currently sits at around £8.5 million. This is just the financial cost; it does not begin to capture the personal cost to individuals some of whom had been given an incorrect life changing diagnosis.

7. I want to acknowledge, as demonstrated by the results of the recall process, that Dr Watt, one of our doctors, had a greater proportion of misdiagnosis than the acceptable norm, and our various systems did not identify that quickly enough. For that I apologise on behalf of the Belfast Trust. The latest outcomes report published by the Department of Health indicates that there was a need to change diagnoses made by Dr Watt in approximately 20% of cases reviewed.

8. Whilst it is the case that there are areas of medicine, of which neurology is one, where diagnoses may not always be clear, or can change or evolve, nevertheless the evidence shows that in Dr Watt's case, the percentage was too high, and our systems did not detect it.

9. As the Chairman has already indicated, the Inquiry report is a very detailed document, and we have only had it for a short time. It will be important for the Belfast Trust, including its Board and senior executive team, to take the necessary time to give detailed consideration to the report, its findings, the lessons that can be learned, and how the Belfast Trust and others can implement the recommendations. However, having had an opportunity to briefly consider the report today, and whilst it is not possible to go into significant detail or address every issue, there are a number of matters that I want to acknowledge.

10. Firstly, one of the issues that the Inquiry has identified is the fact that there are certain medical specialties such as neurology, where the majority of work is conducted with outpatients, and where there is consequently less opportunity for team working, the use of multi-disciplinary teams, and the ability to share and discuss patients with colleagues. Greater team working and patient sharing is likely to make care safer, and therefore it is important that we do all we can to ensure the importance of this is recognised and to provide the opportunities for this to occur. The Medical Director, Mr Hagan has been working with colleagues across the Belfast Trust to strengthen the use of effective team working even for outpatient clinics, and this work is ongoing.

11. Secondly, I want to acknowledge that the Inquiry has found failings by the Belfast Trust in respect of how the Belfast Trust dealt with Dr Michael Watt during his 20 years working as a consultant. Those failings primarily, though not entirely, relate to more historical missed opportunities to detect that there was a deeper problem with the practice of Dr Watt than mere delays in completing his practice administration and providing reports for the assistance of his patients with the likes of their insurers.

12. The Inquiry has identified occasions when some matters relating to Dr Watt did come to the attention of previous Medical Directors of the Belfast Trust. However,

on each of those occasions, the clinical ability of Dr Watt, for the reasons given to the Inquiry by those involved, was not seen as the issue. In fact, Dr Watt was highly regarded as an excellent neurologist. Indeed, many doctors, including myself, took members of our own families to see him when they needed neurological treatment. That is an indication of how he was viewed by his peers, including other doctors. The Inquiry has considered, albeit with the benefit of hindsight, that some of those instances where issues came to the attention of Medical Directors could and should have led to different conclusions or greater enquiry. The Inquiry has concluded that some judgments about Dr Watt, though reached in good faith, caused opportunities to be missed that may have led to the earlier detection that there was a deeper problem with Dr Watt than his known administrative deficiencies. On behalf of the Belfast Trust, I am sorry those opportunities were missed. I also acknowledge and apologise that Dr Watt's known administrative deficiencies were tolerated for much longer than they should have been.

13. The Inquiry has also identified a number of important occasions when information came to the attention of various doctors about Dr Watt and the Inquiry has concluded, contrary to the views the doctors formed at the time, that the information could and should have led to greater enquiry or a concern being escalated within the Belfast Trust, but it wasn't. Whilst it cannot be said with certainty what would have happened had matters been further explored or escalated when the Inquiry considers they should have been, nonetheless, those missed opportunities to explore and escalate meant that opportunities were lost at an earlier stage to potentially identify and address the problems in the practice of Dr Watt.

14. The General Medical Council, the regulator for doctors, is clear that every doctor, wherever they work, should take prompt action if they think patient safety is being compromised. This is because every doctor should make the care of their patients their first concern. That is not just in the Belfast Trust, it is the position for every

doctor. The Inquiry is clear that for some doctors, nurses and managers who did receive important information, they did not deal with that information in the way the Inquiry considers they should have. Where that related to doctors, nurses and managers in the Belfast Trust, then I apologise on behalf of the Belfast Trust. I do so because each time an individual doctor, nurse or manager failed to further enquire, or escalate a concern, when they could and should have, then that also means that the governance systems of the Belfast Trust, failed as a consequence. Any governance system no matter how well developed and comprehensive relies on individuals doing the right thing. If, for whatever reason, this does not happen, then the system will fail.

15. At the same time, and importantly, I acknowledge that the Inquiry has not suggested there was any bad faith on behalf of any doctor, nurse or manager who did not further explore or escalate a concern that the Inquiry has subsequently considered they should have. This is important. Doctors, nurses and managers are human. Like everyone, we, do and will make mistakes. There is not a single person in this room who has not made a mistake at some point in their working career. Doctors, nurses and managers do not and will not get everything right. When things do go wrong, however, as it did in this case, it is important that the senior people in the organisation in which the failure occurred, acknowledge the problem, understand it, work on how it can be fixed, and do all that they can to minimise the risk of it happening again. Today myself and my senior team reaffirm our commitment to do just that. When I took up the post as Chief Executive in 2020 I did it for one reason – to make this organisation a safer place for patients, service users and staff.

16. In an organisation that has to manage the risks that this organisation does, that is not an easy task, but it is a vital one. Whenever there is a concern highlighted we will lift the stone and investigate. We will do so fairly, but we will also not shy away from doing the right thing even if it is difficult, or it comes at a personal cost.

17. Recognising that something is a concern that requires escalation is not always straightforward. In the Belfast Trust every year many doctors do raise genuine concerns, including about colleagues. Those concerns are then escalated to the Medical Director and dealt with by the Medical Director in an appropriate and proportionate manner, as required by the health care system and the GMC. Indeed, the Inquiry in its report gave some examples of this occurring. I have no doubt that doctors in other trusts and in primary care do the same.

18. However, the key question is what can we do to reduce the number of occasions when a concern that should get escalated does not get escalated. That is a much more difficult question to answer, particularly where there is no bad faith involved, because we won't have hindsight available to assist. We have decided, as the senior team in the Belfast Trust, to take the immediate step of reminding all our staff (the vast majority of whom, we are certain, won't need reminding) of their obligation that if they see or become aware of something that they are uncomfortable about or they think may be putting the safety of a patient or patients at risk then they must err on the side of caution, escalate the issue, and, in so doing, allow the senior management of the organisation to have the opportunity to consider how the matter should best be addressed. At the same time, we are also reminding our staff that the Belfast Trust is committed to nurturing a safe environment where staff know that they will not be penalised for speaking up about concerns or mistakes, and, that when they do, they will be treated in a just and fair way.

19. Further, I want to apologise for the fact that the historical handing of complaints about Dr Watt by the Belfast Trust was sometimes unsatisfactory, and that, because of this, opportunities were lost at an earlier stage to potentially identify and address the problems in the practice of Dr Watt.

20. The Belfast Trust recognises that its complaints handling, particularly where the complaint from a patient had a clinical dimension, was insufficiently robust. The

focus of the complaints system, which is a statutory mechanism provided by the Department of Health, has always been primarily about trying to resolve matters to the satisfaction of the patient. It has not been as effective a means of identifying problem patterns of clinical concern about doctors or other staff.

21. The Belfast Trust, during the course of the Inquiry's work, and putting to use learning from the work of the Royal College of Physicians, has developed and introduced a new mechanism for the handling of clinical complaints received by the Belfast Trust. It is referred to by the Belfast Trust as a Clinical Record Review.

22. Now if a complaint is received that relates to the quality of care or treatment by a doctor, then this triggers a requirement for a Clinical Record Review. That Clinical Record Review is carried out by a another similarly qualified doctor who has not been involved in the care of that patient, and who has to complete a structured pro forma that includes their analysis of each element of care and a judgement about the care received. Each element of care has 3 outcomes – Satisfactory, Room for Improvement and Unsatisfactory. Depending on the outcome of the review, then further steps may be triggered. By this means, which is a form of medical peer review through the process of a structured judgment review, there is greater clinical scrutiny of the complaint and a greater ability to potentially identify concerns at an earlier stage. The introduction of this new mechanism has been a significant undertaking. Introducing this type of change right across an organisation the size of the Belfast Trust is a major task. But the Belfast Trust considered that the development and introduction of the Clinical Record Review was an important response to the learning emerging over complaints handling, and an important step in reducing the likelihood of another Dr Watt happening again, especially in highly specialist areas like neurology. This new mechanism is over and above what is presently required by the departmental complaints process.

23. The work of the Inquiry has also demonstrated that the electronic system, which operates across the health and social care system, and which is utilised by the Complaints Department to record, store and retrieve information about complaints, has, historically, not been used robustly enough. It is obviously important in a very large system, where it is not practical to rely on busy people's memories, that the electronic systems need to be robust enough to ensure that when information is subsequently required by someone, such as the Medical Director, that information can be accessed quickly, and is as complete and accurate as it can be. I want to acknowledge the very significant amount of work already undertaken, and being undertaken, by the Complaints Department of the Belfast Trust to address these issues.

24. This leads me to a related issue that the Inquiry turns to on several occasions, particularly given it was considering an organisation the size of the Belfast Trust, and that is that the right information needs to be available to the right person in the organisation at the right time. For instance, the Inquiry identified, as I indicated when addressing the issue of the escalation of concerns, that information, that should have been provided to the Medical Director, was not provided at the time it ought to have been.

25. In a major effort to address this issue the Belfast Trust went ahead and developed and implemented a professional governance system for doctors. In basic terms, it is an electronic system that pulls information automatically from various different departments such as complaints, litigation and coroners cases across the Belfast Trust and amalgamates it into one report for each doctor. It assists all doctors in the Belfast Trust with their appraisal and revalidation responsibilities. However, it is also a significant help to the Medical Director of the Belfast Trust when a concern is highlighted. As there are over 1,000 doctors in the Belfast Trust you will appreciate that the Medical Director having the ability to swiftly access accurate up to date information from a number of sources is very important. It is a system

that the Belfast Trust hopes to develop further and to expand its use into other areas.

26. Furthermore, in 2017, as part of a UK Collaborative to improve patient experience, we piloted actively seeking feedback from inpatients in surgical wards. Since then we have rolled this out across our hospital wards and the results of the independently collected feedback are shared with the ward teams and the senior managers on the same day to allow ongoing improvements and allow a sense check from our patients about their experience of our care. These are just some of the ways that the Belfast Trust has and is responding to the issues identified by an examination of the practice of Dr Watt.

27. I want to say something to the staff of the Belfast Trust, both within Neurosciences and more generally. I first want to acknowledge all the staff who responded to the crisis surrounding the medical practice of Dr Watt. I want to thank you for stepping up when you were most needed. We did not get everything right in our response as the problems associated with Dr Watt began to emerge. Responses to an emerging crisis are rarely perfect. I of course apologise in respect of those matters where the Inquiry has identified a deficiency in the response. However, the Inquiry has confirmed that we did get all the key and major calls correct, and for that I want to say a huge thanks to all the staff concerned. There are obvious points of learning that we will take on board should we ever have to face anything like this in the future.

28. I want to also pay tribute to the medical, nursing and administrative staff and the management team for their work on the recall exercises, and for the enormous efforts you went to in order to ensure patients were correctly diagnosed and on the correct treatment. I include in that the many consultants across the UK and Ireland who helped us in the additional clinics.

29. I also want to acknowledge the very significant numbers of staff, and former staff, who voluntarily engaged with the Inquiry, some on multiple occasions, in order to assist it with its work. I know that was not easy.

30. I also recognise the impact this crisis has had on the morale of staff in Neurosciences and across the Belfast Trust. It is vital for our patients that you continue, every day, to do your work to the very best of your ability, and I want to thank you that you do. Today public confidence in the Belfast Trust and in the wider medical profession is being tested because one doctor let down many of his patients, and, as the report documents, the Belfast Trust missed opportunities to have detected this earlier. However, that one doctor does not reflect the entirety of the 21,000 staff in Belfast Trust today. It is essential that where trust has been lost that it is rebuilt. The vast majority of doctors, both working in the Belfast Trust and elsewhere, provide safe and high quality care for their patients. They provide that care with integrity and compassion. They do so because they put their patients first. Those important facts must not be lost amidst the necessary apologies I give on behalf of the Belfast Trust for the failings identified by this Inquiry.

31. Our staff have worked tirelessly, including over the last 2 years during the covid pandemic, often going well beyond what could reasonably be expected of them. They have made enormous sacrifices to give the public who use our services the best care they can, and to keep them safe. Since January of this year over 3 thousand of the patients who have used our services were asked if they would recommend the Belfast Trust to their family and friends; 99% said they would. This is the best of us, and it is despite the huge pressures on our many services and lengthy waiting lists.

32. The provision of health care carries inherent risk. It can be very difficult. It is unfortunately inevitable, despite the best efforts of systems and people, that things can and will go wrong. What is important is that when things do go wrong, we

are honest and transparent, that we properly analyse how we might operate differently to reduce the likelihood of it going wrong in that way again, and we keep learning to make the organisation as safe a place to work and be cared for as it possibly can be. That is the leadership that I, as Chief Executive, and the senior executive team of the Belfast Trust, offer to our staff and patients.

33. When public inquiries report, and inevitably document in considerable detail where something has gone wrong in an organisation, the heads of the affected organisations are almost always asked are they not going to resign. If I thought it was in the best interests of the patients, service users or staff of the Belfast Trust, I would not hesitate to resign as Chief Executive. That is a question I don't just ask and try to honestly answer when the Belfast Trust receives a critical report. I consider it is a question someone doing this difficult job should ask themselves regularly. I trust that the public will understand when I say it would be an unfortunate outcome for the patients of the Belfast Trust if the person who, as Medical Director, took the steps to stop Dr Watt and launch the neurology recall, was to step away from their responsibilities now as Chief Executive of the Belfast Trust. This is an incredibly difficult time for the health and social care system and the health trusts that operate within it. The situation will not be improved if leaders abandon their positions. I have important work to do in very difficult circumstances in order to build safer and better services for patients, service users and staff, and I intend to get on with doing it. I expect my senior executive team and the Board of the Belfast Trust to do the same.

34. In concluding I want to again speak directly to the patients of Dr Watt, particularly to those who were harmed. I wish you had not come to harm whilst under the care of the Belfast Trust. I am extremely sorry that you did. The Minister has already outlined efforts to have a streamlined compensation mechanism for you, and I encourage you to use that if you consider it appropriate. We will also work to make sure that the normal legal rules around claim time limits do not disadvantage any individual involved with the Belfast Trust. I know we cannot

turn back the clock, and that compensation cannot undo the harm. However, I do want to assure you that we will continue to work tirelessly to try to ensure that you are as safe and as well looked after as you possibly can be when you are under the care of the Belfast Trust.

Dr Cathy Jack
Chief Executive of the Belfast Trust
21 June 2022