Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Protocols for Consultation on the Modernisation and Reorganisation of Services

27 January 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Protocols for Consultation on the Modernisation and Reorganisation of Services

27 January 2011

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Mr Colm Donaghy	)	Belfast Health and Social Care Trust
Dr Miriam McCarthy	)	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	)	
Mr Sean Donaghy	)	Northern Health and Social Care Trust

The Chairperson (Mr Wells):

Folks, you are all extremely well known to us in various guises, and you are very welcome.

Colm Donaghy is the chief executive of the Belfast Health and Social Care Trust. Miriam McCarthy is a regular visitor from the Department. Andrew McCormick is the Department's permanent secretary, and Sean Donaghy is the recently appointed chief executive of the Northern Health and Social Care Trust.

A couple of issues have been flagged up in advance. We understand the constraints that you are under. The Health and Social Care Board met only this morning to discuss one of those items, and we do not expect to hear chapter and verse on everything. We are also aware of the interim management and support (IMAS) report on the Royal Belfast Hospital for Sick Children. Given the immediacy of the issues, it would be remiss of us not to touch on both of them. I hope that you do not regard that as an ambush.

As we have just received a report on the governance arrangements in the Western Health and Social Care Trust, none of us have had a chance to give it any significant degree of attention. The 'News Letter' has requested a photograph of this session, and we normally agree, provided that it does not put anyone off. Such is the interest in the issues, we will allow the photographer to come in.

Andrew, we were disappointed that the first that any of us knew of the reports on the Western Trust and on the children's hospital was when we read about them on the front page of the same local newspaper. We do not accept the Minister's assurance that there are so many consultations, investigations and reports that we cannot see them all. You and I know, and we all know, that we should see reports on major issues that are of concern to the Committee and to the entire Province, and both of those documents are in that category. We have written to the Department to say that we should not be ambushed time and time again through the pages of a local newspaper.

Individual members will want to raise points about the disturbing issue of X-rays at Altnagelvin Area Hospital and all the issues that developed as a result of the report. Why were we not told about the governance review of the Western Trust. Had the story not been leaked, when would we have been told?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):
It is important to repeat what the board said in its press release. It said that it was a performance

report, and, as such, part of its routine fulfilment of its role as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009, which was passed by the Assembly. The board was given statutory responsibility for performance monitoring, management and service improvement for all provider organisations. The report was, therefore, one aspect of its work.

At previous public sessions of the Health and Social Care Board, reference was made to the fact that the work was under way. It was always expected that it would feature in the board's public session today. That is all part of normal business. Nothing is being hidden. The process was entirely planned and open throughout. The board made it known to its members that a review was under way.

The key issue is that we all need to make judgements about proportionality and about the importance of a range of issues. At the end of the day, if the Committee thinks that a particular issue is important, it is important, and we must acknowledge and respond to that. The Minister also has to make judgements about what he regards as important. We have to manage the business in a way that is consistent with good process. We will have to give careful thought to the criteria that help us to judge what is important and what requires major attention in the public domain.

The issues covered by the board's overview of performance in the Western Trust had either already received exhaustive public attention and comment, such as the Donagh and McElhill cases that were well and truly aired, or been resolved and managed. The Committee would have much stronger grounds for concern if the issues in question posed a significant large-scale risk of people coming to harm through poor outcomes. However, that is not the case.

We have to be careful and thoughtful about open scrutiny. One of the absolute advantages of the NHS system is that it is publicly funded and publicly accountable, and we are available to assist the Committee in any way possible. We are also subject to scrutiny by the Public Accounts Committee. That is part of how the system works, and that is why we need teams available to answer the Committee's questions. We are always willing and available to do so. However, careful judgement is required on what is really important and what is not. Through my discussions with John Compton, I was aware of the exercise as it unfolded, but at no stage was I of the view that it was a cause for concern or alarm.

However, certain issues needed to be corrected. The X-ray element of the review was initiated by an adverse incident. However, the trust and the board took appropriate, responsive and proportionate action to make sure that the issue was resolved and that there was no ongoing risk or danger. It was good business that was well carried out and well corrected. Having fixed the immediate problem, they then asked an external expert to review the radiology service at Altnagelvin. Having examined that service, the board and the trust were satisfied that it was in order. Then, as part of the accountability process that the Assembly created through the 2009 Act, the issue was properly brought before a public meeting of the Health and Social Care Board. That was the appropriate escalation. In a normal process, it would then be up to the board, the Department, the Minister and the Committee to make a judgement on whether that issue required further attention and whether there was scope for orderly escalation. The issue would have come through that standard process. Nothing is being hidden. Others decide what appears on the front page of newspapers. However, that is not a judgement that we influence. That is a matter for journalists and editors, and I do not always agree with their judgement on what is important.

The Chairperson:

Andrew, if you had sent the Committee a single paragraph stating what you were doing, the newspaper would not have had a front page. The only reason why the paper had a front page was that the story came out as the result of a leaked document. The problem is that we had the same scenario with the review of the Fire and Rescue Service, the retention of information on swine flu and the more recent issue of the children's hospital. All that was needed was a letter stating: "Folks, this is what we are doing. We want to alert you to x, y and z. We will keep in touch." The way in which the story was leaked created more alarm than had you simply been totally open about it. That is the problem.

Dr McCormick:

We will certainly take that back to the Minister and discuss with him how the situations were handled. However, I would not be all that confident that a short disclosure would have sufficed, because so many people want to find fault and to investigate further. That fact that we are in a febrile environment is not good for the proper delivery of health and social care services.

Our primary responsibility is to consider what is in the interests of patients — that is what we do. There are examples, of which you may be aware, when we acted in patients' interests in a way that led to immediate publicity. That was the appropriate action in those instances. Our

criterion is: what is actually in the public interest? That is not necessarily the same as what interests the public. We are interested in what serves the public. We are accountable to the Minister, and he is accountable to the Committee, so I am not saying that judgement is reserved to us; that is not the case.

We must continue to learn. We will reflect carefully on all that has happened in recent weeks to ensure that we exercise the best possible judgement in deciding how matters are handled and when information is released. In the present context, however, that is not at all straightforward.

The Chairperson:

The halfway house is a private briefing with the Chairperson, Deputy Chairperson and Committee Clerk so that at least these matters do not come back to bite us.

Dr McCormick:

We are very happy to discuss that with the Minister.

The Chairperson:

If you feel that putting certain information into the public domain could negate your efforts to carry out an orderly investigation, a private briefing may provide a way round the problem. Mind you, I do not think that that applies to the issues that I mentioned, but there may be other issues to which that applies. There is quite a bit of interest in this matter. Sue, Alex, and Tommy wish to ask questions. I remind the Committee that we have two issues to address, so we should try to be as quick as we can.

Ms S Ramsey:

Are we dealing with both issues?

The Chairperson:

Yes. We can deal with the two issues together.

Ms S Ramsey:

Thanks very much, Andrew. I am not convinced, to be brutally honest, about some of what you said, such as the Minister deciding "what is important." That leads me to a number of questions. Are you saying that the Minister decided that the Committee should not be informed or given

copies of the report?

Dr McCormick:

The clear process was that the report would go, as we knew it would, to the Health and Social Care Board's public meeting. It would have come out publicly after that. Therefore, there was never any intention or expectation that the report would remain private.

Ms S Ramsey:

We are a scrutiny Committee. Are you saying that the Minister decided that we should not have received prior notice about all those issues that impact on many people — not even the Chairperson or Deputy Chairperson?

Dr McCormick:

We did our best to provide notice. It was just one of those coincidences on a day that was complicated by media involvement. The key point is that the Western Trust issues have been resolved. It was not as though there were crises that needed to be addressed. These were matters of routine accountability, routine management of performance and checking that there were no outstanding risks or dangers to the public. Those matters had already been addressed. As the board's press release states:

"performance standards the Trust is required to meet in respect of these issues are now fully restored."

Ms S Ramsey:

Even regular brief e-mails to let the Committee Clerk, the Chairperson or the Deputy Chairperson know what is happening would be helpful.

Dr McCormick:

We are very happy to discuss that with the Committee and the Minister.

Ms S Ramsey:

I am glad that Colm is here because I want to talk about the Royal. However, you quoted the board's press release, Andrew, which also states:

"This had been triggered by under performance in reporting hospital x-ray at Altnagelvin Hospital, performance against breast care targets, and performance issues in respect of a number of high profile cases in child care and learning disability services."

In answer to questions from Tommy Gallagher and me in the Chamber this week, the Minister said:

"That is part of the board's routine responsibilities in its role as commissioner of services".

The Minister then told me:

"This is a governance review within the trust, which I regard as standard business practice".

Correct me if I am wrong, but if it is standard, why does the board say that the review was "triggered"? The Minister implied that it was nothing to do with the high-profile cases; that it was just standard practice and, therefore, whether there were high-profile cases or not, this would have been standard practice. However, the board's report states that it was triggered because of the high-profile cases. That does not make sense to me.

Dr McCormick:

It is a question of judgement as to the profile of the issues. I will address the couple of issues that you mentioned. One serious adverse incident (SAI) with X-rays at Altnagelvin triggered the review. That incident led the trust to identify that it had a problem. In line with proper practice, it discussed that issue with the board, the agency and the Department. Miriam and I were involved in discussions on that matter last July and August.

We assessed the situation carefully to determine what the issues were and what the appropriate degree of concern and intervention should be. Everyone concerned, with the Western Trust leading, ensured that they were able to identify the scale of the issue and what might have been going on. They ensured that the X-rays that had not been fully reported were fully reported quickly, and, by 20 August, all the most prominent cases had to have been looked at to ensure that there was not a problem. The delays in diagnoses of a small number of cases happened before the summer.

Ms S Ramsey:

I have no difficulty with that. However, it is a question of treating the Committee with a bit of common courtesy. We are the elected representatives, and we are answerable to the public. If we do not get information from the Department that we are paid to scrutinise, we are not doing our job correctly. I am not saying for one second that we should not learn lessons from mistakes, but the Minister should not have been flippant and said that the review was standard. The board said that the review was triggered by high-profile cases, so it was not standard.

Dr McCormick:

I do not accept that there is a difference between the two points of view. I am trying to explain that the X-ray issue was not a major, high-profile concern. There was an issue to be addressed, but it is not as though there was an unmanaged risk or any danger to patients. The scale of the issue was identified quickly, and it was corrected quickly. The board then asked the question: is there a wider issue? It looked at the specific issue quickly, resolved it and then asked the question. I was involved in discussions with John Compton throughout the autumn about whether there was a wider issue.

Ms S Ramsey:

Why not tell us that, Andrew?

Dr McCormick:

We did not know the scale of the issue. At that stage, we were still judging how serious the issue was. It would not have served the public to put a balloon up and cause a hue and cry without reason.

Ms S Ramsey:

The point is that you did not tell us. The leak did not come from the Committee. We can be sensible and mature. If lessons are being learned from mistakes or failures, let us know.

I want to talk about the issue at the children's hospital. You said that one serious adverse incident led to the issue at Altnagelvin. I am also conscious that we need to be careful not to put more information into the public domain as more people could be affected. However, I asked the Minister specifically how many serious adverse incidents there had been in the children's hospital in the past five years. I tried to get an answer from the Minister the other day, but I did not.

What action has been taken on the recommendations that were made 10 months ago? Is there additional information, in reports or in minutes of meetings that the Committee does not receive, that could supplement the documentation? Finally, where did the £300,000 come from? Was that on the back of the reports?

Mr Colm Donaghy (Belfast Health and Social Care Trust):

Chairman, would you like me to deal with the questions on the children's A&E?

The Chairperson:

Yes.

Mr C Donaghy:

I will provide some context and then deal with the specific issues that Sue raised. The IMAS letter/report is now in the public domain. IMAS was invited to carry out a piece of work, with the agreement of the Health and Social Care Board and the trust. Its expertise, in that instance, was in emergency departments. The objective was to get ideas about how we could improve services. We operate in an environment of continuous improvement. I emphasise that IMAS was not invited in as a result of an SAI. It was invited in as part of an improvement process.

The letter that the Belfast Trust received from IMAS has been treated seriously in the context of the recommendations that it made in its report. As far as I can determine, no deliberate decision was taken not to publish the IMAS letter. The trust was of the view that it was in a process of continuous improvement. IMAS did not come into the trust because of a sense that it was a failing service. It came in because we wanted ideas about how we could improve the children's service.

By way of background information, the children's hospital performs extremely well: it is the best performing emergency department in Belfast, and it is comparable with the best performing elsewhere in Northern Ireland. The hospital's standard mortality rate, which is an indication of unnecessary harm or death to children, is as good as any other children's hospital in the UK. It was not failing, and it was not giving the trust any major concerns. However, we recognised that we wanted to improve some of the processes and staffing arrangements in the hospital. Perhaps if it would be useful, I could go through some of that. Sue, you asked particularly about where we were with the recommendations in the IMAS report.

Ms S Ramsey:

Have there been any serious adverse incidents in the past five years?

Mr C Donaghy:

In the past year, I can say, categorically, that no serious adverse incidents have caused harm to children, and I will check the record for the previous four years. I have the information for the past year only. However, there was a serious adverse incident with blood products that did not cause harm.

Ms S Ramsey:

Was that in the past year?

Mr C Donaghy:

That was in the past year, but it did not cause harm to any child. We have criteria against which we judge whether something is a serious adverse incident, and there are quite a number of them in our hospitals. Our staff are only human and, therefore, they make mistakes. Nevertheless, many of the processes and protocols that we have put in place resulted from our work through the patient safety initiative. That has reduced the number of serious adverse incidents, and we can demonstrate that and how it has improved our infection rates. As trusts, we are always striving to go through a continuous process of improvement.

IMAS was in the organisation for one day and, as a result of that visit, sent us a letter highlighting a number of areas in which it felt that we could make improvements, and we have taken that letter seriously. We put together a network that includes primary care, secondary care, the board and the trust, with the purpose of producing an action plan to make those improvements. That network was one of the recommendations in the IMAS report. It is now chaired by a trust director, and it reports directly to our executive team, which I chair. The line of accountability goes through to the executive team and through to me with regard to progress against some of the recommendations.

We acted in the context of the additional medical resource, so we now have one additional medical consultant in place. We recognise that the IMAS recommendation was for more, so we are working closely with the commissioner on a phased approach to increasing the number of staff in place. Nevertheless, we have provided, and are providing, a safe service in the children's hospital, and our staff believe that we do that. The Committee will have heard some of our senior clinicians on the radio recently emphasising that message.

On the nursing side, we have ensured that a senior decision-maker is in place in the department on a 24-hour basis. We will also recruit two more emergency nurse practitioners as additional staff. Some of IMAS's recommendations related to the care pathway. It quite rightly made the point that, if one does not examine the care pathway, it does not matter how many additional staff there are because it still might not be effective. We have examined our care pathway, and we now stream the children who come into the hospital into minors and majors, which was part of the recommendation. Although we have not been able to do that physically, we have been able to do it clinically. In other words, some children are categorised as minor and some as major, but we do not have a separate —

Ms S Ramsey:

The £300,000 that the Minister gave you the other day would enable you to do that.

Mr C Donaghy:

A new children's hospital would enable us to do that, Sue, which would be even better. Our current physical capacity does not allow us to do that. However, we are considering how we can introduce the minors —

Ms S Ramsey:

I thought that the money for a new children's hospital was earmarked about 10 years ago. I do not know where it went, but it was there. That was announced by a British Minister, but sure —

Mr C Donaghy:

Another point that IMAS made concerned the age of the children being treated. The indication was that children as young as 10 years old were going on to adult wards, but that is not the case. I had that matter looked into in detail, and it is not the case that children as young as 10 go on to adult wards. Those children are cared for in children's wards. Another issue concerned children aged between 13 and 16. The current capacity of the children's hospital means that it can treat children only up to the age of 13. Therefore, we make arrangements for children aged 14 and over to be treated on adult wards, but we put in place proper protocols for that to happen. We do not currently have the physical capacity to care for children up to the age of 16 in the children's hospital.

The IMAS report also raised a child protection issue. We are aware that more than one

hospital number was being issued to children when they attended the hospital. The electronic care record is about two years away, and it will help with the community health index (CHI) numbers, which are unique patient identifiers. In the meantime, we have ensured that a child protection nurse is present on each site, and we have very strict child protection protocols. In fact, those protocols are, in my view, stricter than those in some of the trusts in England and elsewhere. We are conscious that we must be acutely aware of child protection issues. Those protocols have been, and are, in place.

The next phase of our improvement work at the children's hospital will happen next year with further staff recruitment. I want to assure the Committee that we treated the letter seriously, and we have put in place actions to mitigate some of the issues raised in its recommendations. We, as a trust, regard that as part of an improvement process. I re-emphasise that IMAS was not invited into the trust because of a serious adverse incident or particular problem.

Ms S Ramsey:

May we have a copy of the action plan, or will I have to buy a paper in the morning to get it?

Mr C Donaghy:

That is OK.

Ms S Ramsey:

Do I have to buy the paper to get it?

Mr C Donaghy:

No. I will give you a copy of the action plan.

Dr McCormick:

I want to reinforce what Colm said. The trust, in conjunction with the board, has been doing exactly the right thing. It remains self-critical and open to challenge and outside assistance. That is the right thing to do, and the issue arose in the context of the good work that is being done.

There is a wide range of risks in health and social care. Our challenge is to manage risk. If we were to manage risk in response to the latest newspaper story, we would become distracted. We have to deal with risk systematically and properly, which means keeping standards under

review. That is a major part of the Department's work. Our professional officers address and issue standards. It is a continuous learning process. I also have to ensure that the right people are in the right roles. That is the systematic way to manage risk. Any attempt to eliminate risk or be critical when something goes wrong would take us down the wrong path of handling situations, and it would not deliver for the people.

Medicine and social care are inherently risky businesses. I urge that we focus on how to support and build confidence among those whom the community asks to carry the risks. Clinicians, front-line staff and trust management are all accountable, because there is a statutory duty on all the organisations to deliver safe services. In all my dealings with chief executives, through accountability meetings and regular dialogue, I stress the importance of the management challenge: the delivery of safe services, the best possible performance and financial balance. That is a wide range of challenges. Clinicians, front-line staff and trust management are accountable for delivering on that basis. There is systematic accountability.

What Colm's organisation did in respect of IMAS is totally consistent with the challenge that we set in the accountability meetings. We ask whether organisations are looking around, examining good practice and trying to learn lessons from elsewhere. We ask whether organisations seek to take proportionate, managed action to put right issues that have been identified. We recognise absolutely that it is a publicly accountable system. We are willing to learn from all that is happening, and from the concerns that you have expressed today, to ensure that we remain publicly accountable and fulfil the proper requirements. However, we must ensure that whatever happens serves the public interest and is proportionate and appropriate. However, the media are not helping us with that at the moment.

The Chairperson:

Andrew, you and I are from a similar generation, although you are slightly younger. There was a song in the pop charts with the lyrics:

"It ain't what you do it's the way that you do it".

The younger people here do not know what I am talking about. It was a song by Bananarama.

You outlined the series of steps that you have taken, and, on both counts, you probably reacted well. The problem is that both issues ambushed us by appearing on the front page of a certain newspaper when we knew nothing about them. Nothing that you have told me about the IMAS

report indicates why there was any need for the secrecy that surrounded the entire document. You said that there was no secrecy, but we knew nothing about the regional hospital that provides children's care for all of Northern Ireland. Honestly, we never had the slightest hint that that was going on. We would not be having this discussion if a simple e-mail had been sent to the Committee Clerk saying that you had commissioned IMAS to examine certain functions in the children's hospital. That would have alerted us to the situation. Some people, such as Sue, might have had issues and wanted more information, which is fair enough. You could also have given the Committee a private briefing. That is the issue.

However, having listened to you, I am content that you probably did the right thing. I am not complaining at all. There are a few matters still to be sewn up in both cases, but it looks as though things are moving in the right direction. Nevertheless, it is not as though this is the first time that it happened. It happens constantly, and we have to extract teeth from the Department in the form of more information. I came from the Committee for Regional Development, and we did not have that problem. We heard it as it was. That was me on my soapbox, and it is the last that you will hear for a while.

Dr McCormick:

For the record, I disagree with Bananarama. Yes, how something is done is important, but what is done is more important.

Mrs O'Neill:

We keep jumping between what is happening in the Western Trust and in the Royal. Should we not stick to the Royal and then come back to the Western Trust?

The Chairperson:

There are strong procedural parallels between the two. Alex, are your questions on the Royal or the Western Trust?

Mr Easton:

I am everywhere.

The Chairperson:

Do not be "vague". Are your questions on the Western Trust? Let us finish the line of

questioning on the Royal and then concentrate on the Western Trust.

Mr Easton:

I can come back in later when we discuss the Western Trust.

The Chairperson:

I will give you first priority on the Western Trust.

Mrs O'Neill:

I have a brief question. It cost somewhere in the region of £10,000 for the IMAS report and the panel of experts that you invited into the trust. Why did you not use the Regulation and Quality Improvement Authority (RQIA)?

Mr C Donaghy:

As an organisation, IMAS has particular expertise in the running of emergency departments and how to improve the services. IMAS has gained that expertise from being involved with a wide range of different hospitals. IMAS was able to bring to the trust its expertise in how to make improvements, particularly in emergency departments. The RQIA would not have had the same level of expertise.

Dr McCormick:

The RQIA could have commissioned expertise. The other distinction is that we need to reserve some of the RQIA's capacity for areas in which there is greater concern. The Department or the Minister commissions the RQIA to undertake an investigation when there are serious issues. The pattern is that the RQIA then draws on external experts to assist in that process. The example that springs to mind was the breast cancer issue several years ago when it was necessary to call in the RQIA, which, in turn, called in external experts to investigate an issue with a doctor's reading of mammograms. That illustrates a different process, which entails a higher level of investigation into a more serious situation. I go back to my theme of judging proportionality and degrees of seriousness. The review was not triggered by a concern but by a desire to promote service improvement. The review highlighted some concerns, and those concerns were then addressed. The two processes are different in nature.

Mr Gallagher:

It is reassuring to hear that services are safe and that you have no concerns about that. Before I ask Andrew a question, will you clarify whether there was a letter and a report from IMAS, or are they one and the same?

Mr C Donaghy:

They are one and the same. I am sure that members have now received the letter, which is addressed to Catherine McNicholl, who is the director of performance and delivery in the Royal Belfast Hospital for Sick Children. That document is the report and letter in one.

Mr Gallagher:

That is all right.

Ms S Ramsey:

Let me see it. The name has been taken off it.

Mr C Donaghy:

Sorry; maybe I should not have mentioned that.

Ms S Ramsey:

Let me see your copy.

Mr C Donaghy:

It is only the name that has been redacted.

Ms S Ramsey:

I just wanted to check.

Mr Gallagher:

Further to what has been said, who deals with the procedures that are in place? You are aware of our dissatisfaction. Andrew, you said that you were "aware" of the report, which led me to conclude that you were not informed about the report. My question applies both to the IMAS report and the report on the Western Trust. Is there a procedure for informing you? How and when were you informed?

Dr McCormick:

It is not a question of procedure; it is a way of life. I meet John Compton at least once a week, and I meet trust chief executives often. As a group of leaders, our clear understanding is that any issue that is causing concern should be raised quickly and as a matter of urgency, which is what happens. I have total confidence in all the chief executives and in the way in which that works. I know that if they have a concern, they will raise it. In fact, my clear message to them is that they are responsible for managing the issues that I mentioned earlier. We hold them to account for what they do, but they have both the right and the responsibility to escalate an issue if it is giving them concern.

The fact is that the IMAS issue was not raised with me because it was not a cause for concern, and the concerns that were identified in the report were being resolved. Others in the Department were aware of what was going on, but it was not flagged up to me because it was not a cause for concern.

On the Western Trust issue, John Compton and I discussed exactly what he was doing. The report was issued to his board only this week, so it could not have come to me any earlier. I was briefed on what was emerging, and I was satisfied that his organisation had done the right things and that the Western Trust had dealt with the issues and restored standards of performance on those issues, as the press release states.

I was in touch with the process as it evolved. Last week, we saw some emerging findings from the report, and we saw the final document this week. We are satisfied that the issues are being addressed. One of the reasons that the review was organised was to ask whether there was any deeper concern about performance in the Western Trust. The answer is no, and we have every reason to have confidence that the management team there have responded to the performance issues, got on top of them and are now in charge. I confirm that there is ongoing sustained confidence in the Western Trust management and in the work that John Compton's organisation carried out on that process.

The level of communication will differ from issue to issue, but we have continuous informal contact. When formalisation or correspondence is needed, we act accordingly. We ensure that the formalities are observed so that there is a clear audit trail and a clear record. Therefore, any

subsequent RQIA or Audit Office investigation into something that had gone wrong, would always find good records and evidence of ongoing contact. We work together as a management team.

Mr Gallagher:

I have no doubt that nothing of any appreciable scale would happen without your finding out about it. However, do you not think that, if an outside inquiry or investigation were being carried out into any of the trusts or the authorities under the Department, it would improve practice for them to put that in writing to you? You would then have dates and times, and you could ensure that everything was properly recorded.

Dr McCormick:

Yes, if we deal with matters in a proportionate way. If there is an investigation of a concern, the answer is absolutely yes. If bodies were undertaking service improvement activity, I would expect them to get on and do as much of it as they possibly could, and I would not require them to document and identify every such case. Extensive service improvement activity goes on at organisational or unit level.

Mr Gallagher:

We regard the two issues that we are discussing as serious. In both cases, would it not have been better for the appropriate trust to have relayed the situation to you in writing?

Dr McCormick:

If there had been a cause for concern, I would agree. However, I hold to the point that the IMAS report did not emerge from an adverse incident; it was not triggered by something that had gone wrong. Rather, the trust was working to identify scope for improvement, which is, in fact, what I ask of them.

Mr Gallagher:

What about the Western Trust issue?

Dr McCormick:

John Compton and I discussed that on several occasions throughout the autumn, so I was fully aware of that.

Mr Gallagher:

You did not, however, receive anything in writing.

Dr McCormick:

There was correspondence. I saw the report when it was completed, which was only recently. I am satisfied that the process was satisfactory, and I assure the Committee that, in managing the whole range of services, we continually seek to maintain assurances. It is clear to me that the Committee's request is that we to find a way to convey that assurance more comprehensively. I need to talk to the Minister about precisely how best to respond to that. I understand and respect your concern, and we need to find a proportionate and sensible response.

Dr Deeny:

You are welcome, Miriam and gentlemen. We must all learn from this latest situation. I reiterate what other members said: at times, the public are shocked that we in the Health Committee do not know what is going on. That issue must be dealt with. We must be kept informed, and, as long as we know what is happening, that could be done in confidence or in closed session. I do not know how many times I have been told that something has happened and then asked why, as a doctor who sits on the Health Committee, I did not know about it. We have all raised that issue. Andrew, when we are contacted by the media wanting immediate comments, it is difficult for us to respond when we have not spoken to you.

As I have just received the details of the Belfast issue, I have not had time to go through them. Colm, I am glad that you mentioned the expertise of IMAS. My perspective is that of a doctor, and I gathered from the media that IMAS's major concerns were staffing through the night and inexperienced doctors. Although I accept that you are addressing those concerns, an unnamed doctor was quoted as saying that he would rather bring his sick child to an out-of-hours centre to see an experienced GP than to an A&E department. That is a serious indictment. I do not know whether that is true, but it was in the press. That more or less suggests that, in the middle of the night, he would rather see someone experienced in looking after children than an inexperienced junior doctor.

Correct me if I am wrong, but was it not suggested in March that there should be a review after six months? Was it not suggested that such a review should involve the Royal College of

Paediatrics and Child Health? That would make sense to me as a doctor, given that we are discussing the main paediatric A&E department in the North. Why was that not done? If I were told, for example, about serious problems with staffing in my practice and advised of a review by the Royal College of General Practitioners in six months' time, I would make damned sure that the problems were dealt with.

Did IMAS recommend that a review should take place in six months and that the Royal College of Paediatrics and Child Health, which is the appropriate group of doctors, should oversee it? Was the review carried out? If not, was the decision not to have a review made by a senior doctor or by management?

Mr C Donaghy:

On the issue of out-of-hours senior medical cover in the children's hospital, a middle-grade doctor for paediatric medicine is always available to the Royal Belfast Hospital for Sick Children to provide 24/7 support.

Dr Deeny:

Is that now, or was that at the review stage? The review might have been before your time.

Mr C Donaghy:

That is the current level of staffing.

Dr Deeny:

I am going back to the report.

Mr C Donaghy:

I will check that, but my understanding is that that was the case prior to the report, too. A specialty trainee for paediatric anaesthetists is always on site at the children's hospital. A paediatric medical consultant, a paediatric surgical consultant and a paediatric anaesthetist consultant provide 24/7 cover and can be there within 15 minutes if required.

Dr Deeny:

Is that the current situation?

Mr C Donaghy:

Yes. Consultants in other specialties are also available to the children's hospital. My assurance is that, if parents take their child to the Royal Belfast Hospital for Sick Children out of hours, they will be dealt with, and a high-quality service will be delivered.

Dr Deeny:

Did IMAS suggest that a review should take place in six months?

Mr C Donaghy:

I have read the letter a few times, but I cannot remember. You may be right, Kieran, and perhaps you could point that out to me. The action plan, which I mentioned to Sue, is reviewed monthly. Primary care, through the local commissioning groups, is also involved in the network. The network reports to the executive team on progress against the action plan. Therefore, review is ongoing. It is not a case of six-monthly reviews; the process is continuous.

The Chairperson:

Are you happy enough, Kieran?

Dr Deeny:

I cannot find that reference in the report, Colm, but it was that senior medical staffing in the emergency department was low. It is nice to be reassured that, no matter what time a child is taken to the Royal Belfast Hospital for Sick Children —

Ms S Ramsey:

Paragraph 2.1.3 on page 5 states that the arrangements are unsafe.

Dr Deeny:

Yes, and it also states that medical staffing of the emergency department is poor, but that was at the time of the review. Colm, you say that there are now senior consultants through the night?

Mr C Donaghy:

Through the night, we have availability of senior consultants. They are no more than 15 minutes away if required. In addition, we have a specialty trainee for paediatric anaesthetics always on site, and a middle-grade doctor is available 24/7.

Ms S Ramsey:

What do you mean by "availability"? Are they not on call? If they are 15 minutes away, where are they?

Mr C Donaghy:

They are on call on the site. They are not necessarily on the children's hospital site but on the Royal site.

Ms S Ramsey:

Therefore, they are not necessarily dedicated to the children's hospital.

Mr C Donaghy:

I will check whether they are exclusively dedicated, but I doubt it.

Ms S Ramsey:

I read the report a few times quickly, because I knew that you were coming in today. In reference to the A&E department of the children's hospital, it does not mention what medical cover is available on the wider Royal site. The report deals with the cover that was on site in the children's hospital, and it states that that level of cover was unsafe.

Dr Deeny:

I just want come in on what Sue said.

Paragraph 2.1.3 states:

"Junior supervision is inadequate due to low senior numbers, and they will be seeing undifferentiated patients without the knowledge to assess and treat them effectively. This is unsafe."

Has that situation now been remedied?

Mr C Donaghy:

Yes.

The Chairperson:

Paul Girvan will be the last member to ask a question on the children's hospital. The vast

majority of points that were due to be discussed at next week's public evidence session have now been covered. Therefore, after Paul has finished, that will be it, and we will not need to bring the officials back next week. I was not expecting Colm to be as forthcoming with information. However, Colm, you have promised to come back to us about a couple points.

Mr C Donaghy:

I will.

The Chairperson:

Apart from that, I think that we can dispense with the need to call you back next week, unless somebody has a major burning issue.

Mr Girvan:

Had this been a glowing report, we would probably never have known about it. However, it was made newsworthy by the fact that some of the issues highlighted about the trust and about what was happening were not favourable. This is where I am coming from: how can a report that was meant to be dealt with and reacted to by the management in confidence, as outlined in the first part, make its way on to the front pages of the papers? That must be stopped. Was there a night of the long knives or something along those lines going on in the trust?

My other frustration is that we did not even get copied in to the report. I can understand that protocol being followed after a favourable and glowing report about the children's hospital. However, some issues were probably going to be highlighted, and that warranted the report being made available to the Committee or, at the very least, to the Minister. The Committee is capable of dealing in confidence with information. It does not necessarily need to be out on the wire.

I am concerned that you paid £10,000 for the report of, as was mentioned on the radio, a one-day visit. How could a full assessment of the A&E department of the Royal Belfast Hospital for Sick Children be made in one day? Is the report an accurate reflection? Should we accept the report in its totality, or are some areas not accurate?

Mr C Donaghy:

The vast majority of the report is an accurate reflection. However, you are quite right, Paul, that in the context of a one-day visit, they cannot always get it 100% right. However, those guys are

experts in their field, and we treated their recommendations seriously.

At one stage in the letter, the suggestion is that the staffing levels could be deemed to be aspirational, given that many English hospitals have not achieved them. Suggestions and recommendations were made to the trust about how it can improve. We have taken those recommendations seriously and are working through them to make the necessary improvements. How that report got into the media, I do not know.

Mr Girvan:

Is the Department carrying out an investigation to find out who was responsible for the major leak of information? How was he or she able to get that information to a reporter before we, as elected representatives, even heard about it? The first time that I heard about it was when someone phoned asking for my comments.

Mr C Donaghy:

I can talk only for the Belfast Trust. We have talked to people in the trust, but we are still no clearer about how that information was leaked.

Ms S Ramsey:

It has been quite a useful session. It is a pity, however, that we did not receive this information last week. If we had, there would not have been a battle. Everyone is striving to get the best for patients.

I have a concern that, perhaps, Andrew can address. The RQIA carried out an in-depth inspection of the children's hospital more than a year ago. You said that IMAS was only there for a day. Part of me is thankful for that, because God knows what issues IMAS would have raised had it been there for a week. The RQIA inspection was in depth, and some of it concerned minor issues. Something must have triggered the IMAS visit. If it was not a serious adverse incident, it had to be something else. Someone did not simply decide one day to invite IMAS to carry out a review.

Mr C Donaghy:

I will provide some background and context, Sue. Over time, we have strived to improve the performance of the emergency departments in the trusts. We became aware of the existence of

IMAS, which is an organisation that pulls together expertise from different trusts. It is made up of people who are employed in the NHS, so they are not private management consultants. They have gained expertise through working in the NHS. The board facilitated a presentation from IMAS. Two gentlemen from IMAS had a meeting with chief executives and John Compton. John facilitated a presentation from IMAS to the various trusts. It was given by people who had expertise and could help to improve the performance of our emergency departments. John then asked whether some of the trusts would like to facilitate a visit from IMAS. The Belfast Trust agreed that the children's hospital would be a good place for IMAS to visit, and it invited IMAS to do so.

Ms S Ramsey:

That is a plausible explanation, but it is in the public domain that all sorts of incidents triggered the visit. Your explanation is sensible.

Andrew, whatever the cloud or blockage that led to the Health Committee being treated with disrespect, it also contributed to the creation of this situation. Give us the information, and let us decide what we think. All the issues appeared on the front page of a local paper. I found the information that we received today more settling than the Minister's response on Tuesday.

Mr Girvan:

What measures are being taken to address the fact that the issue made the front page of the newspaper and that public confidence in the services has been affected? I take comfort and assurance from some of the comments that have been made today. The situation is not as black as it was portrayed. The response in the Chamber on Tuesday did not give me confidence about the way forward. However, I appreciate the openness that we have witnessed here; it has been helpful.

The Chairperson:

Is it a case of Donaghy for Minister?

Ms S Ramsey:

Which one?

The Chairperson:

I was being facetious.

Dr McCormick:

Public confidence is vital. As a publicly funded, publicly accountable service, it is wrong to try to chase a story or particular issues. It is far better to look at the systems to determine which one is right. We need to focus on ensuring that the standards are right, kept under review and well informed by good practice from elsewhere. That is a departmental responsibility.

Secondly, it is a matter of having the right people in the right places. The service depends absolutely on the integrity and commitment of a whole range of individuals: front-line staff at all levels and management at all levels. The best way to ensure that is to ensure that we have the right people in the right places. We have ways in which staff can come forward with issues without expecting that those issues will go straight to the public domain. The effect of overzealous media handling could be that people do not want to take responsibility because it will lead to publicity. That would stop people who are capable of taking on the responsibilities from doing so, which would be extremely detrimental. Therefore, we are all required to be highly responsible. As I said, we are publicly accountable, and we need to find the right way to handle that.

Ms S Ramsey:

With respect, the media are also playing a part in the situation. Do you know what made the story? It was the thought that something was being hidden. If nothing was being hidden, there would not have been a story.

The Chairperson:

That leads me to ask a difficult question of you, Andrew and Colm. You are expecting me to ask this: is there anything out there of which we are not aware, such as a major investigation, report or in-depth review of any description? Is there anything that, if it were to enter the public domain courtesy of some local newspaper, could catch us on the hop or ambush us and leave you saying that you should have let us know about it? What is out there that we do not know about?

Secondly, when did the Minister know about both investigations? At what stage could he have said that he was aware of the Western Trust and Royal issues? Tell us now: what is out

there?

Dr McCormick:

Nothing out there matches the words that you used. Many areas are under review or being pursued by way of service improvement, but there is nothing of which I am aware that matches the words that you used.

The Minister's awareness can be broken down into three areas: IMAS, the Western Trust governance review and the specific aspect of that review that deals with X-rays. The X-ray issue in Altnagelvin was drawn to the Minister's attention last August. He knew about it then, and I was party to the judgement on whether the X-ray issue being handled by the trust and the board was appropriate and proportionate. The considered view was that that was the right thing to do.

As I said, the Minister was also aware that the Western Trust's governance review was going on. However, he did not receive a detailed briefing, because he was still party to forming a judgement on how serious the issues were. Given that the key issue was to try to understand more fully the degree of difficulty of the issues, it was not appropriate to give the Minister a detailed briefing. As soon as that was established, John Compton brought the report to the Minister and spoke to him about it.

The Chairperson:

When?

Dr McCormick:

In the past couple of weeks.

The Chairperson:

Two weeks?

Dr McCormick:

I think that they met last week.

The Chairperson:

It is getting closer and closer to the leak.

Ms S Ramsey:

I have submitted a written question on that.

Dr McCormick:

The point is that it was always known that the issue would come before the board's public meeting today. That was known for several weeks in advance, and the timing was managed on the basis that the conclusions were good and showed that the issue had been resolved. The judgement, therefore, was that the situation was known and under control, and there was nothing about which to be alarmed. The trust had been investigated, and it had restored performance standards. Sorry, I can be more precise about the timing: the leak appeared in the 'Irish News' two weeks ago on Saturday, and the briefing was around that time. The situation was under a proper control process.

The Minister has answered questions directly on IMAS.

The Chairperson:

In answering my question, you used the phrase "used your words". I will twist the question slightly: is there anything out there about which any reasonable person in my position, if suddenly ambushed, would be concerned?

Dr McCormick:

No.

The Chairperson:

Therefore, the gravy train of leaks to the 'Irish News' stops today, and there is nothing more to come.

Dr McCormick:

Never say never because beauty is in the eye of the beholder. People will judge what they choose to be concerned about, so I would be unwise to say never or no. I assure the Committee that we are hiding nothing inappropriately. There is nothing wrong, and there are no adverse incidents or concerns about the safety of services. We have a statutory duty and an obligation to provide safe services. As soon as there is an awareness of anything that is creating unmanageable risk, we act

on it. That is the assurance. In the realm of service delivery and provision, there is a whole range of risks, and I am confident that teams in every part of the service are managing those risks. Undoubtedly, staffing levels in some areas are not ideal, and we have to work on that.

That is why the resourcing of health and social care matters so much across the entire range of budget discussions. There is no ongoing issue about creating unmanaged risk to the public that is not being made open at this point.

Ms S Ramsey:

I would like clarification on the Western Trust issue; are you saying that the Minister was briefed after the article appeared in the 'Irish News'?

Dr McCormick:

No; the full briefing happened at that stage, but the plan had been to brief him as soon as the conclusions had been drawn together.

Ms S Ramsey:

Did the Minister become aware of it —

Dr McCormick:

He was aware that the work was ongoing before that.

Ms S Ramsey:

However, he knew that the Western —

Dr McCormick:

There was no lack of confidence that there was clear accountability from the Health and Social Care Board to the Minister and me. John works closely with us and had drawn that to the Minister's attention.

Ms S Ramsey:

That is fair enough. I just wanted to clear that up.

The Chairperson:

There are many overlapping issues, so we will do this quickly. We can dispense with our letter to

the Minister on the issue, because the questions that we listed — did the RQIA know and when did the Minister know — have all now been asked. If anything else is going to come and bite us, we have asked about the main issues, so that will save some time.

I am slightly concerned about the Western Trust issue. The Health and Social Care Board news release states:

"it became clear there was potential for a substantial number of reports on routine x-rays not to be completed within the agreed standard of a maximum of 28 days."

It goes on to say:

"In August, this was sized at 18,500 of which around 3,400 were chest x-rays."

Am I right in thinking that 18,500 X-rays were not meeting the 28-day target? Is that not an extremely serious issue?

Dr McCormick:

It is important to put that into perspective: it was not that 18,500 X-rays had not been looked at, but the reason for taking the X-ray had not been acted on. Miriam can explain that fully; it is a matter of how the process is managed. I do not accept that it is an indicator of extreme risk.

Dr Miriam McCarthy (Department of Health, Social Services and Public Safety):

I will expand on that: 18,500 is a lot of X-rays, but, to put it in context, tens of thousands of X-rays are done every year. It is a common investigation. If a physician or surgeon orders an X-ray in A&E or in a clinic, normal procedure is that they will look at that X-ray and make a clinical judgement about treatment on the basis of what they see with their expert eye. For example, if they diagnose a fractured wrist, they will treat it appropriately. Some of those X–rays do not require formal reporting; for example, a fracture is a fracture, and if it is clear to the A&E doctor, it may not need to be reported, although it will be listed as unreported.

In other cases, a doctor will make a decision about clinical management but will subsequently send an X-ray to the radiology department for an expert view. A radiologist will provide a formal report in that situation because he or she will have a greater interpretative skill and expertise. Those X-rays will come back as reported. Indeed, for any individual patient with a chest X-ray, for example, there may be several images: one taken from the front and one taken from the side, which constitutes two X-rays but is one event.

Of the 17,500 X-rays mentioned, those are the ones that did not have a formal radiological

report. That does not mean that someone did not look at them and take appropriate action. Ideally, unless it is crystal clear — if it shows, for example, a fractured leg or wrist — we expect most X-rays to go through a formal reporting process, particularly if there are complex medical issues.

The Chairperson:

Was there any evidence among those 17,500 X-rays of someone who had a condition that should have been identified earlier but was not because of the lack of a formal procedure?

Dr M McCarthy:

Before specifically answering that question, I will give members some information: as soon as the trust became aware that there was a potential for people to experience delays, it acted immediately and informed the Department. That was in early August 2010. Simultaneously, it advised us of its plan of action, which it had agreed in conjunction with the board, to review rapidly the entire backlog of X-rays that were still to be reported. Indeed, the first priority group of chest X-rays had been completed by 20 August 2010, and orthopaedic and other X-rays were rapidly worked through within the following couple of months. Therefore, the trust took action very quickly.

There is a suggestion that a very small number of people — in the region of four — may have experienced some delay in diagnosis because of unreported X-rays. All those people have been contacted, their circumstances have been discussed, and their families know of those circumstances. Obviously, we will not discuss individuals, and I do not know the details of individual cases, but it appears that, for the majority of those four people, there would not have been a change in treatment management or a changed decision on appropriateness of treatment. However, the delay may have affected diagnosis, but not necessarily a treatment regime, for a small number of people. Those were all people for whom an X-ray was not seeking a specific diagnosis. They had not presented symptoms such that physicians were looking for a diagnosis of cancer, for example. Those X-rays were carried out as part of a range of tests; for example, cases of outpatients who came in for routine tests in which the pathology on an X-ray was picked up almost coincidentally.

It is important to correct a few matters. I did not hear all the media coverage today, but I think that there might have been a few inaccuracies. Fifty-two people were not recalled; we understand

that eight patients were recalled as a consequence of looking back at all the X-ray reports. Some of those may have simply needed another X-ray to check their details, but thousands of X-rays were not recalled or lost, as I think was reported earlier.

The Chairperson:

Were any of those conditions life-threatening?

Dr McCormick:

It is important not to go into any details that risk identifying individuals, but included in the four that Miriam mentioned was the original case that triggered the investigation. That case arose before July 2010. An X-ray had been taken, the patient was discharged and later returned with more advanced symptoms. That is how the issue came to light. That was the serious adverse incident that gave rise to the investigation. That shows that, in a small number of cases, there was a delay in diagnosis. However, that was quickly identified, and corrective action was taken so that the further unreported X-rays were investigated fully to make sure that the matter was resolved quickly. Therefore, there was clear identification so that, once that process was corrected, the risk that had existed was eliminated. There was a risk that gave rise to an adverse incident, and action was taken to correct it. However, there was a delay in diagnosis for a very small number of people. That is obviously a matter of regret, and the trust has spoken to individuals and families to make sure that they are treated properly in that context.

Mr Easton:

The Chairperson has already asked one of my questions. I used to work in an X-ray department, so I concur with what Miriam said about the processes. For how long were the 18,000 X-ray assessments unreported? Was it a year or six months? Of those 18,000, were the unreported X-rays going to be assessed at some stage after the 28-day period, or was it simply a matter of the length of timing, and they would eventually be looked at?

Dr M McCarthy:

There is an issue concerning capacity. We assume that all X-rays that go to the radiology department will be reported on; that is the normal process. The fact that the Western Trust had a computerised system in place made it easier to identify the numbers for which reporting was delayed, so it was able to track the reporting. Better information highlighted some of the delays, so that allowed the trust to tackle those more efficiently than if the computerised programme had

not been in place.

I am not sure of the exact delay in some of the reporting, but the Department has been advised that the average is around 7·5 months and the longest delay in reporting is 10·5 months. I emphasise: that is for X-rays for patients for whom clinical action has been taken and, for the vast majority, we assume that that will be appropriate — for example, a doctor on a ward looking at someone's chest X-ray and diagnosing a chest infection either getting worse or resolving, and taking appropriate action. It is not as if no one had looked at those X-rays. They had been looked at, and treatment had been progressed. A radiologist's expert view adds a skill that is over and above what other doctors had looked at in the intervening period.

Mr Easton:

Therefore, it is not a case of the X-rays being lost or simply forgotten about but that they went over the 28-day limit but were going to be looked at at some stage.

Dr M McCarthy:

They were not being neglected; they were in the system. There were delays, but those were swiftly addressed when the trust became aware that someone may require action more quickly.

Dr Deeny:

Let us get back to the facts. The first time that I heard about the figure of 18,500 was today at lunchtime. I want to pay tribute to the Western Trust: if I order a routine X-ray from our local hospital on a Monday, I have it on my screen on the Tuesday — within 24 hours — or, at the very latest, the Wednesday. It is that good; it is computerised.

Is 28 days the agreed standard across Northern Ireland for a routine report? I am shocked; I did not know that. That is totally unacceptable in a modern-day Health Service. The Health and Social Care Board's news release states:

"within the agreed standard of a maximum of 28 days."

Surely that is not the agreed standard. I would not accept that for any of my patients. If any doctor in my practice did not have X-ray reports back within a week, they would be furious.

If four of the 18,500 X-rays had problems, by God, that is a lottery. You were very lucky. I have been ordering routine X-rays for years, and sometimes things come back that we do not

expect to find. I was well aware of the breast cancer situation. I know that that has been discussed, and it was made public at a board meeting in September, but I am aware of it from talking to GPs in the area around Altnagelvin, Strabane, and so on.

From talking to GPs up there, I am also aware of concerns about X-rays and reporting, so much so that people are being sent from Strabane to Tyrone County Hospital to get their reports done. I am aware of that, but I am shocked at the figure of 18,500 X-rays. Although the situation has been rectified now, surely the Department must say that that cannot be allowed to happen again. Those people are waiting on results.

I worked as a clinical doctor in a hospital for five years and have been a GP for 25 years. Almost every X-ray goes to a radiology department for a report — that is why we have consultant radiologists — apart, perhaps, from those from senior consultant orthopaedists. X-rays from A&E departments, GPs or wards are all reported on. That is why we have radiologists — because they have that added expertise that you mentioned. To explain away the 18,500 X-rays, even in part, by saying that some X-rays were not reported on is skewing the picture somewhat.

When I heard the figure of 18,500, I could not believe it because, as a clinician and as a GP, my practice — it is just down the road from Altnagelvin — has honestly not had an X-ray not reported on within a week. Miriam, is that standard practice? We cannot accept 28 days for an X-ray report. I could request a routine X-ray because I think that a person with a sore hip has osteoarthritis and, all of a sudden, it could be a cancerous lesion that I have not suspected.

Dr M McCarthy:

I will pick up on a couple of points. Twenty-eight days is the maximum time. We do, as Kieran will be aware, respond much more swiftly to urgent X-rays. I need to check the number of hours, but I think that the standard is either 48 or 72 hours for the reporting of urgent radiological tests.

Ms S Ramsey:

Kieran gets his X-rays quickly because it is known that he is on the Health Committee.

Dr M McCarthy:

Many are turned around much more quickly.

Dr Deeny:

That does not happen in our practice only; it happens all around our area. For routine X-rays, patients go into a radiology department, X-rays are done that day, and the report is on our screens by the following morning. The service seems dreadful in the northern sector of the Western Trust, yet we have an excellent service in the southern sector.

Dr M McCarthy:

What we know is that, in Altnagelvin, given the number of doctors and radiologists available, the capacity to report was not deemed to be sufficient at that time. Therefore, a backlog built up each week and each month.

Dr McCormick:

It is important to go back to Miriam's earlier point about distinguishing between the quick primary look at an X-ray by a lead clinician in A&E or wherever and a more formal detailed report. The assurance is that there was no evidence of a problem with the first response. Therefore, if pictures are sent to Kieran, they are sent where they need to be sent for immediate response. The capacity issue was with the detailed specialist reporting. It is important to emphasise that.

Dr Deeny:

I am sure that GPs also ordered a lot of routine X-rays.

Dr McCormick:

Yes; they would have been provided in good time.

Dr Deeny:

My understanding is that GPs were very concerned about the delay in reports, yet our practice got those the next day. Something is seriously wrong.

Dr McCormick:

When the issue came to light, the Department asked whether there was a backlog or any issue in any other organisation. We got an immediate assurance that there was not. Therefore, the capacity issue was in Altnagelvin. The backlog and the staffing issues have been addressed.

Dr M McCarthy:

Systems have been put in place in the Western Trust to ensure that that will not happen again. The trust is keeping that under regular review. It is all computerised now, and, therefore, X-rays can be tracked much more easily than would have been the case some years ago. We know that the trust acted quickly and proportionately and has put in steps to ensure that it will not happen again. Furthermore, we know that it was not an issue in other trusts, and, as Andrew said, we took that step immediately because we wanted to check whether that issue was only in one place or whether there were other problems. Last August, we identified that there were no issues elsewhere.

Dr Deeny:

I have one final question.

The Chairperson:

We have not moved on to the issue that the officials have come to answer questions about.

Dr Deeny:

You said that the Minister knew in August 2010. It would have been worthwhile to inform the Assembly and the Committee about how serious the X-ray problem was after the summer recess. What measures will you take from now on to communicate more effectively with us so that we do not hear such stories in the press and are put on the spot?

Dr McCormick:

We need to look at issues systematically and discuss with the Minister how to handle confidential sessions, and so on. We are clear about our accountability and responsibility to the Committee. We need to make sure that there is a proportionate judgement on what information is provided at what stages. In August, the clear judgement was that the right things were being done and that there was no ongoing risk. With regard to the proportionality of issues that we were dealing with, all that was necessary was being done. At that stage, there was no major reason or driver to report because there was no outstanding issue.

The Chairperson:

I want to move on to the main issue, which is the provision of central services and the decisions taken by the Belfast Trust.

Mr Gallagher:

I have a few short questions. Are we talking about 18,500 individuals?

Dr M McCarthy:

The short answer to that is: not necessarily. We are talking about 18,500 X-rays. For example, if someone goes for an X-ray of his or her back, he or she may have several images taken, that will count as three X-rays although they are all taken during one session. A report may be attached to one of those X-rays and, therefore, the other two X-rays may appear to be unreported, but the report covers all three. There are some technicalities on measurements, but that is the number of films that were unreported and not the number people.

Mr Gallagher:

Were there reports against either one X-ray, or a group of X-rays as you have just described, or were people brought back for an X-ray? Were all the X-rays able to be identified?

Dr M McCarthy:

I understand that the trust recalled eight people for further X-rays on the basis of its review.

Mr Gallagher:

Does the trust put reports and X-rays together 28 days or three months later and eventually get the information back to a GP or a local hospital?

Dr M McCarthy:

I am not familiar with exactly —

Mr Gallagher:

I want to be assured that it was safe. If my X-ray was in Altnagelvin for two months with no report attached to it, there is a likelihood that everything would not match perfectly. Can you give the Committee an assurance that everything did match perfectly, or is there a possibility that in all cases an X-ray was not a perfect match with a patient's report?

Dr M McCarthy:

The trust's process for dealing with the backlog was robust and was fully supported by the board.

Staff worked additional hours and sessions to ensure that every unreported X-ray was sorted out. That was completed in the autumn. It will have been done to the satisfaction of the chief executive of the trust and, indeed, the board. In that respect, we have been assured that matters have been addressed correctly and that there are no outstanding issues.

It is worth mentioning the content of the report that went to the board today. There were no concerns about professional issues or the quality of the professional expertise on reporting. There was a backlog, and there were delays, but the quality of the clinical judgement of the X-rays was never called into question, which is very reassuring.

Mr Gallagher:

I take it that you can assure the Committee that no patient was brought back and told that there was a bit of a mix-up, that his or her information had been lost and that he or she needed to be X-rayed again.

Dr M McCarthy:

Eight people were recalled for further X-rays. I am not familiar with the reasons for that. However, that sometimes happens. Even if there is no delay, people are sometimes called back because something may look a little suspicious on an X-ray.

Mr Gallagher:

I am talking about somebody being brought back and being told by staff that they were sorry but that the person's information had been lost and a further X-ray was required.

Dr M McCarthy:

We are not aware of that being an issue. We are aware that eight people were brought back. As was mentioned earlier, we are aware that four people may have had some delay in their diagnosis as a consequence. However, they have all been fully informed, and there have been appropriate discussions with the patients and their families.

The Chairperson:

After that preamble, we move on the main issue on which you are here to speak. That is the difficulty that we face of services that are provided regionally by the Belfast Trust and which the other four trusts feed into. The Belfast Trust seems to have made changes to those services with

very little consultation with the other trusts and the service users. Sean must be very annoyed because he has not had a chance to speak all afternoon, but I am sure that he will get an opportunity this time.

Mr Sean Donaghy (Northern Health and Social Care Trust):

I am quite content, so far.

The Chairperson:

It relates particularly to two issues that have arisen recently. One is to do with the neurology ward, and the other concerns Appletree House and the Allen ward for cystic fibrosis. Some of the responses do not hit the target, because we were told about the wonderful organisation and consultation in the trust. That is not the issue. The issue is that it seems to us that the Belfast Trust, which gets a capitation fee to provide services on a Northern Ireland-wide basis, has taken a decision unilaterally without any consultation with the trusts that feed in patients to that or, indeed, in some cases, with the consultants who carry out the service. It has certainly not carried out a consultation with organisations such as Action MS, the National Society for Epilepsy or the Motor Neurone Disease Association. Why do you not consult much more widely than simply in your own trust area? Why do you not consult the other trusts, and why do you not consult the service users, NGOs and charities?

Mr C Donaghy:

Thank you for the opportunity to speak on that. You mentioned neurology and cystic fibrosis. I will deal with cystic fibrosis first and give you the context and background to that issue. You mentioned Allen ward and Cherry Tree House, which is part of Allen ward. In the summer of 2010, around June, it was notified to Allen ward that capital funding would be available in that year to allow the ward to improve the physical environment and the conditions for caring for patients in Allen ward and Cherry Tree House. It was not until September that some of the design proposals were drawn up. To engage with the staff and the wider stakeholders, those design plans were put up on the wall in the ward so that people could see them, and I think that that is what caused some of the public reaction.

The trust held an open meeting to discuss the proposed plans, and requests were made for the inclusion of central monitoring, a sleep room and a pulmonary function lab to be put into the drawings. During October, the trust then engaged with a number of stakeholders, including

parents and the Cystic Fibrosis Trust. I know that Mickey visited the area in December to see the proposals. As a result of those series of visits, we have an agreement with all the stakeholders about the improved refurbishment, which will happen in Cherry Tree House in Allen ward to improve the environment for children who suffer from cystic fibrosis. That is now going ahead, and it is agreed with all the stakeholders.

What caused some consternation was the fact that we put the proposed plans on the ward in October after they had been drawn up in September. I will give some further background on that. As you know, capital funding in our organisation is tight. There has to be an undertaking that, if capital funding is agreed for a particular area, it can be used in the year for which it is allocated. Therefore, the people and the staff were keen to use the funding but to do so in a way that was inclusive for all stakeholders.

If there is a lesson to be learned from that for the trust, it is that we should engage stakeholders in the drawing up of the proposed plans rather than putting up a set of proposed plans. We have put that in place so that stakeholders, rather than seeing a proposal that has now changed as a result of the engagement, are involved before proposed plans are put up in the ward. That is the lesson that we have learned.

The Chairperson:

That issue seems to have resolved itself.

Mr C Donaghy:

There is an agreed outcome.

The Chairperson:

Mickey is next. I know that he has a direct constituency involvement in this matter.

Mr Brady:

It is welcome that a resolution has been reached. The people to whom I have spoken are relatively happy about that, including the Cystic Fibrosis Trust and parents.

When I visited Cherry Tree House and saw Allen ward, it struck me that there is absolutely no doubt that the place needs refurbished. There is no issue with that. That will be welcome

because the circumstances are — I would not say Dickensian — but not great.

When the plans were put up, there was some panic among parents. I do not know that much about cystic fibrosis, but one of the issues that was raised was cross-infection. If children are isolated, there is less risk of cross-infection. I had dealings with a child, and another child came into his class who had cystic fibrosis. The children could not be kept in the same area, apparently because of the risk of cross-infection. It seemed that parents were worried about that.

The family atmosphere at Cherry Tree House also struck me. That came through from the parents. One of my constituent's children, the wee fella whom I was dealing with, is now 11. He was diagnosed with cystic fibrosis very early; I think that he was less than a week old. I do not know the logistics of how it is diagnosed, but apparently it was done very early. Of his 11 years, he had probably spent about four and a half or five years in Cherry Tree House. That means that there was a sense of familiarity for him. He was not going into hospital, per se; he was going to a place that he knew and with which he was familiar. It was the same for his mother.

The plans were explained to us, and they looked brilliant, but when we started to question front-line clinicians such as consultants or social workers, they were not happy. That was admitted to us. Given that they were not happy, we questioned the evidence from people who are not on the front line and who do not deal with matters daily. My understanding is that that problem has also been resolved.

The Chairperson:
It has.

Mr Brady:
That is good. That also struck me in the case of neurology in the Belfast Trust. Many consultants are not happy with what happened there, but the Belfast Trust seems to have, as the Chairman touched on, made a unilateral decision without consultation. I know that there was consultation, but it seemed to come at a much later stage.

I listened to radio interviews with Dr Redmond, who was involved in setting up Cherry Tree House, and she seems to have a fair degree of knowledge. She has been to Boston and has widely travelled and dealt with cystic fibrosis. However, I got the impression, from talking to people in

the trust, that her opinion was almost being rubbished. Perhaps "rubbished" is too strong a word, but words were being used to the effect that she was involved but is a bit out of touch. That woman has, presumably, spent a long 30 years or so dealing with a problem, whose opinion was valid and who should not have been treated with the type of disdain with which I felt that she was treated.

The Chairperson:

Mickey, there are three or four points there. Perhaps we could deal with those.

Mr Brady:

All I am saying is that I think that there are lessons to be learned. From what the witnesses have said today, those lessons appear to have been learned to some degree. I hope that there will not be a repetition.

Mr C Donaghy:

I think that Mickey would agree that, if there was an error on the trust's part, it was to try to move too quickly with the refurbishment to ensure that we could improve the environment for children and use the money within a timescale. It was always the intention to involve stakeholders, but they should have been involved at the point of drawing up the proposed plans, not after those plans had been put up. That said, we have now had that discussion with all the stakeholders, and the outcome is that we have an agreed refurbishment plan for Cherry Tree House in Allen ward.

The Chairperson:

We were aware last week that the issue had been resolved, but we had already invited you to come in to discuss the other issue. Are there any other matters, given that the issue seems to have been resolved? The neurology issue will be a little more difficult.

We will move on to neurology, which has caused much more dissension. Indeed, we had an unusual situation when, in an evidence session, it was quite clear that there was a consultant present who was not singing from the same hymn sheet as some of the officials from the trust. The service provides treatment for folk with neurological conditions from the entire Province. There was no evidence that the other trusts were consulted, and there was certainly no evidence that the wide range of groups representing sufferers of motor neuron disease, multiple sclerosis and epilepsy were consulted. There is a real concern that the final product is far from being a

modernisation or revitalisation of the service. Many see it as a considerable cutback.

There is the issue of single-bed rooms and the difficulty that young epilepsy sufferers face when they are in a mixed ward with people with other conditions. That probably happened before your arrival as chief executive, Colm, but did it ever occur to your predecessor, given that there are many service users and stakeholders, where was the consultation? You are now about to face a more difficult set of questions.

Mr C Donaghy:

I will do my best to field the questions. I want to start by setting neurology in context in relation to the profile of the service. I also want to say — I do not want to be glib; it is a serious issue — that change is not easy. It is always difficult and complex, particularly in a hospital setting in which we provide care for people.

I will give you an idea of the profile of the service. The neurology service is primarily an outpatient service. Each year, there are some 16,000 outpatient attendances, 600 day cases and 700 inpatients, who are split roughly 50:50 into elective inpatients — people who had planned to come in for treatment — and non-elective inpatients — people who have to go into hospital at short notice or unscheduled.

Care is provided by the equivalent of eight and a half neurologists and two neurophysiologists. Our service is a neurosciences service. It is made up of neurosurgery — 40 beds — and neurology — 16 beds. That gives you an idea of the service, which is primarily outpatient-based and day cases, but we require inpatient beds from time to time.

The NHS and the Department of Health produced an ambulatory care document in 2006, which in effect indicates that we should be moving even further to day-case and outpatient-based treatment of neurological conditions and that inpatient care is required less. I will give you an example of that. Tysabri, a drug that is provided to some of our neurological patients — Kieran might be familiar with it — is now provided on a day-case basis rather than an inpatient basis, because that is more appropriate. We provide roughly 10 of those treatments a week. In the past, patients would have been required to be in a bed for two or three days, but now they come in in the morning and go home in the evening. That is appropriate care and treatment and reduces the requirement for us to have beds.

We are providing the same level of service. In fact, I have statistics to give you that show that, since the change, we are treating more, not fewer, people with the neurology service. To return to the reasons for what happened, there was a drive for improvement in care so that we would move in the direction that is recognised — nationally and globally — as the way in which to treat people with neurological conditions. That modernisation means that we need fewer inpatient beds, and we have reduced the number of beds. We recognise the fact that that causes concern and that that was not finally agreed with all our clinicians. However, we engaged with our clinicians, and I note the point that you made about the clinician who attended the Committee evidence session.

The Chairperson:
And the letter that was leaked?

Mr C Donaghy:
I know about the letter. In fact, one of the main aspects of that letter was that the clinicians indicated to the Committee that fewer people would be treated because there were fewer beds. I have the statistics since the change — I am happy to share them with the Committee — which clearly show that we have treated more people in our neurology wards both as inpatients and day cases. We have never turned down an admission that was required because we treat neurology and neurosurgery as our neurosciences. Therefore, we are able to flex up and down the number of beds that neurology requires. If a bed is required for a patient, he or she will get a bed. We have not turned away any patients in that regard.

With that principle — it was a modernisation and efficiency process, and, in fact, there was an improvement rather than a diminution of services to the other trusts — we did not see the need to consult. We told the trusts that they would continue to get at least the same level of service, if not more. As I mentioned earlier, when the issue broke in the public domain and concern was expressed, I phoned all the individual chief executives in the other trusts to assure them that they would not get a diminution in service and, if the neurological consultants in their own hospitals said that there had been a reduction in service or that there had been a reduced service, they were to come back to me, and we would look into the matter. That has not happened, due to the fact that we have been able to treat more patients and have continued to provide the level of service that we provided previously.

I want to give some further context. People view beds as capacity and as an indication that we can treat more patients: they are an inventory. For us, capacity is the skills of the people who deliver the care and the way in which they work. If people can work in a better way that delivers the same or more care with fewer beds, that is the right thing for us to do for the modernisation of our service.

The Chairperson:

That would all sound wonderful if a letter had not been leaked representing consultants with a century of experience in that field stating that everything that you have just said is nonsense. The Committee was not meant to see that letter, but we did. It was extremely informative, and I thought that it was so important that I read most of it into the record in the Assembly so that people knew exactly what was going on. The people who are authorities on the issue say that it is the wrong decision. If patients and the five main charities that represent most of the patients in neurology settings say that it is the wrong decision, why are we sceptical about what you say?

Mr C Donaghy:

Consultants are now intimately involved in the modernisation group in progressing the changes, and the vast majority of them are on board. I have met and reassured Patricia Gordon, who chairs the coalition of voluntary organisations, and we are meeting again in a few weeks' time so that I can give a further reassurance about how the service is being delivered. I am not sure whether Patricia has subsequently been in contact with the Committee. However, after the initial meeting, each of the voluntary organisations was reassured by the information that I have just given the Committee and which I was able to give them at that time.

The Chairperson:

The last time that I met Patricia was here at Stormont when I was wearing a ridiculous-looking Santa Claus hat. She was most unhappy with what was going on, and I was very unhappy with the subsequent photographs that were published, but that is a different issue. In hindsight, Colm, — I am going to bring Sean in here — given that you were servicing such a wide area and bringing patients in from all over Northern Ireland, do you not feel that the consultation with the chief executives should have been done before the decision was made rather than after?

Mr C Donaghy:

Hindsight is a perfect science. If I had known that it would cause such public furore, certainly I would have done that. For the reasons that I stated, the view was that the change would not reduce the level of service provided to the other trusts and the clinicians in those trusts. Therefore, I did not believe that the chief executives would become concerned. As there was no reduction in the service, I did not believe that there was a need to consult those chief executives. I want to set that in the context that we make operational decisions about the delivery of service every day. Those decisions mean that we deliver the service in an improved and efficient way. When I heard the public furore, I phoned the individual chief executives.

The Chairperson:

You phoned your brother in the Northern Trust. Sean, has the Northern Trust seen any changes in the Belfast Trust's delivery of service in this important field?

Mr S Donaghy:

From my perspective, the key thing is that the clinicians who rely on the service have not expressed concern. There has been no indication that they have had difficulty accessing the service when they need to. The public furore, which was kicked up by the press reports, led to some anxiety. The neurologist on whom the Northern Trust relies for advice, and whom we employ directly, was not party to the letter to which you referred. He did not sign any formal statement of concern. Since that time, no concern has been drawn to my attention about the service being anything other than what it needs to be when a patient admission is required.

The Chairperson:

Does any trust, other than the Belfast Trust, provide a regional service? I was trying to think of one, but I could not.

Mr C Donaghy:

Some do, I think.

Mr S Donaghy:

All services that sit on the periphery of one trust or another will find that there is crossover between the two.

The Chairperson:

The Belfast Trust is unique in that it provides a range of services that the other trusts do not. There is a concentration in the City and the Royal for specific issues. Would you accept that the best protocol for the future would be for each chief executive of the four trusts to be consulted, say, 30 days in advance of any change being made?

Mr S Donaghy:

If dips in confidence are expected as a result, it is helpful to alert all parties. It is not always easy to see that in advance. If we have some rubric in respect of changing something in an area close to Belfast or on the borders of the Southern Trust, which binds us to checking that everyone is happy with everything that we are doing beforehand, we will not be able to respond to the context and the scale of the resource constraints that we will face. We need to be able to flex services to meet the demands on them. If there is a dip in confidence, clinicians and senior management should, of course, have an opportunity to be confident about the service. However, it is not always easy to predict perfectly in advance of when that may happen.

Dr McCormick:

I will come in on the issue of protocols and requirements. There are clear obligations for all the organisations. Those obligations are fundamentally satisfactory. I support the broad approach that Colm described, because it fits in with the requirements.

The Health and Social Care (Reform) Act (Northern Ireland) 2009, which completed the review of public administration, places specific obligations on all the organisations, including the trusts, to draw up consultation schemes. In other words, organisations have to set out, in advance, the way in which they will consult when that is appropriate. Some of it is quite old, but there is also clear guidance about the nature of the issues on which trusts are obliged to consult.

The point is exactly as Colm put it: if there is a change in access or the service experience provided, there is an obligation to consult. As Colm said, what went on in neurology did not have that effect. On the contrary, as his stats indicate, there was ongoing service improvement. As is the case with the other issues that we talked about earlier, we obviously have to respond properly, openly and transparently once a concern arises. We accept that entirely. Perhaps part of how we follow that up is to ensure that care and attention is given to the criteria for consultation and the nature of processes.

The 2009 Act already places statutory obligations on every organisation to consult. There are also well-known obligations to consult in respect of equality impact and disability. A framework of protocols exists. That is why the organisations have a systematic, well-managed approach to that aspect. The Committee can, and should, have full confidence in that. If that approach is supplemented by ongoing awareness and sensitivity, that is fine. Sean's point is very important: there will be many requirements for change in the forthcoming period. We need to manage that process faithfully and sensibly in the interests of service users.

The Chairperson:

Were the consultants brought into a room and told that under no circumstances were they to speak to any charitable group, politician or the press?

Mr C Donaghy:

No. I know that there was a report that the trust had attempted to muzzle the consultants, but that was entirely untrue. Our medical director reacted to a request to meet the consultants, which he did. However, for some reason, that was characterised in the press. In fact, we have correspondence from the consultants themselves saying how positive that meeting was. It was not in any way to muzzle the consultants.

The Chairperson:

Were they told at that meeting that they were not to talk to any charitable group, politician or the press?

Mr C Donaghy:

No, they were not.

The Chairperson:

I have to say that I am getting a different message, so that is interesting.

Mr C Donaghy:

Do you mean that you have heard that they were instructed?

The Chairperson:

Yes.

Mr C Donaghy:

All that I can say is: not that I am aware of.

Dr Deeny:

This is of interest to me as well, as I have used the service down the years. This story about the regional service also broke after information was leaked to the media. We did not know about it. Sean, you mentioned that the neurologist in the Northern Trust did not put his name to the letter. However, do you know how many consultant neurologists did?

Mr S Donaghy:

I am not familiar with the letter, so I am not aware of that.

The Chairperson:

I think that it was around eight or nine.

Mr C Donaghy:

I think that it was the eight in the Belfast Trust.

Dr Deeny:

We know that there are more.

The consultant neurologist who came here was quite brave, and we were delighted to have him here to hear his views. I completely take on board the fact that many people who receive medical or surgical treatment are outpatients not inpatients, and that is the way that things are going in the Health Service. However, that consultant said that — this shocked me a bit — there are roughly 16 neurological beds to 16 whole-time equivalent consultant neurologists, which is one bed each in Northern Ireland. However, those beds are not just needed for treatment but for diagnosis. Other people and I are aware of individuals with conditions such as intractable epilepsy and MS who need to be admitted for scans before they can start their treatment. Inpatient beds are still, therefore, needed. I remember the consultant saying that he was worried and concerned that the beds would be filled by only acutely ill patients and that they would not

have enough room to bring in other patients. That was what he said.

I want to ask you about another point that I brought up that day too. I do not like making predictions, particularly about the future. However, as a doctor, I am concerned about this, and when I mentioned it to the consultant, he agreed with me. If our consultant neurologists — you are telling me that things have changed, and I hope that that is the case and that our patients will not suffer —feel that they do not have the services and beds to do the work that they want to do, there is a danger that we could lose newly qualified consultant neurologists from these shores. In the future, they may leave Northern Ireland and move to England or across the Atlantic because they feel that they are better provided for there. We have the same concern about all professions. We saw that happening during the Troubles when we lost so many professional people. I do not want to see that happen to the medical profession because of a lack of services.

Mr C Donaghy:

I will deal with that point first. We had an interesting conversation with the voluntary organisations. They had gone and accessed the number of beds in other equivalent-sized hospitals for similar-sized populations and found that those hospitals had even fewer beds than the reduced number of beds in the Royal. They were asking us whether we were going to go as far as other hospital systems in reducing the number of beds. I want to say to the Committee that beds are not capacity in our system.

Dr Deeny:

I have just one point, Colm. The consultant who was here that day spoke about that issue. He said that that was one reason why the Royal was being compared with hospitals from across the water. However, the Belfast Trust was not comparing like with like, because, unlike other hospitals, the Royal deals with a whole population of almost 1·8 million.

Mr C Donaghy:

Yes, I accept that. Kieran, some of the tertiary hospitals in England deal with populations of four million or five million. The other aspect is stroke care, which was mentioned at your Committee meeting at the time. I reassure the Committee that the capacity for stroke care has not been adversely affected. In fact, we have additional beds. We will also have further beds for acute stroke care from next month.

I will return to my earlier point: no one who requires admission has been refused admission. The service is still available. The inpatient service is still available if people require admission. Although we have reduced the number of neurology beds from 23 to 16, at times, we have up to 24 people with neurological conditions in our neurosciences services. However, we are able to accommodate them in the overall neurosciences bed complement for neurosurgery and neurology. People have not been refused a bed.

Dr Deeny:

Are neurosurgeons happy with the fact that their beds could be used for neurology patients if the need arises?

Mr C Donaghy:

They are.

The Chairperson:

We would like to get finished by 6.00 pm. I will ask Tommy and Paul to ask one question each and for the panel to give a combined answer. We are seven hours into the Committee meeting, which is short by our standards. Paul's question, Tommy's question, combined answer and, I hope, home for Christmas.

Mr Girvan:

You are batting very well, Colm. Was the decision made by management or clinicians?

Mr Gallagher:

Are the patients in that accommodation in mixed-sex wards? Is the situation regarding the accommodation of neurology patients still under review?

Mr C Donaghy:

The decision to go on a path of modernisation was taken by management. At the time, management engaged with consultants about the rationale of how that would be taken forward. Modernisation is still ongoing. There are more improvements that we can make in the treatment that we provide for people with neurological conditions. We are still on that continuous improvement path. The consultants are involved in that process, but the original decision —

Mr Girvan:

They are involved now, but, prior to this, they were not.

Mr C Donaghy:

They were engaged prior to this. The consultants were engaged in the process. It is fair to say that they did not agree with all the proposals, but they were engaged in the process. The consultants are intimately involved in modernisation.

To answer Tommy's question: the wards are mixed-sex wards, but there are separate bays.

The Chairperson:

I would expect that there are separate beds. *[Laughter.]*

Mr C Donaghy:

Sorry, I said "bays". There are separate bays in the ward. We ensure that those are separated by gender as far as possible.

Mr Gallagher:

Is the situation still under review?

Mr C Donaghy:

It is constantly under review, Tommy, as part of the continuous improvement process.

The Chairperson:

Thank you. The Committee Clerk's hearing is much better than mine. I picked you up totally wrongly there. I also said Appletree House, at one stage, rather than Cherry Tree House. I got the wrong fruit. There is an Appletree House in Downpatrick, which is perhaps how I got confused.

Thank you for what has been a marathon session, perhaps one of the longest in the Committee's history. The meeting has clarified an awful lot of issues. We may need to learn some system whereby issues no longer bite us on the front page of a newspaper. We should be able to shrug our shoulders and say that we knew all about that and that there is no issue. Our only procedural difficulty is that things have been kept from us. However, many, many issues

have been clarified and dealt with. We are extremely grateful to you for your time, particularly given the fact that you had only a couple of hours' notice that these issues would arise. That is much appreciated, although I suspect that, even yesterday, you thought that it would come up.