Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Radiology Services:
Belfast Trust and Southern Trust

22 February 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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

Witnesses:

Mr Colm Donaghy	)	Belfast Health and Social Care Trust
Mrs Patricia Donnelly	)	
Dr Stephen Hall	)	Southern Health and Social Care Trust
Mrs Mairead McAlinden	)	

The Chairperson (Mr Wells):

I thank the witnesses for attending. From the Belfast Health and Social Care Trust we have Mr Colm Donaghy, the chief executive, and Patricia Donnelly, the director of acute services; from the Southern Health and Social Care Trust we have Mrs Mairead McAlinden, the chief executive, and Dr Stephen Hall, a consultant radiologist.

Some issues overlap, and some are unique to certain trusts. I suggest that we first deal with the general issue of X-rays, how they are dealt with and the protocols and practices, and we then move to the specific issues that have arisen in different trusts.

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

I welcome the opportunity to speak to the Committee and to reassure members and the public that the Belfast Trust does not have an issue with X-rays. When this type of issue is aired in public, many individuals, including patients, become concerned. We have had enquiries from patients who have been concerned. If possible, I want a message to go out from today's meeting that the Belfast Trust does not have a problem with its X-rays, and people may be reassured that, when they attend the Royal Victoria Hospital, they will be treated properly and will get X-rays in a timely way. Those X-rays will always be dealt with properly and according to our guidelines.

Although what I am about to say might anticipate some of what Mairead has to say, it might be useful if I quickly run down the processes and procedures for X-rays. There has been some confusion and discussion in the public about that process.

The reporting arrangements in the Belfast Trust are according to the legal requirements in the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2000 (IR[MER) , which people have heard about, and which require that all ionising radiation examinations are evaluated. Under IR(ME)R, "evaluation" is defined as:

> "interpretation of the outcome and implications of, and of the information resulting from, a medical exposure".

All specialist examinations, excluding plain film radiography and some ultrasound, receive a written report by a consultant radiologist or a radiologist registrar acting under the supervision of a consultant.

In defined clinical areas, and with the prior agreement of the relevant clinical consultant, a number of plain film X-rays are not routinely reported on by a consultant radiologist. That is covered by procedure J of the employers' procedures for the Belfast Trust, as required under IR(ME)R. Urgent plain films are reported within 24 to 48 hours, and non-urgent plain films are normally reported by a radiologist within 28 days.

Plain film reporting was the issue that appeared in the press, so let me add that the areas reported by a radiologist under plain films are those from GPs, A&E, outpatients, inpatients and

pre-assessments. Areas not reported by a radiologist at the Royal Victoria Hospital and Musgrave Park Hospital are orthopaedics/fractures. They are evaluated by a consultant or specialist registrar in orthopaedics or fractures. Intensive care portable chest X-rays are evaluated by a consultant in intensive care medicine. In cardiology, coronary care unit portable chest X-rays are evaluated by a consultant or specialist registrar in coronary care. Inpatient cardio-thoracic surgery chest X-rays are evaluated by a consultant or specialist registrar in cardio-thoracic surgery. At all times, the clinicians outside radiology have access to a radiologist for a second opinion if required. That is always available.

In the Belfast Trust, we have 47 consultant radiologists, and our activity levels per annum in plain film examinations are as follows: we have roughly 265,000 plain films every year; requested specialist examinations, which include MRI, CT and ultrasound, which are all reported, number 120,000.

The Chairperson:

From reading the information kindly provided by the Southern Trust, I see a similar approach to dealing with X-rays. Mairead, perhaps you could come in on Southern Trust's approach to the more general issue before we get down to specific details.

Mrs Mairead McAlinden (Southern Health and Social Care Trust):

I am happy to do so. Thank you for the invitation to address the Committee. Committee members are aware of the recent media coverage of the Southern Trust, and we have provided a full briefing to the Committee on all the related issues. I hope that that has been helpful. As we received media queries, I have also attempted to keep the Committee informed through the Chairperson and the Deputy Chairperson.

We were asked to appear before the Committee today to talk specifically about radiology. I want to set out the position. In the Southern Trust, over 250,000 radiological examinations are performed each year, of which 170,000 are plain film X-rays. Of that total number, around 18% do not receive a radiology report but are always viewed by a senior consultant, with a second opinion being available from the radiology department on request. The areas in which we read and provide radiological reports for X-rays are all GP plain film X-ray requests; all outpatient plain film X-ray requests; all inpatient and A&E chest X-rays; all minor injury plain films; and all under-16 plain film X-ray requests.

Some consultants in the Southern Trust wrote a letter, and I want to take the opportunity to brief the Committee on that. As I have outlined, the radiology department in the Southern Trust does not read all X-rays, and it never did. However, with the introduction of the new information system for X-rays, known as the Northern Ireland picture archive and communication system (NIPACS), we took the opportunity to respond to some issues raised by consultants and responded to a request that we would in future read all X-rays. That decision was taken in April 2010. It created a demand for an additional 32,000 X-rays to be read, and it took some time to put in place the capacity to do so. I fully acknowledge to the Committee that there was some lack of communication to front-line consultants, which resulted in a letter being written to the medical director in May 2010. As a consequence of that, those consultants were given assurances that the chest X-ray films would be read and that it was taking some time to put the system into place. They are happy with the system that is now in place. All issues were addressed through local discussions and our governance arrangements.

In relation to the consultant from the Southern Trust who has made specific allegations, there was clear guidance from the British Medical Association (BMA) in 2009 as to how concerns should be raised. We have internal processes for that, and I regret that, in this instance, all those internal processes were not exhausted.

I am happy to take any detailed questions.

The Chairperson:

Sue has to go to another meeting at 1.00 pm, so I will let her ask her questions directly after I have asked mine. I suggest that we deal with the generalities of how X-rays are treated in Northern Ireland, and I can see a commonality in the approach that both trusts take. I will ask a couple of questions to get the ball rolling.

We heard evidence through the media of the situation in the Erne Hospital in Enniskillen. The policy there is that all X-rays, no matter what type, are referred to a consultant radiologist for examination and notes. However, that seems to be at variance with what is happening in the Southern Trust and in the Belfast Trust. Why is there that disparity between the trusts? I know that that does not happen in all hospitals in the Western Trust: only the Tyrone County Hospital and the Erne Hospital have that policy.

Mr Donaghy:

I think that Patricia and Stephen would both like to answer that question.

Mrs Patricia Donnelly (Belfast Health and Social Care Trust):

I will take the position in the Belfast Trust, which is similar to parts of the Western Trust. In a hospital that does not have much fracture and orthopaedic activity, one is likely to be able to report all those films because they are mainly from GPs, outpatients or an accident and emergency department. In the Belfast Trust, the Mater Hospital and Belfast City Hospital report all plain film X-rays. We are in a similar position to the Erne Hospital. However, I doubt whether a large acute hospital such as Altnagelvin Area Hospital would be able to do that or whether it would be appropriate, because the orthopaedic surgeons will make the reports on the fracture and orthopaedic work.

The Chairperson:

Why do all hospitals not automatically refer all X-rays to a radiologist just as a precaution?

Mrs Donnelly:

It is partly a matter of resource and risk, and I am sure that Stephen will have something to say on that. It would be the view of radiologists and clinicians in the Belfast Trust that the resources that we have should be used on specialist examinations from GPs that might have undifferentiated conditions. All our orthopaedic surgeons are very clear that, as they do the X-rays, they are in a better position to know whether a fracture has moved or whether a hip that they have replaced is in the right place. Therefore, they themselves want to look at the X-rays. They are expert at looking at such X-rays, and they do not require the opinion of a radiologist. Therefore, if that is not where the risks are for patients, we would not want the money spent in that way.

The Chairperson:

Is the situation similar in the Southern Trust?

Dr Stephen Hall (Southern Health and Social Care Trust):

There are similarities. I thank the Committee for allowing me to sit here and, I hope, clarify some aspects of the situation.

With regard to the comments made about the Erne Hospital, one case does not fit all. The Erne Hospital has a very different profile to the hospital in which we work. It has different staffing levels and, as was said, it has a different profile of examinations. We are not in the position now of arguing the priorities or the safety risks of examinations such as chest X-rays. We have put procedures in place, and we are up to date with all our chest X-rays in the trust, and that includes intensive care and cardiology.

However, there are areas in which, with limited resources, it seems appropriate and safe for a non-radiologist to be responsible for an IR(ME)R-type report. In our trust, that does not currently include orthopaedics, but orthopaedic clinicians do not want my opinion on a post-operative hip because they think that their opinion is satisfactory, and I agree with them. The logical way forward is not for me to spend time reporting examinations that a clinician, who can conform to IR(ME)R guidelines, does not want to be reported.

The Chairperson:

Concern was expressed that, sometimes, decisions do not require a radiologist and that the person analysing the film could be a junior doctor or someone of limited experience. Are there any protocols or rules to ensure that someone of sufficient standing and experience is looking at the films — do you call them films?

Dr Hall:

We call them images or films.

The Chairperson:

Obviously, there would be a worry that somebody on the ward may be given an image and that he or she may not have the experience required to analyse it properly and may come up with the wrong diagnosis. What is the minimum level of experience for someone looking at an image?

Dr Hall:

Our institution took on board the potential risk for chest X-rays being unreported outside the radiology department, and we have progressed that 100%. We did that before the document that was disclosed recently was sent to the medical director. As of this morning, we are up to date within 24 hours rather than within 28 days. That is an advance of which I fully approve.

In our system, we expect that a minimum of a staff grade or a consultant would view and document a report. That is the position in our accident and emergency department where, twice daily, as I think the briefing paper states, invariably a consultant, but sometimes a staff grade who is very experienced in A&E work, documents a report on those images.

The Chairperson:

Is it the same in the Belfast Trust?

Mrs Donnelly:

Yes; it would be a staff grade, senior registrar or consultant.

Ms S Ramsey:

I apologise that I have to leave early. It is important to recognise the fact that you have important jobs. We sometimes arrive at these positions through a lack of information. We also have a job to do in scrutinising and ensuring that things are done properly. I am sure that you do not want to sit here any more than we want to hold an additional meeting, so it is important that that fractured relationship — there is no X-ray involved to see that — is sorted out.

I believe that the media have a responsibility not only to report stories but to ensure that the reporting is right. It is now too easy to blame the media and to say that they are hyping up the situation. The Minister accepts the fact that there is a problem. The story broke, and some misinformation was involved. The Minister accepts that there is a problem, which is why the Regulation and Quality Improvement Authority (RQIA) is coming in. We need to move away from the blame game, and accept it is done.

Are the IR1 forms the same for all members of staff, whether a domestic worker or a consultant?

Dr Hall:

Yes, they are.

Mrs McAlinden:

It should be made clear that the priority and urgency of any issues raised are graded.

Ms S Ramsey:

How are they graded?

Mrs McAlinden:

It — sorry; go ahead, Stephen.

Dr Hall:

I am sorry; it is not good to interrupt my chief executive. We use IR1 forms in the radiology directorate within the whole of the Southern Trust. We have propagated it, publicised it and had meetings with all levels of staff about it. It applies to every level of staff in the trust. Every IR1 form is scrutinised weekly by a manager, a radiographer and a clinical director in radiology. They are graded as to whether they refer to someone who tripped over an X-ray folder that was on the floor or involved a potential error in interpretation. They are graded and put through the governance process weekly.

Ms S Ramsey:

If someone from domestic or catering fills in one of those forms, does it not go into the central pot? Are you saying that it is screened out in their department?

Dr Hall:

Each directorate will have someone who is responsible for collating and collecting forms. That is advertised on the intranet so that if someone is working in a certain system, he or she knows who to send the form to.

Ms S Ramsey:

That is interesting. At a general level, when members ask such questions, the Department tells us that that information is not held centrally. If I were to ask the Southern Trust how many of those forms had been filled in and if they could be broken down by departments, that information should be readily available, given that you say that they are screened out by a manager.

Mrs McAlinden:

The difficulty is that we are currently using a manual system, and the results are then typed into a computerised system. We have plans in the Southern Trust for a Web-based system, and a pilot scheme is ready to start whereby people can type their IR1 forms directly into a system.

Ms S Ramsey:

You can appreciate our concern when we are told that we cannot access that data. I also appreciate the fact that those are screened out by a manager.

It would be useful if we would get more information on the risks raised by clinical people and how you have implemented that. I do not know if the following helps. I am aware, especially in the Southern Trust, of patients waiting for follow-up appointments whose notifications are posted out on a Friday evening with a 24p second-class stamp on them. Those appointments are not received on time because they are sitting in a post office. Someone may have an appointment for a Tuesday but does not receive the letter informing them of that until a Wednesday. That may add to the pressure. The issue of appointment letters needs to be taken on board.

We need more information on your use of the independent sector to address the issue. What is this company, and what is the cost?

Mrs McAlinden:

Is this on the X-ray issue?

Ms S Ramsey:

Yes, it is.

Mrs McAlinden:

We have an arrangement with an independent sector company that is UK-based and that uses consultants who work in the National Health Service (NHS), so they are completely used to our system. That company will help us until the end of March, at a cost of £25,000. Until we have recurring resources to manage the system in exactly the manner that Stephen described of its being responsive and consistent, we will continue with that arrangement. We will send out up to 1,000 films to be read each month by that independent sector company for at least six months. We estimate the maximum cost to be in the region of £30,000.

Dr Hall:

Let me clarify: as an NHS consultant, I have always had concerns about using the independent sector for whatever process. I personally went through all the CVs of the people involved in the

independent company, and I had copies — I did not keep them — of their up-to-date appraisal within the NHS system. So I am happy that those people work in the NHS and should be competent to report the images that are sent to them. However, there is always risk when evaluation is performed outside one's total control, but an audit process will be put in place.

Ms S Ramsey:

Can we be assured that those consultants will not be doing this job on Health Service time? They are being paid additional money for it.

Dr Hall:

We cannot tell that, but I would hope that they would not be doing it within their NHS job plans. Most of them are from across the water.

The Chairperson:

Sam, I said that I would let you in, but Alex must leave soon for a meeting with the Minister at 1.00 pm. I will give Sam extra compensatory time.

Mr Gardiner:

That is quite all right.

Mr Easton:

Your briefing paper states that there were potential risks to patients in reporting arrangements. I take it that some X-rays were not reported on? Were any patients recalled because of their condition when their X-rays were examined?

At some stage, a consultant who is not a radiologist will see an image. Are you satisfied that such consultants will be trained to the same standard as a radiologist? Are they not so trained?

Why do you think that a member of staff felt the need to make an issue about this if no significant problems were identified?

The Chairperson:

Alex, are your questions for the Southern Trust or the Belfast Trust?

Mr Easton:

They are for the Southern Trust.

Mrs McAlinden:

I will ask Stephen Hall to answer the first two of your questions, Alex. I will take the third. Stephen will address the issue of whether consultants who look at X-rays that are not reported by radiology are trained to a sufficient standard.

Dr Hall:

Under the current process, I am confident that clinicians who are recording reports under IR(ME)R guidelines are competent to assess those images and put down reports on those examinations. If there are issues with which they do not feel competent, there is a process in place whereby they can directly get that reported. That facility is there within secondary care. In primary care, there is no issue because we have 100% reporting.

You asked whether, when we got time to catch up on ourselves, we found any significant incidents. When we got to that stage, we put in place an active process for prioritising IR1-type issues, and there were none, I am very glad to say.

Mrs McAlinden:

Alex asked why the consultant raised concerns publicly. My apologies, but I do not know who the consultant is, and I cannot comment on that person's motivations for doing so.

Mr Easton:

It is a strange one.

Mr Gardiner:

First, I declare an interest, as Craigavon Area Hospital is in my constituency. I welcome Mrs McAlinden and Mr Donaghy, who is a former chief executive of the Southern Trust. Not so long ago, the Committee visited the orthopaedic centre at Craigavon Area Hospital, which is state of the art and the best in Europe. We could see for ourselves how busy it was. All the theatres were in use, and we came away from the visit feeling very pleased. As an MLA for the area, I have every confidence in the work that is going on there.

Is the Southern Trust doing anything in radiography that differs from any other hospitals in Northern Ireland? Why has there been a blip? I am glad that it has happened, because the problem has come to light, which means that it can be sorted out and the situation improved.

Mrs McAlinden:

We outlined that there are some differences in X-ray practice across Northern Ireland. We welcome the RQIA review, which will build public confidence that the current systems are safe. I am confident that that will be the case. The Southern Trust takes a risk-managed approach. The X-rays that are not reported by a consultant radiologist are low risk in nature. I will ask Dr Hall to provide additional assurance.

Dr Hall:

As outlined in our briefing paper, we report all examinations that are considered high risk. The highest risk examination in plain radiography would have to be chest X-rays. Prior to April 2010, those were reported on request. Now they are reported in totality by a consultant radiologist. I am happy that the process is in place, and my fellow associate medical directors met last Wednesday, and they also provided assurances that they were happy with the change in process. I also welcome the RQIA review of radiology and radiographic services in the Province. The RQIA has visited Daisy Hill Hospital, which runs a similar system, and was happy that the processes in place were safe at the time of the inspection in December 2010.

Speaking personally, I have to say that I do not think that one model fits all hospitals, so if the RQIA comes up with a gold standard, there will be a pound sign attached to that. We all know about the financial constraints under which we operate at present, and, within those constraints, I am confident that our services are safe. We have a robust governance process that is updated constantly. There was a recent review of governance, and I stand over that with great confidence.

Mr Gardiner:

Is there a time limit from the time that an X-ray is taken to the result being fed back to an individual?

Dr Hall:

A time limit is applied to specialist examinations, for which there is a diagnostic reporting turnaround time. If urgent, the turnaround time is 48 hours, which includes weekends. I have my

own views on that, because it means that some patients do not get appointments for Thursdays or Fridays. If an urgent report was done by the following Monday, that would break the 48-hour limit. There are, therefore, oddities in the system, but we have diagnostic reporting turnaround times for specialist images, which are broken down into urgent and non-urgent. We stick to a 28-day turnaround time for plain radiography. Let it be said that, within the managed network in which we have an agreement with our primary care colleagues, we have a priority reporting service and an e-mail service for priority images with a turnaround time of 24 hours. The target for the remainder of primary care is 95% within five working days. We achieve that sometimes, but we are not far away from it.

Dr Deeny:

You are welcome, ladies and gentlemen. My first question is for the Southern Trust. How many consultants put their name to the letter? Are you saying that all those consultants, including the consultant who went public, are now happy with the current situation?

Mrs McAlinden:

We have to be very precise about this issue. I do not know who the consultant is who went public, so I cannot comment on whether that individual is happy. The letter that the consultants signed was sent in May 2010. I have spoken to our associate medical directors in medicine and surgery, who represent the consultants at senior medical level. Dr Hall and I met them last Wednesday night at 5.00 pm, and we asked them whether they were content with the current arrangements. They said that they were, but they wanted to know how they could more easily get a second opinion by using a computer system. Dr Hall has agreed to look at that technical change. The reassurance that I received from my senior doctors at 5.00 pm last Wednesday was that they are content with the current process.

Dr Deeny:

Is that the department of radiology and your consultant radiologists?

Mrs McAlinden:

Dr Hall represents consultant radiologists in the trust as he is our associate medical director.

Dr Hall:

The letter came when we were progressing change in the plain radiography service in the trust.

The letter was signed by clinicians from the medical fraternity, and a further letter came at a similar time from the accident and emergency staff. Their prime concern was about chest X-ray reporting, which we were already actioning but had not actioned. There was a concern because it is a very specialist process, although we have respiratory physicians who are very competent. The chest X-ray process was the prime concern of inpatients and the accident and emergency staff.

Having got that out of the way, and as of this morning, we are 100% up to date. We do not have a waiting time for chest X-rays in the system. You asked whether all those consultants are happy. They have concerns about other inpatient images. We highlighted the fact that if there are any concerns, there will be a reporting process that can be actioned. We are not formally reporting those at present, but the vast majority of those non-chest X-ray inpatient images are through the orthopaedic and traumatology service, which will not look for a report. We are in a position to report all those other inpatient X-rays if they are requested, but we do not have in place a formal process because we do not have the ability to separate the trauma ones from the others. We will look at the number of those next. If any of my colleagues in the medical fraternity has a grievance, it will be that that small number of images must be requested rather than being formally reported at the outset.

The representative of the A&E staff spoke to all the consultants before our meeting last Wednesday and reassured Mairead and me that they were happy with the process that is in place at the moment.

Dr Deeny:

Mairead, you said that 18% are not reported by radiologists. Stephen, you know as well as I do that some physicians are very good at reading X-rays. I know that some physicians may not be confident. If that is the case, they can request a second opinion, as you mentioned. Some doctors think that they can do everything.

I would have seen the radiology department as a safety net. Why do we have a radiology department in the first place? Consultant physicians may think that they can read them all, as some do — I am sure that some GPs also think that they can do everything — but we need a safety net so that nothing sinister is missed. Surely that is in place?

I have one last question that I will direct at Mairead, and then I will keep quiet. I refer to Alex's question. You do not know the consultant who came forward. His voice was disguised. Mairead mentioned internal processes, and I have been concerned about that for years. I have received hundreds of letters and calls since I was first elected from people who feel that they cannot use the internal processes. Can you explain to me what actually happens? When I say that I have received hundreds of phone calls and letters, I am telling the truth. However, people will not come forward and will not give me their names because they are frightened. Often the complaint is about how matters are managed.

Every one of us here will agree that a healthy Health Service needs a healthy whistle-blowing policy. It has to be a part of the Health Service. Whistle-blowing may not be a nice term, but we need it. If something is wrong, people should feel confident and protected so that they can come forward and question a person's ability to practise, standard of hygiene or whatever.

I have had concerns for years that our internal processes are not working. That is what I am asking you. What is the internal process? For example, if a patient in our practice had a complaint about me — I am accountable to the General Medical Council (GMC) — it makes no sense for him or her to speak to me about it. That person would need to have some avenue. I put it to you that that is why this consultant went on the radio. He had no other way to have his complaint dealt with, and he felt that it would not be dealt with by the current internal process. The problem exists not only in the Southern Trust but across the Health Service in Northern Ireland.

Mrs McAlinden:

There are two important questions to answer. What makes up the 18% of plain film X-rays that we do not read? In general terms, it is as Stephen outlined. They are the X-rays that A&E consultants are content to look at, and they are in other areas of our work in which we received assurances that people are content to deal with them.

Let us imagine the number of people who come through our A&E department, which is more than 200 a day, and members will understand that, when we talk to A&E consultants and they say that they are content to look at non-chest X-rays and feel confident to do that, that makes up a significant proportion of the 18% that we do not read.

In relation to the consultant who spoke publicly, it is important that we treat that consultant with respect. He has important work to do in our hospital. For that reason, I have not sought to know his name.

You are right, Kieran, when you say that whistle-blowers play an important part in our system. There are a number of mechanisms in the Southern Trust, and within all trusts, by which people can legitimately raise concerns. They include everything from the IR1 process, which is a way of logging a concern, to governance meetings, to the important senior medical structure that exists in our trust. There are clinical directors, associate medical directors and a medical director. In addition, there is an independent process in the trust, which is our whistle-blowing policy, which makes it clear that a person who has concerns can go to a non-executive director on our board — in our case, the chairman — and speak independently and confidentially to that person. Our non-executive directors are not operational directors in the trust. They have an important role to play on our trust board, to which they bring independence and rigour. Therefore, under our whistle-blowing policy, the ability to go to that nominated person is an important safety guard in the system.

The Southern Trust's whistle-blowing policy is used. I have received a number of letters, some signed and some anonymous. They are fully investigated. In this case, that procedure was not used. However, I repeat that we must treat this consultant with respect. I am sure that he had his own reasons for doing what he did. We have to move forward from this.

Dr Deeny:

I have one last comment. Some years ago, I had one case, but it was not in your trust. The person who came to me did not want their name to be revealed.

The person had a concern, raised it and was advised to go to the line manager, but the concern was about that line manager. That is the problem. Management has to be accountable. We are accountable to our professional bodies. If a nurse makes a mistake or if I make a mistake, we are, quite rightly, reported. We all make mistakes, and there are things that we could do better. We all know that, and I am the first to put my hand up. However, there has to be some accountability that is visible to the public. What would happen, for example, in the Southern Trust if someone was concerned that his or her line manager was putting patients' health at risk?

Mrs McAlinden:

Individuals can explore a number of avenues. One is to go to our HR department and raise the concern that way, or they can go to their line manager's next in command. They can raise their concerns in several ways. They can do so directly through the personnel department with their staff-side organisation, which is another important mechanism. I meet staff-side representatives once a month. Several mechanisms within the organisation ensure that people have the opportunity to raise concerns.

Dr Deeny:

That is in-house, but let us say that a person still has major concerns that a patient's health or life is at risk. What avenue is left open to them if an individual feels that the complaint has not been dealt with properly or addressed adequately in-house by the internal processes that you described?

Mrs McAlinden:

The GMC advice to doctors and others makes it clear that any clinician who feels that he or she has fully exhausted the internal processes has a right and duty to speak out publicly. One can understand, absolutely in this case, how a doctor could feel that he or she had the right and the responsibility to do that.

The Chairperson:

I remind members that questions can be put to the Southern Trust and to the Belfast Trust. I think that Colm is feeling a bit isolated and lonely because no one is asking him any questions.

Mr Donaghy:

Not at all, Chairperson.

The Chairperson:

At the moment, we are talking about the general issue of X-rays, not about specific allegations.

Mr Callaghan:

I certainly would not like to be accused of bias in any sense, so my questions will generally be addressed to both trusts. The Minister's statement to the Assembly rightly referred to staff being stretched to their limits. I want to tackle some of the points that Sue made from a different angle.

At no point in our deliberations are we trying to engage in the vilification of staff or in witch-hunts. We are trying to ensure that front-line staff have the support and respect that they deserve to deliver an important service to the public, and that goes for all the managers in the system as well.

I want to pick up on the whistle-blowing point for a wee second. It strikes me that, in hierarchical organisations, which the health trusts are, whether we like it or not, there will always be a difficulty with people going above their line manager if their issue is with that line manager. Depending on the personalities and relationships in play, that is not necessarily an easy thing to do. What safeguards are in place in either of the trusts? You may answer for your individual trust or for the service. How are people who come forward to blow the whistle protected from potential victimisation, either overt or subtle, down the line?

Mrs McAlinden:

The Southern Trust has 13,000 staff, and a number of staff raise concerns about working conditions, relationships with their team or with management or whatever. The proper way in which those concerns are dealt with is through the involvement of our HR department. They are entitled to, and do, engage with their staff-side representatives, and there are processes in place for that. It is explicit in our whistle-blowing policy that any member of staff has the right to raise concerns, will be protected in raising those concerns and, as you said, will not be discriminated against afterwards. I am happy to give any further details that the Committee might require, including making our whistle-blowing policy available.

The Chairperson:

Colm, is that the same policy as you have in the Belfast Trust?

Dr Donaghy:

It is the same. I want to underscore that by saying that there are other policies in place in the trust to which people have recourse. We have, for example, a bullying and harassment policy that we take very seriously. If a member of staff has been part of a whistle-blowing process, we take that seriously, investigate it carefully and protect the individual concerned. That is built into our whistle-blowing policy.

I accept entirely what you said, Pól. It is difficult for someone to complain, or bring forward

an issue, about his or her line manager, and it is a courageous thing to do. In that context, the confidentiality of that individual is preserved at all times, as it is confidential information. However, I assure you that an investigation takes place. If there is a serious allegation against a line manager, an independent team is put in place to carry out a detailed investigation into the issues. Obviously, in that and in any context, it is a matter of establishing the facts.

Not that long ago, Chairman, I appeared before you as the result of a consultant's whistle-blowing. From a clinical point of view, our procedure is to maintain high professional standards, which involves a non-executive board member of our organisation taking part in the investigation and in the ongoing process to ensure that the process is independent. At all times, we seek to ensure that the individual who raised the issue is protected and that the serious allegations are thoroughly investigated.

Mr Callaghan:

In the past full year for which statistics are available, how many times have people blown the whistle in your respective trusts? If whistle-blowing involves reporting on perceived deficiencies or improper practice by a line manager, I cannot imagine that it would happen every day.

Mr Donaghy:

It is not a frequent occurrence.

Mr Callaghan:

Can you give us a ballpark figure? I know that the recent incident of whistle-blowing did not happen in your trust, Colm, although you are aware of it. Mairead's trust has expressed disappointment with the consultant concerned. Presumably, you have a sense of how often the whistle-blowing policy is invoked?

Mrs McAlinden:

I, personally, receive letters of a whistle-blowing nature. I do not want to give specific examples, but, in the past year, I can safely say that I have received fewer than 10. I send them to my HR department to be fully investigated in the way that Colm described. Sometimes, those letters are anonymous, and the allegations are not specific enough to allow us to fully investigate them. Therefore, it is difficult to be able to go back to the member of staff to tell him or her what action we have taken as a consequence of the letter.

Mr Callaghan:

I understand entirely. I am sure that other members have been in the same position. Even in the short time that I have been an MLA, and previously in other roles, I have seen correspondence purporting to come from staff that does not give much information to go on. However, I do not think that we are necessarily talking about that. Is a whistle-blowing incident not automatically reported to the trust? Is it a standing item on the trusts' agendas, or is there a quarterly report to the board of the trust?

Mr Donaghy:

I will answer for the Belfast Trust. There is no quarterly report to the trust board in Belfast about whistle-blowing. However, we would be able to determine the number of ongoing cases and investigations in our organisation that could be down to a whistle-blowing issue.

Mrs McAlinden:

The added assurance that I can give is that any whistle-blowing investigation that revealed issues of a serious nature would be brought to the attention of our trust board.

Mr Callaghan:

The Minister's statement focused on two issues. One issue was X-rays not being reported on by appropriately trained staff, and the other was that outpatient reviews were being arranged on the basis of patients' surnames.

The Chairperson:

Which trust are we talking about?

Mr Callaghan:

This is for the Southern Trust. After meeting Mairead and John Compton, the Minister said that he was happy that those issues were not substantiated. However, there may be other issues out there that the Committee might want to consider, which are not specifically encapsulated within those two factors. I notice that the chief executive is smiling.

I have not heard anything during today's meeting or from the media previously, about whether an assessment has been made of the capacity of radiology in either trust. When Professor Gishen

went into the Western Trust, he assessed what was there, what should have been there and what ideally ought to be there in a facility such as Altnagelvin Area Hospital. I have heard nothing of similar assessments in Craigavon Area Hospital, the Royal Victoria Hospital or any other major acute hospital being conducted by an external organisation, a person such as Professor Gishen or internally within the trust. What exactly is the capacity during the period under our consideration? What has the capacity been previously, and what is it now? Has there been an evaluation according to, say, the Royal College of Radiologists, as to what the capacity should be?

A further important and related question is whether issues have been raised internally about capacity. If so, how was that addressed by trust management internally and with the board and Department?

Mrs McAlinden:

I assure you that we regularly review our demand and capacity. We have an increasing demand for X-ray provision. We are seeing more patients, including outpatients, and carrying out more complex investigations than ever before. A demand/capacity analysis of radiology has been and is being conducted within the trust. We carry out such analyses regularly, because they form the bases of business cases for the Health and Social Care Board when we bid for additional funding. As part of a demand/capacity analysis, we are rightfully asked to scrutinise our current practice to make sure that we are being as efficient as we can before submitting a bid for funding to the board. You will, of course, understand that funds are limited and that strong cases have to be put forward. If the question is whether we regularly review our demand and capacity across a range of services, the answer is yes.

Mr Callaghan:

Today, we are talking specifically about radiology. We cannot get into everything else, because we would be here until after the mandate has expired.

Mrs McAlinden:

I will ask Dr Hall to answer specifically about radiology.

Dr Hall:

The question on demand and capacity is a current one, and I can answer it clearly. We are in the

process, as are many trusts, of upgrading our prospective job plans for all consultant staff. As part of that process, which finished in November or December of last year, our performance and planning department produced full documentation with a combination of Royal College guidelines for work practice. Also, and more importantly, our former service delivery unit produced a document on what one would expect a consultant radiologist to do in the course of a four-hour programmed activity (PA).

When we used that data to calculate how many radiologists we needed to function, there was a significant gap between what we had and what we needed. We have attempted to address that in several ways, all of which have safety as the priority. One way is through additionality, whereby we get our own consultants to do additional work. We have expanded and continue to expand the skill mix in radiology. The concept of skill mix is pertinent to this conversation. It involves the training, under Royal College and Society of Radiographers guidelines and with proper mentorship procedures, of skill mix radiographers to carry out additional reporting, thereby leaving a little more slack in what a specialist radiologist is required to report on.

Although we have progressed all of those areas, we are fighting a difficult battle. Within a radiology department, there is virtually no ability to restrict numbers. The workload, therefore, continually rises. We have funded radiologists who have not been appointed because of the lack of radiologists in Northern Ireland's system, so funding is not necessarily the sole issue. However, if we needed the number of radiologists that our capacity suggests, there would, at present, be a lack of funding. All of those issues compound. We have explored all avenues, an obvious one of which is to see whether, within the bounds of safety, we can have examinations that are non-radiology reported. That is where the situation lies now.

Mr Callaghan:

What are the quantums, Dr Hall? Members will recall that when the Western Trust gave evidence, we found out that it had seven radiologists in post at the peak of its backlog. The staff cohort for the department was supposed to be 13·5. When Professor Gishen from Imperial College gave evidence, he said that the cohort, according to good practice, ought to be about 17. Will you give us a sense of the numbers in Craigavon? I would like the same information from the Belfast Trust.

Dr Hall:

At the moment, we have 12 radiologists based on the Craigavon site predominantly, although we mix and match and try to swap staff geographically. NIPACS means that the images are available no matter what part of the trust one is in. We have two permanent radiologists and one locum radiologist on the Daisy Hill site, giving us a total of 16. Staff take maternity leave, sick leave and all the usual reasons for absence apply. Just to keep pace, and even allowing for some reporting by non-radiology department staff, we would need 21 consultants.

The Chairperson:

Colm, perhaps you would give us the figures for the Belfast Trust.

Mr Donaghy:

Sure. In the Royal Victoria Hospital, we have funding for 19·5 radiologists and 17 in post. In the Belfast City Hospital, we have funding for 18 radiologists and 18 in post. In Musgrave Park Hospital, we have funding for four radiologists and four in post. In the Mater Hospital, we have funding for 5·5 radiologists and 5·5 in post. The total number of funded posts in Belfast is 47, and, at the moment, we have 45 in post.

The Chairperson:

In an ideal situation, following on from Pól's question, what would be the full complement to deal with the demand?

Mr Donaghy:

I will caveat my answer by referring to what Tony Nicholson, dean of the faculty of clinical radiology and vice-president of the Royal College of Radiologists, said recently. He applied his comments to the UK as a whole. Where arrangements under IR(ME)R exist, which are legal requirements for the X-rays that do not require to be reported by a radiologist, that is now both acceptable and common practice in the NHS. That applies in our hospital system, too, because of the limited capacity in our system. As Dr Hall said, part of our assessment of capacity comes from our job planning process. We in the Belfast Trust have completed our job planning process for radiologists, so we are aware of the amount of capacity in our system, and that is reflected in the job plans of those individuals. That assessment is continuous. The demand, which Dr Hall outlined, means that we find ourselves in the position, according to our legal requirements under IR(ME)R, that we do not have the capacity for every single X-ray to be read by a radiologist.

Therefore, we have put in place, under our legal requirements in IR(ME)R, as we, Dr Hall and Mairead outlined earlier, a process for those X-rays that are not read or required to be read by a radiologist, which are the lower-risk films.

I will give the Committee an idea of the numbers of plain film X-rays produced by the Belfast Trust: roughly 62, 000 in Belfast City Hospital; 41,000 in the Mater Hospital; 30,000 in Musgrave and 132,000 in the Royal. The annual total of plain film X-rays produced is in the order of 265,000.

Mr Callaghan:

I have a preliminary point before my final question. You shared the numbers for the Belfast Trust with us, Colm, and the Western Trust outlined similar numbers when it appeared before the Committee. Those numbers are daunting for people outside the profession. The Minister referred to staff being stretched to their limits. Although I would be happy to hear otherwise, the impression is that there is an issue of recruitment and retention in hospitals outside Belfast more than in Belfast. It seems that some staff are being stretched beyond their limits or that the demand that is placed on them is beyond what any person might be able to deal with, but that is a matter of resource.

I presume that the RQIA will, to some extent, deal with risk and resource assessment here. Has the RQIA already been in with you, or have you been given a prospective time frame for engagement?

Mr Donaghy:

Patricia has the detail of that for the Belfast Trust.

Mrs Donnelly:

We have two scheduled visits from RQIA under IR(ME)R (Ionising Radiation (Medical Exposure) Regulations 2000). Prior to the issue becoming a public concern, we had already had our regular assessments. The RQIA is due to come at the beginning of March and towards the end of March to two different sites.

The Chairperson:

I am conscious that the Deputy Chairperson has not had a chance to get in at all yet.

Mrs O'Neill:

I think that most areas have been covered. I do not wish to repeat them, but today is a good opportunity to put the record straight. As this whole issue was arising in the media, Mairead kept us informed along the way. My area of concern is current and future recruitment. We have been told that people who have retired have not been replaced. Also, have we received the RQIA terms of reference?

The Chairperson:

The authority is working on them. We do not have them yet.

Mrs O'Neill:

One area that will have to be looked at is why it is not attractive for people to become radiologists. That is really all that I have to say, as I do not wish to repeat everything else.

Mr Callaghan:

The Southern Trust did not answer the point about engagement with the RQIA.

Mrs McAlinden:

I will be brief. It is important to be clear that there are two levels of the RQIA. We receive regular assessment visits by the RQIA. Dr Hall referred to the positive outcome of its visit to Daisy Hill in December last year. The RQIA review that the Minister announced is of a totally different nature. I have not seen the terms of reference, but I imagine that the RQIA will examine the standard approaches across Northern Ireland. As I said, we very much welcome that.

The Chairperson:

Tommy will be the final member to ask about the more general aspects of X-ray provision in the two trusts. We will then move on to the specific issues, such as the allegation about the lady who was "binning" X-ray material and the release of information from the Belfast Trust. Anyone who wants to come back on those specific points can do so, but Tommy will ask about the general X-ray issue.

Mr Gallagher:

I apologise for being late to the meeting. I was in the Chamber for the passing of the Licensing

and Registration of Clubs (Amendment) Bill.

Thank you for your presentations. I will repeat what I said this morning after the Minister made his statement, which is that the Southern Trust, through Mairead, acted very quickly and responsibly last week when the issue emerged.

I want to ask about review appointments, and this is an important question for the Belfast Trust as well. The Southern Trust has about 200,000 reviews a year, and we are told that, by next March, that whole situation will be cleared up and that trusts will be back on target, whatever the target is, for review appointments. Perhaps you would tell me whether there is a new target under the arrangement to which the Minister referred this morning. I am interested in how you will achieve that because we have scarce resources, which contributed to the problem that we are discussing today. This will put further pressure on staff, as there will be less money in your trust's budget.

However, the rumour is that the situation with review patients is particularly bad in the Belfast Trust area. How will the target be achieved?

Mrs McAlinden:

It is important to set the situation in context. Each year, there are well over 300,000 outpatient appointments in the Southern Trust. Roughly one third of those are new appointments, and two thirds are review appointments. It is quite right to state that, when an outpatient review is planned, an indicative date is given in many cases and that we go beyond that date for a relatively small number of patients. A consultant may say that he or she wants to see someone in three months' time, in six months' time or in a year's time. The important message for the Committee is that we prioritise outpatient review appointments on the basis of clinical need and the patient's condition. That is the key point that we must make.

It is right to say that there are pressures on our system. The specialties in which we are experiencing pressure with outpatient reviews are, in many cases, the same specialities in which we are experiencing difficulties meeting the Minister's targets for new outpatient appointments. It is useful to acknowledge the general pressures in our system with which we continue to try to deal.

Tommy asked how we intend to achieve the Minister's target. It is extremely challenging. Our briefing paper contains details of a number of actions that we are taking in the Southern Trust, and I am happy to share those with the Committee: we are ensuring that our consultants ask for an outpatient review only when it is necessary; we are working with local GPs to adopt risk-sharing and care-sharing arrangements; and we are looking at establishing virtual clinics whereby patients might be contacted by phone by either a consultant, one of his or her medical team or a specialist nurse. In the current financial environment, the Minister's target will require us to be innovative and imaginative and to look at new and different solutions if we are to come close to achieving it.

Mr Donaghy:

We have not prepared for particular questions on outpatient reviews, but we will do our best to answer generally. I do not have detailed information about our backlog of outpatient review appointments with me, because I was asked to come and speak about the radiology issues today. However, I will ask Patricia to answer. We are taking a similar approach to that of the Southern Trust.

Mrs Donnelly:

Again, we have been taking exactly the same approach as the Southern Trust. We examine the risks and validate all those who have waited to ensure that they continue to need to be seen. We have more than 600 consultants in Belfast, and there is much variation in their practice. Some will automatically tell a patient to come back without, perhaps, any clear need to see the person at that time. We work with clinical teams to try to look at pathways, to determine whether other staff could review those patients and to consider different ways of sending out questionnaires, having telephone calls or teleconferencing.

We work closely with the board. The board is aware that we have already modernised some of these pathways as much as we can. Therefore, it does not expect that we would necessarily be able to deal with this without displacing much of our other activity. Therefore, the board is being supportive as we look at those schemes that would enable us to try to deal with our backlog through additional finance.

Mr Brady:

I, too, apologise for being late. Tommy and I were sorting out the licensing laws for the North for

the near, and possibly distant, future.

The issue of whistle-blowing has been raised with both trusts. In his statement this morning, the Minister said that it is the right of any member of clinical staff to raise issues publicly, but that they also have a responsibility to go through the internal procedures first. I agree with that. It seems to me that, if a senior clinician feels that he or she has to go public, there must be a problem with those internal procedures.

Both trusts said how much emphasis and importance they place on their internal procedures. However, are those procedures similar to many other documents, in that people know that they exist in writing and that they form part of the contract or the terms and conditions of employment? I do not imagine that whistle-blowing is on the agenda of all your monthly meetings. I imagine that that would not and should not happen, because issues should be dealt with internally and reach that level only when something has gone wrong.

How much emphasis is put on whistle-blowing? Is it redefined constantly? Are people made aware of it and assured that it is not, as in many organisations, something to be feared? As someone who used to work in the Civil Service, I know that that mentality exists, particularly with line management. When complaining about one's immediate line manager, there is the question of whom one goes to next. Are staff made aware that they can complain without fear of repercussions?

Mr Donaghy:

Every single new member of staff receives those policies as part of his or her induction, and it is in the documentation that they sign for. They receive the whistle-blowing, harassment and other HR policies as a matter of course. All of the trusts already had a strong training process in place to ensure that staff were made aware of and knew how to use those individual policies. They also knew what their responsibilities were under the policies and how they would work.

I will go back to Pól's point: it does not make it any easier for someone to raise an issue that they might have. HR and personnel staff are there to assist in a confidential way and to agree with people the most appropriate way to take forward any grievance or issue. We continually enforce the fact that whistle-blowing and other policies are for the protection and benefit of our staff.

Mrs McAlinden:

I want to add to Colm's comments. Our staff-side representatives play an important role. I meet them and the director of HR once a month, and they are an important source of information to us. However, they are also an important source of information to our staff. They are well versed in HR policies as well as the whistle-blowing policy. They play an important role in giving advice to staff who have concerns. No system is perfect. Have we lessons to learn after recent events? Absolutely. Will we try to do better as a consequence of them? I assure you that we will.

The Chairperson:

We have dealt with the general issue of X-ray treatment in the Southern Trust and the Belfast Trust. I think that you have dealt with the issue of the allegations of follow-up appointments being issued on the basis of alphabetical order. For we "Ws" of this world, that was a concern. However, you have dealt effectively with the concern that Mr Adams with an ingrowing toenail would be treated ahead of Mr Wells with a tumour, and we do not need to go back to that. I see that Mr Brady and Mr Callaghan would be very happy with that alphabetical arrangement. However, as one who spends his entire life at the back of every queue, I am not happy with it.

We have a couple of other issues to deal with, and I will start with the Belfast Trust before I move on to the Southern Trust. A leading journalist in Northern Ireland was aware of an issue with X-rays in the Belfast Trust two weeks ago and approached the trust with a concern. The answer that you gave was, I suppose, technically entirely true. I agree with that. Technically, it was entirely true. However, I will use a quick analogy. The other day, Alex Easton asked the Minister how many nurses had left the Department over the past four years, and the Minister said none, because the Department of Health, Social Services and Public Safety does not employ any nurses. That is technically true. However, the Minister knew full well what was behind the question, which was how many had left each trust. Similarly, when that general concern about how X-rays were being treated was put to you or your press office, you technically answered correctly, but you could have allayed public concern. You could have said that that was the answer, but that you knew what was behind the question and explained what was going on to allay any fears. That would have taken much of the sting out of the story.

Mr Donaghy:

I do not know who the senior journalist was, and I am not entirely sure of the context. Maybe I

can answer in a general way for you. If the issue was about X-rays, what happens in that context is that we brief the journalists and have conversations with them. The final press statement might be short, but behind that there will have been a series of conversations. The information that is given to journalists allows them to take a responsible decision on whether to run a story. That is not and was not an issue. In the context of the senior journalist, I am not sure what happened, but from the Belfast Trust perspective, the conversations and the information that we would have given any journalist would have allowed them to determine whether or not they should run a story.

The Chairperson:

It was quite clear that the enquiries that were coming in at that time — I have seen some of them — indicated that there was an issue. Somebody had blown a whistle to say that a large number of X-rays were not being seen by radiologists. The trust was aware that that issue was floating about in the ether. You have given very satisfactory answers on those issues today, but had you taken the opportunity to pre-empt the concern by saying how you dealt with X-rays, we might not even be having a conversation this afternoon.

Mr Donaghy:

Sorry, Chair, I am slightly confused. We did give advice, and we did have the conversations with the journalists concerned. I am at a bit of a loss in dealing with the question. I take it from what you are saying that you believe that the Belfast Trust was not honest —

The Chairperson:

Oh, you were totally honest. To the extent to which you went, you were absolutely honest. The point is that it is important to look behind the concerns that are being expressed. The Minister, for example, should have said that the Department does not employ any nurses but that he knew what the question was getting at. He could then have outlined how many nurses are employed by the trusts.

Mr Donaghy:

Sorry, Chairman. I am not sure whether I can be more helpful, but I will try. The story that appeared in the media about X-rays in the Belfast Trust included our statement, which explained our position. In my view, that statement explained how we dealt with X-rays in a satisfactory and robust way.

The Chairperson:

Sometimes, it is important to look behind the hard facts of the statement to see what is going on and to assess what out there needs to be dealt with quickly and made public, so that the story might not become an issue at all. I suspect that had you issued two weeks ago the statement that appeared on the front pages last week, this issue would not have arisen.

Mrs O'Neill:

Chair, just for clarification, you are referring to an FOI request from a journalist.

The Chairperson:

Yes.

Mr Donaghy:

Oh, it was an FOI request.

The Chairperson:

Sorry, did I not say that?

Mr Donaghy:

No. I thought that you meant the exchange that we would have with journalists. I undertake to look at the response that we gave to the FOI request.

The Chairperson:

OK. We will move on to issues in the Southern Trust. Some accusations were made on Thursday or Friday, one of which came from an anonymous former employee of the trust who alleged that she was given not the X-rays but the notes of the X-rays. There is no doubt that X-rays were retained, and the electronic versions were kept for records. She alleged that she had to make difficult decisions on what should be referred back for further detail, what should be filed and what should be binned. You dealt with this in your document, but it is important that the Committee gives you an opportunity to outline your understanding of the situation. Could this have happened? If it was happening, should someone have seen that it was going on? What position could that person have taken if she was unhappy about what she was being asked to do?

Mrs McAlinden:

I am happy to do that. It is important to say that this matter was brought to my attention at 10.00 pm last Wednesday. We took the opportunity to share information openly and fully with the journalists concerned. Certainly, when Dr Seamus O'Reilly spoke on 'The Stephen Nolan Show' on Friday morning, he gave a full and detailed explanation.

For the Committee's assurance, the system that was covered in that show on Friday is at the end of a detailed checking process being carried out by senior clinicians, and any A&E receptionists to whom I have spoken about it describe it as a filing and sorting system. Their motto is simply: if in doubt, leave it out. That means leave it out for the senior doctor to see. Detailed audits take place in the A&E department, and that is part of that audit process. I am and have been assured that the system and the process are safe.

The Chairperson:

At any time, did anybody raise the problem at a whistle-blowing stage?

Mrs McAlinden:

When I spoke to the supervisors in the A&E department and to staff-side representatives, I was assured that the issue had not been raised. What has been raised — to be absolutely open with the Committee — is an issue of staff looking at how their duties were graded under the Agenda for Change system. The issue was raised in that context, and I understand that some of that information may have been shared with the journalist concerned.

The Chairperson:

Do members have any questions about that particular aspect of the issue?

Mr Gardiner:

Mrs McAlinden, I am led to believe that the person in question is no longer employed by the Southern Trust and that that has been the case for the past 12 to 14 months. Will you confirm whether that is right?

Mrs McAlinden:

Again, the employee must remain anonymous and is entitled to protection covering her employment in the Southern Health and Social Care Trust. It is my understanding that she is a

former employee who was with us on a temporary basis.

Mr Gardiner:

Would that have been about 12 to 14 months ago?

Mrs McAlinden:

She left in 2010.

The Chairperson:

Have there been any discussions with staff in that department in case there are any residual problems or concerns?

Mrs McAlinden:

I met staff on duty in A&E on Thursday. I have spoken to a number of the supervisors in the A&E department, and I have had conservations with senior staff-side representatives, who assured me that those issues have not been raised formally with them.

Mr Callaghan:

I have a meeting with the Minister, so I have to go.

The Chairperson:

We are still quorate, so we can finish off. I have a final question, because I want to be absolutely clear about something that I did not ask about earlier. Is there any question of chest X-rays not being seen by a radiologist in either trust? Is it clear that all chest X-rays are seen by radiologists in both trusts?

Dr Hall:

Although I cannot answer for other trusts, I can answer for our trust, and the answer is yes. All chest X-rays dating back to 1 April 2010 have now been formally reported on by a consultant radiologist.

The Chairperson:

Is that the same for Belfast?

Mrs McAlinden:

It is slightly different, in that all general chest X-rays have been reported on by radiologists, but there are specific areas, such as critical care, the coronary care unit and inpatient cardiothoracic surgery, which our chief executive mentioned in his opening statement, in which all the consultants are chest experts. Usually, their patients are so ill that they do not come to the imaging department, so a mobile unit takes their chest X-rays. In the critical care unit, which is the biggest user of the mobile unit, the consultants look at X-rays. They have a weekly meeting with a consultant radiologist to review their findings.

The Chairperson:

I have a final question for the Southern Trust. In 2009, there was one case in which an A&E clinician misinterpreted an X-ray, leading to a late diagnosis. I understand that that case has been investigated fully and that action has been taken. Are any of the issues that we talked about today implicated in that matter, or was it simply a misreading of an X-ray? In other words, was it misread by the wrong person or misfiled? Is there anything implicit in that statement that we could interpret as having been caused by what has been discussed today?

Mrs McAlinden:

We have to be very careful, because that is a specific issue. I am happy to provide a briefing to the Committee on the detail of that case. It is important to know that that issue was pre-2010, from when, as Stephen said, we have been reading all chest X-rays. If required, I am happy to give each Committee member a detailed briefing.

The Chairperson:

Do members have any other questions? Is everyone happy? Thank you very much for all the information, particularly the detailed briefing document. I know that this has been a difficult time for all concerned, but we appreciate your coming before us so quickly and answering all our questions. Thank you.