COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Performance Report and Aspects of Services Provided by the Western Health and Social Care Trust

3 February 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Performance Report and Aspects of Services Provided by the Western Health and Social Care Trust

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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 Paul Girvan

Witnesses:

Mr John Compton	)	Health and Social Care Board
Dr Carolyn Harper	)	Public Health Agency
Dr Brendan Devlin	)	
Dr Anne Kilgallen	)	Western Health and Social Care Trust
Ms Elaine Way	)	

The Chairperson (Mr Wells):

I introduce the witnesses: Ms Elaine Way, who has been with the Committee previously, is the chief executive of the Western Health and Social Care Trust; Dr Anne Kilgallen is the medical director of the Western Trust; Dr Brendan Devlin is the lead clinician for radiology at the Western Trust; Mr John Compton, who is a weekly visitor to the Committee, is the chief executive of the Health and Social Care Board; and Dr Carolyn Harper, who is the executive medical director and director of public health at the Public Health Agency, has also been with us recently.

I am sure that the witnesses know the routine. You have 10 minutes for a presentation, after which members will ask questions. I will give priority to those members who represent the Western Trust and also to the Deputy Chairperson.

Mr John Compton (Health and Social Care Board):

My understanding is that we are here to talk about the review that was commissioned by the Health and Social Care Board and attendant matters contained in it.

In 2010, a series of unrelated events occurred in the west of the Province. Those were all satisfactorily resolved or are in the process of being resolved. The outstanding issue is that of Millie Martin, which is subject to criminal investigations and a case management review.

In discussion with the chief executive of the Western Trust, we took the view that it would be sensible and prudent to look at some of the governance issues with regard to the organisation and agreed jointly that that would be a sensible and productive way forward. A review was carried out during that autumn period, which culminated in a visit to the organisation and interviews with a range of personnel in early December. The review was brought into the public domain at our board meeting in January 2011.

Recently, the matter of X-rays has been of particular interest. I speak straightforwardly, and for everyone, when I say that we wish to apologise to anyone directly affected by that incident, and we understand only too well the impact that it has had on individuals and families. It is important for us to show that we attended to the difficulty, fixed it and are moving forward properly and constructively.

In late July, it came to the board's attention through a serious adverse incident that there may be a difficulty in X-rays at Altnagelvin Area Hospital. After further work with the trust, it became clear that a substantial number of X-rays remained unreported inside the facility. We worked with the trust and required it, first, to curtail the growth of the problem and, secondly, to address the outstanding issues. That was done properly and responsibly, attending to all risk criteria that were involved and was completed over August, September and October. It is now fully on track and has been so since then.

In addition, Dr Carolyn Harper secured the involvement of Professor Philip Gishen, who looked at the functioning of the unit and provided us with a report. We have copies of his report that we can leave with you today for your perusal. Again, he was complimentary about the professional performance of the department and raised no concerns in that area. Of course, that is a matter that, in any performance situation, one would be obligated to inquire into.

In handling those issues, our first obligation is always to patients. First, we scale the problem to see if it can be fixed. We then attend to the problem and to the individuals who are directly involved. Subsequently, in a proper and timely manner, we make the issues known in a public arena. I believe that, as a commissioning organisation, we did that.

Concurrently, we worked with the trust on performance on issues of breast care. At our board meeting, we were more than pleased to report that the difficulties that had been experienced over a relatively short period of time in the organisation had been attended to and fixed. In particular, we were pleased to report that the 14-day target for breast surgery had been fully reinstated and restored and that it had been for some time ahead of our January meeting.

All other matters that were raised in the judgement — I am looking at the review from the Treacy judgement, as it is known, on outstanding carers' assessment — were attended to in a timely manner. All those issues were taken into account, and other issues and governance arrangements were considered, and we concluded that the performance of the organisation in understanding and handling risk was entirely satisfactory. Of course, the nature of a review, as it is taken forward, is to seek to improve things. There are a number of recommendations in that review that we shared with the organisation. We will monitor the implementation of those recommendations in our normal performance management meetings with the trust. Those meetings take place monthly between senior officers in both organisations and professionals as

required, and, bimonthly, they involve the chief executives of both organisations. I remain confident that our recommendations will be fully implemented.

No matter what happens in such situations, when a spotlight is shone on a problem or difficulty, it quite rightly acquires public attention. Any of the trusts, at any point in time — the Western Trust is no different —will be providing between 200 and 250 different types of services to a population. The fact that, in a performance arrangement, one uncovers a difficulty in one area is not a reflection, nor should it be a straightforward assimilation that reflects that the trust, as an organisation, is not delivering its task.

I am on the record as saying that, at the same time as we were discussing issues with X-rays, I was meeting a range of cancer patients who asked me to apply the good practice that is evident in the Altnagelvin accident and emergency department in the handling of patients who have had chemotherapy or who are at the end of life and have turned up at the department. That good practice relates to how those patients feel that they have been handled, progressed and treated.

There needs to be a sense of perspective and balance. When we uncover problems that affect individuals, it is enormously difficult for them. The importance of a proper and responsible performance management system is that it is designed to protect individuals and ensure that we fix problems when we find them. It sometimes takes much courage to hold up a mirror to look for difficulties. Once people know about a problem, the questions are: have they fixed it, and are they moving forward?

Given the information that we gathered and the work that we did with the organisation, the problems with its performance have been addressed and attended to. The governance review that we undertook during the same period also indicated that any changes that are required in the organisation are of a relatively modest nature and that nothing is fatally incorrect.

Mrs O’Neill:

Thank you for your presentation and for coming along today.

Elaine, I will direct my question to you. The reason why I felt that you should appear before the Committee today is that last week we discussed the problem of the Committee being drip-fed information with the DHSSPS permanent secretary. It happens time and again in the Department,

not just in the Western Trust. We learned about this issue, the review and the report through the media. I do not think that that is good enough for a scrutiny Committee of the Department of Health, Social Services and Public Safety. I want to know why you did not think it appropriate to approach the Committee and advise us of what was happening and that it would appear in the media. In that way, we would at least have been able to respond. It need not have been such a negative — not that it was not negative — but it would have put members in a better position to respond to the media queries that arose as a result.

I ask you, as the person directly accountable in the Western Trust, why you did not inform the Committee of what was going to happen so that members would be prepared to deal with questions as a result of it.

Andrew McCormick was here last week, speaking to the performance report. Again, he missed out information that we learned about the following day from the media about four patients being diagnosed with cancer and that someone may have died. That information was also drip-fed to us. The Committee has not been given the respect due to it or its place. We should be given that information so that we can respond.

Ms Elaine Way (Western Health and Social Care Trust):
The first time that I knew that the issue was so widely out in the public domain was on the Saturday morning when I read it in the 'Irish News'. The first thing that I did was to ring John. The record will show that, as soon as I became aware in July 2010 that there was an issue of delays in the reporting of plain-film X-rays, I immediately spoke to the Health and Social Care Board and the Department of Health, Social Services and Public Safety. Therefore, it was immediately triggered as what we would call a "serious adverse incident" (SAI).

I know that John Compton, in his board meetings, had talked openly about governance reviews, issues, and so on. There was no plan on our part to try to hide anything about the issue. When it first became known as a potential serious adverse incident in July 2010, the first thing that we did was to ask whether the patients who had been directly impacted on had been told. We were assured by the clinicians who were treating them that the patients whom they knew about at that time had been told. That was our first concern.

I want to join John in offering my personal apologies. I will take responsibility for what I see

as a failing on the part of the Western Trust in this area. I am profoundly sorry if any patient or their family has a delayed diagnosis. I hope that, in the process today, we will have the opportunity to explain what happened, why it happened and the measures that we have taken to ensure that it cannot happen again.

We did not try to hide this from anyone. It has been four years since the Health Committee was established, and I am not aware of a situation, Michelle, in which we in the Western Trust would have approached the Health Committee directly to say: here is a particular issue. Normally, issues in the Western Trust area are raised either through the Health and Social Care Board or the Department.

Mrs O'Neill:
We raised the very issue of that communication with the permanent secretary last week.

Ms Way:
I read that.

Mrs O'Neill:
I put that to you as the chief executive of the Western Trust and the person whom you say is directly responsible.

Let me pick up on the four patients who were recalled. What length of time passed between their X-rays and their recalls? There is no need to name names.

Ms Way:
We said in the past week that the shortest delay on the four patients was seven months and the longest was 10·5 months.

Mrs O'Neill:
When those people were recalled and the treatment started, at what point did the trust apologise and speak in detail? I know that you are doing that publicly today. With all the media hype around the case, has the trust been corresponding with the families regularly on the issue?

Ms Way:

Absolutely. I will ask Anne to respond.

Dr Anne Kilgallen (Western Health and Social Care Trust):

The main concern has been that the clinical team provides the appropriate care, investigates cases and treats the families involved. I have corresponded formally with the families to offer apologies, but, more importantly, I have put arrangements in place to meet them and have begun that process. Our main aim until now has been to ensure that they had appropriate treatment.

Ms Way:

It is important to stress that, when the treating clinicians became aware that there was a delay, I was assured immediately that the patients had been told.

Mrs O'Neill:

Obviously, that should be your first preference.

Ms Way:

Exactly, that is, yes.

Mrs O'Neill:

I am aware of a meeting that took place this morning with one of the families. It was only this morning that the trust apologised to that family. To be cynical, that makes me think that it was because you were coming before the Committee today.

Ms Way:

Absolutely not. It places us in a position in which, of course, I cannot go into the details of individuals' circumstances. Dr Devlin will explain later that it is not easy to ascertain, first, whether there was a delayed diagnosis and, secondly, whether any such delay had an impact. Much work has had to be done to establish whether there was a delayed diagnosis. I was at my board meeting this morning in Omagh, at which I said that there is a perception that once an X-ray is taken, it should be easily read. Dr Devlin will speak to the fact that it is a very complex process and that clinical judgements have to be made. We need clarity before we rush out to tell someone the facts of their case. Brendan, I do not know whether you want to leave that explanation until later, when we talk about how it happened and what we did.

Dr Brendan Devlin (Western Health and Social Care Trust):
I am happy to say that later on.

Mrs O'Neill:
We should go for that now.

Dr Devlin:
We are talking here about a number of investigations that were not specifically undertaken to diagnose cancer in anyone in particular. We are talking about a number of incidental but significant diagnoses that have been turned up during the passage of a large number of routine investigations. Not for one moment would I suggest that it is desirable that examinations are performed and not fully evaluated. We have to look very seriously at how we get enough capacity into the system to ensure that everything that we do can be fully evaluated.

That said, those were routine examinations, and, initially, the key issue was to evaluate the examinations and determine the level or extent of any significant pathology that had been missed or not identified at the time. It is possible that we could have examined a large number of those and not found anything significant of any kind. In fact, for comparison purposes, Tallaght Hospital in Dublin recently evaluated 55,000 examinations and found almost no significant pathology. A further 34,000 examinations were evaluated in the whole of the South of Ireland, and, again, almost no significant pathology was identified.

Quite a lot of work has to be undertaken in this situation to determine whether anything significant was missed in the first place. When it is determined that some things have been missed, the first recourse has to be through the clinical team and its relationship with the patient to establish that. It takes quite some time, perhaps more time than seems reasonable looking from outside, to gather all the facts and determine whether a diagnosis was known in the past or whether it is a new or significant diagnosis, and to put it into the clinical context with a patient's previous history. Complexity is involved in getting to the stage at which concrete information is available.

That may sound like a bit of an excuse, but in a backlog situation, when we are trying to find out retrospectively what has happened in those clinical circumstances, it is quite a complex

process to determine the significance of all the findings that are identified. One problem with chest X-rays — most of the pathology that we are talking about here was identified in chest X-rays — is that there is a plethora of relatively normal abnormal findings that are of some, but not much, significance. To put them all into a clinical context takes quite some time; to identify a nodule in one patient's chest X-ray may be of significance, while a similar-looking nodule in another patient's X-ray may be of no significance. A great deal of judgement and correlation is involved. I do not know whether that clarifies the situation for you. It is not easy to jump immediately to outright communication with everyone, because it takes quite some time to establish the significance of all the findings that have been unearthed.

Mrs O'Neill:

I accept that. I am sure that it is complicated. I do not have a medical background, and I do not understand it all, but I do understand the impact that it has on families and individuals. One reason why the families came forward is because they found the language from the trust to be unsympathetic. The trust felt that the problem had been solved, but the families' problems have not been solved because they are living with a cancer diagnosis. We are dealing with real people, real emotions and real feelings. The key issue now is that people get their treatment and that there is ongoing communication with those people.

Mr Callaghan:

I will start by seeking clarification on a couple of issues. You will probably not have had an opportunity to read the Hansard report that we were given this morning of last week's session, but you may have read it on the Internet. There was a bit of confusion during that session about the number of cases involved. At times, Dr McCarthy from the Department referred to a figure of 17,500, and other people referred to a figure of 18,500. Can we get some clarity on that?

Ms Way:

The figure is 18,500.

Mr Callaghan:

I appreciate what Brendan said about the purposes for which those X-rays were initially commissioned. To enable us to have a broad understanding on the record, will you tell us what spectrum of areas of treatment were involved in those X-rays? There are references in various reports to orthopaedics and chest X-rays. Can you expand on that?

Ms Way:

We always hesitate when it comes to issues such as that, Pól, because we are concerned about not risking patient confidentiality. However, I will put it in the broadest terms. If, for example, a patient is admitted to Altnagelvin by his or her GP, or through A&E, he or she will be admitted to a particular ward where a junior doctor will order a range of tests. Sometimes, one of those tests will be a chest X-ray. If a patient is admitted to a cardiology ward, the consultant cardiologist will look at a chest X-ray and say that the heart looks OK and is not enlarged, but he or she will not be looking for cancer. That is what we have been trying to say in relation to those particular X-rays.

X-rays are divided into routine and urgent categories, and the X-rays in question were routine. There was a backlog, and I hope that we will have an opportunity to explain why there was a backlog. Those X-rays cover issues such as heart investigations and heart problems. Nobody was referred to find out whether they had cancer.

Mr Callaghan:

I accept that. That is reflective of what was said last week. However, I cannot fathom how a question about 18,500 X-rays can risk prejudicing anybody's breaching confidentiality. I would be happy with an answer that deals with hundreds or thousands, leaving aside whatever issues we might have in respect of smaller numbers. However, I am still not sure that I understand. I will put it another way: who in the hospital or in the trust system asked for the X-rays?

Ms Way:

Junior doctors can ask for them.

Mr Callaghan:

I do not mean the grade of staff. I mean the areas. You mentioned A&E. Who can order X-rays in A&E?

Ms Way:

Chest X-rays will be ordered by physicians. It could be a cardiologist, a lung cancer specialist or a general physician.

Dr Kilgallen:

Broadly speaking, fewer than 3,500 were chest X-rays, about 4,000 were simple tummy X-rays, and about 10,500 were orthopaedic X-rays.

Mr Callaghan:

The report refers to performance standards being met. I am talking about the report that is publicly available from the board. There is a Jesuitical difference between the permanent secretary from the Department saying last week that the issues are now being addressed and someone saying that the issues are now rectified and entirely fit for purpose. Where are we with the implementation of the report's recommendations? One recommendation refers to the recruitment of radiology posts and various other issues, and there are a few bullet points. What progress has there been with those issues?

Ms Way:

The Gishen report, as we call it, was commissioned by John. The backlog had been cleared by the end of October 2010, but, regrettably, there were delayed diagnoses in the cases of four patients. John felt that it was important to bring in some external expertise to examine whether the department was working at optimum professionalism, standards, capacity, and so on. A team of eminent individuals from Imperial College London came across, met very many of us and spent days covering the entire trust area. At the end of that process, the messages, which are reflected in the report, are that the radiologists at Altnagelvin Area Hospital are working very hard and to the appropriate standards but that there are not enough of them. In addition, the equipment is not fit for purpose for a twenty-first-century medical imaging department.

Immediate recommendations were that we required a second CT scanner — Altnagelvin has only one CT scanner — an MRI scanner and that there should be 3·5 full-time equivalent additional radiologists. That is a very significant sum of money when it is added up. That money will be given to me by John Compton because I do not have any money other than the money that he gives me. However, I doubt that John has much money lying around because there are pressures and increasing demands, so we agree that we need to decide what we can do immediately to try to resolve the problem. Dr Devlin is here as the lead clinician. The staff in Altnagelvin, be they radiographers, radiologists or admin, are putting me under pressure to make the case strongly for the need for investment to improve the department. There will be a tough conversation between John and me, but we cannot implement until we get the money.

Mr Compton:

Perhaps I can help to clarify the situation. Broadly speaking, the report said three things. You will read the report and form your own view, but, in shorthand terms, it said, first, that although everybody in the radiology department works well and is sound professionally, the department needs to look at how it organises itself. Secondly, we need to do something about the equipment and infrastructure in the department. Thirdly, we need to grow the number of radiologists in the trust area. We will work with the trust, and it, in turn, will look at how it organises itself and works itself through. I understand that there has been further contact between Dr Devlin and his team and Professor Gishen in London. That is a good network and a good way of establishing and working forward. That is the first action that has taken place. Secondly, a second CT scanner is coming. If it has not already arrived, it is about to arrive in the facility, so that is a here and now, immediate response. We are also working on the basis of planning for an additional MRI scanner coming into the area.

With regards to the workforce, we will have to have a long conversation, not about only money. Money will be an issue, but nobody should run away from the need to fix the problem. Not everything in the world can be blamed on money. It is important in the running of health services, but money is not the exclusive issue. There are — Elaine can keep me right — about 13·5 radiological posts in the Altnagelvin area. For a variety of reasons, the organisation has not been successful in recruiting for those posts. That is partly because there is a shortage of radiologists nationally across the UK. The problem is not to do with people not wanting to work at Altnagelvin; there are probably not enough of those individuals right across the UK. The report states that 13·5 posts are fine but that the number should be closer to 17. We do not have a problem with that. Our first port of call is to work with the organisation to figure out how we get to the 13·5 substantive posts. The organisation has been working with a range of permanent posts and locum support. I want to make it absolutely clear that there has been no commentary or criticism at all of anybody who has been working there — far from it. In fact, very complimentary comments have been made about the professional standards.

As a Province, we invested a huge amount of money in computerised radiography. Indeed, Professor Gishen, who works in a prestigious radiological department, told me that he was envious of the system that is now in place in Northern Ireland. However, we have to work at this. We cannot solve the problem overnight, and we cannot manufacture 17 radiologists.

Furthermore, we cannot put equipment in overnight: we have to procure it and then acquire it, but we have made strident efforts to do that.

We are also involved with our local commissioning group. It is important that the local commissioning group has a say on this issue and on ultrasounds, which is another part of it. We piloted a different type of arrangement with the local commissioning group to ensure speed of access, reporting and turnaround. Therefore, a range of actions are being taken directly in the radiological field to improve, secure and build public confidence in the system.

I come back to the point about people holding a mirror up to themselves and finding a problem. It takes confidence to acknowledge the fact that there is a problem. However, once a problem has been acknowledged, it is most important to rectify it. There is evidence to show that the problems have been identified and addressed and that we have taken a serious look at where we are going in the future. There will be investment in Altnagelvin Area Hospital, despite any difficulties or problems. That is not a promise of an open chequebook for anybody, but there will be a direct recognition of the difficulties that there have been there. However, underneath it all, we have to acknowledge the fact that we are living in a world in which we are struggling to attract individuals to a discipline and specialty in which there is a national shortage as opposed to a shortage in this area alone.

Mr Callaghan:
At the time of the backlog, you talked about a complement of 13·5 posts. From public sector experience, I am familiar with the fact that a published complement is not necessarily the same as the number of people who are in post. How many were in post at the time of the problem?

Ms Way:
At the peak of the backlog, we had seven permanent posts out of a possible workforce of 13·5. That is one reason why this happened. In June 2008, two very experienced radiologists retired, and between the two of them, they reported 48% of all plain-film X-rays at Altnagelvin. I have in front of me the details of how hard we tried to fill those posts. I assure the Committee that we paid for three locums to try to meet the full complement. I am looking to Dr Devlin to see whether he will give a nod on this. At no time did the trust say, “Look, you have got only this amount of money, so you have got to live within that.” We really felt that it was important to have the locums there to do the work. The way in which a consultant’s job plan generally works

is that there are 10 programmed activities, 2·5 of which are special programmed activities. However, the locums did not do that, so we got them to do extra work reading X-rays, and so on. Therefore, the work of three locums was almost equivalent to the work of four consultants. However, we would have taken more locums if we could.

Dr Devlin:
I have been the lead radiologist in the department since July 2010. Since that time, the pace of work, activity and management radiology interaction have been intense. I am apologising for what has happened in the past. That is not the way that I want our service to perform. My focus is on ensuring that my service performs to the appropriate level in future. The amount of management clinician engagement in recent months has been very encouraging. It is important for us to reflect on the fact that radiology has changed colossally in the past 10 years and that the work practice and engagement of radiologists in multidisciplinary team meetings for the delivery of cancer services have changed out of all recognition. It is now time to re-evaluate radiology so that we can secure the right level of staff, equipment and organisation. That is very important.

We now have the NIPACS system, which give us a much better handle on demand and performance issues so that, virtually in real time, we can see where we are, and are not, performing well and focus our resources to ensure that all areas of our service — that is vital — are performing as well as they can.

We now have a new Health and Social Care Board and are entering a new era of joined-up discussions and decision-making, which we need at a time of financial stringency. Overall, out of this disastrous situation that occurred here, we can see some benefit coming from it. Look at us again in a year, 18 months' or two years' time, and you will find a dynamic and growing organisation and a service of which we will be proud.

Mr Callaghan:
There have been various media reports on this issue. It would be helpful if various authorities in the Health Service could appreciate that the role of this Committee is not merely to criticise but also to support. It is an important function of the Committee to support the good work done by the huge majority of Health Service staff. I speak for my party, and I think that it is a broadly held view, when I say that none of our considerations or deliberations is about witch hunts or suggestions that there is malpractice on the part of any member of staff. However, if there are

capacity issues we all, including the Committee, have to look into it.

I have to say, John and Elaine, that it is welcome that there is investment in addressing this demand and other issues. You may say that the report was not concluded until such-and-such a time and the board got it. However, some of the issues that are now being presented should have been at least flagged to the Committee back in the summer. That was when Elaine said that she first learned about the problem. It is clear from last week, John, that that is when the board learned of it. That might have helped us.

Let me make just one point. For the past number of weeks, we have been discussing a budget, and this issue was not even on the radar. I must move on because the Chairperson will soon call time on me.

The Chairperson:
You spoke about a number of issues that are central, but I do not know where your question is.

Mr Callaghan:
There are a number of questions. I was trying to be helpful.

I will refer to some of the issues raised by the report in the media this week about the individual who is variously reported as being 80 or 82 years of age. That family says that the X-ray was taken in August 2009. That is almost eight or nine months from when Elaine, as chief executive of the trust, was made aware of the backlog issue. Is the trust saying that that was a one-off mistake, or was it part of the trend? If so, it begs the question about why it was not picked up, at least at the level of chief executive, between August 2009 and July 2010. That seems to be a serious management issue.

We have also been told in reports this week that a medic reviewed the case in March 2010. As far as I can make out from the Hansard report, and so on, that was before the board/trust-commissioned review took place. Someone was reviewing something for some reason in March 2010. Let us do the sums. That was roughly four months before you as chief executive were told about it.

Ms Way:

No. I hope that the Hansard report will show that what I said was that in July 2010, I was made aware of a serious adverse incident. I was made aware of the fact that, among the backlog of unreported X-rays, there was a potential delay in diagnosis. That is the case to which you referred, Pól. Therefore, in July 2010, I was told that it appeared that there had been — we actually did quite an extensive, lengthy investigation into that — and that is when we declared that as a serious —

Mr Callaghan:

Will you please run that past me again? I am not sure that I understand.

Ms Way:

I did know that there were problems with unreported X-rays. That is partly why John undertook the governance review. He was looking, for example, at whether the trust would have this issue on risk registers, or whether the trust would have said that it had a difficulty in recruiting radiologists, which puts the department under pressure. The answer to those questions is yes: we had.

We knew that once the two radiologists indicated that they were going to retire — they did 48% of the plain-film reading — we were going to have a challenge to replace them, particularly with people who would do plain-film reading. That is why we tried to replace their posts quickly. The fact that problems and delays were developing was put on the risk register. We had a plan in place, which partly included our own radiologists working out of hours but also involved sending some plain films out to be reported elsewhere. We were working our way through those.

John made the important point that it is not just about the fixed 18,500 cases, because other people were coming in just as some cases were being cleared. We were working through those cases in the firm belief that those were the lowest priority, lowest risk, non-urgent films that we had. The importance of the July 2010 date is that it was the trigger for the discovery of a patient who appeared to have had a late diagnosis. In fact, what was said to me in July 2010 was that it appeared that two patients had a delayed diagnosis. When both cases were looked at, we were able to confirm that one had, and the other had not.

Mr Callaghan:

That is out of the four patients?

Ms Way:

That is right.

Mr Callaghan:

The second four patients that are referred to in the report —

Mr Compton:

There was only one group of four.

Mr Callaghan:

There was only one group of four?

Mr Compton:

Yes.

Mr Callaghan:

I will come back to that in a minute. The Department referred to four others.

Ms Way:

There were 18,500 plain-film X-rays, and of those, eight people were recalled, some to have another X-ray. It was established that four patients had a delayed diagnosis.

The Chairperson:

So the other four were clear?

Ms Way:

They may have had other issues. It can often happen that a patient who has an X-ray that is not necessarily clear or readable has to be called back. That does not mean that the patient might not have something wrong but that there was no delayed diagnosis of cancer.

Mr Callaghan:

I was going to ask specifically about the adverse incident that triggered the issue. It is fairly clear that you are saying that, in July 2010, you, as chief executive, were told that there was a delayed diagnosis as a consequence of the backlog of which you were already aware. When were you aware of the scale of the backlog of 18,500 cases? As a layperson, it seems to me that if there were 18,500 X-rays with delayed evaluations, although the trust may consider them routine, there was always going to be a likelihood, or at least a good probability or possibility, that serious mistakes would be made, which, unfortunately, has turned out to be the case. When did you have any sense that those sorts of numbers — a five-figure number — were involved?

Ms Way:

I would have been aware over a number of months that there were a number outstanding. However, I am looking to Brendan —

Mr Callaghan:

Does that mean after Christmas 2009? This man's case dates back to August 2009. If that case was missed in August 2009, was that just the start of it? Unfortunately for that man, there seems to have been a terribly adverse consequence, according to the report. Was there already within the trust's management echelons an appreciation that there was a serious issue? If so, what was done about the number of X-rays that were not being evaluated properly? "When" and "what" are the two issues that I am trying to get to.

Ms Way:

It takes us back to the question of why this happened. That is part of what we wanted to talk about. A range of issues were coming together. I know that, as I tell this story, it sounds as though it cannot be that difficult. In reality, however, not only were we dealing with increased demand with fewer radiologists but we were trying to move from the old Northern Ireland radiology system (NIRADS) to NIPACS. We were probably one of the last trusts in Northern Ireland to introduce NIPACS, in May 2010. The importance of NIPACS is that it uses electronic referral, which means that every time an X-ray is ordered, it is on the system, and, until it is reported, it will not come off the system. We were in the process of changing from one to the other. So if you are asking me whether I was aware that there was huge pressure within radiology, with a combination of staff numbers down, increased demand and changing systems, I absolutely was. However, I also had an assurance from the director that there was a plan in place

to make sure that that could be managed.

I will go back to something that Michelle said earlier, about which I feel very strongly. As a patient in the Health Service, it is a reasonable expectation that if somebody does a test on a patient, it is reported in a timely fashion. Not all X-rays have been reported in the past; there has always been a certain number that have not been reported, because that is the way that things were. I am looking to Brendan to confirm that that is the case.

Brendan said that some good things have come out of this. One of those good things has been that, because we have had the new NIPACS system since May 2010, every single X-ray that is ordered is on the system and will be reported by a radiologist instead of a physician looking at it. As we sit here, all chest X-rays, which were the most significant and the top priority, are currently read within 14 days in Altnagelvin, even though the target for reading non-urgent X-rays is 28 days.

The Chairperson:

That is all very interesting, but I have to ask the Nixon question: when did you know and what did you know? We are looking for a date, not a cogent explanation of how the situation arose. I am also aiming my comments at Dr Devlin. There must have been a certain date in your diary when you realised that there was a problem, and we need to know when that was rather than a continuum.

Ms Way:

I would not be able to say to you today that there is a date when I had an alarm bell ringing other than July 2010. As John said, we provide some 200 to 250 service areas, many of which I will get certain pressures on. I was aware, through our governance committee and directorate reports to the governance committee, that, among a range of issues that were mentioned as risks that we were managing, there were problems in radiology. As the chief executive, the alarm bell to say that there could be a serious problem went off in July 2010.

The Chairperson:

You were aware that there was a problem, and your director told you that there was a plan to solve the problem. When did you know that that plan was not working?

Ms Way:

The plan was never going to reach an end until we got more radiology resource, because we did not have enough staff to be able to do all the work that was coming through the door. The important thing to recognise is that the Western Trust, which has been an organisation for nearly four years, appointed a permanent director of acute services in October 2010, who is the fifth person to hold that position. Such jobs are hugely challenging and involve the management of many risks across the geography.

The entire trust board would have known through its governance committee that there was a difficulty in reporting these. I can provide you with the dates of the governance committee meetings at which the issue would have been listed. However, the assurance was given that there was a plan to mitigate the risk of those being unreported, which included external outsourcing and our radiologists undertaking further work.

The trigger for me was when they said to me in July 2010 that it looked as though two people had had a delayed diagnosis. My view then was that we needed to sort the situation and sort it quickly. So the plan was escalated.

Mr Callaghan:

I want to go back to the business about March 2010. You are saying that you were aware that there was a five-figure quantum of X-rays that were in the backlog at some stage a number of months before July 2010. With no disrespect to the Chairperson, I will amend the Nixon question a little.

Was it prior to March 2010, for example? Obviously, what I am getting at is whether the March 2010 review of that gentleman's X-ray was part of the plan. Was it part of the response to the issue that you say you were told was being taken forward? If so, was the board informed of it or was the assessment made that it was not a matter about which the board needed to be informed?

Ms Way:

There was no serious adverse incident. As far as the trust was concerned, we were dealing with non-urgent routine X-rays and trying to clear them ourselves with a mixture of internal and external resources. We would not have felt the need to tell the board.

Mr Callaghan:

Elaine, you said earlier that the trust is getting a new CT scanner. John, you said that as a result of all this an MRI scanner is coming. I do not really understand how the board, which, presumably, would have to finance those things, was not made aware of the backlog. Presumably, it would have helped to make a case to the board that extra investment was needed in radiology. I accept that, evidently, there was pressure on the radiology department and on the staff who worked there. However, I do not really understand why the board would not have been notified of that. Perhaps it was notified of a routine pressure, if you put it like that.

Ms Way:

We work not only directly with John in Belfast but with the commissioning support unit of the Health and Social Care Board in Derry, which is led by Paul Cavanagh. Certainly, prior to either March 2010 or July 2010, we would have been saying to our commissioners that we were under real pressure in radiology. When I meet Paul on a one-to-one basis, I provide him with an extensive list of a wide range of pressures that we are under as an organisation. For example, last Thursday when we were in Armagh for the Health and Social Care Board's launch of the performance report, I was getting e-mails from clinicians who were saying that there are other pressures, issues and governance concerns. The reality is that I have a long list of pressures and concerns that I share on an ongoing basis with the Health and Social Care Board.

Mr Callaghan:

Is there an anticipated date for delivery of, say, the MRI scanner? Can the Committee receive a report of actions that are being taken, for instance, in recruitment? We all accept that you cannot force somebody to work somewhere. However, to give us a sense of —

Dr Devlin:

I am the lead clinician in radiology at Altnagelvin Area Hospital. I am not particularly keen to bounce people into saying that they will provide something, and by a certain date, because I would prefer us to have a grown-up discussion and an integrated installation in a planned way, so that what we do will be sustainable in the future for better service delivery. What I plead for as we go forward from this is to get a better, more coherent conversation going on between the commissioners and the people who deliver the service, so that we move forward with sustainable developments that will work well. I think that we have had rather too much of a knee-jerk

reaction to fix this, that and the other. If we could move more towards a planned approach to spending money, particularly in the current environment, we would get better value for money.

Reflecting on the question of when people knew and so on, I say that those kinds of problems in clinical services tend to grow slowly. You put a bit of a fix in place, and it seems to work for a while. Then, someone retires or goes off sick, and you have people off on maternity leave and sabbaticals, and, before you know where you are, the thing that worked quite well is, all of a sudden, not working well. Therefore, it is not that easy to just say that you must have known about an issue on a particular day and that it should have been fixed the next week. To be fair to my management colleagues who are trying to fix those things: it is rather difficult.

When you have a significant imbalance between staffing resource and demand on the service, the service has a tendency to become quite inefficient because you have to fire fight and focus on areas where you absolutely must deliver today. You can deliver only the service that you must deliver today because there is no extra capacity. It is a rather complex issue. That is not to say that we have done it 100% as well as we could have. We are happy to hold our hands up and say that it could have been done better. We are where we are, and the real challenge is for us to ensure that we do better as we move into the future.

Mr Callaghan:

From some of the descriptions there, Brendan, it sounds as though you could be working in politics. Is the performance report that the board published a summary of a bigger document or is it the full report? I mean in respect of the X-ray issue.

Mr Compton:

The Gishen document covers the X-ray issue. The report is a summary of the findings. We will leave copies with the Committee.

If it is helpful, I will reinforce the points that my colleagues have made. The sensible way of looking at it is that there was a building problem in the organisation that was being managed. It became heavily accentuated at the time of the retirements at the beginning of the summer, and everyone became aware of the nature of the problem in July 2010.

The first thing that we wanted to do when the adverse incident came to us was to scale and

size the problem and to address the problem by not allowing it to get any bigger. That happened immediately, and it happened over a three-month period. We worked closely with the trust. What does that mean in terms of performance? The trust reported weekly to us the number of X-rays in the backlog that had been seen and the target number for the week ahead. All of that was attended to, and all of that took place. We managed to clear the backlog during that period, for a variety of reasons, by October. The first priority was to deal with the individuals and the families, and we managed to do that.

Secondly, we wanted to assure ourselves that there was nothing fundamentally broken, and we did that in November. Finally, in December, we asked whether it was symptomatic of something wider, and we looked at that and published in January. We went through the method of how we handled the issue in a timely and orderly way.

I could not agree more with Brendan in respect of having a much more joined-up arrangement. There are a couple of things, such as getting the second CT scanner for the facility. It is a barn door sort of thing. It will not be a big, controversial issue. However, the scale of MRI and the nature of the radiologists that we should be recruiting — the sub-specialities that they should have — are the sort of issues that require us to sit down and have a close and detailed debate. We have focus and direction, and we will get to a better place over time. We are already in a much better place for the population in the area, as a consequence.

You might ask why the board did not know before that. Partly, it has to do with technology. The numbers involved are huge. We are talking about 18,500 X-rays. My colleagues can keep me right, but that is about 12·5% to 15% of the total activity that goes on in that department during the year. So, we are dealing with very big numbers. Until the introduction of the computerised system in the May/June period, it was simply not practicable to have anything that allowed us to access and report on the performance right across Northern Ireland. We could have been dealing with hundreds and hundreds of thousands of such tests. It was simply not possible to see where it was happening and how many days it was taking. We have a much better system, in which we have invested heavily. We now have a better place to go with regard to performance and understanding that performance. That is the issue. It is a very difficult thing. Would we prefer to be sitting here talking about other things? Of course we would. This is not what we want to be here to talk about.

With regard to the interrelationship and interplay between the Health Committee and the Health Service, I have no difficulty in having an open and constructive relationship with the Health Committee. If we need to fix that or to do it in a different way, I am more than happy to sit down with the Health Committee, the Department, the Minister or whoever in order to get to a point where people feel more satisfied about information flows and how those information flows take place. We have no difficulty about doing that. However, the Committee will be as aware as I am that there are systems, processes and protocols about how those things operate. As officers inside the system, we have to operate within existing protocols. If those protocols change to allow a different type of interrelationship, it would be all to the good. We would have no difficulty with that at all.

The Chairperson:
To be honest, John, that would solve about 90% of our problems. As I said, it is not what you do; it is the way in which you do it.

Mr Callaghan:
Brendan's argument for better planning was an absolutely credible point to make to the Committee. However, you will understand the frustration among members of the Committee — I joined the Committee only at the end of November, and I am sure that people who were on it before then are also frustrated — because better long-term planning, with input from the Committee, requires the Committee to know about things other than through a leak on the front page of a local newspaper. Those things work both ways, and that goes back to the point about communication flows.

The final thing that I want to deal with is the issue of apologies, because, at the end of the day, we are dealing with patients and families, and the community in Derry was a bit taken aback when the son of the elderly patient went on record saying that they had not got a direct apology. In effect, he was suggesting that a generic apology was issued, and that was it. The board's press statement referred to a meeting between the trust and the family and to the fact that regret had been expressed. In human terms, that falls short of an apology. Is it the case that the four families of the patients involved did not get a direct apology, and does the trust accept that it would have been better to make a direct, personal apology to families affected by what were evidently serious incidents and experiences for the lives of those families?

Ms Way:

We can learn from how this one was handled. When the serious adverse incident was drawn to my attention in July 2010, we were getting into the whole Donagh issue, so the Western Health and Social Care Trust was dealing with quite a number of high profile issues, as John would call them. When this matter was drawn to my attention, the first thing that I asked was whether the people had been told, because I believe that that is the primary responsibility. I was assured that people had been told, and I spoke to the clinician who had spoken to the family. I interpreted what he said to me as being very direct about what had happened and apologising for that.

This week, when we were pushed by the media about whether the trust had apologised, we spoke again to the clinician, and he was rehearsing what had been said. The language that he used was "deep regret", which is why we quoted those words. I would not wish to put words into people's mouths that they do not believe that they said. It is very difficult to know how to get that one right, and I am still reflecting on what is the right thing to do. Is it right to bring people in to the chief executive's office or the medical director's office and say that such and such has happened and that we are sorry? If that would help, we will do it. In fact, I know that Anne has done that. It surprised us that our actions this week in trying to offer an apology to the families through the media actually had the impact with certain families of adding to their pain, which is not what we wanted to do.

The Chairperson:

There will be a wash-up session at the end, Pól. You have had a fair run of questions.

Dr Deeny:

You are welcome, ladies and gentlemen. I know that the situation is difficult. I have a couple of quickies. Anne, you mentioned the 18,500 X-rays. It came across that they were all hospital initiated, but I presume that a lot of them were from GPs?

Dr Kilgallen:

No, almost none of them were. As a team, the radiologists decided that GP-requested X-rays would not be seen by the clinician, because GPs were not in the hospital. Any hospital doctor has an opportunity to immediately see an X-ray taken in the hospital, but, as you know, a GP does not have that facility. So, GP-requested films are reported as a priority. They are the top priority for reporting in the department.

Dr Deeny:

I declare an interest as a member of Western Local Commissioning Group (LCG). I have been aware from GP colleagues and other members that there has been a discrepancy between the north and the south of the trust area. In fairness to the trust: last year, I commended you, Elaine, on the wonderful X-ray department in Omagh. GPs get routine X-rays back on the computer system in 24 to 48 hours. That is good.

Ms Way:

That is wonderful.

Dr Deeny:

It is excellent. I know that there was a discrepancy between the north and the south of the trust area. However, prior to computerisation, even written reports were coming back within a week. That was what we expected.

What shocked me about this was the number: 18,500 X-rays. When I worked in a hospital in the 1980s, regardless of who ordered the X-ray — even if it was a consultant — it ended up in the radiology department, and it was reported on by a consultant radiologist. That is why we have consultant radiologists. They have the expertise.

Dr Devlin:

I presume that you are talking about the pre-digital era of plain X-rays on a piece of film. Standard research work suggests that, in the era of films and paper-based requests, up to 20% of films and requests never made it back to the radiology department for reporting. There was a whole level of non-reporting, just on the basis of the human / hard copy interaction and stuff being in the wrong place, not filed properly and all that kind of thing. That does not happen any more. One of our problems with the digital system is that when you turn it on, all of a sudden, you have 10%, 15% or 20% more work to do because it is all there. None of it gets lost.

A classic study was done many years ago in England. Pre-operative chest X-rays were done in radiology departments and put in a folder and someone stapled them. It is interesting to see how many of those were looked at properly. However, the digital system that we have now allows for a much more secure system to deliver care. It also allows us to identify where we are

not performing. That is very hopeful for the future. Now, we can have a much more pragmatic approach, in real time, to questions of how we are doing, what we are not doing and where we need to focus. Having come through a bad place where we do not want to be again, we have the potential to deliver a much better service.

Dr Deeny:

GPs were aware that there was a discrepancy between the north and the south of the trust area. Those of us in the southern sector of the Western Trust normally complain about the service. This time, it is the other way round. We are saying that the service you are giving us is very good, whereas our northern colleagues were concerned about reports coming out.

Ms Way:

I am told by radiologists in Altnagelvin Area Hospital that there are issues about the areas that John mentioned. For example, we have to go out for certain radiologists who specialise in particular areas, such as interventional radiology. I am told that all our radiologists in the Omagh and Fermanagh areas read everything that they can read. Specialist ones still go to Altnagelvin. We can get more productivity out of the fact that there are general radiologists in the south of the area, and there are particular challenges with the mix that we need for certain modalities and specialisms in Altnagelvin.

Dr Deeny:

I was asked to ask you this question. Were any of those individual X-rays ever misplaced?

Ms Way:

No; never.

Dr Deeny:

That is good.

I will wear my GP hat for a moment. This is the first I knew that the backlog was all hospital-based X-rays. Let us say that X-rays are ordered by a junior doctor in a hospital. People are normally brought back as outpatients and the result is reviewed with them, or patients are told to go and see their GP in three or four weeks' time and that the report will be with their GP. Where did they fall down there? Patients will ring up and want to know when they are to be seen again.

Dr Devlin:

It may well have been the case that a large number of those examinations were evaluated but that the evaluation was not documented beyond someone saying, "That is OK; on you go". It is the formal evaluation that is included in the record that we are talking about. A large number of those examinations probably were evaluated, but in an informal way by the clinician. Does that make sense to you?

Dr Deeny:

It does.

Dr Devlin:

The whole issue was the lack of the formal report.

Dr Deeny:

OK. So, there was no issue with GP-requested X-rays in Altnagelvin; it was just hospital requests.

Ms Way:

Yes.

Dr Deeny:

You talked about staffing. Tyrone County Hospital lost a consultant, from whom we got excellent reports, some months ago. I am glad to hear that all X-rays will be reported on now by yourselves — it is good to meet you, Brendan. I am reassured that everything will be done now. It is good to have the equipment, but it seems to me that the first thing you need to look at is personnel. It is about finding people with those qualities. As far as I am aware, my hospital colleagues in the southern sector of the trust were very happy with the reporting that was coming through on time, as we GPs were. Then we saw what was going on in the so-called regional hospital.

Ms Way:

Please be assured that I have commended the radiologists in Omagh and Fermanagh. I have reported — I have reported it in Altnagelvin as well — what happened when the national clinical

governance support team from England came across to do the review on the former Sperrin Lakeland Trust. Padhraic Conneally and his team got a gold star for their outstanding performance. Brendan talked earlier about digital films. One of the things that Professor Gishen said to us — it is in the report — is that we must now use the fact that we have that technology, which we have had since last May, to get our colleagues in Omagh and Fermanagh to help ensure that we can report on films in a timely manner.

Dr Deeny:
I was going to suggest that, Elaine.

The Chairperson:
Kieran, we have to keep moving.

Dr Deeny:
This man here got in.

The Chairperson:
Yes, but he was asking questions.

Dr Deeny:
I will ask a question as well. You have thrown me off.

The Chairperson:
It has to be a question.

Dr Deeny:
It is a question. I have forgotten what it was. Can I come back to it?

The Chairperson:
I will let you in at the end. Tommy. Please ask questions, Tommy.

Mr Gallagher:
I will ask several questions, with your indulgence, Chairperson. I want to go back to the date again, because I am still not clear about when this matter came to the attention of the trust. There

is a clear date on which Elaine says she became aware of the issue. She said that it was in July 2010. The working part of July in Northern Ireland is the early part of the month and the holiday part is thereafter. Because of that, it is pretty easy to place things that happened in July in one's mind. Can you say whether it was early or late July?

Ms Way:

It was on 13 July, the day after the Twelfth. I had been on holiday for the fortnight before that. I had an early holiday, and that was my first day back at work.

Dr Kilgallen:

At that point, the patient had already been seen and placed on a treatment pathway. The patient was seen on 7 July.

Mr Gallagher:

Why then was there a delay in informing John Compton, who said that he became aware of the matter in late July? Last week, speaking on the Minister's behalf, Andrew McCormick said that the Minister learned of it in August. Why did it take so long?

Ms Way:

On 13 July, there was a concern in the trust that there were two patients who had a delayed diagnosis. We had to start a process of investigation to establish the facts. When we went through that investigation, we established that one patient had suffered a delayed diagnosis. The other patient had not. We continued the process by filling out a serious adverse incident form and putting that into the system, which requires us to notify the Health and Social Care Board and the Department at the same time.

Personally, I do not remember what happened as regards the Health and Social Care Board. Probably someone like Carolyn would have contacted Anne as the medical director. However, Dr McCormick certainly contacted me directly. The purpose of the direct contact was to clarify exactly what the issues were and what plans we were putting in place etc so that he could brief the Minister.

Mr Gallagher:

When was that?

Ms Way:

That was in August. I do not remember the date, but it was the day that I was in Lakeview Hospital to meet the parents of the adults with learning disability who were concerned that the brothers had been admitted to Lakeview. It was a Friday.

Mr Compton:

Perhaps I could be helpful by providing some dates. It was originally discovered by the trust on 13 July; that is the information that we had. We received information of a serious adverse incident on 29 July. That is not unusual. Elaine has indicated that there were necessary pieces of work to be done. The trust would have known that we would ask a set of questions, so there was an attempt to get the first-line questions asked. The immediate action was that we were in touch with colleagues and Dr Harper from the Public Health Agency. After a number of informal iterations between the two organisations, there was correspondence between the chief executive and myself on 13 August to outline the expectations and requirements in respect of how to fix it and put in place systems to attend to it.

In parallel with that, we identified experts who might come and help us. We went through a range of potential options until we finalised with Professor Gishen. All the necessary reporting arrangements took place in a timely manner. We started to receive reports from the trust in August on the activity and restitution from the position that had emerged and been finalised at that point.

Mr Gallagher:

OK. Two of the four people who turned out to be cancer patients as a result of the diagnoses were notified in July. When did the other two know?

Ms Way:

No. I think that I said that we suspected that two had a delayed diagnosis. One did not have a delayed diagnosis, so there was one. All patients were identified by —

Dr Kilgallen:

July, August and going into September. The investigative process takes some time. The latest that the X-ray would have been called into question was early September, but that is not to say

that the individual was made aware of the diagnosis at that time. The individual would have been made aware of a need to investigate further.

Mr Gallagher:

OK. May I ask Carolyn to clarify whether her role and involvement in this matter was as a representative of the Public Health Agency?

Dr Carolyn Harper (Public Health Agency):

I have a dual role in that I provide medical advice to the board in its commissioning. That is part of our structure. The Public Health Agency provides medical advice to the board, so I act as medical director for the board.

Mr Gallagher:

Which role was it?

Dr Harper:

It was more the role of medical director for the board, but I am an employee of the Public Health Agency.

Mr Gallagher:

You worked on the breast care difficulties.

Dr Harper:

Yes. A number of consultants in public health medicine support the board's commissioning and performance staff in planning services and responding to issues that come up through the performance management of services.

Mr Gallagher:

When exactly did you carry out your work?

Dr Harper:

In terms of?

Mr Gallagher:

You said that you dealt with breast care difficulties. I presume that you became involved once you were contacted by the Western Trust about the matter? How long was your involvement? Was it in July, in August or over a longer period?

Dr Harper:

The issues relating to performance around breast cancer waiting times were picked up in July through the routine monthly performance management meetings that the board has with all the trusts. Actions were put in place over the next two or three months. By November, performance had returned to 99% compliance and then hit 100%. That performance has been maintained.

Mr Gallagher:

Once the problem was brought to light, was the Public Health Agency, at any time, involved in the review or in any other aspect of the incident?

Dr Harper:

We were involved in supporting performance staff in the board on breast cancer performance times. We were also involved with the radiology report, and we approached Professor Gishen and secured his services to conduct the independent review. I was a member of the team that conducted the performance review of the wider systems in the trust.

The Chairperson:

We have given the folk from the Western Trust a reasonably fair opportunity. I have a few questions for them. During last Thursday's meeting, I asked the Department whether anything else was out there. Dr McCormick gave me a categorical assurance that everything was out in the open and that we, therefore, had nothing further to worry about. Then, on the Friday, we turned on our televisions to find that the BBC had information of which we were totally unaware. As you know, Marie-Louise Connolly interviewed one of the families concerned, and an obvious question flows from that interview. It appears that, in one case — we do not know or need to know the identity of the individuals concerned — the results were not processed twice: in August 2009 and March 2010. A fleeting reference was made to that in the performance review, but no detail was given. Without going into the specifics, how could that situation have arisen? How could someone have been missed twice? I understand that the patient concerned was an 80-year old man who is terminally ill with lung cancer, so it is a very serious situation. What

happened to allow that to occur?

Ms Way:

I do not want to say anything today that has not been first said directly to the family. We contacted the family through our clinical staff to ask if we could meet them, and we are waiting to hear whether they will facilitate that meeting. The family was very hurt by the fact that our medical director talked to the media, on Monday or Friday, about offering an apology, and I do not want to add to that hurt today. We believe that we should meet that family and talk through that journey with the patient and the family first.

The Chairperson:

I understand the concept of patient confidentiality, and no one will ever want to know the name and address of the patient or even the details of the clinical examination. However, the principle is that the Committee should have been told at the last meeting that four people were not told that they had cancer. My understanding from the information that is coming from the Western Trust is that they have all been diagnosed with lung cancer. I cannot see how your telling us that and telling us that someone was misdiagnosed twice could possibly reveal anyone's identity.

Ms Way:

I think that the gentleman who spoke locally on the radio would be identifiable in the Derry area, and I do not think that I can give details of what happened in that case. We were very open last week about the fact that there were four patients. From our perspective, last Thursday, Anne and I went to the Health and Social Care Board for the presentation on the wider performance report. Before we had even left the room, we were contacted by text and told that 'Talkback' was running a programme telling the public that 18,500 X-rays had been lost. From that moment on, we were trying to clarify exactly what happened. We have been open about the number of patients involved and about the length of the delays, with seven months being the shortest and 10 and a half months the longest. However, I believe that there are people in Derry who could identify that person from the interviews, and I just cannot comment on that case. I am happy to meet the family, and we have made that offer.

The Chairperson:

After you meet the family, will you be at liberty to reveal how twice —

Ms Way:

Yes, if they give us permission to do so.

The Chairperson:

The breast screening issue was largely overshadowed by the X-rays, but the 14-day reporting performance for breast cancer went down to 22% at one stage. Was any woman's health compromised by that drop to 22%?

Dr Devlin:

I am delighted to have the opportunity to talk about that. The target that we failed to hit referred to the time taken from the point of referral to being seen at the clinic. However, the target time between referral and any lady receiving treatment that she needed was maintained. It would have been possible for us to see those ladies, pat them on the head and say that it was nice to see them but that they should come back when we have time to see them at our triple assessment clinic. However, we did not do that. Patients were not being seen within two weeks — it was a little bit longer — but they were being seen at the triple assessment clinic, at which they were able to get all of their diagnostic work done. The time from referral to receiving treatment, which is, I suggest, probably more significant than the time waiting to be seen, was within the normal target. With the extra work that has been put in place since then, that target is now being achieved.

The Chairperson:

That does not answer the question. The question was whether any woman's health was compromised as a result.

Dr Devlin:

That is why I said that the time to receive treatment was not affected. The time that was taken to receive treatment for anyone who needed treatment was not impaired or affected.

The Chairperson:

So nobody was missed as a result of that?

Ms Way:

No. Definitely not.

The Chairperson:

In other words, had the deadline been met, no woman's position would have been any different?

Ms Way:

No.

Dr Devlin:

That is right.

The Chairperson:

That is crucial.

Dr Devlin:

It is there as a target. However, it is possible for us to achieve that target and not help the women in any way, but we choose not to do that.

The Chairperson:

It is an important statement that no one was prejudiced by that.

When it became apparent that there was a problem, why did you continue to take routine X-rays when you knew that a large backlog had developed? I understand that there are X-rays and there are X-rays; I have had quite a few recently. Sometimes, a person has a bit of a scare, and a chest X-ray is taken to see whether there is a growth. Other people have X-rays when they hurt their ankle. You can see the difference between the two: one may help to fix the person's ankle, but it is not a life-and-death situation. Why did you continue to take routine X-rays when you knew that you could not cope with what was coming through the system already?

Dr Devlin:

Realistically, we do not have any opportunity or option to stop taking X-rays of patients who turn up with something wrong that requires action. Unless it is decided to close the hospital, the routine processing of clinical cases cannot stop. I bring you back to the point that, in these cases, we were talking about the issuance of the formal report. That is not to say that many of those X-rays were not being used in the normal clinical diagnostic process and being evaluated by the people who had requested them as part of the diagnostic process. I do not follow the logic in

saying that just because there is a problem in one area it should be stopped entirely. I do not think that the person arriving at the hospital would appreciate that argument.

The Chairperson:

You could have prioritised your X-rays —

Ms Way:

We did.

The Chairperson:

— and left the sore ankles while you did the —

Dr Devlin:

You are assuming that there was no prioritising. In a situation in which there is not the capacity to do all the work, prioritising is automatic. It is not that the radiologists in Altnagelvin were sitting around not doing any work; they were prioritising the work and doing what was considered the most likely to produce significant diagnoses, which tends to be A&E, GP and inpatient cases.

The Chairperson:

Dr Devlin, you are the lead clinician in this field in the Western Trust.

Dr Devlin:

I am.

Ms Way:

In Altnagelvin.

Dr Devlin:

In Altnagelvin, since July 2010.

The Chairperson:

Is there any disparity between you and Ms Way? When did you know that there was a problem? Was that before the chief executive knew?

Dr Devlin:

Clearly, I know before the chief executive knows because I work in the X-ray department.

The Chairperson:

When did you know?

Dr Devlin:

When did I know?

The Chairperson:

When did you know that there was a problem?

Dr Devlin:

We knew that there was a gradually growing problem ever since the time of the staffing issues, which started when we lost two senior members of staff who did a lot of that kind of work. From that time on, a variety of attempts was made by the trust to try to ameliorate that position with varying degrees of success.

The Chairperson:

A date, please. When?

Dr Devlin:

I think that we are talking —

Ms Way:

The two radiologists retired in 2008, but they came back on a sessional basis to support us —

Dr Devlin:

June 2008 is when those two members of staff retired.

The Chairperson:

When did you know that a serious situation was developing as a result?

Dr Devlin:

We do not know that a serious situation is developing for quite some time, but a situation was gradually developing from that time.

The Chairperson:

This is what I find exasperating. There was a classic interview on the 'The Stephen Nolan Show' during the —

Dr Devlin:

Excuse me for a second. You asked when we knew that a serious situation was developing. We did not really know that there was a serious situation until it was identified that somebody had come to any harm. All that you are talking about is a potential, which is set against the other pressures and strains of the service, based on the fact of having seven or eight members of staff instead of 12.

The Chairperson:

On a certain radio show — I will not name it — a leading spokesman for the Public Health Agency gave a brilliant 40-minute interview without actually providing anyone with the information that they wanted. It was classic, a masterpiece. The following day, the information that the interviewer had tried to get for 40 minutes became available. Suddenly, the information came out, and the Public Health Agency's problems disappeared because, once there was openness, transparency and clarity, people understood what was going on. I will walk out of this room thinking that I have had the same experience this afternoon. There are dates in people's diaries and e-mails that show when this all became apparent. However, no one has actually said that it was 13 September or 14 December. That is what we need to know, because those dates have major implications. Had that serious incident not occurred, when would we have known just how bad things were? That triggered your alert in July 2010 —

Dr Devlin:

Sorry, but it is important to realise that the incident did not trigger the look-back exercise. The work to fix the backlog had been ongoing before that. It is important to understand that the look-back exercise and the backlog issue were under way before that.

Ms Way:

Dr Devlin was appointed to his role as lead clinician in Altnagelvin in July 2010. He was appointed to the role just when we had the serious adverse incident, and he has worked very closely with managers and the medical director to resolve the issue. When we merged into a big trust, we tried to have a lead clinician for a certain area who would work right across the area, and that issue is flagged up in the Gishen report. The person appointed as lead clinician was Dr Padhraic Conneally, who is based in Omagh and Fermanagh. One of the things that did not work — I said this to Professor Gishen and it is reflected in the report — is that taking into account the challenges, issues, busyness, pressures and lack of resource, Altnagelvin needed its own lead clinician, and Dr Devlin was appointed only in July 2010.

The Chairperson:

It is clear that we will not get any dates, and we have to accept that the information will not be forthcoming. Those dates are vital, and I am sure that the information is contained in diaries. If the situation was known about long before the serious incident and action was not taken, questions have to be answered. It worries me that I will get the dates from some newspaper tomorrow morning. That is the problem, and the difficulty when working with the trust, the board and the Department is always that the information will come out anyhow. The problem is that it comes out and bites us as a Committee, whereas I gave you an opportunity last week to come out with information but you did not take it.

Mr Compton:

I want to state, to be helpful, that no one is trying to obfuscate anything. The board's understanding is that there was a building problem and that the trust was trying to deal with the backlog during the 2010 period. An event occurred on 13 July: a notification that there might be a serious adverse incident. When one reports a serious adverse incident, it may or may not be a serious adverse incident. However, this turned out to be a serious adverse incident, and that triggered the action and the date. As I understand it, that is the date on which the system recognised that what was being attempted to be managed in the normal business arena would not be managed in the normal business arena because it had escalated to a different place.

As far as all management is concerned, there is the normal management of any problem at any point in time, and then there are escalation arrangements. The escalation is the important issue. As we understand it, although the trust can correct me, there is a building problem. The trust is

trying to resolve that problem. There is a change in the dynamics when there appears to be a serious adverse incident. That escalates the problem to a different level, and it leads to a serious set of actions from the board and the trust to sort out the problem and properly to scope, scale and size it to ensure that proper management and proper processes are in place to deal with all of that.

That is absolutely transparent. It is important, and you are quite right to say, that no one should leave the Committee today feeling that, in some way or other, that there has not been straightforwardness about this matter. That is the straightforwardness.

The Chairperson:
That is the same straightforwardness that told us that the statistics on swine flu were not available but they appeared 12 hours later, John. That is what I am suspicious of.

Mr Compton:
I do not want to get into an unhelpful debate, but when it is discovered that there might be a problem and it is being attended to, the assumption is that it is being resolved. However, if it turns out that the problem is not sorting itself out, what date should be picked? It is difficult to say whether it is this date or that date. As a general rule, we operate inside the system, but the date that we pick is the date on which the serious adverse incident emerged. That is an important issue for us, and that is the important date here.

The Chairperson:
What would have happened had the serious adverse incident not emerged?

Ms Way:
We would have cleared all of them. We had made a decision that all of them would be cleared because, as Dr Devlin said, we had introduced, in May 2010, the new Northern Ireland Picture Archiving and Communications System (NIPACS), where all the films were recorded. Dr Kilgallen has asked to explain the situation because she stepped in and took the leadership role, and she sorted it out within three months.

Dr Kilgallen:
I want to explain that, in the period leading up to the adverse incident, we advertised four times to fill posts. We made strenuous efforts to attract suitably qualified doctors as locums, and we had

some very good locums during that period. We also arranged to transfer some films electronically for reporting outside the trust. Therefore, those measures were ongoing prior to the serious adverse incident. When we became aware of that incident, we formed a small team and escalated what we had done previously. We redoubled our recruitment efforts, increased the number of films, acted on the turnaround time for the films going outwith the trust, and we ensured that all clinicians responded rapidly when reports came back to the trust so that we could act quickly to identify people.

Therefore, steps were in place throughout the time leading up to the adverse incident to get on top of the situation and to clear the unreported films. When the adverse incident happened, we immediately escalated what we had been doing. We dealt with the backlog in the following weeks and months, prioritising chest X-rays, which an earlier questioner identified. However, the backlog was not all the same. We were able to identify and prioritise, and we processed all of those X-rays over the subsequent period.

The Chairperson:
The adverse incident related to someone who had been X-rayed, not analysed and then reported with serious advanced cancer.

Dr Kilgallen:
Yes.

The Chairperson:
That is what triggered it. The question was how the condition could have gone undetected if he had had an X-ray.

Dr Kilgallen:
Yes. From our point of view, that was the immediate question for us. Here is an X-ray that has been in the system but does not have a formal report, and the consequence is a delay for the patient.

(The Deputy Chairperson [Mrs O’Neill] in the Chair)

Mr Girvan:

Thank you for coming before the Committee today. I know that it may not be the most pleasant experience, but I have a number of concerns. I would like to come back on a point that Anne made. She mentioned outsourcing to achieve clarity on some of the 18,500 X-rays. Where was that undertaken? Was it undertaken in another trust?

Dr Kilgallen:

No, those films were dealt with by the independent sector. Over time, we had worked up a contract with an independent company called Medica**,** which uses suitably qualified consultant radiologists to provide the service. Before the adverse incident occurred, we spent some time developing a contract that would have appropriate governance arrangements in place so that we could safely outsource films for reporting. Therefore, we already had that arrangement in place. At the point when the adverse incident occurred, we redoubled the use of that outsourcing.

Mr Girvan:

I come back to the large volume of X-rays involved — some 18,500. Those sorts of figures are daunting for a Committee. There were not 18,500 patients, as one patient might have had several X-rays. The other point is that, of the 18,500 X-rays, four were identified as problematic. It is only by the providence of God that the number is so low. However, I took comfort from what Brendan said, which was that when the radiologists looked at the X-rays they spotted that they showed something serious, and most of them had been picked up. It was the ones that had gone through without an official recording and report that were identified.

If 18,500 X-rays were not evaluated, why is a case being made for more equipment rather than for more radiologists? My point is that money should not be thrown at buying hardware when there are not enough staff on the ground to use it. It was mentioned that more money was needed to buy radiology equipment. If you are sitting with 18,500 X-rays that have not even been properly assessed, why go down the route of buying more equipment? Given that you do not have the right number of radiologists now, that would only add to the problem.

Dr Devlin:

That is a very good question, and I am glad that you asked it. The comments about buying equipment, such as CT and MR scanners, were made by the external group that looked at our department. They said that it was a pleasant department and a nice place in which to work but

that it looked like a department from the 1990s. They asked where all of our CT equipment and MR equipment was. What they meant was that we are not configured and that the profile of our equipment is not appropriate to modern radiology in 2011. The external group is from a place in London that has lots of that equipment, and staff there are able to perform and to respond to the demands that are placed upon them.

That is a separate issue that is unrelated to the capacity to report the plain films. It was a comment made by the external review team on the type of service that we deliver at present. The team said that our equipment does not reflect the imaging requirements of a modern acute hospital. Do you understand what I mean? It is a different slant.

Mr Girvan:
You said that, from now on, all slides and all X-rays will be on a computer database and controlled in that format. Does the equipment that is currently used have the capability of uplinking directly to that network?

Dr Devlin:
Absolutely.

Dr Harper:
The response is that, as well as clearing the immediate backlog and getting in place systems to deal with it, we must also look forward and minimise the risk of a recurrence. Some of Professor Gishen's recommendations related to the capacity of equipment and staff. The availability of backup equipment gives the service a bit of resilience in relation to its ability to put patients through X-ray machines and fairly technical equipment in a timely manner. It is a matter of planning and looking to the future, as Brendan mentioned, and of putting in place extra capacity.

Mr Girvan:
I welcome some of the report's recommendations, some of which indicate the need for a more regular review process and for more openness between one department and another. In this case, our primary focus is the radiology department, but I am sure that other areas might show their head in the future.

I do not agree with some of the arguments. There is probably more management in the Health

Service now than ever before. Some people might disagree, but there are all sorts of managers, including bed managers, whether or not they have clinical titles.

The issues in question should be picked up weekly. You should be able to say that you have conducted 1,000 X-rays in a week but reported on only 800 and, therefore, that staff may have to work through the night to check the remaining 200.

If there is a backlog of work in any line of work in the private sector, someone asks the lads to work through the night to clear it. There must be an ability to react, and that has been lost in the health system. It has become a case of people's attitude being that they finish at 5.00 pm and so they leave at that time. Clock-watching seems to be a part of the —

Ms Way:
You will not be surprised by my jumping in immediately on behalf of the staff. In truth, we would not have been able to do the work that we did to try to address the backlog, which is fully my responsibility, had it not been for the front-line staff, the radiographers, the administration staff and the radiologists working far above and beyond the call of duty.

I absolutely agree with your point that we ought to have a sheet that states the number of X-rays taken and the number cleared. We are now able to do that because we have a computerised system that shows the number outstanding. That is why John is able to monitor us so quickly. We have a commitment to clearing the outstanding ones within the set timescales. However, it is a point well made.

Mr Brady:
The issue of breast cancer clinics was raised. Underperformance was reported in September, but by November, performance was back up to 99%. Was that because of a problem with resources? If so, were resources redeployed to bring the numbers back up and improve the turnaround?

I want to ask Dr Devlin a question. This might sound simplistic but you were asked:

"whether any woman's health was compromised as a result"

of the 14-day target not being met. If someone is not seen and not diagnosed, how does the doctor decide on treatment? There is a sequence: a patient is referred by a GP or healthcare professional; the expert or specialist decides what needs to be done; the patient is referred,

presumably for biopsy —

Dr Devlin:

If I may just come in there, that is not quite right. If the patients are not seen for weeks and months, obviously, treatment will be delayed and they could be affected. However, we are talking about the target. If the target is 14 days and a patient is seen at 15 days, the target has not been met but it has made no substantial difference to when the patient is treated.

What I am trying to say is that we were a bit behind with the target. Some units might call women to be seen in the first instance and then to return for a full evaluation. That would mean women attending hospital twice to get to the stage where they would have got to with us with a slightly longer performance target. However, in our situation, the degree of underachievement on the target did not affect when most patients received treatment. Had it been a terribly long delay —

Mr Brady:

I accept that. However, there is, presumably, a reason for having a specific target of 14 days for breast cancer, which is, by its nature, sometimes aggressive and sometimes not. An early diagnosis helps with any condition. You do yourselves no favours by not making the information on targets clearer. If you do not achieve the 14-day target, someone reading that could assume that you missed it by two or three months. If you state that you missed the 14-day target by only a week or a few days, it would be reasonable for people to assume that no one's treatment or diagnosis was compromised.

Dr Devlin:

I take your point.

Ms Way:

That is not how it seems.

Mr Brady:

You need to go back to the report and make that clearer. The report is in the public domain, and people will ask themselves by how much was the target missed. The Chairperson asked whether any women were put at risk, to which you answered no, and you gave a reasonable explanation.

However, that is not made clear in the report.

Dr Devlin:
I take your point.

Mr Compton:
Let me be clear that, in cancer care, we have a range of targets. At the board's public monthly meeting, we report our current position on a range of issues, including breast cancer.

(The Chairperson [Mr Wells] in the Chair)

We could have a lengthy debate about the benefits and non-benefits of targets. The targets are derived from best professional practice. The 14-day target, the 30-day target for treatment and the 61-day target are all important, and we report on them all. What is important here, to support Brendan's perspective, is to get an idea of the scale involved. In October, 76% of people were seen within the target time, and, in November, that figure was 99%. Only two patients were seen outside the 14-day target, and 17 days was the longest anyone waited, so there is a need for perspective here. Nonetheless, these targets are deemed to be important. It is important that the organisation of our response to cancer services is timely. One key message that applies across the whole of the community is that timely and prompt diagnosis and prompt personal attention to issues are hugely important, and that is why this is monitored.

Mr Brady:
I accept that, but it seems to me that, by not going into more detail, you leave yourselves open to criticism.

Mr Compton:
I accept that.

Mr Brady:
In some cases, that criticism may be legitimate and in others it may not. If, as you are saying, the target is missed by only three days, I do not think that it could be reasonably argued that anyone was being put at risk, but that is not made clear. I asked Dr Harper whether resources were the

reason that the target was not achieved and then, within a relatively short period, was achieved in 99% of cases. I asked whether it was because of under-resourcing or whether resources were not being properly deployed during that time.

Dr Harper:

Trust colleagues may be able to comment more properly on the detail, but, across a range of services, these are fluid situations. Changeover in personnel can happen, and that is often when there is a short-term disruption in service that means that, for a short period, performance drops below the acceptable standard.

For the record, during the period of underperformance on breast cancer waiting times, the longest wait any patient had was 33 days. In terms of the natural history of breast cancer, that does not have any material effect on the outcome for those patients. Breast cancer has a much longer natural history.

Ms Way:

There were issues, and we would say that the problem was a mixture of resources and the fact that we could have better managed some areas. The problem occurred over the holiday period, and one radiologist was off. We carry out a triple assessment in the urgent clinic, and the breast surgeon was away on audit, and so on. John has made it clear to me that his expectation is that 100% will continue. We have to plan better so that staff numbers are not down at particular times of the year.

Mr Brady:

Some people may be considered to be more at risk of breast cancer and may need to be seen earlier for screening because of family histories and various other factors, but dealing with those cases involves a more planned regime.

Mr Gardiner:

The incident was most unfortunate, particularly for the patients and those working in the organisation. What have you learned from it?

Ms Way:

We are still learning. I am reflecting on some of the comments made today on how we handled

the incident, such as the offering of apologies, and on our relationship with the Health Committee. Over the past while, Dr Devlin has told me that the only way to improve services for patients and clients is if people who are on the front line and delivering those services are in charge of how they are designed and delivered. He has told me that, to ensure that such an incident does not happen again, he wants our permission to ensure that he is wholly involved in discussions on the redesign of the service.

We have been working very hard. I hope that you have had the opportunity to read the wider performance review. If so, you will have read about how we are trying to improve what we call clinical engagement, which is jargon, but it is about giving more power to front-line professionals. The biggest lesson that we learned from the situation is that the people who provide hands-on care for patients day and daily must have a louder voice and greater influence.

Mr Gardiner:
Therefore, it should never happen again.

Ms Way:
I have given an assurance to John that, if we see from the computer system that there is a backlog, we will immediately say that something must be done to sort it out. Professor Gishen's report states that, should we get into difficulty and want to outsource some of the reading, we can, for example, link in with his team at Imperial College and they will provide support. Therefore, it should never happen again.

Mr Gardiner:
So, in one sense, it has been helpful. However, it has also been a bad and expensive experience.

Ms Way:
Absolutely.

Mr Compton:
I have a couple of observations. First, we have a new system in place in the health and social care service, and when there is a different way of handling performance management, people sometimes find certain things that they would probably prefer not to find. However, the good thing is to find them and fix them. I think that, to be honest, that has worked well for us.

The second thing that worked well was the response of the organisation. Everybody in the organisation has been 100% committed to fixing the problem. Members of staff were genuinely upset and distressed about what happened to the individuals involved, and that sense of upset and distress was shared throughout the system. People work in the health and social care service to do good not bad, and they are distressed when things do not go quite right.

If we are honest, I think that we are struggling to learn about communication. However, we will say that we think that we are open, honest and transparent and that we tell everything that there is to tell. We say that because we genuinely believe it. However, we also have to listen to what other people say, and if we are not, perhaps, straightforward on occasion, we have to learn the lesson of what "straightforward" means to other people and pay attention to that. For me, that is the real issue here.

The Chairperson:
It would also mean far fewer question-and-answer sessions for you and the Committee. Had we been told about this review at the start, you probably would not be here today. If the Deputy Chairperson wants to come in, I will let her do so in a moment, because it was Michelle's idea to have this session.

You made a couple of comments on which you may be able to come back to us. First, after you speak to the family of the 80-year-old gentleman, you may be able to tell us why it appears that his diagnosis was missed twice — that is a very pertinent question. We would like to know the answer to that if possible.

Secondly, when you go back to your various offices, you may come across e-mails, notes in your diaries or post-it notes on your computer telling you when you might reasonably have known about the problem — before its emergence in July 2010. It would be helpful for us to know that, just in case a certain newspaper or a certain BBC commentator finds out anyway. If the information came out in that way, it would place us in a difficult position. Michelle, do you have any final questions before we call it a day?

Mrs O'Neill:
Yes; I will be brief. I welcome the improvements that have taken place. I do not doubt for one

second the staff's commitment to wanting to change things to make them better. However, after listening to you today, if you asked me whether this could have been prevented, I would say that it could. That is my interpretation of our discussions today. On a managerial level, it could have been prevented. Given that you were able to fix the problem within three or four months of a serious adverse incident, you could have fixed the problem that had been building up over the past number of years. That is my opinion, and I will leave it at that.

Dr Deeny:

I would like reassurance for the public. Brendan, the right number of consultant radiologists is still not in place. Until that time, will the two other X-ray departments be used for routine X-rays, such as chest and skeletal X-rays, which can easily be done there? John, you said that the problem has been rectified: is that part of the rectification process?

Mr Compton:

Yes.

Dr Deeny:

Who is Professor Gishen?

Ms Way:

He is a professor of radiology at Imperial College London.

Dr Deeny:

So, that is why he was picked.

Ms Way:

Yes.

Dr Deeny:

Altnagelvin still faces a problem because it remains short of radiologists. Will the other two hospital X-ray departments be used for routine X-rays?

Ms Way:

We still have locums in place, and we are still using them. We need enough resource at the

Altnagelvin site to have flexibility across all modalities. However, we will carry out a reading right across the organisation. Brendan's point was that, if there is capacity elsewhere in Northern Ireland, that area would be our first resource.

I wish to make one final comment on John's point about communication and how difficult that is. John and I have been talking to other chief executives about how we handle such situations. The performance report states, for example, that the Western Trust has 45 risks on its corporate risk register, which it is managing. The suggestion is that 45 is too high a number of risks to have on a corporate risk register. I talked to my trust board about that this morning and made the point that, even if we take those risks off the corporate risk register, those are the risks that we manage at any given time.

I would be delighted to ask people please to understand that the 12,500 staff in the Western Trust, who manage and try to mitigate risks daily, are trying to do their best for the population whom we serve. Over the past weeks and months, the Western Trust has been reviewed a number of times by a number of bodies, both external and internal. As chief executive of the Western Trust, the one thing that I hold on to is that it has been acknowledged by all that we are an open organisation, that staff will say if something has gone wrong and that we will work hard to fix that and learn from it. As I said today to our trust board, health and social care is very complex and very risky, and I believe that we have to make sure that we own up to things if they go wrong and make sure that we fix them.

The Chairperson:
Thank you very much. It has been a two-hour session, in which everyone has had an opportunity to question you. We would welcome any correspondence on this issue that you may want to send us at a later date.