Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Northern Ireland Human Rights Commission Inquiry into Emergency Healthcare

18 June 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mrs Virginia McVea	Northern Ireland Human Rights Commission
Dr David Russell	Northern Ireland Human Rights Commission

The Chairperson: Folks, you are very welcome. I know that John Corey is not able to attend today, but we have Virginia McVea, director of the Human Rights Commission, and David Russell, its deputy director. Thank you for taking the time to attend. The normal protocol is that you give us a 10-minute presentation, and we will then open up the meeting to Committee members' comments or questions.

Mrs Virginia McVea (Northern Ireland Human Rights Commission): Thank you very much, Chair. I pass on again John Corey's apologies for not being able to be with you. There was an oversight on our part: John had long-standing commitment to an EU body that he sits on in Brussels. Apologies for that, and thank you very much for the opportunity to appear before the Committee today.

When developing its strategic plan for 2013-16, the commission embarked on a new manner of engagement, participation and consultation with civic society, NGOs, public authorities and other oversight agencies, which resulted in the three pillars of our strategic plan. Those are human rights and good governance; human rights on austerity; and human rights in dealing with the past. The drill-down in the good governance and austerity pillars called for consideration of health and social care, and the commission began 2013 by thinking about how it would operationalise those issues for health and social care over the three-year period. One example of the way in which we are working is the service-level agreements (SLAs). We have a service-level agreement with the Northern Ireland Ombudsman and we have just concluded the final draft of a guidance document for ombudsmen on human rights-based approaches to the work of an ombudsman. That is being showcased to ombudsmen and national human rights institutions globally as a way of working. Another example is the service-level agreement with the Health and Social Care Board (HSCB). We have been providing advice and training on review arrangements for vulnerable adults; regional policies on services for adults with sensory impairments; procurement; and other Transforming Your Care issues. However, advice and training is only one element of our work, and, as members may be aware, we additionally have investigative and legal powers. Since we opened our doors, the commission has been running investigations. It has carried out a number of investigations that touched on health and social care; for example, the investigation, the report of which was published recently, into dignity in nursing homes and, previously, the investigation into right-to-life issues.

We began our work on health and human rights a number of years ago, and when we decided, under the strategic plan, that we were going to look at Health and Social Care, we were trying to think what the most effective way of working is, in addition to the training-and-advice routes that we had already been deploying. A methodology came to mind that we thought would be particularly useful in that arena. Such a methodology is called a "national inquiry" elsewhere in the world. In Northern Ireland, we refer to it as a "human rights inquiry". The key value of the methodology is that it is centred on public participation and the participation of those involved in any work areas that are touched on.

We came to a triangulation opportunity. We had our strategic plan, which stated that all those agencies and the members of the public that we engaged with wanted to look at health and social care issues. We had the issue to do with the methodology and a participative element, and then we had the area that we were going to look at. Given the areas that I referred to before, around nursing homes, and so on, and what we were doing with the Health and Social Care Board, emergency healthcare seemed to be the appropriate place for the commission to be doing some of its work. The participative methodology of a national inquiry seemed the most attuned to engaging in emergency healthcare services.

The methodology has probably been used most in the Asia-Pacific region. Various manuals and training materials have been prepared on the methodology, which has been acknowledged by the United Nations itself and by the International Coordinating Committee (ICC), which oversees all the national human rights institutions across the world. To try to give this some kind of life for you, I have taken some of the pages out of the Asia-Pacific manual for national human rights institutions in running these types of inquiry and brought them along today so that you can have a look at them separately. I will pass them around.

Mr Dunne: Thank you.

Mrs McVea: In essence, the way in which it works is that you scope out a subject area and do a certain amount of research work. The heart of the matter is the public inquiry and its hearings. The commission is planning to run public hearings across Northern Ireland in September and October, as you will know from the documentation that you were provided with earlier. Necessary for the format of those hearings is a range of powers within the national human rights institution; for example, powers to compel evidence and witnesses. All of that is in place under the Northern Ireland Act 1998. It is also necessary that we work with a panel, the members of which are, in this instance, the chief commissioner, whose name, we hope, will be announced very soon; one of our current commissioners, Marion Reynolds, who comes from a social services inspectorate background; and the former UN special rapporteur on health, Professor Paul Hunt.

The presence of Professor Paul Hunt speaks volumes about the level of interest globally in what we are doing here. It is recognised internationally that emergency services are, as the Chair said, the front window into healthcare services in a jurisdiction, and public participation and that of healthcare workers has very often been missing in review and transformation of healthcare systems.

Our public hearings will run in September and October, and, during those hearings, we will receive evidence from officials. We have requested that the Minister, as happens internationally, attend and give evidence, on two occasions, hopefully — at the opening and the closing of the public hearings. We are hoping for the involvement of healthcare workers, as well as of members of the public and, indeed, the media, which has been very much involved in bringing many of the stories across the jurisdiction to the public's attention. After the public hearings, all the evidence will be analysed, and a report with recommendations will be produced in spring next year.

We are a very small organisation with a very small budget, and we will be working to try to have a focus on emergency care. We are not clinicians or healthcare management experts. Our expertise is in human rights. So, the focus of the inquiry will be on quality, information and participation, and participation in decisions around care and the availability of information to service users is fairly self-explanatory. On the quality issue, the key will be responsiveness to need and dignity in care, and we will also look at the skills of staff working in those areas. That will also roll out from it as well. Those are the three key areas that we will be working in.

In addition to the normal methodology for a national inquiry, we have opened a confidential telephone line. We wanted to give everyone, including those working in the healthcare system and those receiving care, as much opportunity as possible to tell their stories. We are also having focus groups and working with community groups across Northern Ireland in advance of the public hearings, and, as you can imagine, the stories that are emerging cover the spectrum of care. We are hearing about mental health issues and issues concerning children, older people and people who have long-term illnesses and require fairly constant engagement with the healthcare system.

That is a rough outline of how the system will work. We very much hope to be able to report to the Committee. It would be very helpful if the Committee were in a position at some point to give evidence, and, to drill down further, we will be calling on all MLAs to do work in their constituencies. We are already receiving letters from MLAs about stories and issues in their constituencies, and we would like to use this opportunity again to ask MLAs if they will help us, a small organisation, connect with the public.

In conclusion, because of some proposed cuts to our budget for 2015-16, which we have advised creates difficulties for us in fulfilling our statutory duties under the Northern Ireland Act and, as a national human rights institution, our duties under the UN Paris principles, questions have been asked about our running this inquiry. As a very small organisation, we have set aside about £70,000 to do it in its entirety. It was planned for in the way in which I set out at the start, from the strategic plan through to our business plan for this business year. So, the proposed cuts do not impact on the work of the inquiry, but I highlight to you that this type of work, which is so vital for engagement and empowering people to claim their own rights and understand them, is put in jeopardy when those proposals are moving forward. They are for next year, not for this year, and it is useful to have the opportunity to explain that to the Committee at the outset.

The Chairperson: Thank you for that. It is probably important to say that this inquiry is unprecedented. It is extremely important that we get the overview of the human rights obligations and that, effectively, the words being used describe how emergency care respects and protects human rights and their framework in legislation. It is important to have that sense of it.

I am particularly interested in your powers to compel witnesses. You referred to that power being there. You also refer to public hearings and being able to seek departmental officials and even the Minister to attend. Will you elaborate on that? Is that confirmed?

Mrs McVea: The Northern Ireland Human Rights Commission is accredited A status in the UN system. That means that Northern Ireland gets the chance to have its voice heard on the world stage. However, the payment for that opportunity for Northern Ireland to have its voice heard in the UN treaty body system is that it has to adhere to certain standards. Some of those standards relate to your powers. So, as an A-status national human rights institution, the commission has the power to carry out investigations. For those to be meaningful, it has the power, for example, to enter places of detention and to compel witnesses and the production of evidence.

As you can imagine, so that the process can move forward expeditiously, we do not want to be drawn into long debates. The key issue here is that this is a unique opportunity. The attention being paid to emergency services worldwide is unprecedented. Given the reviews conducted by other bodies that are looking at clinical and at healthcare management elements, it is a perfect time, with Transforming Your Care, to make sure that the legal obligations around issues of dignity, which are so crucial to people using the service and those who work there every day, are explained. People can use the word "dignity", but the questions are these: what does that mean for waits on trolleys, involvement in your care, being able to use the toilet facilities or having food and drink?

Yes, we have all the powers to compel, but we very much hope that it will be a proactively participative process for the benefit of all people in Northern Ireland and that it will enhance Transforming Your Care and the reform of our healthcare services.

The Chairperson: OK. Thank you. Without pre-empting the findings of the inquiry, because we may have instincts and views but we cannot pre-empt the findings, if we fast-forward to spring of — is it 2014?

Mrs McVea: Spring of 2015.

The Chairperson: Sorry, 2015. What will happen with the recommendations?

Mrs McVea: They will be presented to government, as all our advice would be, and shared. We are very much looking for your support. We will present the recommendations as we would with other pieces of work, and then we will conduct a follow-up. The various UN treaty body monitoring systems will then come into play; for example, the International Covenant on Economic, Social and Cultural Rights will be looking at the UK. That is where the right to the highest attainable standard of health sits. It will examine those kinds of issues and provide a further vehicle of accountability. It will be looking to see what government has done with the recommendations of the national human rights institution.

We provide advice, and then it is very much over to government. However, because of the UN and EU systems, government, too, will be held to account. The UK Government have already ratified that treaty and said that, since 1976, the right to

> *"the highest attainable standard of physical and mental health"*

is protected in all policies, procedures and practices in the UK. The question is how that measures up.

The Chairperson: What will happen if, as part of the inquiry, a pattern emerges around neglect or there are systemic issues of concern? We are obviously aware of the serious issues around serious adverse incidents and the reporting, or lack of reporting, of those to families. If the commission becomes aware of specific issues of concern, will it alert us and/or the Department? What is the protocol?

Mrs McVea: We have a process of escalation. As a public authority, we have duties under the right to life and the right not to be treated in an inhuman or degrading fashion. We must escalate those risks ourselves. Having worked with this and escalated matters before, Dr Russell, to provide assurance to the Committee, can speak to an example in our nursing home report and what we did.

Dr David Russell (Northern Ireland Human Rights Commission): The internal process for previous investigations is exactly the same as we will follow here. It is quite simple. Regulation and inspectorate bodies already exist in the healthcare system. If it were a systemic issue and had happened historically, the commission might not escalate immediately. We might hold back on that evidence, having taken our own mind on it, and that would go into our report.

If it were a case of an individual, for example, and we received a complaint that was in the here and now, and if the commission were of the view that there was an ongoing breach of that individual's human rights, we would send it to the relevant responsible body and ask it to act immediately and come back to the commission immediately on the action that it took so that we would be satisfied that the proper process was being followed to protect the individual concerned.

It is unlikely in an individual case that we would report back to the Committee, but when it comes to systemic or potential systemic abuses or violations of human rights in the longer term, we will be very much engaging with the Committee on our view as to what would be necessary actions by the Department or relevant trusts or authorities to rectify that wrong.

The Chairperson: OK, thank you for that.

Mr McCarthy: To what extent will the issues faced by patients with a learning disability or, as you mentioned, a mental health condition be taken into account?

Mrs McVea: They will, under the heading "quality". There is a point included on responsiveness to need because we want to look at particular vulnerabilities. If you start to list them all, it is a bit unwieldy, but yes, absolutely. We have already had information, by way of example, from adults with sensory impairments about some of the difficulties that they face when they go into a waiting room in emergency services. Different issues with sight have arisen, with people having been told to press certain buttons and whatnot and to wait for people. People with a hearing difficulty need to know who to approach, and then there is the response that they receive. Therefore, it will be vital.

Dr Russell: As part of the methodology, the commission is taking evidence through its confidential phone lines, but our staff team working on the investigations is also engaging directly with groups of people. The commission's focus in all its work is always on the most vulnerable and marginalised. That is our starting point. For example, in looking for the evidence base from the trusts, policies and processes around vulnerable and marginalised groups, including people with learning disabilities, would be very much to the forefront of our mind.

Mr McCarthy: OK. That is fine.

Mr Brady: Thanks very much for the presentation. The public meetings — there is one in Newry, I think, in September — will be advertised in the local press and, presumably, on local radio. They will be well advertised, because you obviously want as big a participation as possible.

Mrs McVea: That is crucial to us. We are small and have a tiny budget. This week, we sent out this poster that I am holding up. Posters will also be sent to all MLAs, so you should receive one. It was in the main papers last week, I think, and is in the vast majority of local papers this week. We also put out the timings for the public inquiries so that people have that information in advance.

Mr Brady: I am thinking about nearer the time, what with the meetings being in September.

There is a Freephone number. You are talking about family members, patients and healthcare workers, but that opens the door for whistle-blowers. That has been part of the recent culture, for want of a better word, and rightly so. People feel that whistle-blowing is the only way in which they can get their message across.

I presume that you will get people phoning in with particular circumstances. I know that the conversation will be confidential, but will those people be treated any differently? You are going to have people very well placed in the healthcare system who see systemic failure or particular failures, such as what has happened in particular episodes in, say, an A&E unit. I am sure that it will be factored in, but I am just wondering.

Mrs McVea: People should feel very confident in approaching us, not least because, for whistle-blowing, the Human Rights Commission is a recognised agency. We want people to tell their good stories about how things worked well for them, but we also recognise that people might feel very anxious. We have been approached by healthcare workers, but we have been working very closely with unions, especially Unison, to make sure that we have all the systems in place so that union members feel confident and comfortable in approaching us. We will also have opportunities for some evidence to be heard in camera, if that is deemed necessary. Obviously, the whole point of the process is to be as open and transparent as possible, but those situations may well arise.

Dr Russell: As Virginia said, the commission is a designated body under the relevant legislation. Individual staff members who come forward to the commission, or whom MLAs have been in contact with and want to direct to the commission, can be perfectly assured that they can be afforded the whistle-blowing protections under the necessary legislation. We understand that that takes immediate effect from when they come to the commission, and we would act very much in their defence in that regard.

For senior clinicians, for example, who might have evidence, a slightly different tack will be taken with how the evidence comes to us. If any senior officials were forthcoming to the commission of their own accord and wanted to be afforded that level of protection, the commission would consider whether it is necessary, as Virginia said, to take evidence in closed session. It is not ideal for the methodology because the hearings will be in public. I say that because there will be a distinction between public officials called by the commission to give evidence and those who come forward of their own volition to provide evidence to it. It will be the expectation, from which the commission is unlikely to deviate, that public officials will be required to give their evidence in public, before cameras and the media. The public sessions will be open to the media.

Mr Brady: That was my next question. On advocacy for people who feel that they need it, the unions are involved. However, people should not be compelled to give that evidence in public if it were deemed to have an adverse effect on the person's employment or whatever. The unions will be factored into all of this, presumably.

Mrs McVea: Yes. We have done that. In addition, a pilot project has been operating through DOJ around advocacy, vulnerable witnesses and whatnot. We have been liaising with that project in our development. We do not have sufficient staff to match an advocate to each individual, but the evidence will be planned beforehand. We will know the people coming forward to the public hearings in large measure, and we will be able to provide them with support. If we were to come across a situation in which we deemed that the level of support provided could not be made for some reason, the interests of those individuals would always come first.

Mr D McIlveen: Thank you for your presentation. I just want to get a bit of a better understanding around the fibre of the report and what it is possibly going to look like out the other end. What health-related research and work has the Human Rights Commission been involved in in the past? Are there recent examples of other work that you have done on health?

Mrs McVea: I was trying to remember this as I was coming up. About seven years ago — I hope that that is close enough to not be too far out — the Human Rights Commission held the first conference on health and human rights. It was fairly groundbreaking, even in the UK. In fact, it was one of the earliest occasions on which the UN special rapporteur — Paul Hunt was in post at the time — came over to Northern Ireland to explore the connection between human rights and health. Following that, there was development in the public authorities to pay closer attention because equality had been the key issue. So, we looked at it there. We did a lot of work around the right to life. We worked, for example, with senior QC Tony McGleenan around death investigation. We worked closely with the senior coroner on what is required and the connection between healthcare examinations in the system and the inquest procedure in criminal procedures. As a further development, we looked at nursing home care, and were very much in the realms of dignity and exploring what that meant in real terms by applying human rights to the quality of people's day-to-day life and the dignity in the care that they received. Those are key areas: the right to life; the right relating to inhuman and degrading treatment; the right to a private and family life. Sometimes, I describe the right to a private and family life as the sin bin of human rights: if you are not sure where it goes, that is often the place you go to. It is about your opportunity to develop as an individual and all that that might encompass. It is all those areas. Moreover, in relation to the treaty body monitoring system, we have to advise the UN, through the UK state reports, on a range of civil and political rights and on economic, social and cultural rights. That has been ongoing since the commission came into operation.

Mr D McIlveen: I say this with the greatest respect, because I am as curious as anyone else is to see the outcome of the report, but I suppose that we on the Committee are no strangers to having a list of problems brought to us. However, what we are not so good at getting is a list of solutions. I have seen the groups that you are calling on for evidence. It is probably fair to say that you will get a significant response. We are dealing with staff, patients and unions, all of which will have grievances and many ways to put those across; your report will be just one of many. What will be done internally, from your point of view, with the necessary expertise, to ensure balance in the report?

I see a list of people and groups, whose responses I could probably predict accurately . I am sure that you would be very passionate about the fact that every report published has to have balance. Take, for example, Jim Stewart, former chair of the Northern Health Trust. On 9 May, he described the Northern Ireland healthcare system as Third World. I have visited at least two Third World countries and their hospitals; I have also been an in-patient in hospitals in Northern Ireland. I know where I would rather be an in-patient. I think that the benchmarking in that statement is wildly wrong. We are in a privileged environment here. How can we make sure that mavericks do not come forward with scurrilous and unjust criticism of the health professionals who work very hard, day and daily? How can we make sure that there is balance in the report, once we get to the other side?

Mrs McVea: In your question you referred to three things: you asked that people bring you solutions not problems; you talked about how to deal with balance; and you asked about benchmarking. By way of example when it comes to solutions, even in the way in which we are setting out to do the inquiry, it is as solution-focused as an institution such as ours has the statutory remit to be. In looking at dignity, the solution that we are bringing is not simply to say that people need to be treated with dignity. How does it help us simply to tell the stories of when we think people were not treated with dignity? It is our job as the national human rights institution to bring you the law and to say at what point we think the right to dignity and the right relating to inhuman and degrading treatment are being breached or violated. Our job is to say where we think there is a difficulty and what needs to be the priority for solutions. Otherwise, you have the possibility of a scattergun approach. Our job is to apply human rights in a meaningful way so that decision-makers can prioritise and make the decisions that they have to when giving advice on process.

A lot of human rights discourse is about balance. It is our job to tell you what is absolute; it is our job to say, at this point, in terms of inhuman and degrading treatment, it has gone over the line. There is no balancing job to be done on legal obligations; at this point, it is into breach, and there is no other competing right that can knock it out of that zone.

When you talk about the Third World, one of the great benefits of this project is having Paul Hunt as special rapporteur. He was key in addressing issues of maternal morbidity and infant mortality rates in the Developing World. He has worked there extensively as well as in the developed world, and he understands the comparisons. He likes to be able to provide advice to government on the difference. If the bar is set at a certain level for a state to progressively improve the right to the highest attainable standard, it is working up from a lower level. That is different from where the bar has been set by the state in the UK, and we have to work up from that point. He is probably more aware than anyone else in a room at any time of how that compares with the rest of the world.

Finally, on benchmarking, it is about having international input. It is our job to look at the benchmarks that are already set in law. It is not our job to aspire to new benchmarks or to create new bucket lists of what we might like; it will be based purely on the law and the legal obligations as we unpack them. Those will be the benchmarks as opposed to any other aspirational notions, and they will be rooted in human rights law. We will not be able to trangress into areas that might be more clinical, although we will take some clinical advice as required.

Mr Beggs: Thanks for your presentation. Just for clarity, which of the 30 articles of the Universal Declaration of Human Rights is your inquiry focused on?

Mrs McVea: Primarily, to be honest, we are focused on economic, social and cultural rights. I think that it is in article 12, general comment 14 on the highest attainable standard of health. You will catch me out on the universal declaration if I have to go through the list. It is mainly about issues relating to dignity and the right to life. The universal declaration is not, in itself, a legal document; it merely sets the scene for the civil and political rights and the economic, social and cultural rights that fall beneath. Those are the ones that the UN treaty system examines. Perhaps David will be smart and tell you the article numbers.

Dr Russell: I was going to be very direct and say that we are not focused on the Universal Declaration of Human Rights at all. It is not a binding treaty; it is simply a direction and is therefore not binding on the Northern Ireland Executive. Our primary treaty would be the International Covenant on Economic, Social and Cultural Rights, which includes the right to the highest attainable physical and mental health.

Mr Beggs: What covenant?

Dr Russell: The International Covenant on Economic, Social and Cultural Rights.

Mr Beggs: Has the UK signed up to that?

Dr Russell: The UK has ratified it, and it is binding on the Executive under section 26 of the Northern Ireland Act 1998.

Mr Beggs: You said that the inquiry will cost about £70,000. Does that include staff costs?

Mrs McVea: No, it does not. We have a very small —

Mr Beggs: What estimate would you have of the staff costs associated with it? How many of your staff will be committed over the six months or year?

Mrs McVea: We probably have two key staff committed to it on a permanent basis. We have a project lead in the legal team and a research lead. It will not take up the entirety of their time, but it will take up part of it. If you were to make a rough stab at allowing for a part of their time, you would be talking about £60,000. However, those are estimates.

Mr Beggs: Most people accept that many of the difficulties in health are because of the mismatch between resources and the pressures and demand. Your inquiry is focused purely on the acute sector: why have you not included the primary sector? Are there too many people going to the acute sector, which is causing the problem; are there sufficient GP out-of-hours services; or is there sufficient investment in preventative healthcare? Why did you decide to look only at one element?

Mrs McVea: The issues that you identified are very likely to come up in the inquiry. If you go to, say, accident and emergency, there are roads into accident and emergency and there are routes out, and a necessary part of this inquiry will be to take those into account. That said, because of the size of our organisation, the terms of reference are important. I imagine that, on a number of occasions, we are likely to be pulled in the direction of mission creep or going down other lines; however, the issues that you identify, particularly GP out-of-hours services, are likely to be central to the process.

Mr Beggs: Finally, it strikes me that overworked and overburdened staff in crises have frequently been concentrating on the next fire fight, or whose life is at risk, and the issue of dignity, with others, can fall. To get an outcome from this we need more health resources, but, given that the DUP and Sinn Féin, the lead parties, have refused to provide additional health resources as part of the Budget, where is your process going?

Mrs McVea: We are not starting with the assumption that this is all resource-driven. The advice that we have received internationally, and which you could have locally, is that not everything is dependent upon resources. Certainly, a good deal of decision-making is based on prioritisation, and, under human rights law, the right to life and the right to be free from inhuman and degrading treatment both operate, to all intents and purposes, as absolute rights. It is therefore not possible to decide that, well, I have to fight this fire and therefore the dignity issue has to go to one side. Part of the message that we will bring across is that it is not possible to let dignity slide under human rights law, and we will then explain what we mean by "dignity".

I have no doubt that the issue of resources may arise, but decisions about prioritisation in our health and social care system become a matter for democratically elected representatives. Across the Budget as a whole, the issue of human rights is about looking for a democratic system; therefore that also becomes a matter for democratically elected representatives.

Mr McKinney: Thanks for your presentation. I would like to follow on from one of Roy's points, but in a wider sense. It has always been the SDLP's view that the accident and emergency thing is basically a symptom not a cause. While Roy is suggesting looking at other dynamics — for example, GP services — we believe that the change agenda itself has potentially led to some of the dynamics that are causing the problem. Will your narrative include that, or will it include any evidence from before the introduction of TYC as a comparator to the situation now? Will there be an assessment, if you like, of the veracity of our claim? I do not want it to be an assessment of our view, but I am talking about the context of your inquiry.

Mrs McVea: I hope that the view of the SDLP is voiced in the inquiry. In order for this to make sense as a self-contained document, both in Northern Ireland and anywhere else in the world, we will have to put it into context. People will have to be able to read how we came to this position and what the current situation is, so I think that, necessarily, that context and Transforming Your Care will come into play.

The notion of how it impacts on the rest of the system is probably something that will come up in the evidence, particularly the evidence of healthcare workers and government officials because they are the people who are often best placed to tell the story. They can say that they think that things work like this for good or ill, because, for example, they think that there is a difficulty with older people being in accident and emergency for too long because they cannot be admitted quickly enough and there may be another process to admit people; or that they think that there is a difficulty in accident and emergency because people with long-term illnesses are having to wait there when already the professionals know that they have a need and that they will be coming back time and time again. I hope that in the evidence presented by political representatives and healthcare workers in the main they will be telling the story with as much of a whole image as they can.

Mr McKinney: It is just that I have identified a potential flaw that was clearly articulated by yourself. You said that one issue could get subsumed into another process. If we end up dealing with the A&E issue simply on a rights basis, and the authorities try to respond to the rights agenda consistent with your report, we ignore the wider dynamic.

Mrs McVea: I hope that it was not a flaw but rather that the genius in the plan is to say that if you look at accident and emergency and talk about what dignity means there, just as when you talk about what dignity means in a nursing home, it does not necessarily have to change dramatically with each environment. Whether talking about care in the community with domiciliary, acute or long-term care, dignity issues apply across the board.

We have only one tiny lens to look at it, but there is absolutely no reason why strategically those lessons could not be applied elsewhere, so that the lessons from the nursing home care report on quality of life and dignity could be equally applied to a domiciliary care setting. We hope that the Health and Social Care Board, RQIA and others will take it as a key standard to apply in all sectors of care.

Mr Dunne: Thanks for your presentation. Could you clarify why you selected health? Why health at the moment? Do you just want to add to the plethora of media attention that health has got? Are you just trying to get on the bandwagon? Is that what it is about? Can you clarify why you are going for health?

Mrs McVea: This has been a developing area over many years, as you will be able to track in even the annual reports of the Human Rights Commission.

Mr Dunne: Has it been about seven years since your last —

Mrs McVea: Not since the last but since we began very particularly looking at health and social care with that conference, for example, and then a number of other reports. We have a broad remit in Northern Ireland; there has been a lot of focus on prisons, immigration status and services. We have looked at a wide range of issues. In the feedback that we got in our strategic planning process, health and social care came up time and again. We listen to what the public, government officials and civil servants were saying to us and built that into our strategic plan.

Having had it in our strategic, and then in our business, plan, the bandwagon effect did not come into play. As it happens, all those media reports have been coming out, which only copper-fastens that we were right to listen to the public when they said, "We want you to look at health and social care issues such as nursing homes." That was the overwhelming feedback after the publication of the report.

Dr Russell: The commission has other work ongoing in the area. In the next year, we will publish a major research report on the rights of carers, focused on those who care for children and on older people caring for adults in their families. We are looking at that from a health and social care perspective as well.

We also share with the Equality Commission. We are the designated, independent monitoring mechanism for the Convention on the Rights of Persons with Disabilities. The UK will be examined on that treaty next year for the first time, so the commission is very much looking at health and social care in that aspect of our work.

The current cohort of the commission has made a point of going out at least once a month to local communities throughout Northern Ireland. It is fair to say, because I have been with them on many of those visits, that that has helped to set our strategic plan and our business plan. Members of the public have repeatedly called on the commission to look at two things in the public interest, one of which was health and social care. Understandably, emergency care featured highly in those discussions.

The other was poverty in an age of austerity. The commission is undertaking a significant piece of work on that. When we asked the public what they thought the commission should be doing for them and what human rights were central to the lives of people living here, the recurrent themes were health and poverty.

Mr Dunne: Were you encouraged by outside groups or agencies to get involved in this study, or were you asked to come in and do it?

Mrs McVea: No, not least because, under the Paris principles that I referred to before, we must act entirely independently. The way that we deal with the listening is, as David described, both through our community engagements and through the strategic planning process. We also run legal clinics in Northern Ireland and, again, we see whether patterns emerge from that so that we can deal, in a more effective and efficient way, with any systemic problems that there may be.

Mr Dunne: Just as a matter of interest, did your organisation give evidence to the Transforming Your Care public sessions?

Mrs McVea: No. I do not think that we were involved in the public sessions, because I met John Compton on a number of occasions and we were asked to deliver a masterclass to the Transforming Your Care team and, with that also, the service level agreement with the Health and Social Care Board. So we were trying to be as practical as we possibly could. It would then have been inappropriate, arguably, for us to sit in a public session and take up other people's time when we had those routes in.

Mr Dunne: But you took up the opportunity to have an input into Transforming Your Care?

Mrs McVea: Yes.

Mr Dunne: OK. You obviously recognise Roy's point about the huge workload and demand on the health service. How will you ensure that there is balance between the constant outcry from certain people about the health service, and recognising the huge numbers of people and the volume of work that goes through Health and Social Care services at the moment? We know from our constituency offices that we get complaints mainly about getting into the service. The majority of people, once they are in the service, are satisfied with it. In fact, they are very positive and give positive feedback about the standard of care from health professionals. It is important that you address that balance. How do you hope to do that?

Mrs McVea: Because this is focused on a public participation methodology, we will try to encourage everybody to tell their stories. We have been very clear, in all the media work that we have done to date and in anything that we are putting out, that we want all the stories in order that we get a balanced report.

Mr Dunne: Including positive feedback?

Mrs McVea: Absolutely. It is important to give positive feedback.

Mr Dunne: Do you do positive feedback?

Mrs McVea: We do positive feedback all the time.

Mr Dunne: That is good; that is encouraging.

Mrs McVea: The idea is for somebody who has a good system that is operating in one trust to share as much of that good practice as we possibly can and tell those good stories. We know, when we have been engaging, whether on nursing homes or domiciliary care, you hear stories about unsung heroes who went out in the snow and got somebody a cardigan in the Abbey Centre. In terms of the business and what we have a statutory duty to provide to government, it is not necessarily our job to provide all those stories because we would not then be as effective and efficient as we could be. However, in this inquiry, yes, it is vital, and we want to use the opportunity, here and anywhere else, to say "Please tell us the positive stories, the good stories and, particularly, share good practice."

Dr Russell: The other thing is about public hearings. The commission will not just hear witness testimony from those who called over the confidential telephone lines to tell about a bad experience. It will also call those who can give evidence that may give a completely different view of healthcare in the emergency services.

Generally, with regards to our operation, if you want to get a sense of the sort of report that the commission will produce, members might want to look at the recent investigation report on racist hate crime. There, you will see the tone of a commission report. It identifies bad practice and lack of compliance with human rights standards in part; however, it also recognises good work by police officers and policies by the Department that were fulfilling human rights standards and, in some instances, went beyond what the minimum core obligation of the state required.

Mr Dunne: The trusts operate a complaints system that we all use and put cases through from our constituency offices. Will you be looking at those, their processes and procedures, as a part of this inquiry and get feedback on how they manage them?

Mrs McVea: It will be important that the trusts provide evidence on the quality of care and participation and information. We have requested a long list of documentation and materials through the Department and then the chief executives of the trusts. We are waiting for that to come in.

Mr Dunne: Thanks very much, folks.

The Chairperson: A few questions occurred to me as you were speaking. Is there a sense of the uptake of the confidential telephone line?

Mrs McVea: There is. It is interesting, given the last comments. We are getting dramatic stories coming through, as you can imagine with a confidential telephone line, and as we had anticipated ourselves. It was important to provide that service. However, it is much more likely that people will be motivated by bad stories. We have had good stories coming through, but they are, by far, the smaller proportion. We wanted to have that service available, but it is important that other people come through and tell their stories. They may not be life-and-death stories; they may not be horror stories. However, we want to know what your experience was so that we get that spread. We will do that, as David said, through focus and community groups. We also encourage people to use the telephone line to tell their story, whatever it may be.

The Chairperson: Are you utilising the work of the 10,000 Voices report?

Mrs McVea: Yes. We have been working closely with the Patient and Client Council in the scoping and development of the inquiry, and the 10,000 Voices report will form part of that. It is a huge collection of stories. They are not all about emergency services; they are across the system. That will feed into it as well.

The Chairperson: By way of conclusion, I thank you both. It has been useful to get a sense that the focus is on participation, which can often be missing, not just in health. However, we are dealing with health, and sometimes it is about ensuring that that focus is there and the person is central to the process. You have been very clear about the context of the work and how it relates to your strategic plan. It is important for the Committee to reflect on the universal principles and the fact that dignity goes across the piece. It is about how a piece of work like this can underpin the concept of dignity in the legislative framework. I wish you well. We will continue —

Mr D McIlveen: Sorry, Chair. Thank you very much for your indulgence. I echo everything that the Chair said, but I just want clarification on one tiny point that you made. Virginia, in response to Gordon's question, are you absolutely crystal clear that this specific report was instigated at the behest of the Human Rights Commission and was not a result of a request from either within or without the Committee?

Mrs McVea: Yes.

Mr D McIlveen: Absolutely crystal clear on that.

Mrs McVea: Yes.

Mr D McIlveen: Thank you for that.

The Chairperson: Thank you for clarifying that. We look forward to the work continuing. We will reflect, within our remit, on how the Committee work's on TYC can best support and enhance the work that you do. Thank you for taking the time today. It has been very informative.