Northern Ireland Assembly

Public Accounts Committee

OFFICIAL REPORT (Hansard)

Inquiry into the Safety of Services Provided by Health and Social Care Trusts

14 November 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Sean Rogers

Witnesses:

Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Ms Julie Thompson	Department of Health, Social Services and Public Safety
Dr Paddy Woods	Department of Health, Social Services and Public Safety

In attendance:

Mr Kieran Donnelly	Comptroller and Auditor General
Ms Fiona Hamill	Treasury Officer of Accounts

The Deputy Chairperson: Today we are considering the Comptroller and Auditor General's report on the safety of services provided by health and social care trusts. Does any member wish to express an interest?

Mr Anderson: I have a family member who works in Health and Social Care (HSC).

The Deputy Chairperson: Dr Andrew McCormick, accounting officer for the Department of Health, Social Services and Public Safety (DHSSPS), is here to respond to the Committee today. Dr McCormick, you are very welcome. Please introduce your team.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Thank you, Chairman. With me this afternoon are Paddy Woods, deputy chief medical officer, and Julie Thompson, senior finance director.

The Deputy Chairperson: Thank you. Given that the Audit Office report covers a wide area, I would be grateful if the witnesses could ensure that any responses are succinct. I repeat: succinct. Dr McCormick, I understand that you wish to make some introductory comments.

Dr McCormick: Thank you for the opportunity, Chairman. This is a very interesting and important topic, and we give top priority and attention to it all the time. If I may, I will just make one or two comments to set the scene and draw out the context.

The oversight of safety is a fundamental responsibility for me as accounting officer and for the accountable officers in each of the organisations, primarily the trusts, and it is the top issue on which we engage. We expect to be able to provide, and patients readily expect that they will get, the best possible care, and that that will be safe. However, as I have said before in this room in evidence sessions to the Health Committee, the best health systems, the best hospitals and the best doctors in the world have avoidable deaths, and the health service in Northern Ireland is not an exception. The key question for us all is how to minimise and manage risk to patients while still providing risky treatments.

Professor Cyril Chantler said:

> *"Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous."*

That is a very good thing, because medicine is much more effective than it used to be. However, it involves expecting professionals to undertake procedures, to carry out activities and to manage a whole range of things that are inherently risky. The question then is how to minimise and manage that risk. We need to make sure that we have the best possible organisational leadership, strong governance systems, good policies and processes, a good work environment and good communication. We need to measure and handle the complexity of work. We need to do all those things while ensuring that we maximise the knowledge, skills and motivation of staff. Clinical governance is the top corporate responsibility of each and every HSC organisation, and each chief executive is personally responsible to me for clinical governance.

We have a range of research on how unintended harm and unnecessary death arise in the worst cases. Most of the time, it is a result of a combination of circumstances in a system rather than the failings of an individual. Patient safety demands that we design effective systems. We need to minimise the risk of a single mistake or error — we are all human — leading to a bad outcome. We have undertaken a range of initiatives, going back to Best Practice, Best Care in 2002. In 2006, there was a framework for sustainable improvement in health and personal social services called Safety First. We have had a regular series of reports on the learning arising from serious adverse incidents (SAIs). Most recently, and very importantly, in November 2011, there was the publication of 'Quality 2020', which is a strategy designed to ensure that we do everything possible to promote quality and safety across the system.

However, we are not complacent, and we cannot possibly afford to be. What we have to do is create and nurture a learning culture and a systems approach. We need to ensure that our accountability is fair but not punitive. So, balancing the culture is very important. We need proper individual accountability, so that if an individual is not performing or does something that is outside the standard of professional practice, their professional regulator will act on that. That has to be part of what happens. However, the wider context is more complex and subtle, as I am sure will come out more fully in the questioning.

I hope that that was helpful by way of setting the scene.

The Deputy Chairperson: Thank you, Dr McCormick. I am sure that members will want to develop those themes. In turn, members will be putting their own questions, and I am sure they will want to pick up on some of the things you said.

I will begin along the lines of your introductory remarks. High-profile cases of patient harm strongly influence our views of the health and safety and social care services, but the report shows that the problem goes far beyond the headlines. Paragraph 1.5 of the report refers to the fact that 83,000 adverse incidents are reported each year. The truth is that we still know far too little about how often patients are being harmed by hospital treatment. Would you like to comment on that?

Dr McCormick: I understand and accept that we need to do further work to improve the information systems. To put that number of 83,000 in context, there are 2·8 million interactions a year between the service and individual patients, so the vast majority of what happens in the service is safe and effective. We are clear that we have a good information base that we have developed in relation to

the more serious aspects of the things that go wrong. So the process for serious adverse incidents is clear and good. We are developing, and will introduce next year, the fully fledged system for bringing together, at regional level, all the information on learning from all adverse incidents. To complete that into 2014 will be a very important step, and that will place us, as a small, relatively simple region, ahead of other jurisdictions in the information that we will have. We accept that there is more to be done, and that will improve the handling and understanding of information. The whole essence of this is to learn from what goes wrong and make sure that we act to minimise recurrence. The hardest thing to defend is the same thing going wrong again, so we have to learn from the things that go wrong. We have a good system for learning from the serious incidents, and we are working further to improve that. That is part of the priority that we are giving to the issue.

The Deputy Chairperson: Dr McCormick, in your introductory remarks, you made reference to Safety First, from 2006. The Department was before the Public Accounts Committee 10 years ago, and we had loads of promises. Today, you have an opportunity to demonstrate that patients in Health and Social Care are safer than they were when you previously reported 10 years ago. How can you do that?

Dr McCormick: It is important to say that we have made a range of particular interventions to improve safety. It needs to be put in the context of the fact that medicine has changed in that period, so there are things that are done now that would not have been possible 10 years ago. They are well worth doing because they can extend life or improve quality of life in a very significant way, but that may mean that there are more things going wrong because more risky things are being undertaken. The key point far beyond any increase in such incidents is the increase in benefit. I would focus on the increase in the benefit of a better and improving healthcare system to patients, clients and the public in Northern Ireland. That is worldwide, of course. We are following through with applying innovations that are developed across the world, including here, and making sure that those are available, so that we have an improving standard of care and significant research-based interventions that improve safety. I can give details on that. However, we are still seeing a level of adverse and serious adverse incidents. At one level, it is inevitable that there will be some. Our job is to minimise them and to make sure that we learn from them.

The Deputy Chairperson: At this stage, two members, Trevor Clarke and Michael Copeland, have indicated their intention to ask questions.

Mr Clarke: You covered my question, sorry. That is OK.

Mr Copeland: You are very welcome, Andrew. I would like clarification. Are the 83,000 adverse incidents that the Chair referred to only adverse incidents that occurred within health service facilities, involving health service staff? A tremendous number of procedures are carried out in private clinics, paid for by the health service and, in some cases, using health service staff. Is the 83,000 the total number of adverse incidents concerning anyone receiving medical treatment? Or is there another figure paid for by the public, but outside that remit?

Dr McCormick: It embraces all activities that are the responsibility of the public sector. Even if it is carried out on behalf of the public sector by an independent sector provider, if it is contracted in that way, it will be covered by the statistics and will be required to be reported. Certainly, a significant proportion of the 83,000 come from the independent care home sector, and those are reported through the Regulation and Quality Improvement Authority (RQIA) as part of its functions. We would not pick up incidents in which an individual has sought private service, without that being within the governance of the public sector.

Mr Copeland: Is the public purse indemnified from claims arising from a procedure that has been carried out on behalf of, but not by, the health service?

Dr McCormick: The contracts that are drawn up with independent sector providers include provision to ensure that there is a proper handling of risk. Julie has the details in front of her. The model contract that we have with independent sector providers who are, say, undertaking a waiting list initiative or whatever, provides for the proper handling of the risk.

Ms Julie Thompson (Department of Health, Social Services and Public Safety): They have to ensure that they cover the cost of that within their own arrangements. That is part of the standard

contract arrangements that we have with the independent sector for clinical negligence claims, for example.

Mr Copeland: That is the potential cost of settlement of claims.

Ms Thompson: Yes, that it has to cover effectively.

Mr Copeland: That is not included in the figures that we have for those that are settled by the health service.

Dr McCormick: By definition, that will be excluded.

Mr Clarke: Dr McCormick, you said that a big proportion of the 83,000 relate to the independent sector. It is easy for us to accept that, but we have no evidence of it. Can you give us the figures that indicate that?

Dr McCormick: We can provide a breakdown of the figures per trust.

Mr Clarke: Proportionally, then, in the numbers that were referred in the independent sector versus the number that turned into actual negligence claims, as opposed to the number that you process yourselves versus actual claims. Even without looking at those figures, the proportion probably suggests that there is a bigger possibility of a claim against you than against an independent. I will stand corrected if you can provide me with evidence that proves otherwise.

Dr McCormick: I am not sure how much detail is available. We will give the Committee a breakdown of what is available. Of the 83,000, nearly 13,000 were reported by RQIA. My understanding is that the majority of those are from the independent care home sector. There are very limited independent hospital services in Northern Ireland. The majority of independent sector activity is in social care, nursing homes and residential care.

Mr Clarke: You referred to Northern Ireland. We are all aware of the pressures here in Northern Ireland, but some of this carries outside Northern Ireland. Let us not exclude that from the figures that you present to us. We are all aware that people travel to Dublin, Cardiff and other places for specialist surgery. Let us look at the broader picture. That is all part of the work that you have contracted out and part of the statistics. You made what I thought was a bit of a loose comment in your first response to Michael when, without coming armed with the evidence, you suggested that the figures might be higher proportionately.

Dr McCormick: I did not intend to imply that. I am sorry. I did not mean to convey that.

The Deputy Chairperson: Let us develop the theme a little bit. Members may be keen to ask about their own individual cases, but please do not do that.

Paragraph 3.5 mentions arrangements for promoting regional learning from serious adverse incidents through various patient safety reports. Dr McCormick, you will know that people are much more interested in how their local trust is performing. I am sure that you would agree with that. I am sure that you would also agree with the Committee that the public have a right to know how their local trust compares to other trusts in respect of patient safety. Do you accept that?

Dr McCormick: Yes.

The Deputy Chairperson: What steps have you taken to ensure that someone reading HSC patient safety reports can easily compare performance across different trusts and specialities?

Dr McCormick: It is important that there is an understanding of the context facing each individual organisation. That will vary between the organisations because of their different functions. We have available, and can provide for the Committee, a fuller breakdown of the incidence of serious adverse incidents by trust.

It is important to recognise that the trusts are unified organisations. Although they provide services on individual sites, they are coherent and unified organisations with medical staffing organised in

networks. There is a mutual dependency between, for example, a larger hospital and a smaller hospital. Look at the relationship between, for example, Craigavon hospital and Daisy Hill. They both have their particular staff present on site, but they also have an inherent and well-planned mutual dependency. It is important to focus only on information at trust level, and we can provide that. We have details of, and can answer questions on, the incidence of adverse incidents across the six trusts, if you include the Ambulance Service as a regional organisation. We can talk about that.

It is important to recognise that there are also important differences in context and the mix of services that are provided. By no means all, but many of the regional specialities are provided in the Belfast Trust. Those are often higher risk. It is important to recognise that if a hospital is providing higher-risk services, there might be a larger incidence of adverse incidents. That does not mean that the standard of care is lower. On the contrary, it might well be evidence that the standard of care is higher because that is where the specialist staff are available to take on the more difficult, more serious cases.

So, it is very important to look at this in context. However, I accept entirely that there is great local interest. It is important that there is confidence throughout the community that all services are as safe as they can be. I am very clear from all my dealings with the trusts that they accept the statutory obligation to provide safe services and that where there is a risk to that, we hear about it and act on it.

The Deputy Chairperson: Dr McCormick, I could not agree more. Indeed, you have encouraged me to ask a question that is not in the script. You will be aware that, recently, one man died in the A&E department of one of the Belfast hospitals. When a so-called independent team was set up to inquire into that, it was made up of members of the other trusts. Is that something that you would want to look at in the future when trying to rebuild confidence among members of the public?

Dr McCormick: It is very important for confidence that every part of the service is subject to scrutiny and accountability that is open and transparent. Good practice says that it is very important that an investigation of something that has gone wrong involves peers in Northern Ireland or, in more complex cases, experts from outside this jurisdiction. That shows a clear attitude among the leadership teams that people are in this business to learn from what goes wrong, identify the learning points and apply those conscientiously and systematically. I agree entirely with you that there should be that independent scrutiny.

The Deputy Chairperson: That is very important for the record. We appreciate your honesty on that.

Mr Clarke: Thanks for your indulgence again, Deputy Chairperson. In response to one of your earlier points, Dr McCormick, a bit like the Comptroller and Auditor General last week, was fairly defensive of the Belfast Trust, given it is accepted that it deals with more complex cases.

Dr McCormick, what information did you provide to the Audit Office on the level of these cases and the nature of the complaints? It is easy to lift this report and suggest that the Belfast Trust looks the worst. It is easy to make a defence that they deal with the most complex cases. However, there is nothing in here to convince me that these may not have been routine operations or procedures. There is nothing here to convince me that we are talking about complex cases. What information did you offer the Audit Office in relation to the nature of the cases that are referred to in the report?

Dr McCormick: That is an inherently complex point. I am very willing to engage further if there is further information that we can provide. We sought to bring to the Audit Office, as part of its development of the report, the relevant and available information. There is plenty of detail available on each of the individual cases. There is a record in relation to each SAI, for example. Going through those exhaustively and undertaking an analytical scrutiny of the context in which they arose is at the heart of your point, and it is a very important point. Is more going wrong in complex areas of work, or are there too many things going wrong in relatively straightforward and routine contexts? We do need to get to that.

Mr Clarke: I appreciate that the Audit Office can work on the information only in numbers but not in detail. If you are taking this seriously, as you said you were in your opening remarks, you are bound to appreciate how difficult it is for us to accept this, even with respect to your answer, as did the Audit Office last week, when it suggested — possibly in your defence — that the Belfast Trust deals with the complex cases. However, there is nothing here that is evidence of that.

We listened to the media last week — thankfully it was not in Northern Ireland — and heard about a practitioner who was involved in many cases. If there are numbers of opportunities to do something when there have been complaints against an individual or individuals, something should be done. We should not just rest on the fact that they are working in a complex area or on complex cases, and that that is acceptable. To my mind, it is not acceptable. We saw evidence last week in the media, when someone was disciplined on the mainland.

I think that we need to have more drilling down on the figures. We see 35% in the Belfast Trust, but that is all it is telling us. It does not actually tell us what areas are involved. Indeed, reading the report regarding any of the trust areas, it does not tell me whether there are repeat cases or whether the same individuals are involved, and it does not tell me whether there is a pattern. I think we need to get more information in order to drill down into this in further detail.

Dr McCormick: I am happy to engage in that. It is a very important line of thinking. What I can point to is that we are seeking to learn from each case, and that many cases lead to particular follow-up by way of learning letters. An overview is then taken by the HSC Board, which is the manager of the SAI process. It looks for common themes coming out of the series of incidents that it is looking at.

We have details of the learning communications that have been issued in relation to safety and quality, which I can provide to the Committee. Several times a year, messages are sent out as issues arise, either within this jurisdiction or elsewhere, when something needs to be communicated. It is hard to use statistics to generalise.

The most important thing is to understand what has happened on a case-by-case basis, what underlay that, and, where we can, take corrective attention and draw it to the attention of those working in the particular field affected. Some themes are very general. For example, we have intervened in relation to how to assess a patient who might be deteriorating. If someone is deteriorating, and that is not noticed quickly enough, intervention might not be made in time to save them. We have had a number of cases of that nature in the past. So, we have early warning systems and systematic ways in which vital signs are monitored to ensure that intervention happens in time. Those are ways of learning lessons, and that draws out the point.

Mr Clarke: The only difficulty I have is that although that is a good sound bite as regards what you are trying to do, statistics — and statistics are all that we have here — show that over the past number of years, there has been no evidence of improvement. Although the sound bite concerns what you want to do to improve the service, the statistics do not back up what you are saying. I stand to be convinced about what your Department is doing to improve things because, statistically, there is no improvement.

Dr McCormick: Indeed. I have to acknowledge that. We have not yet touched on the level of reporting, although I am sure the point is coming. Several variables affect the total number of incidents reported. There is the actual level of harm happening and then there is the propensity to report, which varies. We know that this is a cause for concern and we cannot be complacent about it. We have to encourage a context in which every member of staff, families and individuals can feel free to challenge. That has to be the culture. In that context, some rise in the number of incidents could include some improvement in reporting, which would be a good thing. It is possible that we could have a steady or improving level of actual patient safety but with more incidents coming through. I am speaking hypothetically. I am not saying that that is the case. Our focus has to be on prevention. Once an incident has happened, it is vital to learn from it. The really important thing to do is maximise prevention.

Mr Clarke: The danger with that is that we have all been involved with the district policing partnerships, and we know how incidents are reported. In the past, when we saw a rise in crime, the police told us that it was due to more people reporting crimes. I am afraid of coming back here in a couple of years time and the health trusts saying that the reason there has been an increase is because they made it easier for people to report the problems. That is not drilling down to find the root of the problems. From sitting on the district policing partnerships, we all know that when there is a spike in crime the standard response from the senior civil servants involved is that it is because more people are reporting crimes.

Dr McCormick: I am not going to argue with that. It is a potential point; I will not make it more strongly.

The Deputy Chairperson: At this stage, I feel the need to remind myself, the witnesses and members of my opening remarks. We have to be succinct. It is a long report, and we have to get through it in reasonable time.

Moving on conveniently, the Audit Office approached the Royal College of Nursing (RCN) about its views. That was very important, because all of us agree that nursing staff are the backbone of any hospital or institution and that their views are very important. Turning to paragraph 3.14 of the report, I was shocked at the response from the RCN. The report states:

> *"While it assured us that Northern Ireland nurses are fully aware of their professional responsibility to raise concerns about patient safety and standards of care, it told us that, in its view, there remains a certain level of reluctance about raising concerns among nursing staff."*

This is very serious, coming as it does from a prestigious organisation, the RCN. How do you intend to address that, Dr McCormick?

Dr McCormick: I share the concern about those remarks and I recognise that they are very serious. We will do all that is possible to promote a culture in which every individual feels free to raise concerns, and is protected and supported. Clinical governance is all about empowering every individual to speak up, challenge and share in the responsibility for patient safety. The Minister issued a circular to all staff throughout the health and social care system earlier this year. The substance of the letter was about whistle-blowing, but the first section said that whistle-blowing should not be necessary if the leadership in every organisation creates and promotes a culture in which everyone can challenge everyone else.

I react with considerable concern to what has been reported. It is important to emphasise the professional responsibility that everyone has to act in a way that promotes patient safety. I undertake to continue to convey the message to my chief executive colleagues that that has to be the culture that we promote.

The Deputy Chairperson: Dr McCormick, I am glad that you mentioned the word "culture" because there is a culture that does not encourage such behaviour. The general public and those who use the health service will judge you by your actions. Have you met representatives of the RCN?

Dr McCormick: I meet them regularly. I have not had —

The Deputy Chairperson: I am sorry, my question was very specific. Have you met representatives of the RCN in relation to the reluctance of their staff to assist you in identifying the serious problems in the health service, namely the 83,000 adverse incidents that we talked about earlier?

Dr McCormick: I have not had that specific meeting but I will do so. My colleagues in the Department have discussed the issue with RCN representatives. I need to follow through on that and I undertake to do so.

The Deputy Chairperson: Appendix 2 of the report provides a summary of the action taken by the Department on the recommendations in its 2002 report. The fourth recommendation refers to the need to be proactive to reduce the projected future costs of negligence cases. The Department responded by advising HSC bodies that patients affected by an adverse incident are less likely to sue when they are provided with an expression of sympathy and a full and factual explanation and, if appropriate, offered early corrective treatment. That is, in fact, good practice globally. Dr McCormick, did the Department follow up with the HSC bodies to establish whether the policy had been adopted?

Dr McCormick: We have regular engagement with the service on that. We probably need to do further follow-up as a result of this hearing to ensure that further evidence is produced of fulfilment of the undertakings given by the Department to the Committee and, in turn, by the trusts to us. They have responded acknowledging that it is the right thing to do, but we recognise and understand that further assurance is required regularly. It is not sufficient for this to be a one-off exercise following 2002. It has to be regular and consistent on a daily basis to pursue that point.

The Deputy Chairperson: Which HSC bodies did not adopt the policy?

Dr McCormick: I am not aware of any of them not adopting the policy as such. Undoubtedly, there will be some variation in performance against it and the extent to which it has been fully delivered, but I need to pursue that further and secure some further evidence for you on that point.

The Deputy Chairperson: We may return to that. No doubt, members will be aware from their constituency work of individual cases in which the standards of care have not lived up to what was expected.

I repeat what I said earlier: I ask members to keep their supplementary questions brief and clear. I will be keeping an eye on the time today, and I want everyone to remain focused. I have no doubt that they will. The first member is Paul Girvan.

Mr Girvan: I will let Mr Anderson ask his question.

Mr Anderson: I thank my colleague for allowing me to ask my question at this stage as I have another meeting to attend. Thank you for coming along. There are many very important issues, and some of them have been drawn out and debated in the initial questioning. My colleague Trevor touched on reporting. In paragraph 3.10, attention is drawn to the low level of adverse incidents reported in the acute sector. However, paragraph 4.5 states that 60% of complaints each year relate to the acute sector, most of which concern poor quality of care or treatment, staff attitude or the quality of communication. Typically, what redress is offered to a patient or client whose complaint is upheld?

Dr McCormick: There is a very clear procedure for handling complaints, and as the Venn diagram in the report draws out, not every complaint turns into a claim for compensation. The approach that we have taken in revising the complaints procedure over the past few years is to promote the maximum effort by each organisation to engage with the person who feels aggrieved and feels that they have not been provided with the appropriate standard of care at an early stage, to offer discussion, explanation and, where appropriate, an apology and to do those things straightforwardly and easily at local level. There should not be any reluctance or defensiveness, and the system should be very human in facing up to the fact that people will be in distress for one reason or another. They should receive a compassionate and caring response. The complaints procedure talks about local resolution being the first and best way forward.

We then have, as a second stage, the availability of access to the ombudsman. The ombudsman takes us to task firmly and fairly on a range of issues and will, at times, require action to be taken, including some financial redress on his recommendation. That is certainly part and parcel of how things work, and it is entirely appropriate. It is also fully provided for in our complaints procedure. Should the person affected still feel that they have further issues to pursue, they are not precluded from taking forward a claim for compensation through the courts. We want those procedures to be applied fairly and humanely, with genuine humanity and compassion throughout the process. That is vital, because we recognise that the system can appear intimidating. It is an enormous and complex system, and it can be forbiddingly technical. So it is very important that it is reduced to a straightforward engagement at a human level.

Mr Anderson: You kept saying "should" throughout your answer. I think that it should be "must". I do not know whether that is the case, so perhaps you can tell us.

Dr McCormick: It is what is expected. It is the only right thing that can be done. I regularly meet the chief executive of the Patient and Client Council (PCC) and the chief executive of the RQIA and I listen to what they are saying, because their job is to understand what is going in the system and bring to light what should be and must be applied that is not being applied.

If there is a consistent pattern of complaints or evidence emerging from inspections or reviews undertaken by the RQIA, I need to understand that and speak, as appropriate, to the chief executives of the organisations, be they the trusts or whoever else, and say, "I am hearing that things are not going as they should. That needs to change." We have regular accountability discussions with all the organisations that are accountable to the Department. That is routine, and we make sure that that agenda provides for any appropriate or necessary challenge to the patient experience and the quality and standard of care. I accept what you say: these things must be applied. If there is a departure from the acceptable standard, we need to draw together the evidence and intervene and act on that. That is part of our responsibility, and it is what we do.

Mr Anderson: So why are there 60%? Do you agree that the standards are not being applied, given the high level of 60% in acute cases?

Dr McCormick: It is understandable that acute services have a higher incidence of complex and risky activities and there is, therefore, more risk of something going wrong. Also, there is the risk that, in the heat of that context, something inappropriate might be said or done. So I would not say that I am surprised that 60% of the complaints are in the acute sector. That is reasonably understandable. It means that we need to make sure that the attitudes and standards of care in that sector are given particular and consistent attention.

Mr Anderson: That being so, if 60% is understandable, what percentage do you think is — for want of a better word — acceptable? We are trying to get to zero, but what, to your mind, is acceptable?

Dr McCormick: I think that the objective is to get to a place in which the number of complaints, in absolute terms, is reduced. If the proportion from the acute sector were lower, that would imply that the proportion from some other sector was increasing, which would be no more acceptable. What we have to focus on is seeking to improve the standard of care that is being provided and reduce the risk or probability of something happening that gives rise to a complaint. So, we have to bear down on the issues. Therefore, the focus of our attention is on raising standards, promoting good practice and sharing evidence of how to do things effectively in order to ensure that time is available for the kind of explanation that helps people to have confidence that they are receiving the best possible care. So, there is a range of things that we can do. However, it is difficult to get at that percentage, to be honest.

Mr Anderson: What is that range of things?

Dr McCormick: It is promoting the application of good professional standards, ensuring that people are trained regularly in both the specifics of their clinical responsibilities and with regard to patient experience, and every other aspect of care. So, promoting good practice is the best thing that we can do in this context.

Mr Anderson: The Chair referred to something 10 years ago, before my time, which, probably, has not been acted upon. So, we are still looking for action in many areas and on many points in order to make inroads into this matter and reduce the number of complaints.

Dr McCormick: We always will be. In a service provided by 60,000 to 70,000 individuals, there is a continual turnover of staff. We know the right message to get across and the right leadership to apply. However, it has to be applied continuously. Realistically, we can never expect to reach the stage where the problem is solved. It requires continuous attention, refreshing of training and drawing out of new good practice as it emerges.

Mr Anderson: Are we getting that? Are we doing that?

Dr McCormick: Sorry: an immense effort goes into that. Generally, a very high standard of service is being provided. We are looking at a number of complaints and adverse incidents. Those are to be regretted. We are not at all complacent about the fact that they happen. To eliminate them completely would be unrealistic because there is an element of human error that arises. We have to simply ensure that there is consistent and steady leadership, so that —

Mr Anderson: So, how long has that been going on? You say that it is continuous. Has that procedure been continuous since 10, five or two years ago or is it beginning now?

Dr McCormick: The general effort to provide a high standard of care has been inherent in the health service since its inception. Part of what is happening is that there is more systematic awareness of the issues and, therefore, more responsibility on us as a leadership team to apply and promote good practice. Many features of that would have come to light in the past 10 years. There is no doubt that, in the next 10 years, there will be further things that could and should be done. We will have to pursue that. That will be an ongoing responsibility. I do not think that we can expect it ever to be solved completely unless we could have care provided by perfect people.

Mr Anderson: It could get a lot better.

Dr McCormick: Yes. I agree. That is our aspiration and determination.

The Deputy Chairperson: I will bring in Trevor Clarke in a second. Sydney Anderson, it is interesting that you said that it was before your time. It was not before my time, sadly.

Dr McCormick, we have heard all of this before. We have had all the promises before. Is there a monitoring system in place that quickly identifies where the clusters of complaints come from? What kind of early action can you promise the Committee that you will take to ensure that we do not have 83,000 complaints in 10 years' time, when I certainly will not be here? I think that anyone who listens to this today will be looking for answers. We have had the standard-issue promises. We get them from other accounting officers as well. The Health Department has been here before, 10 years ago. You had your own report in 2006. Really, you have failed. Today, you need to put on record what has changed because the media has not been good to you in the past year. There have been too many front-page stories, and we really need to know what system is in place to identify the problem hospitals and institutions and what action you can take to stop this immediately and not when the next Audit Office report comes out.

Dr McCormick: The things that are happening continuously include the clear monitoring of complaints and adverse incidents in each trust. So, there is a significant role for the board and the non-executive directors. Most trusts have a committee, which is chaired by a non-executive director, and which draws together information, challenges the leadership team in the organisation and asks why certain things are happening. The committee will have information along the lines you are describing; that is, where the clusters and patterns are. Individuals in each organisation are responsible for drawing that information together, understanding it and interpreting it. So, that is the first line of defence. The first responsibility has to be within each organisation, and they are accountable to me in fulfilling that responsibility.

The second line of defence is through the PCC, which is an individual organisation responsible, as the name suggests, for assisting patients and clients. If they are not getting satisfaction from a trust or a provider organisation, they can seek and receive assistance. Part of that facilitates the joining together of information by the PCC about the pattern of complaints or things that are causing problems or are going wrong. The PCC has direct access to the Department, which is why I meet its chief executive regularly to hear and understand what is going on. I can then use my authority, which comes from you, of course, as I am accountable to you. Therefore, I am accountable to you, and they are accountable to me: that is how it works. As I am vulnerable to criticism and challenge from you, I then say to the trusts, as accountable officer, that they must answer to me to secure improvement.

We have a process of accountability that is being developed and refined continuously to make sure that we are delivering. However, I am not going to promise that I can eliminate adverse incidents. That would be an unfair and unrealistic promise to make. What I can promise is that we will do everything in our power to promote patient safety, good practice, and improvement.

However, it needs to be accepted and recognised that there is inherent risk: medicine is risky. The only way to reduce the number of incidents of this nature is to stop intervening and let people die of their conditions. If someone dies without medical intervention, it would not be deemed to be an adverse incident, but it would be a very wrong thing to happen. We have a responsibility to intervene and to take risks. I recognise that we have a challenge in the context of the media reporting what we do, but I have no complaint about that. We need to make sure that there is support for people in the clinical teams who say to themselves, "If I do this, I am taking a risk and it might go wrong, but I am going to do it." We need people who are prepared to do that. I was talking to a team this morning, and they know that in one in 100 cases, one of their patients will die. However, I need them to keep doing what they are doing, because we need the 99 other patients to do better than they would otherwise. That is a risk that society has to live with. There will always be adverse incidents; there will always be serious adverse incidents, and there will always be avoidable deaths. It would be wrong of me to promise otherwise.

The Deputy Chairperson: You referred to the media. In recent times, we have learned that even the media cannot escape responsibility, which we have seen in the case of the BBC. People are asking at what stage those in the health service will take responsibility. When will the heads roll when things systematically fail?

Dr McCormick: As you say, it would be if and when things systematically fail. It is clear that if there is a pattern in which the same thing goes wrong time and again, that would require a more serious level of intervention and accountability, and there are clear responses to that.

Mr Clarke: This is probably a good time for me to come in. You have left me a nice opening. In response to what you said, Dr McCormick, about us holding you to account, I am actually the new boy here — I am the youngest. We talked about a couple of dinosaurs a few minutes ago.

The Deputy Chairperson: Youngest?

Mr Clarke: I am the youngest here, and probably have the least experience, but when I read about you, I found out that you have been in post for seven years. I think I have a job to do to hold you to account, and I think that, in seven years, you have failed. To my colleague, you used the words "defensive" and "intimidating", and the phrase "show compassion". During the five years I have been in this job, I have had many people coming in — and I am sure that my colleagues have had individuals coming in — referring to complaints about the health trusts. I suggest that every word you have used is continuing practice. I have always found the Department to be "defensive". I have seldom seen it "show compassion", but it is certainly "intimidating". Those were your words, and I think they were well chosen. I accept that there can be human error.

As regards the length of time that you have been in post, I would like to be back here in the future, but I would not like to be back with you sitting there and with no change made. If it has taken you seven years, and we are reading the report that the Audit Office has for us today, dear help us.

Dr McCormick: I am convinced that many things are safer now than they were seven years ago. Many things are being done that could not have been done seven years ago because medical science has advanced. I think that the statistic that is invisible is the improving benefit of the interventions throughout the health and social care system. To me, that vastly outweighs the level of harm. There is a level of harm that is inherently unavoidable, because we provide services through human beings. We can show a series of interventions on —

Mr Clarke: I think that that point is acceptable, but there are cases when it is not. To go back to your use of the word "defensive"; in many cases, if the Department put its hand up and said that it made a mistake, that would prevent complaints, but you continue to defend your position right up until the matter goes to court, which does not convince me that this is not leading to statistics increasing, and it will not correct the mistakes that have been made. We all accept that there is human error, but there is no excuse for defending something over a period of years, getting to court and then settling, with an admission that you were wrong. There is a culture of defensiveness in your Department, which has to change. There has to be an acceptance that you can make mistakes and you have to be more upfront in that acceptance to the general public. Then, I do not think we would be talking about 83,000 cases.

Dr McCormick: I accept and agree entirely that the right approach we should be taking is to be open and transparent, to be responsive and to engage in a way that says that something has happened here, it should not have happened, we want to acknowledge mistakes and apologise upfront. That is there.

In preparation for this hearing, I have seen internal documents in one of the trusts that say exactly that. It is not always easy to promote the application of that behaviour throughout a big system, and I acknowledge that there have been strong degrees of defensiveness in the past, including up to the present. We need to continually work at that.

My undertaking to the Committee is that my message to the service is that it should be open, transparent, responsive and human. I have been seeking to do that over the past number of years. That is the consistent approach taken by the chief executive group that I lead. We have more to do. I recognise and accept that, but I am determined to go forward and continue to do it.

The Deputy Chairperson: Can we go back briefly to Sydney Anderson? Apologies. We all make mistakes. I forgot that you were asking the questions, Sydney.

Mr Anderson: This is an area in which many questions can be asked and should be asked. Paragraph 4.7 refers to patients' fear of reprisal if they complain, which is similar to the views expressed by some health and social care workers about reporting errors. We have heard many

things here today about clinical governance, best possible patient care, minimising risk in a culture of making services as safe as can be achieved. We have had all the fancy words and phrases. However, the situation is not good when you have patients and staff in fear of making a complaint. How will you persuade individuals that health and social care organisations see complaints not as something to run away from but an opportunity to learn from?

Dr McCormick: The scenario that you described is totally unacceptable to me. Having a situation in which a patient or member of staff is afraid to speak up or to complain can never be tolerated and must be rooted out. I am convinced that no chief executive in Northern Ireland would tolerate such an attitude. We need to continue to reinforce that message persistently and to point to and publicise the fact that there is a complaints procedure that is designed to open the access door to trust management and, if needs be, to the ombudsman. There must be a welcoming and positive response throughout the culture of the organisations. I am happy to use your expressions of concern in this hearing to take that message to some speaking opportunities at health service management conferences next week, and I undertake to speak out. This issue matters immensely in ensuring that we learn from things that go wrong rather than suppress or oppose, which are completely wrong and unacceptable responses.

Ms Thompson: The report points out that the regional board reviewed the complaints process, and one of its recommendations was about how to deal with cultural issues across the service and, equally, how to increase user satisfaction. Those recommendations that have come through will need to be implemented, and it is planned to do so as we move forward. So, the two issues that you drew out were picked up as part of that regional learning on the complaints process and are to be improved on as we look forward.

Mr Anderson: I will be brief, Chair, because I know that there is a lot of work to be done here today. Would you say that the situation is improving? It was, or may still be, that management did, or does, not always listen to staff. If there was a fear culture; why? If there was a fear culture, it must have been triggered by something that may go back to management. Is there a fear of reprisals? Was or is there something going on? Do you agree that such a culture was there and may still be there in places?

Dr McCormick: I detect the features of it. At times, organisations can tend to regard reputational damage as a bad thing. Part of our consistent engagement with the trusts at present is to say that the interest of the patient, the safety of the service provided and the patient's experience and human interaction come first and foremost, and well ahead of an organisation's reputation. Somebody can get very good care but have a bad experience, and we need to fix and sort out both aspects. I think that there is a commitment across the leadership team to achieve that.

However, at times, there has been a view that organisational reputation is important, which is unsurprising in that we create, and give responsibilities to, organisations that, at some time and on some level, inherently compete with one another. They want to be seen as being the best, and, therefore, bad news or negative stories can take away from that. So, there is a human element there, but the message from me to them has to be, and is, that it is the patient first. Nobody is reluctant to take that message on board. The leadership teams get that point.

Mr Anderson: The clear message going out from here today is that the culture needs to change. It is good to hear from Julie that in a few weeks' time, you will speak at a conference. So, the message must go out that things need to change.

The Deputy Chairperson: We are an hour into the meeting, and only one member has asked questions. I will move on to Mitchel McLaughlin, but before that Sean Rogers and Michael Copeland have supplementary questions to ask. I ask you to be brief.

Mr Rogers: In response to what the Deputy Chair said earlier, you said that there was clear monitoring of adverse incidents. However, looking at the report, a wide category of adverse incidents are not collected or analysed. There is a conflict between what you are saying and what is in the report.

Dr McCormick: We have an established and systematic approach to serious adverse incidents. They are compiled, handled and managed, and there is then appropriate follow-up to lessons learned at that level. Also, each organisation will look at the full range of adverse incidents and draw information

together. That way of doing things is broadly in line with the practice in other parts of the UK. So, we are not out of line in that approach to handling the issue.

We have the plan to develop and introduce the regional adverse incident learning (RAIL) system to provide a more comprehensive regional and systematic drawing together of all kinds of adverse incidents. That is on track, it is planned and it is being worked through. That will complete the process of information handling in the best possible way.

Mr Rogers: You mention RAIL, which came out of recommendation 5 in the 2002 report. That was to facilitate improved learning and sharing of lessons for all adverse incidents, including near misses. Granted, it was for criminal negligence, but, like my colleagues across the table, I question the promise you are making now, because in 2002, an action was recommended, yet 10 years later we are still talking about it.

Dr McCormick: The direct follow-up to the 2002 report included the creation and implementation of the system to deal with serious adverse incidents. That way of doing things began in July 2004, so there was a period of scrutiny and consideration of how to do it, but there was direct action following the 2002 report. That was a very important step. As I said, our practice is broadly in line with that in other parts of the UK, so we are not behind the game in that sense.

When the RAIL system is introduced, we will have a smoother and more systematic handling of that information than anywhere else. So, at that stage, we will be better off. There was definitely an effective response when it came to drawing together information directly on the issue of clinical negligence, which is where the report and hearing in 2002 focused. However, we have undertaken systematic work to develop and apply handling and learning from serious adverse incidents. That system came into being in July 2004.

Mr Rogers: The 2002 report talks about all adverse incidents, including near misses. We still do not have a situation in which information on all adverse incidents is collected or analysed. I am looking at the bottom of page 47 of the report.

Dr McCormick: As regards the summary of the recommendation, mechanisms have been introduced to facilitate learning and the sharing of lessons learned. The term used in 2002 was, "adverse clinical incidents". The definition of "serious adverse incidents" was only introduced in our response of July 2004. So, we did make a genuine response.

I acknowledge that we had hoped that the RAIL system would have moved more quickly. We had certainly set in train the action to introduce it from around 2010. It is on track to come into being and to provide the full and complete response. We also have a genuine ability in each organisation to draw together the information from all incidents, including near misses.

Dr Paddy Woods (Department of Health, Social Services and Public Safety): It is fair to say that there has been an incremental exercise, arising from 2002, mainly focused on clinical negligence cases. Some, all, or a limited number of them may result from serious adverse incidents. With the RAIL project, we will go beyond serious adverse incidents and include all adverse incidents, which will take us beyond arrangements in any other jurisdiction in the developed world. The preparation for that has been quite extensive, because we are breaking new ground.

As well as that, there were attempts in the mid-2000s to link up with the National Patient Safety Agency's (NPSA) national reporting and learning system, which ultimately proved fruitless and introduced delay. At that time, it was felt that that might be the optimal way of dealing with the problem.

The Deputy Chairperson: I have misled members. The supplementary questions were only supposed to relate to the issues arising from Sydney Anderson's questions. You will get your turn to ask your own questions.

Mr Rogers: My question was a direct result of the response to the question about the closer monitoring of adverse incidents.

The Deputy Chairperson: I accept that.

Mr Copeland: To the best of my memory, my supplementary question relates to Sydney's questions. You will probably want to reply to this in writing because it is a bit convoluted. You said that the processes that you are employing are "under continual improvement and review", which I accept. However, as the Deputy Chairperson said, the process goes back over 10 years. Would it be possible to get a chronology of the process of continual improvement and review so that we can assess how it is relevant to where we are now? There seem to be some quite serious questions around this issue. We are charged with asking those questions, but it is not fair to ask you to give that information off the top of your head, so I am quite happy to take a reply in writing, if that is satisfactory.

Dr McCormick: I am happy to do that, and I can give a brief summary of some of the main points, which we will develop more fully in writing.

Best Practice, Best Care was in 2002. In 2003, there was a major piece of legislation taken through the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, which led to the creation of the RQIA as a statutory regulator and included a statutory duty of quality. So, entrenched in legislation is the obligation on every organisation to provide quality services; and, believe me, chief executives take that obligation very seriously.

The reporting system for SAIs came in 2004, Safety First was in 2006, as were the quality standards. In 2006, we developed links with various UK-wide organisations, including NPSA. We had the creation of the HSC safety forum in 2007. The further piece of legislation that took forward the RPA further entrenched the obligations on the promotion of health and well-being. We revised the complaints procedure in 2009. The initiation of the RAIL process kicked-off in 2010, and we had a quality strategy in 2011.

So, almost every year, there has been some specific initiative designed to improve the system and secure a focus and attention on patient safety. We can elaborate on that in writing.

The Deputy Chairperson: For the record, I accept that Sean Rogers' question did relate to that of Sydney Anderson.

Mr Mitchel McLaughlin: Good afternoon. It has almost been like waiting for an appointment to see —

Dr McCormick: Oh dear.

Mr Mitchel McLaughlin: Turning to paragraphs 1.11 and 1.12 of the report, they are very interesting in that they discuss 'Safety First: A Framework for Sustainable Improvement in the HPSS'. They set out how we can create an informed safety culture in our hospitals and identify four main components. I will not read out the paragraphs — I am sure you have read them — but the four main components of an informed safety culture they identify are a reporting culture, a just culture, a flexible culture and a learning culture.

The paragraphs go on to discuss separating the actions of individuals involved in adverse incidents by examining the systems approach and recognising that there might be a chain of events that leads to particular circumstances. As far as it goes, that seems to be a fair approach, expect that does not really discuss the role, if any, of the clients or patients. Do you accept that this approach, as described, is inward looking?

Dr McCormick: I take the point. Part of what we have focused on more recently is the recognition that engagement with individuals is a vital part of how we go forward. Our 2009 legislation and our further interventions since then have emphasised the responsibility of organisations to secure patient and public involvement. They need to have schemes that provide for engagement, consultation and an open and transparent context of working. It is a point that we accept and recognise —

Mr Mitchel McLaughlin: We are describing a seamless regional approach across all trust areas. They all take the same approach. When an adverse incident is reported, are clients or patients notified automatically? Is it possible that a patient or client could be involved in an adverse incident and never know?

Dr Woods: By definition, it is possible. It is certainly the case that in serious adverse incidents, there is a requirement to undertake a root-cause analysis of what gave rise to the incident. Intrinsic to that

is the involvement of patients and their carers. That is a critical perspective in determining what happened and the course of events from all the perspectives relevant to the incident.

Mr Mitchel McLaughlin: That is quite interesting. It seems to indicate that there is a very conscious policy in other circumstances not to tell patients. Is that what you just told us?

Dr McCormick: No.

Dr Woods: No. I am saying that it is very conscious. First, there is a requirement to undertake a root-cause analysis when there is a serious adverse incident, and —

Mr Mitchel McLaughlin: Yes, the informing and involvement of patients and clients in an investigation into a serious adverse incident is de rigueur. That seems to make it clear that a distinction is made, and as a matter of conscious policy, you would not always automatically inform patients or clients who were involved in an adverse incident that is not regarded as a serious adverse incident. In those cases, it seems that the policy is that it is not necessary to inform patients or clients. Who makes that judgement call?

Dr McCormick: The attitude and responsibility has to be to engage with patients. The reason why the answer is not black and white is because the range of things that are classified as adverse incidents is very wide. It includes aspects that would affect individuals, but it could also include aspects of the management and organisation of the trust, and so on. It may not be essential to communicate with patients in each and every case. It depends on the context and effect of what has happened, and something could happen that would not have any major consequence for an individual.

I think that it is fair enough to look at this in a sensible way. However, if there is any doubt or there could be any effect on an individual, the attitude and the culture has to be that there should be communication with patients as a matter of principle.

The 83,000 incidents are very diverse. There may be some evidence from internal trust documentation that shows the kind of message that is given by trusts to their staff on how to do those things. Julie may have that to hand.

Ms Thompson: That is picked up in our guidance to trusts, particularly on how they should deal with apologies and explanations. It advises that each trust should consider how and when to express sympathy, and if things go wrong, that they should provide as full and as factual an explanation as possible. That goes alongside looking at the correct treatments. It is then picked up in individual trust policies and is recommended and endorsed to staff that they should carry that through. The guidance is not prescriptive about the standard, style or level of an incident. It is a wide-ranging response to deal with patients and users appropriately.

Mr Mitchel McLaughlin: Thank you for that. Dr McCormick, you did not address the question of who makes the judgement call. I am trying to understand — I do not understand — the difference between a serious adverse incident and an adverse incident. Is there a written code or specification?

Dr McCormick: Yes.

Mr Mitchel McLaughlin: In this fair and just culture we are talking about, you are trying to encourage staff to report issues that go wrong so that you can learn lessons and address the level of incidents that occur.

Paragraph 1.12 describes the circumstances in which disciplinary action could follow. Clearly, that would be a disincentive for staff to report incidents. You have a policy that, as far as it goes, seems to be an acceptable approach, but I am concerned that if there are obvious shortcomings in it, why those have not been recognised and picked up. A patient could be involved in an adverse incident, and someone else will decide whether it is a serious adverse incident and whether the patient will be informed if they were unaware of it. That does not seem to follow through on the principles that underlie the Safety First policy.

Dr McCormick: I understand what you are saying. When a patient has been affected by something like that, the principle should be to inform as the norm. In many cases, patients will be very well aware of the incident, but if they are not aware that something nearly went wrong that might have hurt them,

an open and transparent culture would mean sharing that with them. In many cases, and if there were no serious impact, it may just involve telling them that no harm was done.

The decision about what an adverse incident is as opposed to a serious adverse incident is a matter of frequent and live debate at senior level. However, clear criteria are used and we can share those with the Committee. There is a clear responsibility on each organisation to deal with those incidents transparently, and if there is a pattern of reluctance to record incidents in the proper way in an organisation, we will take action. We have a lot of reporting and scrutiny, and incidents will emerge. There is no point in anyone trying to hold back and not classify something that meets the criteria, because, thankfully, we have a context in which there is a lot of openness and scrutiny. Again, I acknowledge the positive benefit from whistle-blowing and from some media reporting. That can be beneficial, and it should ensure that nobody can say, "I will not report that as a serious adverse incident because I will get away with it and nobody will ever know". Thankfully, most times, people do know, and, specifically, we will take action against an organisation if a pattern of under-reporting emerges. We require organisations to be transparent, and that includes, as we have drawn out, the principle and obligation to be direct and frank with individuals. I am not saying that we are at a place where that is fully achieved, but our determination is that this is the right culture and the only culture that we will promote and tolerate.

Mr Mitchel McLaughlin: We will move on to paragraphs 1.16 and 1.17. They tell us that the actual scale of harm caused to patients and the true cost of that harm are unknown and talk about research in England that demonstrates that around 10% of patients treated are likely to suffer harm and that half of those incidents should have been avoidable. That rate of damage or harm would not be tolerated in the nuclear industry, and we are talking about the health service. If we cannot get the accurate data, and you tell me that there is a reporting culture and lots of information is gathered, how will we manage to deliver on the safety programme?

Dr McCormick: The correct response to that is to identify evidence-based understanding of scope to make improvement and to require organisations to apply evidence-based good practice. That is part of the general approach that we take to working with the organisations, and a lot of that comes from within them because the reason why doctors, nurses and the other professionals who work in the health service get up every morning is to provide a safe service. Many times, the ideas to promote safety come from them, and we need to make sure that evidence-based good practice is being applied.

I would focus on seeking to ensure a culture of service improvement, and that is why we follow, for example, the evidence that we obtained from the Institute for Healthcare Improvement in the US, which has a very good system to quickly identify where a change in practice can lead to saving lives. There was a 100,000 Lives campaign in the US. The leader of that was challenged, within his family, on the point that some improvement is not a number and soon is not a time, and the objective of securing actual numbers of lives saved within a number of years was undertaken. We seek to follow that pattern and ensure interventions that will actually save lives, such as reducing surgical site infections and dealing with ventilator-associated pneumonia. A range of evidence-based interventions will save lives, and the focus should be on that. Requiring organisations to apply evidence-based good practice is, to me, the right thing to do to bear down on the risk that is inherent in modern medicine.

Mr Mitchel McLaughlin: You will have read the report and maybe even the original research that demonstrated the level of casualty or adverse incident that could affect patients. The statistic of 10% prompts a question. If 10% of people who get on an aeroplane get hurt, you would not get on a plane.

Dr McCormick: I am aware of the research from 2001. It was derived from two hospitals in the London area and based on a study of about 1,000 records over a period of about six months. So, it is quite a limited evidence base, and the authors of the paper acknowledged that there were real difficulties in extrapolating. I absolutely acknowledge that adverse incidents happening in the health service is a serious problem. In questioning the figure of one in 10, I am pointing out that it was from one context and at one time over 10 years ago. It is not the figure that is important but the recognition that there is a real issue that we have to address systematically and continuously. I do not advocate taking time to research exactly what is happening. I would rather research what we can do to improve patient safety and focus leadership attention and professional engagement on that, because that is how we make the best possible difference.

Mr Mitchel McLaughlin: Would you see no benefit in having a local or regional retrospective?

Dr McCormick: I question the value of it. There is lots of knowledge about how to make improvements. The problem is applying that knowledge systematically and achieving the change in culture on which I was challenged earlier. That is the difficult bit that it is well worth focusing our leadership energy on. Further research is likely to confirm that we have a problem. I am saying that we know that we have a problem, so I would rather not undertake research to confirm something that we are sure of already. I would rather focus on how to make improvement.

Mr Mitchel McLaughlin: On the next page, figure 2 shows us that the number of new clinical and social care negligence claims has increased in each of the past three years. What does that say about the priority given to safety?

Dr McCormick: It is important to see the clinical negligence numbers in figure 2 and throughout the report in the context of what has been happening. There is a fairly steady level of claims and significant expenditure in that area. However, as the report acknowledges, we have undertaken a lot of work to seek to accelerate the process. Good work has been done by the directorate of legal services to deal with old cases. Indeed, the number of old cases was challenged in an Assembly debate, and it is not right for justice to be delayed. That is wrong in principle. So, considerable effort has gone into bringing forward the rate of addressing claims in the courts. A significant number of those are listed to seek resolution in the courts well into next year. That led to higher expenditure this and last year and in recent years than would reflect the steady state. We are partly dealing with expenditure related to old cases because of the determined effort to clear old cases. That is an important point of context that the report fully acknowledges.

Mr Mitchel McLaughlin: Are you saying that that is the reason for the increase?

Dr McCormick: A significant part of the increase is down to clearing the backlog.

Ms Thompson: You are quite right to point out that the number of new cases is increasing each year. That trend is ongoing across the UK. For example, into 2011-12, we had a 4% increase in our new claims. England experienced a 6% increase and Wales, the previous year, a 10% increase in levels of new claims. The increase in the number of claims lodged is happening across the UK, and it goes back to the issues around the increasing complexity of what is happening in the health service and the work being performed. So, in the broader context, claims are increasing right across the UK on an ongoing basis and our level is slightly lower than those experienced across the rest of the UK.

Mr Clarke: Again, we have complacency from the Department. It is as if we should be giving it a gold star because we are doing better than the rest of the UK and we have only a 4% increase in our claims. Honestly, I do not really care what is happening on the mainland; I am concerned with what is going on here in Northern Ireland. I think that it was a very complacent answer to suggest that we have only a 4% increase when others have 10%. That is not acceptable. I would rather you were telling us today that we had a 4% decrease. It is very defensive.

I also think that Dr McCormick's response to my colleague about why they did not want to drill down and did not think that there was any worth in doing so was a terrible indictment on your Department, because if you drill down into that, you might find out where some of the failings in your own Department are.

Dr McCormick: I think that we acknowledge the need to understand better where things are going wrong.

Mr Clarke: I do not think that you do appreciate that there is a need for an understanding because you said that the time would be better spent looking at ways of improving things as opposed to accepting that there has been wrongdoing in your Department. I am going back to when Mitchel asked the question initially. I do not think that Mitchel touched on the total cost of the claims; I think that he clearly stayed away from that. It was clearly the rise. However, you wanted to draw a parallel with the cost of the claims, which was fair enough. The total cases closed will bring rise to the overall cost. I think that you failed to answer the question, albeit Julie did not do any justification by trying to suggest that a 4% increase was very good in comparison with the mainland.

Dr McCormick: Sorry, I would not say that.

Mr Clarke: Well, that is how it came across.

Dr McCormick: If that is the case, I want to withdraw it.

Mr Clarke: We sit here today with 83,000 cases on the books, as it stands, and that is the attitude of the Department. You are drawing a comparison between yourselves and your counterparts in GB. You are suggesting that you are doing a good job, just because they have 10% and you have a 4% increase. I would say that you are doing a very bad job.

Dr McCormick: I am not claiming that; I do not want to claim that.

The Deputy Chairperson: For the sake of justice, I should give Dr McCormick one brief opportunity to clarify the position for Trevor Clarke and for anyone else.

Dr McCormick: We need to make sure that we are doing everything possible to bear down on claims. To me, the important thing to do is to promote patient safety and a culture in which people feel free to claim. It is possible that improving the culture could mean more claims. That would be an indictment in itself, but it would be a good thing to happen. We are also prepared to undertake any analysis that the Committee might recommend in relation to investigate why things are going wrong. We are entirely open to that. Ultimately, we are subject to your authority; we are accountable to you. We are offering our views in good faith, but we are subject to what you recommend. We are prepared to look at the balance between action to apply what we know will make a difference in improving patient safety and understanding root causes. Understanding root causes is vital. I think that we need to look at that very carefully and seriously.

The Deputy Chairperson: I call Mr Paul Girvan, who has shown remarkable patience.

Mr Girvan: Dr McCormick, thank you very much for coming along. I want to go back to the point that Mitchel raised about severe adverse incidents. Each and every one of us sitting round the table deals with constituents, day and daily. We hear about cases, some of which would make your hair stand on end. There are people who have no one to voice their complaint and, therefore, no mechanism for bringing it forward. Some of those people may be senile, and many are buried. Sometimes, a case can be buried and never comes to light. Sometimes, the cases involving people who have passed away, due to something that went wrong, never come to light.

Of the 83,000 cases that are mentioned, how many are taken for inaction because nothing was done and the person never even got to hospital? By that, I mean that, in a number of cases, people never actually had treatment but were waiting to have treatment. I am talking about the likes of people who, perhaps, were on a waiting list for cardiac surgery but died. Some of the families have said that they died simply because they were kept on a waiting list and were delayed and became another one off the list. It is not that they were ever off the list, because the person, having passed away, is no longer a statistic. Are any of those included in the 83,000 complaints, or would some of those never have made it to the complaint list?

Dr McCormick: I will need to come back to you on the specific point that you have raised on the inclusion of non-events or things that should have happened. I follow and accept, clearly, the point that you are making. It is one reason why, from my point of view, ensuring timely access to service is a fundamental obligation. That is why our position on waiting times in a number of specialties is not defensible at present. Considerable effort is being made to improve, but we have to do better on access times. Thankfully, there is a clear clinical prioritisation so that waiting times for treatment to deal with life-threatening conditions is prioritised. We need to research on the point that you have made and come back. We need to make sure that, whatever about the fact at present, going forwards, there is a recognition that action that should have happened needs to be identified and recorded and be seen as part of our system, if it is not already. I need to check the facts on that.

Mr Girvan: Maybe you can respond to the Committee on that. Some of the patients have no voice, so no complaint would ever be lodged. I do not know whether it is because of the culture in it. Trevor talked about the need to hold the hands up and say that something went wrong and this is what happened. In a lot of the cases, some of the people who I spoke to said that all that they required was a sympathetic apology. Because they never got that, they hardened their position, so it went on and progressed to ending up in court. Instead of, in the early stages, hearing one sympathetic word from staff, they came up against what they deemed to be stonewalling in a system that was designed to

restrict them from hearing what happened to their relative or their loved one. As a result, they decided that they were not going to let it drop and pursued the issue. That has added to the workload that you as a Department have had as well as probably lining the coffers of many expensive lawyers in the legal system in Northern Ireland.

Dr McCormick: I accept the point that you make entirely.

Mr Girvan: That leads me on to my main question. Paragraph 2.4 refers to the tracking process. The final bullet point in that paragraph refers to the systems that have been established by the trusts to track progress and action taken in response to patient safety alerts. Based on the information from those systems, how effective are the trusts at complying with safety alerts? What steps have been taken to validate the systems? What sanctions are placed on trusts where they fail to comply with safety alerts in the implementation of good practice? I appreciate that that is quite a convoluted series of questions, but there are very clear examples. The pseudomonas outbreak that we had in early 2012 had already been identified in Altnagelvin. I do not know what was going on — perhaps someone was living in a silo. Because they did not want to make this publicly aware, it was kept there. We had another outbreak in a Belfast Trust hospital, and, as a result, the pair were not linked up. There seems to be a definite culture of trying to suppress what had been identified as a problem. We could maybe — I do not say definitely — have saved lives because of an intervention on something that had happened in another trust area where a problem and what had caused it had been identified. So, by taking on board some of the recommendations of that, they could have probably implemented changes throughout the whole organisation.

Dr McCormick: I am happy to respond both to the general point that you make about the handling of safety alerts and the specifics. We learned some very important lessons from pseudomonas and from the very penetrating insights in the two reports that RQIA, led by Pat Troop as an independent leader, brought together and brought to the Assembly and the Health Committee in the spring.

On the general point, we follow up safety alerts, and we require trusts to tell us whether they have complied with them or not. We have recently recognised the need to specify. If compliance is complete, that is fine. We had a requirement for them to refer to partial compliance, but that is too broad. We need to be specific and ask whether they have substantially complied, so that most of the important things are in place even if it is not total and complete. That is the place we want them to get to as a minimum. That is policed and monitored by the team that Paddy leads in our safety, quality and standards directorate. That is then brought to the twice-yearly accountability meetings, where we ask whether they have complied. If we have information in relation to non-compliance on any important safety alert, that is specifically discussed. What is going on and why? Those questions are asked. Trusts are well aware that if there is a safety incident in an area where they have been the recipient of a safety alert, that is bad for them. It is not quite as bad as the same thing recurring in the same organisation, but it is a bad point. It would lead to criticism and challenge, privately in my accountability meetings with them, and they know that there is a risk of that being very serious in the public domain as well.

On pseudomonas in particular, the Minister and I both said, in evidence sessions to the Health Committee in this very room, that we expected every safety alert to be taken seriously and every circular to be read, understood, channelled and handled. We know, and Pat Troop's report confirmed, that every organisation has a system for receiving, interpreting and disseminating the various alerts that come from the Department and from other sources. One of our penetrating points was to be more formal and official in our communications and to recognise that it is not sufficient to say that everybody knows because Northern Ireland is a small place and everybody talks to each other. Yes, people do talk a lot, and there was a level of awareness between the Belfast Trust and Western Trust about what had happened, but there was also a series of circumstances in relation to the taps especially. What came out scientifically about the taps was very unfortunate. People had introduced new taps that they thought would be safer, but it turned out that, scientifically, they were less safe. That was ironic and very unfortunate. People had been trying to improve things, but the very step taken to improve things had turned out to create a risk. We discovered that and acted on it. There was a problem with communication and with responsiveness, which came out very clearly in Pat Troop's report. We need to police it and see it through.

Mr Girvan: It just brings you back to the point of when something is identified as causing a major problem, such as pseudomonas. I know that comments have been made in relation to the nuclear industry and how a problem would be identified. I think back to something that happened with Boeing, when the board and the director of Boeing were going to be charged with manslaughter simply

because a memo from a junior engineer who saw a problem had not been adhered to. The director of Boeing was up on a manslaughter charge in, I think, the Italian courts. The same thing happened with a Formula 1 motor racing team, where certain people were held responsible because they had not paid attention to something. That did not even involve a serious incident in which people lost their life; rather, a potential risk was identified that senior officials had not acted on. When a major problem was identified at Altnagelvin, sufficient action was not taken to ensure that that came to the fore immediately. The Minister, therefore, had to stand in front of the House and answer questions, as did you, along with John Compton, in front of the Health Committee. I think that we have now identified a mechanism, but I want to ensure that that is in place, so that we will not have to revisit this in years to come.

That leads me nicely on to my next one. Paragraph 2.15 is to do with routine staff appraisals across the health service. It seems that there is a fairly low rate of reappraisal — 5% in some cases — and that staff development needs are not often assessed. Do those figures concern you? How do you intend to improve upon the situation? How can you have confidence that the care provided to patients and clients is safe when so little regard is given to assessing, maintaining and improving the competency of staff?

Some staff are very competent but their people skills are sadly lacking. Look at the number of complaints received about A&E. I am not necessarily blaming front line staff for that. Sometimes, management fail front line staff, because they give inadequate attention to the stress and strain that those staff are under. I know of one case — I do not want to go into any detail on it — where there was a major complaint about the blasé attitude of staff, which was, "There are a lot of sick people in here, so tough". That is not the way to deal with something. Those who complained were not being abusive or nasty, but they came back thinking that perhaps that was the right way to get action, because the people who were abusive got all the attention. It ended up that their family member passed away two or three days later. The first line at A&E was the problem, as was the attitude to patient safety and the way that staff responded to that. I am not one to blame front line staff, because sometimes they are under such pressure, and management sometimes cause that pressure. I am just wondering about paragraph 2.15 and how you feel that some of those areas can be dealt with.

Dr McCormick: I understand that that is a major concern arising from the report. I wrote to the trusts specifically on that point seeking a response before this hearing. I took very seriously the evidence presented on staff appraisal. Before coming to that specifically, I can give an important level of assurance on this aspect of work, in that appraisal is an essential part of good management, but continuous supervision and assessment are part of what is happening day and daily. So, the Committee can have confidence that, on a day-to-day basis, professional staff are being supervised and assessed. We should not wait until an annual appraisal to challenge someone. Annual appraisals are important, but more important, if things are going wrong or someone is not quite up to the mark, is challenging that person in the context of their normal work. If we have a supportive and learning culture, a supervisor can say, "You did the following things well, but you could improve on this". If that is happening all the time — and it is happening all the time — it provides assurance. The clinical staff take safety issues very seriously. If there is a risk, they will nip it in the bud. Nipping it in the bud and dealing with things in a daily context is the right thing to do.

Appraisal is also important. We have good information in relation to medical and dental staff. As we move towards revalidation, that will be cemented and secure. There will be a continuous refreshment and revalidation. Paddy can talk about the detail of this if you wish.

The lower numbers, the more concerning numbers, are in the wider groups of staff. The context is that the Agenda for Change terms and conditions of service require the application of the knowledge and skills framework. That requires an assessment of individuals' training requirements on a regular basis; that is an inherent part of the system. We are looking to improve. Some of the percentages are unacceptably low. We are engaging with the Ambulance Service, in particular. The staff groups referred to in the report involve relatively small numbers, but they are still very important staff. It is important that there is both regular supervision and the application of the knowledge and skills framework approach in Agenda for Change to secure the right outcomes. The letter that I sent highlighted to the service the need for organisations to ensure that the performance of all staff is assessed regularly. I said that; I did not qualify it or put any subordinate clauses around it. That is a requirement on the organisations that we will pursue. We have had accountability meetings with two trusts in the past two days. We raised that point at those meetings and have had assurances that improvement is being made.

Mr Girvan: Does the Department ever engage in something that goes on in the private sector day and daily, namely a mystery shopper going in to carry out an assessment? The family that I am talking about were in A&E with their loved one, with the same condition, on two Friday afternoons. It was similarly busy on both occasions, but there was a sea change in the level of service from one occasion to the other. It could be identified that there were definitely staff who were creating a problem on a specific shift, and that needs to be focused on. That should be done. Does the Department go in as a fly on the wall to assess and observe what is going on?

Dr McCormick: We do not do that systematically. It has been done occasionally, and some quite important points have been made as a result. It is not done systematically, but we are certainly open to looking at it. It is important not to undermine confidence by giving the appearance of trying to catch people out. However, some unannounced inspections are carried out. For example, some of the RQIA hygiene inspections were planned on the basis of being unannounced, surprise visits. That is also part of what we talked about with the Committee in relation to the inspection of the independent sector homes. It is important to follow up that point and assess the value and effect that this would have. Getting an honest recognition of genuine problems is important. We need to find ways to make sure that there is good and effective challenge of — I am sure that it is not systematic bad intention — any pattern of behaviour that is not within the culture that we seek to promote. We need to take your suggestion seriously.

Mr Girvan: I think back to a problem that we had some time ago involving a number of ladies who had been brought in for mammograms. A problem was identified with how some of those mammograms were carried out. It seemed that a large number of cases had been missed. Why did it take so long for some of those things to be picked up? So many cases went through before a problem was flagged up. This is about the flagging up of issues, retraining and ensuring that the reporting comes back. The next thing that we heard was a headline on the Radio Ulster morning news that 1,400 women were being called back. The fear that that sort of thing causes in the community is horrendous. What happened that it took so long for some of those issues to be picked up? It is the sort of thing that does not give the public much confidence. Some of them will read a report like this and say, "I am safer not bothering going. I will just stay at home and take my chances." I am not saying that that is the case, but a lot of people will highlight that point.

Dr McCormick: If I recall correctly, the breast radiology case that you describe was in a difficult context. The vulnerability is where a service is being carried out by a single-handed practitioner, as was the case there. There are a number of areas in Northern Ireland where we have to provide services on that kind of basis. The important thing is to ensure that there is systematic peer involvement and that if someone is trying to keep something going but working in isolation, all the more attention is given to double-checking. That should be done without judging or making people feel that they are under unfair scrutiny. However, there should be a degree of peer challenge and a supportive network to maximise the safety services. We had an RQIA report on that case. It drew out some very important learning points in respect of timeliness of intervention and how to secure safety. It is a very important learning case for us.

The Deputy Chairperson: For the record, members and witnesses, we are now past the two-hour stage. Paul mentioned Formula One, although I am not trying to influence you. Sean Rogers has kindly given way to Mitchel McLaughlin, who has to leave shortly.

Mr Mitchel McLaughlin: I will remember your stricture about Formula One when I go to my next appointment.

At paragraph 4.13, figure 4 sets out the costs of settling claims. It is quite a stupendous figure really: £116 million. On a ratio of 2:1, the legal costs were £39 million. I just wonder how many hospitals you could build for that kind of money or how other Departments could use that kind of money if it were available. Will you talk to us about the changes that have been introduced in the past number of years — that five-year period, say — to reduce the costs of defending negligence claims and to reduce the time that it takes to process them?

Dr McCormick: A lot of important work has been done in the past number of years — the past five years, as you say — to seek to bear down on those costs. Lead responsibility for that lies with the director of legal services in the Business Services Organisation, which provides support to the health service bodies on this issue. So, action has been taken to seek to reduce the defence costs. We have looked at the way in which we contract for counsel and the way that that works. There has been significant work to standardise and put caps on that kind of cost. We look at what is necessary to

benchmark and minimise our defence costs. Plaintiff costs fall to us as well, and it is important to challenge, without being unreasonable, the bills that come in and make sure that they are fair and acceptable given that we are responsible for public money in that context. We are seeking to do what is possible. It is quite a complex field, and quite a lot of factors go into the make-up of it. There are some important differences with elsewhere, but we are seeking to apply what we can to bear down on the legal costs and, as you said, increase timeliness and accelerate the process.

We welcome the view taken by the courts that procedures should be more timely and that we should seek to find alternatives to going to court, where possible. Given that harm has happened in the service, we cannot prevent or deny the right of access of a complainant to the courts, so we have to do what we can to minimise their need to go there. A range of things are being done to accelerate the process and bring forward and resolve some of the longer claims that are outstanding. That has been quite systematic. For example, in the financial year 2010-11, there was a significant drive to bear down on costs. The table shows a trend that, towards the end of financial year 2010-11, a significant number of cases were settled. Some of the plaintiff legal costs may have fallen into 2011-12, and you can see that it is not the most natural time series; 2010-11 looks a bit low, and 2011-12 looks a bit high. We have looked at that and think that there is probably some distortion of that trend. However, all that is about our efforts to accelerate the processing of claims to meet our obligations and to try to contain cost where we can.

Mr Mitchel McLaughlin: I am slightly confused, looking at that, about the difference between 2009-2010 and 2010-11. Are you saying that 2010-11 was a blip?

Dr McCormick: It is probably most helpful to look at the trend and the percentages. The key point is that in 2010-11 and 2011-12, there was a concerted drive to clear old cases. So, some of the increase in compensation paid relates to old cases being cleared as well as the ongoing normal business. That partly explains the increase in expenditure in 2010-11 and 2011-12. The pattern across the years is that plaintiff costs run on average at 20% and defence costs on average at 10%. Most of the years are consistent with that. The 2010-11 figure shows a plaintiff cost of 13%, and that is probably a bit low against the normal trend. We think, perhaps, that some of that is because some of the plaintiff costs related to claims settled in 2010-11, because quite a few claims were settled late in the financial year. The claim may have been settled in January, February or March, but the plaintiff costs may not have been paid until 2011-12.

Mr Mitchel McLaughlin: What is the impact of the involvement of those in the directorate of legal services (DLS)? Do they arrange the defence for the Department, help in the assessment process or both?

Dr McCormick: They give advice and deal with the processing of the case through the court. They draw together the evidence on behalf of the trust and then secure counsel services in processing through the court. Part of their job is to seek to secure a fair outcome from the point of view of fulfilling our obligations to people who have suffered harm while also protecting the public purse. Their job is to find that balance and to be fair to both sides.

Mr Mitchel McLaughlin: Has the involvement of the directorate of legal services impacted on the percentage of cases that actually go to court, as opposed to, for example, negotiation between claimants' legal representatives and the Department that results in agreed settlements?

Dr McCormick: Some of that is down to earlier stages in the process whereby trusts are encouraged to seek to resolve issues without the need to go to court. Again, that is where the kinds of behaviours that we talked about earlier are so important, and we must do better on that.

Mr Mitchel McLaughlin: OK. I may just have presented that question in a misleading way. I did not intend to do so. I assume that a judgement call is always made somewhere. The decision was that you really needed to defend that case because you believed that you could defend it. That resulted in going to court. Obviously, you cannot guarantee the outcome. I am interested in how the involvement of the directorate of legal services has materially improved the process, because once you are committed to court, you lose control of the timetable. Lawyers and barristers will take their own sweet time in working their way through that process. Is there a material impact? What is the benefit of using the directorate of legal services if you still have to get external legal expertise to help you to defend your case?

Dr McCormick: They will provide essential expertise in processing responses and identifying when it is right to settle out of court and when it is right to let the process go through to the final stages. So, they have expertise and consistency in processing those cases.

Mr Mitchel McLaughlin: Does that not mean in practice that you will actually continue with that factor of 2:1 with regard to settlement awards and the cost of legal services, both for the complainant and yourselves?

Dr McCormick: There is some degree to which the process is not within our —

Mr Mitchel McLaughlin: I am trying to give you the opportunity to explain how you have improved, but I have to say that I am not getting it.

Dr McCormick: We are seeking to make sure that we process things smoothly in timing and that we do all that we can. DLS is doing what is possible to bear down on costs. So, improvement has been made. The underlying numbers are still as they are because a large number of claims have to be settled, including some very old ones. Some of the old high-cost cases would be in the realms of damages for birth injuries, and things like that, where you are talking about compensation, care and loss of earnings. There are lots of things that amount to large amounts of money. The right thing to do is to be responsible and handle those issues properly and fairly, and to seek to make maximum improvement. We are doing what we can to improve.

Mr Mitchel McLaughlin: Have you detected any impact from the review of legal aid?

Dr McCormick: Not directly.

Mr Mitchel McLaughlin: So, we are still dealing with high-cost cases?

Dr McCormick: Some aspects of cost are outside our control, as the report draws out. With the historic trend, courts locally are likely to make higher awards for personal injury than courts across the water. That is just a difference of fact. It is not within our sphere of influence. That is a matter for the courts.

Mr Mitchel McLaughlin: Paragraph 4.17 and figure 7 show that the majority of settlements result in compensation of £50,000 or less. Is that mainly as a result of court judgements or of negotiated settlements?

Ms Thompson: As the report points out, around 24% of claims result in compensation being paid, but you are quite right; that is not necessarily paid through the courts system. It can be agreed outwith the courts system. The report also points out that we need to look more at the smaller-value claims and maybe do something in a more cost-effective manner with them.

The court is actively advocating the use of mediation and alternative dispute resolution. We need to provide evidence on an ongoing basis of how that happens in cases. That is something that DLS will be working on with the Courts and Tribunals Service. So, we have acknowledged that we need to look at that recommendation, particularly as regards the smaller-value cases, to see whether there is a more cost-effective way of managing the legal side.

Mr Mitchel McLaughlin: There is an underlying issue. If the majority of settlements are £50,000 or less, are any statistics being thrown up on cases in which the legal costs exceed the amount awarded?

Dr McCormick: That is a genuine issue that needs to be looked at. Therefore, as Julie said, we accept the need to look hard for alternative means of resolution. We are aware of the approach being taken in other parts of the UK. I would not say that anywhere has this problem totally resolved. It is possible that some of the approaches taken might produce almost a perverse incentive to make low-value payments, which might then create a culture of wanting to make claims as there would be an automatic, or a semi-automatic, payment. We need to watch out for that, particularly given our responsibility to protect the public purse.

Mr Mitchel McLaughlin: Are you indicating that, at the moment, you do not monitor that?

Dr McCormick: We monitor things in the context of the way in which our system works, and we are satisfied that there is scrutiny of, and attention paid to, each settlement. So, each one is individually justifiable. What I am saying is that my understanding of what is being proposed in other jurisdictions is that if we were to follow that pattern, there could be some value in accelerating the process but there would also be some risk of an unintended consequence.

Mr Mitchel McLaughlin: I understand that.

Dr McCormick: We need to watch out for that.

Mr Mitchel McLaughlin: There are probably more examples, but it occurs to me that there are three obvious examples: a negotiated settlement; the classic on-the-steps-of-the-court arrangement; and the outcome of a full court process. Do you have a statistical breakdown of that?

Dr McCormick: We will get some more details on that for the Committee.

Mr Mitchel McLaughlin: I accept that there may be other classes of compensation claims or settlements, but I would have thought that an analysis of those categories would inform your consideration of where the value-for-money aspect can be addressed.

Finally, I presume that the directorate of legal service's costs are just costed into the overall figures for legal services, compensation claims and settlements.

Dr McCormick: Yes, the figures that show the costs will include the relevant attribution of costs from DLS.

Mr Clarke: Following on from Mitchel's last point, I take it that we are going to get a paper detailing the cases that you won and the ones that you lost.

I am wee bit unclear about the legal costs. In figure 7, it is quite clear that legal costs are not included.

Dr McCormick: That was intended to present the scale of the compensation paid, but the figure —

Mr Clarke: Can you furnish us with a copy of the statistics for the legal costs in each of those categories?

Ms Thompson: Yes, we can; absolutely.

Mr Clarke: That would bear some weight and would help to answer some of Mitchel's questions.

Mr Rogers: I want to take you back to figure 3, "Reported Serious Adverse Incidents". Surely, valuable patient safety lessons are to be learned from an evaluation of all adverse incidents, and even the near misses. Focusing on just the serious adverse incidents could create a tolerance of near misses and low-grade harm. Why are we not maximising the potential to learn by collating all the information?

Dr McCormick: The intention is to do exactly that. We have drawn significant value from the existing reporting system, and we will continue to do so because there are very significant lessons to be drawn from serious adverse incidents. Once the RAIL system is in place, it is intended that it will provide exactly what you are asking for, namely a comprehensive pulling together of information, systematically and analytically, so that patterns can be more clearly identified and acted on. Paddy will provide more detail on the benefits that will result from the completion of the RAIL system.

Dr Woods: Even at this point in time, trusts will draw together all their adverse incidents, draw lessons from them and produce reports on adverse incidents in their organisations. As part of the accountability process, we will ask them to assure us that that is happening and that, very importantly, they are sharing more widely in the system any lessons that they have learned that are applicable elsewhere.

The expectation with the RAIL process is that all adverse incidents will be drawn together and analysed and that the lessons learned from the totality of adverse incidents will be drawn together and disseminated for learning across the piece. The expectation is also that, in addition, there will be learning from issues that arise from clinical negligence cases and complaints. As the Venn diagram in the report shows, they are separate but interrelated: they overlap in some respects, but they all present the opportunity for learning and the avoidance of repetition.

That is a fundamental element of the RAIL project. It also points to the complexity involved in pulling all those things together, because, when we do that, we will be the first jurisdiction in the developed world to pull those things together across a jurisdiction. There are states in the United States and parts of Australia that do it, but nowhere else in the world has done it for health and social care, which is a further factor. All the other systems in the world confine themselves to healthcare adverse incidents.

Mr Rogers: Mitchel made a point earlier about a systems approach. There has really been a breakdown in the systems approach up to now.

Dr Woods: There has been an incremental build in the systems approach in that we have concentrated on regional learning arising from serious adverse incidents. We have not neglected adverse incidents, although they are not collated on a region-wide basis. However, we expect trusts to aggregate their adverse incidents to learn the lessons from them and share them where wider learning opportunities arise.

Mr Rogers: Figure 3 shows that over 2,000 serious adverse incidents have been reported. Obviously, the ultimate price that patients pay when they are harmed is losing their life. Can you give us the number of cases from those 2,000 that involved fatalities?

Dr Woods: I do not have that figure to hand. We can produce them for you.

Mr Rogers: My other point is about paragraphs 4.35 and 4.36. You answered the question about paragraph 4.36 with regard to the level of damages. You said that it was a matter of fact that the English system awards more money. Will you comment on paragraph 4.35, which states that trusts here do not contribute to compensation claims? How do you feel about that, given that so much money comes from trusts in England?

Dr McCormick: This is partly a factor of different stages of the system's evolution. It also links to the fact that we have had within the process some delayed cases. So when the new trusts came into being in 2007, and we went from 17 to 5, it would have been potentially destabilising to have given the new trusts delegated responsibility for managing a volatile and significant level of expenditure. We have tried to form a balanced judgement. There is a case, as is drawn out in the report, for aligning responsibility for this cost with all the causal factors. In principle, that is the right thing to do, and, in looking at it a couple of times, our financial review groups have said that we should move in that direction. We did not do so in 2007 because it would have burdened new organisations with the legacy of past failings from other sources, so we thought that it was not the right thing to do at that time. We are keeping it under review, and we can see the arguments of principle. There are some advantages to us at present in that it is simpler and smoother to manage the budget centrally. That is not without some advantage, but we are very open to changing that. We can look at that again to see what is the best thing to do.

Ms Thompson: It is partly related to the number of outstanding cases. As that number falls, as one of the figures in the report shows, you then come down to a less volatile way of dealing with cases. That means that we should be able to reach a point with the trusts at which it is understood how much each should pay into a pool, which is how the system operates across other elements of the UK. So you have to have some understanding and an ability to forecast to enable you to put the costs through to the trusts in that way. We would be happy to look at that to see whether the time is now right, or would be right in the near future, to look towards doing that.

Mr Rogers: Finally, paragraphs 4.42 to 4.45 relate to alternative dispute resolution. Rather than facing court proceedings, patients and their families have a right to expect a full explanation, an apology and an undertaking that if harm has been done, it will not be repeated. Keeping that in mind, do you think that it would be prudent to develop some alternative to legal action, which could reduce the costs and stress and perhaps result in a more positive outcome for the patient?

Dr McCormick: As the report states, we have accepted that recommendation from the Audit Office. We are looking at finding an alternative way forward and looking carefully at what is being applied elsewhere. Other parts of the UK are at different stages. There is also some potential learning from other jurisdictions. We have not yet identified a model from any other jurisdiction where this is a solved problem. Everyone is still learning, but the reason for seeking alternatives is very strong. If it is possible to provide a better, more responsive system at a lower legal cost, that is devoutly to be pursued. We are committing to work on that to identify alternatives, and if that means finding a compromise among other models and applying it, that is what we will do. Therefore, I accept the point and the recommendation.

The Deputy Chairperson: We have come a long road since Brangam and Bagnall and those who ripped off the health service. However, as I listen to you this afternoon, despite improvements in technology, record keeping, and so on, you seem still to be discussing ways in which you can reduce clinical negligence and better link the whole service. Have some people been sitting on their hands?

Dr McCormick: I would not say so. Rather, there is a strong motivation to take forward initiatives on patient safety. There are two parts to what you said. On patient safety, Paddy and the team in the Department's safety, quality and standards directorate and Michael McBride as Chief Medical Officer have shown strong personal commitment and leadership in introducing patient safety initiatives and exploring, developing and applying good practice. So we have strong leadership there and from many across the trusts who contribute to the patient safety forum. John Compton chaired that for a while, and that position is now with the Public Health Agency. There has been strong input and leadership from many across the service. There is a strong commitment to patient safety.

In response to your question on cost, we had to address the damage that was done through what happened in the Brangam Bagnall episode, which had very serious consequences, including recommendations from the Committee on dealing with that issue. We learned major lessons. A highly motivated team in the directorate of legal services is dealing with and clearing a caseload backlog. That has been a priority, and if that has limited all of our capacity, including mine, to change the system, I accept that we have not done all that we possibly could, but that is not through complacency or an absence of motivation. We are not complacent about this area of work. We know how much could be saved and that bearing down on this cost, including legal costs, would provide money for front line care. The previous Minister made strong statements about that in the Assembly a couple of years ago, and the current Minister wants to secure as much money as possible for the front line, so the motivation is inherent. I appreciate that it is difficult to satisfy you. Rightly, you place high demands on us to improve, and we undertake to seek to respond as positively as we can.

The Deputy Chairperson: Dr McCormick, if it is any help to you when you are dealing with the health trusts, and I am sure that I speak for all the members, patience is totally exhausted. We do not and cannot tolerate people living in fear of going into hospital and the public then paying out to meet horrendous compensation bills with money that should be going into public services.

Mr Copeland: I have four questions, three of which I am happy to talk to the Committee Clerk about and have answered by letter in the interest of expediency. I will start with a question that is not in front of me. It is widely accepted that we now live in a society that is more litigious than it used to be. Is that factored into your thinking anywhere along the line and, if it is, in what context? Does there automatically exist in the back of your mind the thought that you will be sued? If so, does that have an impact on the way in which services are provided? I ask because my son is at Queen's medical school, and I am considering telling him to think again. People are now more inclined to go to law. I am not saying that there is a claims industry exactly but is there some outside influence? That is not to suggest for one minute that people are not entitled to lodge claims when they feel that such incidents have happened. However, is there any suggestion of people being led to law by commercial interests that lie outside the service?

Dr McCormick: It is difficult to produce hard evidence of that. We are concerned that the tendency to go to law in Northern Ireland is greater than in other jurisdictions. I understand that there is some reluctance in the legal profession to move to more specialist panels, as is the case in England. There are also no win, no fee provisions in England. Together, they have some effect in limiting the propensity for smaller claims to go forward. There are probably some cultural factors involved but those are beyond our control. You asked us what we do about this, and the answer is that we need to anticipate the issue. You mentioned medical school, and I think that it is absolutely right for there to be a clear understanding of risk management. That is part of how life works. I go back to what I said

at the very beginning. I think that, as a society, we need to support those prepared to take risks. If I am in need of medical treatment, I want someone who has the courage to do what needs to be done, even knowing that something may go wrong, unintentionally, and despite the best of efforts. Again, I think of people working in highly stressed contexts in emergency departments or highly specialist services. As a society, we need to be behind those prepared to take risks, not create the consequence of people saying that they better not do something in case they are sued. That would be a very bad outcome. We need to promote and handle that very carefully. From our point of view, anticipating things going wrong and determining how to manage risk in a systematic way is a clear part of our responsibilities and something that we need to address smartly. We must really apply ourselves to this.

Mr Copeland: Thinking back to a previous career, which involved military service, I know that, when under fire, if you can get the casualty out of the killing area and back to the hospital, the survival rate is extremely high. I just wonder whether there is a cultural difference in there somewhere.

Dr Woods: There is a bit, from the point of view of healthcare practitioners. Those in the military appreciate that the environment in which they work is high risk and dangerous. For many years, probably until the past decade, the expectation was the rather unrealistic one that the practice of healthcare did not entail risk or a propensity for harm. A realistic approach is a start, and a big part of that is acknowledging that and then, as we have been discussing for most of this afternoon, systematically recording, analysing and learning from it. That is a relatively new perspective for the healthcare professions. In that regard, I do not worry so much about your son; it is the older generation like me who came up in a different culture. Part of the ongoing day-to-day push towards openness is recognising and managing risk. The first element in dealing with risk adequately is appreciating that it exists in the first place. That is not always the case. It is certainly a common theme throughout much of the material that we have been discussing today.

Mr Copeland: Andrew, paragraph 3.26 states that the latest policy document, 'Quality 2020', contains an undertaking to:

> *"devise a set of outcome measures, with quality indicators focused on safety, effectiveness and patient/client experience."*

I am slightly puzzled that such indicators were not already in use, or were they but their name has changed? I become concerned when I see passé phrases, because I see so many of them, and they all originate in the same sort of psyche. Without such benchmarking information — that is on the assumption that you have not been using it to date — how have the trusts and the Department been able to set explicit, challenging and measurable goals for improving safety performance year on year?

Dr McCormick: The background is that a systematic approach to quality and safety with the kind of metrics being developed is relatively new. It is consistent with the recognition, which I mentioned a short time ago, of the degrees of risk that apply. The Quality 2020 strategy systematically brings together thinking that has been evolving over the past few years to ensure that we apply ourselves to this in a very systematic way and that it is given a strong leadership message. If you look back to, say, 2006, 2007 and 2008, the only show in town, and the metric on which attention was entirely focused, was access times in elective care. We had been singled out as having the longest waiting times in the UK for elective care, and that was the only thing that mattered. Shifting the attention in a more balanced way to a mature view of quality is a very good thing. I do not claim originality, nor do I say that we dreamed this up, but we have sought to give it really strong leadership. I appreciate that some of the phraseology can appear broad-brush and bland, but not when applied in a systematic and rigorous way, and I assure you that the statutory duty of quality gets people's attention and that the risk of being charged with corporate manslaughter is a live topic of conversation among chief executives. We know that this matters, so applying ourselves to sorting out these issues is very important.

Mr Copeland: I would like to raise a further point of information for my and the Committee's consideration. If one of these incidents occurs, a set series of steps kicks into place. Are those set by the trusts independently, and are they fine as long as they conform to the broad set of departmental guidelines? Is there a standard method of reporting that is instantly identifiable and transferable from one trust to another so that, at the end of a given period, the information comes to you in the form in which you need it and can be put to the purpose for which it was collated?

Dr McCormick: There is a prescribed and standard format for the reporting of SAIs to the Health and Social Care Board (HSCB) and for early alerts to the Department. There are some basic requirements. However, some detail has to vary according to the context because quite a broad range of categories apply. Paddy, do you want to say something about that?

Dr Woods: In broad terms, it is fair to say that the manner in which these are reported and followed up on is consistent across the piece.

Mr Copeland: Is the manner in which they are interpreted the same?

Dr McCormick: That is one of the key advantages of their being dealt with at a regional level by the Health and Social Care Board, which has the responsibility for collating SAIs across Northern Ireland. The HSCB wants, seeks and secures consistent information that it can turn into learning letters that are sent out into the system. Such letters will state: "In light of the following SAIs, the HSCB has reached the following conclusions." The letters then advise which points need to be attended to. Again, we have significant advantages in being a relatively small system.

The Deputy Chairperson: Michael, will you let Paul in at this point?

Mr Copeland: Yes.

Mr Girvan: My question is really about information and how it is passed through the organisation. Problems sometimes occur when information is not passed through.

I appreciate that you said that you will put together the RAIL database mentioned in paragraph 3.24. My point links in exactly with what Michael said. There are other software systems in operation, and there are risks involved in introducing any new software. We saw that previously when we paid a lot of money for software. That software ended up being owned by another company, not the people who paid for it to be developed, and it was then sold to other governments to run their systems. Given the risks involved in developing any new IT system, why were options such as joining the national reporting and learning system or purchasing an off-the-shelf package not considered? They could have delivered the same results.

Dr McCormick: I understand what you are saying. Paddy, do you want to take that question?

Dr Woods: Quite some time was devoted to trying to establish a link with the national reporting and learning system. However, that system does not cover social care, which would have been an issue for us. Subsequent events and the dispersal of NPSA across various organisations in England would suggest that, unfortunately, a link with that system was never going to be a realistic prospect. The history of the production of all singing, all dancing IT systems in the public sector, particularly in the health service, is not a happy one. However, the aim with the RAIL system is to, first, pilot it in one organisation and then road test all the areas that we want to cover. We recognise that we will be breaking new ground and that this system is not replicated anywhere else in the developed world. On that basis, we will pilot the system in one organisation to mitigate the risk that you mentioned. Depending on the results of that pilot, we will then roll it out across Health and Social Care.

Mr Girvan: What is the time frame for that?

Dr Woods: Assuming that we get agreement for the Department's business case, the expectation is that the pilot will be completed by the end of 2013, with a view to the overall system being in place by the end of 2014.

Mr Girvan: What will the new system cost?

Dr Woods: I do not have that figure to hand. Apologies.

Mr Girvan: Could we get that? Sometimes, we see very expensive systems that are nothing more than databases that everyone in the health profession can access.

From the outside, it does not seem too complicated, but it might be very complicated. Sometimes, those who write such programmes want to make them seem complicated so that it appears as though

they are the only people who can write them. Gone are the days when notes were put up on a noticeboard and passed around everybody that way. I would like you to come back to us with the projected cost of the system — by that, I mean realistic projections.

The Deputy Chairperson: Paul, you may have noticed that Mr Michael Copeland has now left the meeting. Do you have any further questions?

Mr Girvan: We could go on all night if you want.

The Deputy Chairperson: I have been trying desperately to persuade you not to do that. Are you finished?

Mr Girvan: OK, yes.

The Deputy Chairperson: This has been an extremely important session. Health and social care services affect every member of society at some stage in their lives, and patient safety, which we have focused on, must be at the heart of all health and social care provision. I welcome the Department's appreciation of that and look forward to future improvements in service delivery.

The Committee will consider the evidence and produce its report in due course. Of course, we may wish to write to you for further information. Thank you for your evidence today, and —

Mr Clarke: Chairperson, I do not have a question but I want to make a comment.

The Deputy Chairperson: I knew that I was not going to get off that easily.

Mr Clarke: It is a caveat to your closing embarks. There will be questions, and in the absence of satisfactory answers, I ask for your indulgence in reserving the right to call the witnesses back. Is that appropriate?

The Deputy Chairperson: Trevor, thank you for that. It was a very useful contribution. Of course there will be questions. I imagine that someone will look back at the 2002 recommendations, investigate why many of those have not been honoured and ask what can be done in future to ensure that there is not another case of déjà vu. The public must be assured that there should be no fear of health service provision and that the awful problem of compensation will be better handled. I thank the witnesses. I also thank Hansard for its coverage of today's discussion.