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Contents

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Northern Ireland Assembly

Tuesday 1 May 2012

The Assembly met at 10.30 am (Mr Speaker in the Chair).

Members observed two minutes' silence.

Private Members' Business

Healthcare: Patient Safety

Mr Speaker: The Business Committee has agreed to allow up to one hour and 30 minutes for the debate. The proposer will have 10 minutes to propose and 10 minutes to make a winding-up speech. All other Members who wish to speak will have five minutes.

Ms P Bradley: I beg to move

> *That this Assembly calls on the Minister of Health, Social Services and Public Safety to put in place a robust strategy to promote patient safety across the health service.*

As a former employee of our National Health Service, I am very proud of healthcare in Northern Ireland. I have seen at first hand the dedication and expertise of our staff as well as how hard they work to ensure that the people of Northern Ireland have access to the best healthcare they can provide. By tabling the motion, I do not mean to attack or demoralise our hard-working health service staff; rather, I intend to support them by giving them additional tools to allow them to continue providing this important service.

When anyone needs to access our health service, they do so in the belief that they will get the right treatment as quickly as possible in a safe and controlled environment and that it will be free at the point of delivery. Of course, the NHS is not free: everyone in this country contributes in some form to the cost of the NHS, and therefore everyone has an interest in ensuring that it performs to the very best of its ability.

The European Union defines quality healthcare as healthcare that is effective, safe and responds to the needs and preferences of patients. In Northern Ireland, our 10-year quality strategy has safety as one of its three main headings. That shows how seriously we in Northern Ireland take our responsibility for patient safety. It is entirely correct that safety should be at the top of the healthcare agenda. The role of safety is one of the cornerstone beliefs of anyone entering our medical professions, with the instruction to first do no harm at the centre.

It is important that we understand what we mean by "safe". Medicine is a practice that is driven by humans. Sadly, humans can and will make mistakes, which means that, in healthcare, there will always be some element of risk. Providing safe care involves placing an emphasis on providers to be proactive when identifying the risks and promoting strategies that will minimise those risks. That will, in turn, promote reliability, reduce variation in the care provided and minimise harm to service users.

When we talk of patient harm, we cover a wide range of harm, from not enough attention by nursing staff to mistakes over missed medicine, to unnecessary surgery and, finally, to the most serious, which results in death. Therefore, it is important to remember that safety incidences can involve a wide range of factors, from infrastructure, training, treatment protocols, procedure and communication to simple administrative errors. Safety is the responsibility of all staff — clinical and non-clinical. When adverse events occur, the service providers should ensure that the maximum lessons are learned and procedures, where appropriate, implemented to reduce the risk of the incident recurring.

It is not just in the United Kingdom that the role of safety in healthcare has received prominence. A number of international studies have examined the area of patient care. Those studies put the rate of adverse events in acute care at between 2·7% and 16·6%. Even at the lower end of the scale, this is an issue of deep concern. In the 1990s, it was increasingly noted that the majority of harm inflicted on patients

was not done deliberately, negligently or through serious incompetence but through competent clinicians working in inadequate systems. That was the central premise of landmark publications such as 'To Err Is Human'. That publication argued that attempts to improve patient safety should focus not on punishing individuals when errors occur but on moving away from a blame culture that encourages the covering-up of incidents and fails to identify underlying causes and to learn lessons that could prevent the repetition of such incidents. Thus, it is my belief that we need to ensure that any robust strategy includes an open, no-blame reporting culture.

It is worth remembering that harm does not occur only when the patient is in a hospital setting. Harm can be done when the patient is in the community attending many of the other services. The NHS is a multifaceted organisation, and there is always potential for harm to occur. Therefore, our approach to ensuring patient safety must also be multifaceted. As highlighted in the 'Safety First' document, there are four main components of an informed safety culture: a reporting culture, a just culture, a flexible culture and a learning culture. Any safety strategy must endeavour to ensure that those cultures are promoted in the strategy and are communicated to the personnel involved.

We should also look to learn from examples of best practice elsewhere in the UK. Where an adverse incident has occurred or has been prevented from happening, systems need to be in place to assist individuals and organisations to learn from mistakes. In developing the safety strategy, we must also ensure that the voices of front line healthcare staff are listened to and actioned on. It is a sad fact that, often, the voices of those at the coalface are ignored in developing strategies, and yet that group of people has a rich insight into what needs to be done and what is actually happening. We ignore them at our peril.

Systems and procedures can go only so far, however, in reducing risk. We must also encourage individual patients to feel confident enough to question medical professionals and challenge them over issues such as hand-washing. In Northern Ireland, we have a reverence for the medical profession that is long-instilled in us. People need to take personal responsibility and be proactive about their care and the care of their loved ones. That should complement our safety strategy and provide another important interface to prevent mistakes. The health service must also, as a whole, communicate to patients when a mistake or near miss occurs. By doing so, we can encourage the free flow of information from both sides, promote the learning aspect and turn the negative into a positive. The empowerment of patients is provided for in our 'Quality 2020' paper.

Aside from the massive human costs of mistakes, the majority of which are, thankfully, no-harm or low-harm incidents, we must be aware that such incidents have an economic cost to our NHS. That takes financial resources away from patient care. It is a drain that we can work together to ensure is kept to a minimum. No country has yet succeeded in completely eradicating any risk of harm. In a time of austerity, it is right and just that we look at ways to reduce unnecessary spending without affecting front line services. By developing a robust safety strategy, we have the opportunity to do that.

Patient safety is a core domain of quality, and it demands a system-wide effort. It requires a range of actions and applies to all healthcare disciplines equally. We are not alone in trying to ensure patient safety. We must work to learn from other regions in the UK and other countries about how best to develop a strategy that will be practical, workable and will have an impact. International studies suggest that 10% of patients admitted to hospital will experience some form of harm associated with their admission. However, we should remember that not all that harm is preventable or serious. That notwithstanding, we must work tirelessly to ensure that preventable harm is prevented, regardless of the level of harm.

Ms S Ramsey (The Chairperson of the Committee for Health, Social Services and Public Safety): Go raibh maith agat, a Cheann Comhairle. I welcome the opportunity to address the House as the Chair of the Committee for Health, Social Services and Public Safety. I commend the proposer of the motion for securing this important debate.

The Committee has been very concerned, particularly over the past three months, about patient safety in our hospitals and in different aspects of our health service. Others will go into that. The reality is that people go to hospital because they are already vulnerable, sick, unwell, suffering from chronic illness at times

or have been in an accident of some sort. When people go to hospital, they have a right to expect that they are in a safe environment and will not come into harm's way. However, as Paula outlined, that is, unfortunately, not always the case. Recently, there have been incidents of people going to A&E and not receiving the care that they are entitled to. We are all aware of the tragic case of the man who died on a trolley in the Royal in early March. There have been other cases where people's health has deteriorated because they had to endure a long wait in A&E and could not get a bed.

The Committee has taken a proactive approach to the situation in A&Es, because we know that it is an issue that our constituents are worried about. On 22 March, the Committee undertook an official visit to the A&E at the Royal Hospital. We were all hugely impressed by the dedication and professionalism of all the medical staff we met. The nurses, doctors and support staff are all committed to sorting out the situation and have already put in place new measures to try to improve the flow of patients through A&E. However, we need a more joined-up approach across hospitals, particularly for discharge from wards, so that more beds are freed up for patients from A&E who need to be admitted.

The Minister announced the creation of an A&E improvement action group that will report to the health board. The Committee will take evidence from that group next month to see exactly what has been done to improve the situation. We have also commissioned a Research and Information Service paper on A&E waiting times and are holding an evidence session with the Department on the acute service budget for 2012-13.

The other issue of major concern with patient safety that the Committee has been dealing with is the pseudomonas outbreak at neonatal units. The Committee held a special meeting during recess and was briefed by Professor Troop on her interim report, which contained 15 recommendations. At our meeting tomorrow, we will consider a letter from the Minister detailing the update on those recommendations. We will all be very interested in that. The final report from Professor Troop will be published towards the end of May. In advance of that report, the Committee will visit the neonatal unit at the Royal to see conditions for ourselves.

The Committee wishes to see patient safety as the number-one priority and calls on the Minister, the Health and Social Care Board and the trusts to do all that they can to make that a reality.

10.45 am

Mr McCallister: I congratulate Ms Bradley on securing today's debate. In her opening remarks she set out the main themes of patient safety, the main concerns that people have across the board and how we identify the shortfalls when the system goes wrong. An important message to get out from the House is that, thankfully, most incidents are low-harm or not harmful at all.

As a general view, the fault in our hospitals is the fault of the systems; it is not the fault of the staff. Generally, when things go wrong, the system is to blame; it is no reflection on the high quality of the staff whom we have working across our health and social care system. Patients and families rightly expect a top-quality health service; that is what we all demand and want for our families and loved ones. We have to get the systems right because, ironically, people can be at more risk in hospital than at home. Later, Ms Ramsey, the Chair of the Committee, will speak about the tragic effects of the pseudomonas outbreak. We have also had issues with clostridium difficile across the hospital sector, particularly in Antrim Area Hospital. Therefore, it is about looking at where the systems let us down.

As Ms Bradley rightly pointed out, it is about recording the issues, identifying problems and learning from them, whether in primary or secondary care or in the community. When things go wrong, it is important that the health service says that mistakes have been made and that we identify those mistakes quickly and change the system to take account of that. It is important to deal with those mistakes and empower patients to feel that they have a voice in the system and that things will change if they highlight where problems take place.

I agree that there is an economic cost to the health service when things go wrong. Thankfully, as has been said, most cases are lower risk, apart from the obvious awful example of pseudomonas, where the cost to families is immeasurable. None of us would ever want to be in that position. However, there is a cost to extended hospital stays, which is a major problem in the health service and a major strain on resources. That is why the risk has to be reduced.

I am under no illusion that we will ever eliminate risk totally. However, it is about managing and minimising risk, identifying problems quickly and dealing with them quickly and correctly, having a swift response and telling patients that there has been a mistake. Therefore, it is important to get the systems in place. Patients rightly expect the highest standard of care, as we all do. If we get the systems right, the staff will respond, because it is the systems that have traditionally let us down in that area.

Mr McDevitt: I join colleagues in thanking Ms Bradley for proposing the motion today. Before I address the substance of the motion, it is probably worth reflecting on whether the Assembly can be credible in its critique of the health service and health managers when it is so deficient in its own functioning at times. These are gravely serious issues, and I have huge sympathy for the Minister in the position he finds himself in as the political head of the health service in Northern Ireland. However, we come to the House with private Members' business. The only business today is private Members' business. In fact, since Easter, all the House has had has been private Members' business. When you hold that against our ability to do what we were sent here to do by the people — to legislate — many in positions of authority outside the political sphere can, unfortunately, point the finger back at us.

Mr Wells: Will the Member give way?

Mr McDevitt: Yes.

Mr Wells: There was a written response from the Minister yesterday about the potential legislation coming through from the Department. Can I guarantee the Member that, by the end of this calendar year, he will not be disappointed about the legislation that is coming forward?

Mr McDevitt: I wonder if that is a reply from the Minister who will introduce the legislation or from the Minister who is proposing to introduce the legislation.

The record stands for itself. We have had six Bills since we came back from the election. Three of them were Budget Bills, which were unavoidable; one was introduced by my colleague, the Minister of the Environment; and another was introduced by the Minister for Social Development. That does not make us very credible when it comes to calling on others to up their game. I want to put on the record of the House my appeal to everyone in a position to influence these matters to up their game.

I move now to patient safety. It is undoubtedly the case that public incidents, such as the tragic death of an elderly man in the Royal Victoria A&E recently, undermine public confidence in the health service. They really drill down into public fears and apprehensions about the state of our health service. It is also worth noting that, in 2006, the Department of Health, Social Services and Public Safety produced a report, 'Safety First: A Framework for Sustainable Improvement in the HPSS'. In that report, the Department talked about changing the health service's culture in order to create a culture in which safety could be prioritised. It identified several key characteristics of a culture that puts safety first:

> *"a reporting culture; a just culture; a flexible culture; and a learning culture."*

The report goes on to say:

> *"A just culture is one that is seen to be open and fair to staff. Creating such a culture encourages the reporting of incidents, which is essential to the success of data collection and subsequent improvement in activity, systems, and care."*

The report talks about an open and fair culture as one in which staff are not blamed, criticised or disciplined as a result of genuine slip-ups or mistakes that might have led to an incident. However, where serious misconduct or gross negligence has taken place and where there would be robust discipline, the report talks about determining the concept of blameworthiness and making sure that the organisation as a whole is able to learn from mistakes.

I would like to hold that report of 2006 up to recent experience in the health service. When there have been slip-ups and mistakes in the health service in recent times, what has followed has been witch-hunts. So, we need to ask ourselves whether the culture of the health service is undermining its ability to promote a safety-first culture. My appeal today is for people at every level in the health service to understand that a culture that is based on the principles outlined in that document would keep patients safer, promote active learning and not leave many health service professionals concerned about the consequences of reporting, internally or externally, which is their right and, many would argue, their duty.

I hope that from today's debate we are able to promote a culture based on —

Mr Speaker: The Member's time is almost up.

Mr McDevitt: — those types of values.

Mr Wells: On a point of order, Mr Speaker. I think that Mr McDevitt was entitled to an extra minute.

Mr Speaker: I apologise to the Member. If he wants to continue, he can.

Mr McDevitt: No.

Mr Speaker: I realised that the Member was finished. He did not need the extra minute. *[Laughter.]*

Mr McCarthy: I also express my gratitude to the Members who tabled this important motion. The Alliance Party fully supports the motion, which talks about patient safety across the health service. We would also include safety for everyone engaged in providing a first-class health service throughout Northern Ireland, be that patients, staff, ambulance or fire crew or whoever. We fully support the zero tolerance initiative, outside and inside a hospital setting.

Concern has to be expressed about patient safety, given the huge cuts imposed by the Tory-led Government at Westminster, which, undoubtedly, will have a significant impact on all services provided by the National Health Service in Northern Ireland. Stern warnings have been issued. In September last year, it was reported that health chiefs admitted that:

> *"they will fail to meet a range of ... targets laid out to ensure patient safety and minimise suffering for ... the most vulnerable ... in society."*

Indeed, there have been warnings from the trade union UNISON that lives are being or could be put at risk and that the public must be made aware of what is planned.

The motion calls for:

> *"a robust strategy to promote patient safety".*

In November of last year, the Department issued a 10-year strategy to promote and improve quality in health and social care here at home. It comes under three headings: safety; effectiveness; and patient and client focus. We all acknowledge that providing health and social care is a complex, sophisticated and, indeed, increasingly technological service involving a diversity of people working together in multidisciplinary teams, providing this service day and night, all year round. They work through, in a compassionate and professional manner, an enormous volume of engagements each year, be it hospital admissions, patient appointments or consultations and so on with patients, families and carers at a time when they are in pain and suffering. For all those people, it is a fundamental expectation that the service they provide will be as safe as possible.

The unfortunate fact is, of course, that, in such a highly complex and stressful environment, things can go wrong. Thankfully, it is in only a tiny proportion of cases that mistakes are made. However, a high-quality healthcare service needs to protect and improve by learning from all such happenings and so minimising the chance of them happening again. There can never be room for complacency. Safety must always be an aspect of quality that needs to be guarded. Equally, a high-quality service should mean that the services provided are the right ones, at the right time and in the right place. In other words, they must be effective in dealing with patients' clinical and social needs. Just as importantly, services must have a clear patient and client focus. There is abundant evidence that such an approach delivers improved health and well-being outcomes. Patients are entitled to be treated with dignity and respect and must be fully involved in decisions affecting their treatment, care and support.

Patient safety must be at the forefront of this and any strategy. On behalf of the Alliance Party, I fully support the motion.

Mr Dunne: I welcome the opportunity to speak on what is a very important matter for everyone in Northern Ireland. Patient safety must be the central priority across our health service. Now is the time to put in place a robust strategy to promote patient safety and ensure that it is the top priority.

Everyone in Northern Ireland rightly expects and deserves a high level of service, whether that is in a front line hospital setting, a community location or even their home. I welcome the work to date by the Health Minister, Edwin Poots, in prioritising the needs of patients. I trust that that important work will continue. I would add that the vast majority of complaints that we get from constituents are not about the standard of care in our health service but about getting into the system, delays, waiting lists and trolley

waits. Those are the real issues that need to be addressed.

(Mr Deputy Speaker [Mr Dallat] in the Chair)

11.00 am

I welcome progress on the Quality 2020 strategy, and I trust it will lead to real advantages in our health service. The three significant themes of any strategy aimed at improving patient safety are quite rightly set out as safety, effectiveness and a focus on patients. I welcome the ambitious and positive strategic vision set out for Northern Ireland, which is that it should be seen as a leader for excellence internationally and, most importantly, by the people of Northern Ireland, who quite rightly deserve the high level of patient safety for which we strive.

Patient responsibility is an important issue. Patients also have to act responsibly. The abuse and overload of our A&Es by those who do not need treatment at such a location needs to be addressed. Attacks on our staff within hospitals must stop, and so, too, must failure to turn up for appointments. All those issues have a negative effect on patient safety and the quality of care.

We have many positives and strengths within our health service, not least one of our best assets, our staff, who provide an excellent service to our population and go about their work in a professional and dedicated manner. I know of many staff who make many personal sacrifices on a daily basis to help improve patients' lives and quality of care. In any strategy, staff have a key role to play in setting up and implementing changes and improvements. There is a need to ensure that staff are equipped with the necessary skills and knowledge to improve and implement changes in our health service. There is a feeling among staff that the system is too bureaucratic, with a top-heavy management structure in place. Staff need a sense of ownership and an improved sense of morale, and they need to become fully involved with any proposed changes. The provision and carrying out of health and social care is complex, and the reality is that it will never be fully error-free. However, there is always room for improvement, and we must ensure that any potential risk is kept to a minimum.

I welcome the commitment in the strategy to a person-centred approach; a fundamental approach that must be fully implemented. Quality is about patient satisfaction, and quality of care is about patient care, setting standards, working to ensure compliance through quality systems, monitoring performance, and ensuring non-recurrence of issues that arise. Those are the basics of quality improvement, and it is important that standards continue to rise. We must strive to ensure quality of care.

An effective partnership and communication between those who receive care and those providing services must be in place. Improving communication can often be one of the most cost-effective, practical and effective measures that can help to improve patient safety and the quality of their care. We need to ensure that trust and confidence between patients, their families and staff are maintained and improved. I support the motion.

Mr Brady: Go raibh maith agat, a LeasCheann Comhairle. I, too, welcome the important motion before the Assembly.

Paula Bradley talked about hospitals being "a safe and controlled environment". I suppose that a simple approach in considering that would be to ensure that people come out of hospital in better condition than when they went in. Unfortunately, that has not always been the case in recent times.

Many years ago, when I was relatively young, when you went into hospital, the first thing you smelt was disinfectant, so there was a perceived atmosphere of cleanliness and hygiene. At that time, obviously, there was a different regime, with matrons, etc. You had probably 10 people cleaning five wards, whereas now you have five people cleaning 10 wards. Presumably, that is because of reduced finances: we may be told different, but that seems generally to be the case.

As to what has been happening lately in relation to the implementation of the Compton review, we have been told that there will be streamlining and cutbacks in hospitals. Will that increase patient safety? If it does not improve patient safety, will management be held accountable? The incidences of patient safety and people who suffered particular injuries in hospital were alluded to, although with MRSA that has been a huge problem. In the Northern Health and Social Care Trust within the past few years, with clostridium difficile, a number of elderly people died. That needs to be addressed.

Paula Bradley talked about the health service being multifaceted. I want to raise a concern

with the Minister, which is the issue of patients' safety within their own homes. Many of them are older people who have been discharged from hospital early and who need a very good support infrastructure in their homes. There are numerous safety risks for an elderly person, particularly one who has been ill and is in recovery.

One issue that needs to be addressed is malnutrition, because that affects more than one in three adults admitted to care homes and into hospital. For a lot of older people who live in their own homes, social isolation can result in disinterest in food, and immobility may lead to difficulties with shopping and preparing, cooking and eating food. Problems with incontinence may stop individuals from eating and drinking normally, and innocent medication can result in reduced appetites. These are all people who are suffering from particular illnesses and, at some time, may be admitted to hospital. However, obviously, the issue is to try to prevent that happening.

It has to be said that malnutrition is a significant burden on the health sector. The estimated expenditure on malnutrition-related disease in England, Scotland and Wales, and here in the North, in 2007 was thought to be in excess of £13 billion.

Many older people prefer to stay in their own homes within their communities, and meals on wheels are a positive measure to fulfil that ambition. Age NI recently highlighted that low-level services, such as meals on wheels, can enable older people to live independently and may prevent the development of significant health issues later in life.

Mr McCarthy: I am very grateful to the Member for giving way. Does he agree that great concern must be expressed about the recent lifting of the bar in relation to eligibility for meals on wheels? As a result, there is a huge reduction in the number of people receiving meals on wheels.

Mr Brady: I thank the Member for his intervention. Certainly, he raises a very important point. Many on the Health Committee have been out with the service and have seen at first hand how important it is. Meals on wheels provides not only a nutritious diet for older people but a safety and welfare check. In some instances, it is set up in conjunction with social services, and if the delivery person has concerns, people can be contacted immediately.

In four of the five health trusts, persons aged 85 and over were the largest cohort receiving meals on wheels at the end of March 2011. Those who carry out the service should be highly praised for the work they do, as should all staff in the health service. I do not think that what we are talking about in relation to patient safety is by any stretch of the imagination a criticism of the staff who do fantastic work in the conditions that they are sometimes forced to work in.

I commend the work being carried out to combat malnutrition, but not enough measures are being carried out to tackle the issue of patient safety in a community setting. I ask the Minister to treat patient safety as a priority, especially within the community setting, and to take a proactive approach in identifying and minimising such risks for patients.

Mr G Robinson: I congratulate my colleagues in bringing the motion to the House today. It would be unfair if I did not, first, thank and commend the dedicated staff of the health service for all the great work that they do, day in and day out, and remind people that although errors sometimes occur, staff are never praised enough when things go right, as they do on a daily basis, 99·99% of the time. I also condemn anyone who abuses the valued staff in our hospitals and A&E departments.

This is a debate that I welcome as I was involved in some patient safety issues in the last mandate, which were protracted and difficult to solve; a situation that will not, I believe, occur under the present Minister. I also believe that the tools required to achieve the patient safety on which the debate centres are already in place. They may need some adjustments, but they are there to be used. What we must have is strict enforcement. We can have handbooks and guidance notes up to our ears, but if their content is not implemented, there is no point in having them.

We have already seen this Minister act decisively when action needed to be taken. When the tragic loss of babies to pseudomonas was discovered, he immediately ordered changes of equipment to prevent further loss of life. I believe that this Minister is the one to tackle the challenge head-on, and do so successfully. It should also be stated that money is not the only issue that can help us promote patient safety. It could well be that greater enforcement powers

are needed and that trusts need to take a proactive stance when it comes to hand-washing or the use of hand-sanitising gels on wards by staff and visitors alike.

Patient safety is delivered on the wards of our hospitals, in people's homes and in specialist accommodation. Therefore, those areas are the front line in protecting patient safety. I firmly believe that the key to ensuring that we further minimise the small risk to patient safety lies in enforcement and ask that the Minister look especially at that area during his discussions on a patient safety strategy.

Mr Gardiner: I join others in expressing gratitude to Ms Bradley for securing this very worthwhile debate. It is for the benefit of all our people. Patient safety is a key consideration for the health service. I understand that as many as one in 10 of all people admitted to hospital suffers an adverse incident of one sort or another, such as falling out of bed or a cleanliness-related incident. It could also be an element of a surgical or post-operative procedure.

It is my understanding that the previous Health Minister, Michael McGimpsey, had taken steps to put in place a patient safety strategy, and I would be interested to know how that has worked out in practice. I am aware of findings that one trolley round in a hospital had been interrupted over 100 times by others calling it. It was decided that, in future, that round would not be interrupted for any reason.

Any patient safety policy needs to incorporate what are called "never events", which are things that should not happen. They include wrong site surgery; wrong implants; retained foreign objects after an operation; wrongly prepared high-risk injections and medication; maladministration of potassium-containing solutions, such as IV fluids; wrong route of administration of oral treatment; maladministration of insulin; suicide using non-collapsible rails; the escape of a transferred prisoner; falls from unrestricted windows; entrapment in bed rails; misplaced nasal or gastric tubes; administration of the wrong gas; failure to monitor and respond to oxygen saturation; misidentification of patients; severe scalding of patients; and maternal deaths after caesarean surgery.

That list serves to show how complex such a patient safety policy can be. It must be based on anticipated events. I say to the Minister that all those precautions have already been identified by the Royal College of Nursing as being essential parts of patient safety policy. The list grows longer each year.

Ms Gildernew: Go raibh maith agat, a LeasCheann Comhairle. Like others, I support the motion and thank its proposer for bringing the debate to the House today.

11.15 am

Upon hearing Mr Gardiner's list and the issues covered by colleagues in the House this morning, one could be forgiven for thinking that hospitals are not very safe places. So, from the outset, I want to commend the work of staff not just in our hospitals but in nursing homes and right across our healthcare system, because they do challenging and difficult work daily to protect people in hospitals. Notwithstanding that, we recognise that there are very many issues with patient safety and that certain things could be done much better. Ms Ramsey covered, for example, the whole issue of A&E and what the Health Committee is doing to try to ensure that the safety of patients in A&E is better than it has been of late. Obviously, that issue has received quite a bit of attention in the media over the past weeks and months.

Mr Brady talked about nursing homes and emphasised the important issue of malnutrition. I welcome his raising of that issue, which has been highlighted a number of times in the House over the past decade. The fact is that many elderly and vulnerable patients who go into hospital suffer from malnourishment, so it is much more difficult for them to benefit from the treatments in hospital because their bodies are already so weak and starved. We in the House have also laboured the point about the whole area of prevention and about how the Minister should be looking at areas such as transport, particularly rural transport schemes, to help people to keep well and enjoy a better quality and much happier life, which keeps them out of the healthcare system and does not put a burden on the system.

To that end, I would like to talk briefly about the issue of osteoporosis, which was raised on the Floor of the House towards the end of last year, and about how effective treatments are not widely available at the moment, so our elderly population is not getting the benefit of them. We heard the staggering fact that if somebody over 70 breaks a hip, they have a one-in-10 chance of seeing the anniversary of that fall. Yet, if they

are in a nursing home, their chances increase to four in 10. So, it goes up from 10% to 40% just by dint of the fact that they live in nursing home accommodation. That says something about the level of patient care and safety given to people in nursing homes. So, I think that we have to get a handle on the issues that show that people are not getting the proper level of care and support.

Another issue that has been highlighted in the media — I understand that there is an ongoing inquiry about this — is the amount of drugs given to patients, especially those going for an operation, and the appropriate amount of anaesthetic that someone can receive depending on their size and weight. There have been a number of cases recently where babies were not given the proper amount of drugs, with tragic and fatal consequences. Again, to bring the point back to the fact that healthcare workers work in a very difficult environment, a mistake can cost a life, and to that end, there has to be a robust patient safety strategy in place to protect the most vulnerable.

I recognise that staff support, peer support and proper supervision are important for people who work in our healthcare system. If somebody is in doubt, they should have the confidence to ask a colleague, be it in their own hospital or another hospital, and the ability to seek a second opinion and get reassurance that the decision they are taking and the pathway they have chosen is the correct one for a patient. It is hugely important that staff know that there is a team of people around them to help them to come to the right decision. Equally, we need to give people the confidence to say something if they see a colleague administering medicine in a bad way or making the wrong decisions for patients.

Mr Deputy Speaker: Bring your remarks to a close, please.

Ms Gildernew: Whistleblowers should be protected and given the ability to point out mistakes, when they are made, in order to protect patient safety.

Mr Durkan: Go raibh maith agat, a LeasCheann Comhairle. What I had been about to say has largely been covered, but I will reiterate my party's support for the motion. It is very important that we put patient safety to the forefront of the Health Department's thoughts. Obviously, a lot of the direction and thoughts of the Department have of late been, and will be increasingly, focused on reducing expenditure because of the Budget that this Assembly passed last year. However, it is vital that when these efficiencies are being sought, patient care is not compromised in any way.

I congratulate the proposers for the timeliness of the motion in the wake of some highly publicised and very tragic incidents over the past couple of months, many of which could have been avoided had there been greater emphasis on public safety. I also echo the sentiments that some of the contributors to the debate have expressed about health servants and the huge and important role that they play. The Assembly must do everything that it can to support them in their role.

Mr Allister: It is good to have an opportunity to discuss something that is much more relevant to our constituents than some of the business that we discussed, for example, yesterday in this House, when, as time fillers, we ranged far and wide into excepted and foreign matters and all sorts of things, so it is good to return to an issue that is germane to the —

Mr Deputy Speaker: Perhaps the Member would practice it now and talk on the motion. *[Laughter.]*

Mr Allister: Yes, I am just setting the scene, Mr Deputy Speaker. It is good to have an opportunity to talk about something that is germane to our constituents.

Of course, by its very nature, when things go wrong in our health service we all hear about it. Equally however, when, on the vast bulk of occasions, things go as they should, we never think about it and we rarely hear about it. Therefore, it is right to record our appreciation and respect for the staff who keep our health service ticking over adequately and functioning, in the main, successfully.

Mr Wells: The Member raises a valid point. Two weeks ago, the Southern Health and Social Care Trust won the award for the best telemedicine service in the United Kingdom, beating scores of trusts throughout England, Scotland and Wales. The Minister, quite rightly, held a reception in the Long Gallery to mark that tremendous performance, which got about one inch of media coverage. That was a good news story, but, sadly, the media were not interested in it. The media are only interested, as the Member said, in the occasional event when things go wrong.

Mr Allister: I am not entirely going to join in on media-bashing, because as politicians we all use the media in our own ways, but it is a

legitimate point that when the health service works as it should, very often none of us has anything to say. When things go wrong, of course, we all have lots to say. Nevertheless, the staff are there for the good times and the bad times, and we appreciate all that they do.

I wanted to focus, in the couple of minutes that I have, on an issue that has not yet been mentioned in the debate. When a patient has recourse to the health service, we are not just talking about their care when they get to hospital and in the hospital — we all know about rising waiting times and all that — but, very often, when patients avail themselves of the emergency services, about the time that elapses between the call to the ambulance and when it arrives and takes them to the hospital.

The Minister will be aware of a reply that he gave to me a few weeks ago about the downtime of ambulances and how we had, in some of our hospitals in the sample month of February, very unacceptable downtimes — the time that passes from when the patient arrives until he or she is handed over to the professional staff in the hospital. In one case, the downtime was five hours and 26 minutes — a staggering period — from when an ambulance arrived at the Ulster Hospital until it was free to leave again.

In a number of cases, it took two hours or three hours, which is utterly unacceptable. My purpose in making that point is my concern for the patient in such a situation. During that time, the patient has not been handed over to the nursing and healthcare staff in a hospital. What about the patient's safety at that time? That, equally, has to be a radical concern for us all. Therefore, when the Minister responds to the debate, will he be able to tell us whether steps have been taken and guidelines are in place to expedite the handover period for patients? The answer that I was given covers all eventualities. It could cover the unlikely situation of an ambulance breaking down until it leaves a site again, but it is quite clear from the volume that if 30% of ambulance downtimes at the Royal Victoria Hospital and the Ulster Hospital were taking more than 45 minutes, it has, patently, to involve lengthy delays for patients being held until they are handed over, whether in the corridor or elsewhere. I trust that in responding to this debate on the concept of safety, the Minister might be able to reassure us that steps are being taken to address that issue.

This might be the first debate since the matter arose, so when the Minister responds, might he have the stature to apologise publicly to the Member for Strangford Mr McCarthy for the quite appalling and unparliamentary terms that were used to him in a previous debate?

Mr Deputy Speaker: Order, please. The Member has really gone well off the motion.

Mr Allister: I am still on a point that troubles many in the House, which is that a public apology should be made for what was publicly said.

Mr Deputy Speaker: The Member knows well that the Speaker has already dealt with the matter, and I regret that it has been raised again.

Mr Poots (The Minister of Health, Social Services and Public Safety): I have listened with considerable interest, and I welcome the opportunity to respond to this important motion and, indeed, to the important issues that Members raised. From my first day as Minister, I have made it clear that the underlying objective for me and, I believe, all the people who work in our health and social care system is to protect and improve the quality of those services. That means that services must be safe, effective and focused on patients and clients, who must, rightly, be at the heart of everything we do. For that reason, I launched my Department's quality strategy, Quality 2020, in November last year, a copy of which can be accessed in the Assembly Library or on my Department's website.

Mr McDevitt raised the issue of the business that we conduct in the House and the current lack of legislation in the early part of this Assembly mandate. If we were to compare our business in the first term with that of Scotland or Wales, we would find that they are not in a much different position with legislation. Legislation often takes around a year to come through, and Members should reflect on that. This year, we introduced strategies for mental health, nutrition, allied health, maternity, obesity, and investment, and this quality strategy, Quality 2020. The strategies are not just pieces of paper but important documents that set clear guidelines for people who work in our system. We expect those people to adhere to the guidelines, which should not be taken lightly or treated as some frivolous kind of business. They are serious elements of business, and we need to respect that. In the previous mandate, as Minister of the Environment, I think that I introduced eight pieces of legislation in the space of two years.

That will not be happening in the Department of Health, Social Services and Public Safety, because it is not that type of Department. We will focus more strongly on strategies as a way forward.

Quality 2020 builds on the work of the past 10 years, and its purpose is to create a new strategic framework and a plan of action that will help to promote and improve quality in health and social care services.

Mr Gardiner said that the previous Minister had launched a number of initiatives on patient safety. One of those was the safety forum that was launched in 2007, and that has had a significant beneficial impact over time.

11.30 am

We want to present a clear vision for the future in which the health and social care system aspires to be recognised internationally, but especially by the people in Northern Ireland, as a leader for excellence in health and social care. That is a huge challenge, because we can see that we have more and more work to do. We have an older population, and we have many new medical devices and new drugs that will prolong people's lives. That is a good thing, but it applies greater pressure to our system, and our budgets are largely flatlining. So, in all of that, we have huge challenges to meet to enable us to deliver on the demands that are expected of us. We have to be innovative and assertive in how we go about our business to achieve that.

We recognise that, over the next 10 years, we will have major challenges, but we also recognise that many opportunities lie ahead, and we should ensure that we are ready to deal effectively with the challenges and opportunities in order to protect and improve quality. This is the vehicle through which I plan to progress priority work to further promote high quality in health and social care in Northern Ireland.

It is important to note that Quality 2020 defines quality for health and social care by three key components: safety, effectiveness and patient focus. In particular, Quality 2020 builds on our achievements in assuring patient safety over recent years, including embedding robust clinical and social care governance practices and procedures through which health and social care bodies are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical and social care can flourish. That also includes creating an informed, open and fair safety culture across the health and social care system, raising awareness of risk, sharing learning, implementing change, ensuring compliance with recognised best practice, and involving and communicating with the public. It also includes establishing links with a number of external agencies as a source of expertise, such as the National Patient Safety Agency and the National Institute for Health and Clinical Excellence, and the establishment of local agencies to provide assurance and spread best practice, such as through the Regulation and Quality Improvement Authority or the Health and Social Care (HSC) Safety Forum.

It is recognised internationally that healthcare is not as safe as it should or, indeed, could be. Frankly, unintended harm and unnecessary deaths are too frequent an outcome in all healthcare systems, and Northern Ireland is not an exception in that regard. There are many factors that impact on the safety of care, including organisational leadership, governance systems, policies and processes, the work environment, team communication, task complexity and patient characteristics as well as the knowledge, skills and motivation of staff. Given the multiplicity of those factors, it is well established in research that most of the unintended harm and unnecessary deaths are due to a combination of circumstances within a system rather than the failings of a single individual.

It is essential to recognise that the vast majority of patients experience care that is safe and of a very high quality. Indeed, two million people are treated each year in Northern Ireland. Obviously, people are being treated more than once because that is a greater number than our population. However, the fact is that, on occasions, very often in very complex and stressful environments, things will go wrong for a variety of reasons. While that only applies in a tiny proportion of cases, for those patients involved, any harm is traumatic. So, for us to deliver a high-quality health and social care service, it is absolutely vital that we learn from those occasions and apply consistency, minimise risk and, where possible, eradicate that. There can never be room for complacency. Safety will always be the component of quality that needs to be guarded as foremost and continually improved.

Quality 2020 seeks to support existing patient safety arrangements established in HSC, which are already delivering quality improvements. The strategy aims to transform the culture. That means creating a new, dynamic culture that is ever more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service. It also aims to strengthen the workforce. We want to equip those who work in the health and social care system, including the volunteers and carers — they are very important people in the system — with the skills and knowledge they will need to deliver safe, effective services.

We want to measure the improvements. That means improving outcomes measures to ensure the delivery of continuous improvement. We want to raise the standards to produce a coherent framework of robust and meaningful standards against which performance can be assessed. Benchmarking is vital. We want to integrate the care, to build on Northern Ireland's integrated health and social care system and develop integrated pathways of care for patients and clients to improve the quality of experience for them.

I have recently approved the implementation plan for Quality 2020 and am happy to share that with Members, particularly the Health Committee. Its implementation will lead to various initiatives, including those focused on patient safety, supporting the many initiatives of the health service organisations in the work that they undertake in seeking to fulfil the statutory duty of quality. My officials will now commence the establishment of the management structures and delivery mechanisms, which will be led by the Chief Medical Officer, with the first meeting of the steering group being scheduled within the coming weeks.

The implementation plan identified a number of projects that need to be initiated immediately and progressively over the first three years, with one, in particular, focused immediately on managing implementation and compliance with safety alerts. Thereafter, triennial reviews will reassess priorities in order to protect the integrity of the strategy and to continue protecting and improving quality, including safety of services.

I am heartened by the correspondence that I receive from members of the public, indicating that they are receiving good quality care. When they listen to some of the stuff that goes out in the media, a lot of them will put pen to paper and pass on the message about what really happens in our health and social care system. I want to pay tribute to the excellent staff that we have for the hard work that they engage in and for the fact that they deliver, day and daily, for tens of thousands of people across Northern Ireland. We need to give them the appropriate recognition for the work that they engage in in a safe way. We want to ensure that we support them in doing that.

Mr Allister raised the issue of ambulance downtimes. He referred to a particular circumstance in the Ulster Hospital, where the ambulance downtime was five hours and 26 minutes. I understand that, at that time, the norovirus was present in the Ulster Hospital for around two weeks and that the hospital was under exceptional pressure, which it dealt with and overcame in due course. That was a very difficult period that it had to deal with at that point. For individuals, remaining in the care of paramedics is remaining in the care of people who are skilled at a particular task. Should that person's condition deteriorate, paramedics will avail themselves of other services and, indeed, other staff within the hospital to ensure that patient safety is upheld.

We need to develop and alter the system to ensure that there is a better flow of patients through our hospitals. Patients should not arrive at the accident and emergency department and be pushed through the system; rather, a flow should already exist, and accident and emergency departments should not have to wait as long to get people into the main-stay wards, where appropriate.

I am also of the view that our emergency departments should have the best staff with the best diagnostic equipment at the front door of the hospital, because I believe that that can substantially change the number of inappropriate admissions to hospital and ensure that we can move forward. To do that, we will need to have consultants on emergency departments at those critical times. Therefore, people who want a multiplicity of emergency departments manned by junior doctors across the country will not be able to achieve that.

In concluding, I am strongly committed to the principle of protecting and improving the quality of health and social care services, especially safety. As a key component of quality, patient

safety has been and continues to be a priority for me and all those working in the health and social care system. I am convinced that Quality 2020 is a robust strategy that will play a major role in protecting and improving the quality, especially the safety, of health and social care services for the people of Northern Ireland over the next 10 years.

Finally, I thank those who tabled the motion, and I am grateful for the helpful comments that were made during the debate. I assure Members that all the points that were raised will be addressed as part of the implementation of Quality 2020. In that way, the people of Northern Ireland should know that no effort will be spared in ensuring that our health services will be of the highest possible quality, thus safe, effective and focused on patients and clients. I am convinced that, by that means, we can truly become a leader for excellence in health and social care.

Mr Wells: Mr Deputy Speaker, 1 May 2012 will go down as "Health Day" in the Assembly. In addition to this debate, we have the debate on pseudomonas later and questions to the Department of Health. Indeed, three important health events are going on in this Building. We have a pain summit in Room 115, a multiple sclerosis reception and one of our leading consultants, Dr Morrow, is to receive a justified award at 5.00 pm. Given that today is just an insight into what is going on, it indicates the intensity of the workload in the Health Department.

I am disappointed that, with the exception of Mr Robinson and Mr Allister, to a large extent, this debate has been a case of the Health Committee talking to itself. Health is an important Department, and it is responsible for 40% of the expenditure of the Northern Ireland block grant and employs 70,000 people. So, it disappoints me that the only Members who showed interest in a debate about such an important Department are, with one or two exceptions, Health Committee members. As an Assembly, we need to address that issue. This was an opportunity for those without the insight of the Health Committee to express their concerns and make other comments about this issue, but that did not happen.

Mr McCarthy: I am grateful to the Member for giving way. He will be delighted to know that not only are a number of MLAs here interested, but, above his head in the Public Gallery, a class from Drumlins Integrated Primary School in Ballynahinch is listening to his contribution.

Mr Wells: That is an extremely important group of people, because many of their parents would have votes in South Down. Therefore, I will be extremely pleasant to Drumlins Integrated Primary School —

Mr Deputy Speaker: I remind Members that you do not make reference to people in the Public Gallery. A little bit, OK, but do not prolong it.

Mr Wells: Mr Deputy Speaker, of course I did not instigate that particular transgression.

I congratulate North Belfast Member Paula Bradley for raising this issue in the Assembly. She made the important point that most of what are called accidents arise from consultants, surgeons or other health professionals making genuinely honest mistakes. Given the huge numbers who pass through our hospitals and clinics in Northern Ireland, it is inevitable that mistakes are occasionally made or that proper action leads to unexpected outcomes. I was quite surprised by Mrs Bradley's comment that 10% of all patients will suffer some form of harm, albeit that much of it will not be serious. There was also an indication that 2% of instances can be something about which to be very concerned.

The Chair of the Committee — I believe that she has been anointed permanent Chair, and I congratulate her on that — raised the issue of the Committee's work on pseudomonas. The Committee took that extremely seriously and regards it as an absolute priority.

She pointed out, quite rightly, that the Committee responded immediately to the Minister's request to return during the Easter recess to deal with an extremely serious issue in the health service.

11.45 am

John McCallister raised the point that systems and not people tend to be the problem. Indeed, systems and structures, rather than surgeons and staff, are the concern as far as health safety is concerned.

Mr McDevitt: I thank Mr Wells for giving way. Of course, there is an issue with systems and structures, but there is also an underlying cultural issue. That issue was identified in 2006, and we need to keep it at the front of our minds when debating this issue. The culture in the health service needs to be open and allow self-critique, honest critique and, occasionally, whistle-blowing, without the fear of persecution or prejudice.

Mr Wells: Yes; and Mr McCallister made that important point in his speech. He said that we require total openness and that, when the system, the structure or the culture goes wrong and something is amiss, there must be a willingness to come forward and honestly admit that a mistake has been made so that we can learn from it. I totally agree with him on that point.

Mr McDevitt spoke next, and I welcome him back to the Health Committee. He made a positive contribution in his previous sojourn on the Committee when I was Chairman, and I look forward to his future contributions. That is particularly so as he is a representative for South Belfast, where such a large and significant proportion of the health service estate is positioned.

Mr McDevitt said that he was disappointed with the lack of legislation. I hope that my interjection to him and the point the Minister made about the sheer mass of documents, strategies and consultation papers that come from the Department have eased his disappointment. I suspect that, if he recalls his previous time on the Committee, he will be looking forward to an extremely busy time during his new sojourn on the Committee. In my opinion, the Health Committee reflects the work of the busiest Department in the Executive, and I have never heard anyone on the Committee complaining about a lack of documents, strategies or written material coming before us. Indeed, I suspect that many of us complain that the workload is intense. However, having said that, Mr McDevitt made a positive contribution to the Health Committee previously and I welcome him back.

Mr McDevitt also asked for openness and fairness to staff, and I think that we all accept that. Having dealt with many of these issues over the past three years and with what are called serious adverse incidents, I very rarely found that staff members had gone in with the purpose or intention of doing something wrong, that they were lazy or did not pay attention to detail. Time and again it was genuine human error, and you have to accept that those things will happen. We cannot avoid risk, but we must manage it and stand up and find out where we went wrong and how we can improve things.

Kieran McCarthy was the next Member who spoke, and I have to be very careful about saying anything critical about him. However, as he often does, he lambasted the Department. I am sure that, in the village of Kircubbin, Mr McCarthy is a very pleasant and likeable man. Mr McCarthy blamed the cuts. Mr McCarthy, am I wrong in thinking that the Alliance Party is affiliated to the Liberal Democrats in GB? Is it not therefore in the coalition of the Conservative Party and the Liberal Democrat Party? Therefore, when you criticise the coalition Government, you are, to some extent, criticising your bedfellows in the Liberal Democrats, unless I am totally wrong about that relationship.

Like many other Members, Mr McCarthy raised the 10-year strategy and said that it is based on safety, effectiveness and a client focus. The Minister went further and explained exactly what he proposes to do with the outworkings of that strategy.

Gordon Dunne also raised the 10-year strategy and welcomed the progress that has been made. I think that he made a very interesting and novel point. He said that responsibility is on not only the health clinicians, the Minister, the trusts and the boards; it is also on the patients. I was alarmed at a recent question for written answer about the incidents of alcohol abuse in hospitals. Indeed, the Minister has statistics that reveal that 30% of the patients who report to Altnagelvin Hospital are under the influence of alcohol. That is placing an intolerable burden on staff, particularly those who work in A&E departments at night and at weekends. There is a responsibility on the general public — the 1·8 million of us who use the health service in Northern Ireland — to act responsibly and to not place intolerable burdens on those who are trying desperately to look after us from the cradle to the grave. Why, I wonder, are we having difficulty getting junior doctors to work in A&Es at night and at weekends, when one in every three patients they encounter — indeed, on a Saturday night, it is probably a lot more — is under the influence of drink and abusive?

Just yesterday, another written answer — I do read the copious written answers that the Minister provides — highlighted the sheer extent of resources being allocated for security staff in our hospitals, particularly the Belfast big three. Money is effectively being used to prevent patients from attacking or abusing hospital staff, and that is a waste. I found the statistics provided yesterday quite frightening.

Mickey Brady brought up the issue of looking at the whole health service, not just A&E. He

was absolutely right to take us back to the fact that there is much more to consider than simply what happens under the surgeon's knife, as it were. He raised the issues of cutbacks in meals on wheels and malnutrition in hospitals. He mentioned the shocking statistic that one in three people over a certain age is malnourished.

George Robinson, quite rightly, highlighted the swift action taken by the Minister in dealing with recent incidents affecting patient safety. We all remember, for instance, the Minister initiating the Troop review. Within three months it had reported back, and we will get the full report on 31 May. That is in stark contrast to other ongoing inquires that were initiated by previous Ministers, took years even to get going and could take a decade to report. Therefore, effective, quick action has been taken. Indeed, when there was clearly an issue of patient safety in the Belfast Trust, the Minister came in very quickly and enforced special measures on it.

Mr Deputy Speaker: Bring your remarks to a close, please.

Mr Wells: I thank all Members who took part in this useful debate.

Question put and agreed to.

Resolved:

> *That this Assembly calls on the Minister of Health, Social Services and Public Safety to put in place a robust strategy to promote patient safety across the health service.*

Hospitals: Pseudomonas Incidents in Neonatal Units

Mr Deputy Speaker: The Business Committee has agreed to allow up to one hour and 30 minutes for the debate. The proposer will have 10 minutes to propose the motion and 10 minutes in which to make a winding-up speech. All other Members who wish to speak will have five minutes.

Ms S Ramsey: I beg to move

> *That this Assembly notes with concern the recent interim report on pseudomonas incidents in neonatal units and its recommendation that the development of the new regional neonatal intensive care unit should be expedited as soon as possible; and calls on the Minister of Health, Social Services and Public Safety to bring forward a time frame for the completion of the new regional women and children's hospital.*

Go raibh maith agat, a LeasCheann Comhairle. At the outset, I want to take the opportunity to thank the Business Committee for selecting the motion. On the back of the motion we have just discussed, it is important that we are moving on to this one. I know we were talking about patient safety, but a lot of Members talked about pseudomonas and its impact.

This time last year, probably none of us — well, maybe one or two — nor the majority of the people outside had ever heard of pseudomonas or realised the impact that it could have on the most vulnerable in intensive care units, and especially on babies in neonatal units. Now, everybody knows the word "pseudomonas" and, sadly, the impact that it can have — none more so than the families who lost babies to the outbreak in neonatal units. I think that I speak for everybody in the Chamber when I say that our thoughts and prayers remain with those families, who still suffer today.

I welcome the interim report. When the Deputy Chairperson of the Committee was making his winding-up speech on the previous debate, he outlined the time frame for the interim report on the pseudomonas outbreak. The Committee had a special meeting during the Easter recess. The Minister and I spoke about that and thought it important for the Committee, rather than leaving the matter for two weeks, to come together to look at Professor Troop's findings. It is sad that it took the death of a number of babies for us to get to that point.

The interim report's 15 recommendations should be implemented as soon as possible. Indeed, recommendation 15 refers to the development of a new regional neonatal intensive care unit at the Royal.

In his press release dated 4 April, and in our conversation at the Committee on the same day, the Minister said that he intended to implement all the recommendations of the interim report of the pseudomonas review, which was published that day. He said:

> *"The Interim Report contains 15 recommendations. … A number of these can be implemented immediately, and will be."*

I welcome that. He said he had asked his Department to develop an action plan with a timetable for taking forward the recommendations that require a significant lead-in time or investment.

I welcome the Minister's commitment to ensuring that the lessons from the pseudomonas outbreak are learned and to implementing as quickly as possible those 15 recommendations. However, the last bit about lead-in time panics me a bit, because when we talk about the new women and children's hospital, we are talking about maternity services in Belfast and maternity services and neonatal services across the region.

It was in the early 1990s that it became clear that radical change was needed for maternity services, not only at Belfast City Hospital but at the Royal. Everybody knew that the buildings at that time were inadequate and that the services were split between two hospitals. In June 2003, it was announced that the new regional hospital for women and children would be sited at the Royal. In 2005, it was reported that funding for the design of the new building, which would apparently lead to one of the best maternity facilities in the world, was available. So, there are a number of questions going back to that time. Was that funding made available? What happened to that funding? Where is the state-of-the-art facility?

In 2008, the then Health Minister stated that the facility would not be built for another seven years. In December 2011, Minister Poots stated that the women's hospital would be open in 2014. At that time, he said that the condition of the children's hospital was an absolute disgrace. I agree with the Minister on that.

The children's hospital will be delivered, we are told, as a separate project to the new women and children's hospital and will be delivered in phases. However, considering the state of the children's hospital, and considering the debate we just had on patient safety, we need to know where the plans are.

I do not want to be completely negative. I take the opportunity to welcome the funding of over £150 million for the critical care building at the Royal, and the £30 million for the maternity hospital. However, again, I cannot comprehend the rationale for delivering the children's hospital as a separate project if we are saying that the current facility is an absolute disgrace. The women and children's hospital has always been viewed as one project.

I will throw something into the mix. Two years ago, I was doing a bit of research on women's health for a community and voluntary group that I am a member of. On the day I was doing that research, a statement was put out by the World Health Organization that shocked me, and I hope it does not relate to here. The statement said that women are still dying in the world because men are in charge. I am concerned about why we are waiting years and years for a women and children's facility to be built and completed.

My party colleague Paul Maskey and I met representatives from the Belfast Trust at the end of last week. Although it is a regional facility, it is in our constituency, and, as constituency MLAs, we are keen to ensure that the Belfast Trust plays its part. Although I am concerned that the plans are not coming together as one project, I was impressed with the presentation from the representatives of the Belfast Trust, because I could not comprehend or get clear in my mind how the work could be done in phases. We saw the plans for the maternity unit going into the critical care unit, the new maternity unit being built and the neonatal unit being there and linking up to the children's hospital. However, if we do the work in phases, I am concerned that once we complete the maternity unit and the neonatal unit, the children's hospital could end up somewhere else.

12.00 pm

The Minister, in the previous debate, said that we needed to embrace change and have new thinking and innovation. Everybody in the Assembly and our community is well aware

of the downturn and the economic recession. Everybody is well aware of the difficulty that the construction industry has faced and is well aware of the difficulties that young people who are in an apprentice scheme have in getting a placement. If we want radical, new thinking and innovation, why do the Executive, through you, Minister, not start conversations with the Department of Enterprise, Trade and Investment (DETI) and the Department for Employment and Learning (DEL), so that they are part of ensuring that the project is delivered? That would kick-start the construction industry; it would allow our young people to get onto apprenticeship schemes; and it would mean that it is not always the Health Department that has to foot the bill. To ensure that the project is started and completed, I suggest that a conversation takes place in the Executive about how other Ministers can play their part and ensure that we have a collective approach so that the problem is not always left at your door. DETI, DEL and others can play their part. We will end up with the new state-of-the-art women and children's hospital that has been promised for over 20 years.

Mr Wells: At the outset, it is appropriate to echo the concerns and sympathy of others to those who have lost babies in these tragic circumstances. The loss of any baby during pregnancy or shortly after birth is a dreadfully traumatising event for parents, but to lose a child and subsequently discover that something could have been done that would have saved the life of that prematurely born baby makes the grief even greater and more difficult to bear. I pay tribute to the families and the couples involved for the resolve and courage that they have shown. If nothing else comes out of this debate and the whole investigation of the pseudomonas incident, if we can ensure that no other families in Northern Ireland have to go through that trauma, some good will have come out of what has been a tragic situation.

As Members will recall, there was a pseudomonas incident in Altnagelvin hospital in Londonderry. That led to the issuing of an internal memo on 22 December by the Chief Medical Officer. That document has been made available to members of the Health Committee, and I have read it many times. Perhaps it is my naivety, but, in my opinion, that document did not indicate the gravity of the situation that had developed. Fundamentally, the document did not mention that a child had died. That is an absolutely essential piece of information that should have been in that memo.

Unfortunately, the memo was issued three days before Christmas. Now, we are all human, and, on 22 December, my thoughts were not on health policy or the actions of the Minister or the health trusts. On 22 December, the thoughts of most folk in Northern Ireland are on Christmas, presents for the children and family get-togethers. Although it is has been refuted by the Department, it is inevitable that, in some instances, that memo sat in an in tray for action after Christmas. That would have been entirely understandable but not justified. There is no evidence that, following that alert, much action was taken in some parts of the health trust estate.

Sadly, to compound matters, it took several days after the deaths in the Royal for it to be announced that the infection had been detected in the last two metres of the plumbing system in the hospital. When, with hindsight, one reads all the documentation on pseudomonas, it is blindingly obvious to even a layperson like me that, in the vast majority of cases, that is where pseudomonas infections occur. A very similar set of circumstances emerged in Turkey, of all places. A report was issued that indicated that, if pseudomonas arises, the most obvious place to check is the last section of the plumbing. So I was a bit surprised that it took so long before it was known exactly what had happened.

The delay in the health service estate contrasts with the very swift action of the Minister. The Minister immediately grabbed hold of the extremely worrying situation and appointed Professor Troop and her team to look into it. I urge Members to look at the make-up of that team: it really was an extremely experienced and professional group of people with expertise on the issue. The time frame was that we would have an interim report between January and May — that has already been issued — and the full report by 31 May. The full report will deal with who knew what and when and what happened and will trace the paper trail in the whole unfortunate incident. We must congratulate the Minister on moving so quickly on this and on his commitment that the 15 interim recommendations made by Professor Troop will be initiated immediately. Practices that were clearly causing concern, such as using tap water to wash babies' nappies and using the water supply to defrost donated breast milk, were stopped immediately.

I had the privilege of visiting Craigavon Area Hospital's neonatal unit two weeks ago along with the chair of the Southern Trust, and I saw the actions being taken there.

Mr Deputy Speaker: Bring your remarks to a close, please.

Mr Wells: That unit is certainly taking Troop very seriously, and I am sure that that is happening throughout the trust.

Mr McCallister: At the outset, I want to echo my colleagues' words of sympathy. I can imagine nothing worse than what parents and families are going through after the loss of a very young baby. It must be almost unbearable. Those families are in all our thoughts and prayers, and they will need prayers and support for many weeks and years to come.

Mr Wells talked us through the time frame. The timing of the memo was unfortunate, as we were coming up to the Christmas break. He is right to point out that many people focus on that break and that can lead to lapses. The debate is timely as it comes after the patient safety debate. Listening to Mr Wells's speech, I was struck by the thought that these incidents were a case in point: the system let families down very badly. The system was not quite in place and so could not detect quickly that this was a major problem. The documentation was not there to inform us that there had been a death in Altnagelvin. Those were failings in the system. As an Assembly and a Committee, we have to ensure that the system is got right, so that this does not happen again. A proper system can prevent an issue from spreading when time is very much of the essence. Those issues have to be resolved, and I am encouraged by the fact that the Minister will implement the report's recommendations.

Ms Ramsey talked through some of the history of getting to this stage, including the delays and setbacks with the women and children's hospital over 20 years, a period in which maybe four or five different political parties have held the office of Minister. We are all supportive of finding a resolution. Progress has been made. Ms Ramsey said that she was not that keen for the two projects to be separated, with work ongoing at the children's end. I look forward to the Minister's response to hear what he has to say and where we are going on the project. Will it be delivered, even if it is some years off? Are we absolutely committing ourselves to delivering on this much-needed project? We all accept that, with the economic downturn, there are huge constraints on budgets, but are we going to buy into the project as an Assembly, accept the recommendations of the report and set ourselves the target of delivering on this and lifting the standards in how we look after women and children in our society? That is something that we all support. So, we have to get the systems in place.

It is a dreadfully painful lesson for the health service and for the families to have to learn, at a very high cost. However, we have to put in place a better system to make sure that we identify problems such as pseudomonas early, look for knowledge and expertise around the world and put that in place quickly, respond to it quickly and get on top of the situation as fast as is humanly possible to minimise the absolutely appalling losses that families across Northern Ireland suffered earlier this year.

Mr McDevitt: I join colleagues in expressing my sympathies and those of the SDLP again to the families who continue to live through such an incredibly distressful and tragic period of their lives. It is also important to acknowledge our solidarity with the front line staff and other carers who will undoubtedly live with the legacy of those events for a long time.

I welcome the fact that the second phase of Professor Troop's inquiry will focus, to some extent, on the families' experience during this time. I hope that their voice is heard loudly and clearly in Professor Troop's final report. Often, we do not pay enough attention to that voice in the system, and we should always listen carefully to it.

I wish to put on record an acknowledgement of the way in which the Department responded to the crisis, once it became clear that it was a crisis of considerable magnitude. It was refreshing to see Professor Troop's team's ability to respond quickly with an interim report and relatively quickly with a final report. It will undoubtedly play a considerable role in mitigating the potential reputational impact of events like this on the health service, and I think that is worthy of note today.

I thank Mr Wells for welcoming me back to the Health Committee. When I was reading myself into some of the details of these matters over the past couple of weeks, it struck me that Professor Troop identified a couple of different

types of issue in her interim report. There are issues of practice and fundamental issues such as the fact that there is still not a regional network in place. One recommendation reads:

> *"The review team considers that the arrangements for the provision of neonatal care would be greatly strengthened by the establishment of a formal neonatal network."*

That obviously makes one worried and makes one want to think about the great opportunities that might have been missed over recent years for the lack of a network. Also, Professor Troop notes in her interim report that

> *"The network should ensure that neonatal resources across the region are utilised to best effect and that units are working to common policies and procedures."*

That is an issue that arises time and time again in her interim report. I hope that the Minister, in his response to today's debate, will have some good news for us with regard to progress on such matters. It does not strike me that it would cost a huge amount of money to get a network in place. It would probably require a fair bit of time and a lot of determination. Generally speaking, time and determination can be found even when money is scarce.

The interim report's findings around the lack of a consistent approach in respect of the declaration of the outbreak are worrying. The report states:

> *"The review team has concluded that there was no agreed approach across neonatal units in place for the declaration of outbreaks. Environmental sampling including testing of water for pseudomonas was not carried out prior to the confirmation of the outbreaks in Altnagelvin or RJMS."*

Again, that is a recommendation or issue that could be addressed without the need for extra money. It just requires determination, doggedness and resolution on behalf of the system.

12.15 pm

There is a similar recommendation around the lack of agreed surveillance procedures for pseudomonas. I wonder if the Minister, in his summation, might talk more generally about surveillance around microbial infection in neonatal units. I am no clinician, but, although we are talking about pseudomonas today, I suspect that the general rule around best practice would apply to general surveillance for microbes, particularly those that could cause infection in neonatal units. What urgent steps are being taken to address those?

Mr Deputy Speaker: Bring your remarks to a close.

Mr McDevitt: Finally and in the last few seconds, I join those who acknowledge the need for the new facility. One of clearest things the report says is that the current facilities in the Royal are not adequate and make isolation very difficult.

Mr McCarthy: I thank the Members for bringing what I consider to be one of the most important issues before the Assembly this morning. However, I consider the wording of the motion to be much too weak. It says that the Assembly:

> *"notes with concern the recent interim report on pseudomonas".*

We are speaking about the loss of four innocent infants' lives. Surely, "concern" should be replaced by "shock, horror and disgust". We are talking about something that ought never to have happened. The interim report is a factual account of what took place in our hospitals, and it is a damning indictment, highlighting neglect, incompetence and plain tardiness in reacting to a very serious set of circumstances.

I am glad to have the Minister responsible for health in the Chamber this afternoon. I sincerely hope that, when he rises to respond to the debate, rather than trading insults with any Member, he will accept his responsibilities and admit to the serious failures that resulted in the shocking death of four innocent babies. I hope that he does not hide behind the as yet unpublished second part of Professor Troop's report.

Like others, I acknowledge the absolute heartbreak of the parents who have lost their much-loved babies after they contracted pseudomonas. We should never forget their anguish and must do everything in our power to ensure that no other families have to endure such devastating suffering and loss. We offer our deepest sympathy and support to those families at this awful time. I also pay tribute to the families who have come forward to speak to the review team. They have shown immense courage in their efforts to help ensure the safety of other infants in neonatal units.

As has been said, the review team has made 15 recommendations. It is imperative that all recommendations are addressed as soon as

possible, particularly recommendation 15 about the provision of the new regional neonatal intensive care unit at the Royal Jubilee Maternity Service.

It cannot be emphasised enough that the lives of vulnerable newborn babies depend on the recommendations being expedited efficiently and effectively, with all stakeholders being fully engaged and informed in the process. The action plan being developed by the Department, which shows the timetable to take forward the recommendations, must, at all times, be transparent and open both to discussion and to hearing the concerns of all those affected.

Overall, it is clear from the 15 recommendations that the standardisation of all protocols relating to infection control in neonatal units is of paramount importance. There should be appropriate regional guidance for all protocols. There should be independent audits, and all organisations and units across Northern Ireland must be completely co-ordinated. In particular, a regional neonatal network must formally be established across Northern Ireland.

It is of the greatest importance that we draw immediate attention to the fact that the review team has made it clear that the design of the Royal Jubilee maternity unit does not help the staff carry out good principles of infection prevention and control. That is unacceptable. We have read that the unit does not have the right facilities for isolation; that there is limited space for circulation in the intensive care units; and that the distance between cots and sluice rooms is likely to have contributed to the use of hand washing sinks to dispose of water after cleaning babies and, thus, potentially, to the spread of contamination in taps. We have read that the water pipes are old — I understand that the unit was built in the early 1930s. Finally, we have read that the roof of the building was leaking. That is horrifying. We, as public representatives, expect staff to take care of the most vulnerable newborn babies in these outrageous conditions: shame on those in charge.

There was good feedback from the staff on their dedication to the care of their patients. They cannot be expected —

Mr Deputy Speaker: Draw your remarks to a close, please.

Mr McCarthy: They cannot be expected to cope with the appalling condition of the physical environment in the current unit. The Troop report clearly indicated —

Mr Deputy Speaker: The Member's time is up.

Mr McCarthy: — that, had those in charge acted sooner —

Mr Deputy Speaker: The Member's time is up.

Mr McCarthy: — some of those young lives could have been saved.

Ms P Bradley: I support the motion. In doing so, I thank the Members who tabled such an important motion. I also extend my sympathy and condolences to the families whose babies tragically lost their life due to this infection. The pseudomonas outbreak in our neonatal units has come at a huge human cost. All we can do now for the families is try to ensure that whatever lessons can be learned are learned.

As we know from Members who spoke previously, the interim report highlighted 15 changes and lessons that can reduce the chance of bacteria getting a hold in such a way ever again. The material state of our buildings and their fixtures and fittings had an impact on the spread of the bacteria and how difficult it was to control. The report highlights the daily difficulties encountered by staff as they go about their duty of ensuring that the most vulnerable of patients get the best possible care. The behaviour and attentiveness of staff was never called into question. We have some of the very best people working in what have come to light as being less than ideal conditions. Their attitude and dedication is something that we, as a community and society, should be grateful for. The conditions that we ask them to work under in the Royal Jubilee neonatal unit are not something we should be entirely proud of.

The promise of a new neonatal intensive care unit has been in front of us for some time. We know that we cannot produce a hospital overnight. The majority of the problems experienced at the Royal Jubilee have been caused by, among other things, the closure of other units while capacity was not being met at the Royal site. I welcome the fact that the new women's hospital project is under way. When complete, that will hopefully reduce the pressures on our hard-working, dedicated staff and mean that, once again, we can be content with the conditions that we ask our staff to work under.

I commend the Minister for acting so swiftly in commissioning reports on what we did well during the pseudomonas outbreak and, of course, what we did not quite so well and the lessons that we can learn. The report might not have always made easy reading for the Minister or, indeed, the Committee, but it has definitely focused attention on what we need to focus on to ensure that we continue to provide the best possible care for the most vulnerable in our hospitals.

Ms Gildernew: Go raibh míle maith agat, a LeasCheann Comhairle. I am pleased to be part of the team that tabled the motion. Like others in the House, I would like to take the opportunity to extend my deepest sympathy and condolences to the families of the babies who died as a result of the pseudomonas outbreak. Their grief and pain are ongoing. They have been through the loss of a baby, and the loss of a child is something that I do not believe any parent ever gets over.

This is a very shocking issue, not least because information was not as forthcoming as we wanted it to be. I first learned of the pseudomonas outbreak from the media on the evening of 19 January. Staff, management and the Minister were trying to ascertain what the source of the infection was over that weekend and in subsequent days. Then, there was much scrutiny of the memo sent on 22 December and the warnings imparted to health professionals as a result of it.

Members will understand that I will not be as sycophantic as Mr Wells. He and I had a meeting with the Minister on 24 January. I was quite shocked, when I left his room and came down to the Chamber for the statement, to find that Raymond McCartney was able to furnish me with more information than I had heard from the Minister because he had been in contact with the family in Derry who had lost their baby in Altnagelvin Area Hospital. At that stage, it was very clear that the source of the outbreak had been identified as the taps, yet that was not made clear to me or to the Deputy Chair of the Health Committee. That is a worry.

We are not here seeking someone to blame, but it is hugely important that the lessons in the Troop report are learnt. I welcome the Minister's statement that he will implement all 15 recommendations. Every assurance must be given that this can never happen again and that families and very vulnerable babies will be protected.

Mr Wells: Will the Member give way?

Ms Gildernew: No, I will not.

The issue of pseudomonas and the gravity of the situation over those weeks has not been helped by my dealings with people who have been before the Health Committee talking about those very vulnerable children. We know that the babies in the neonatal unit were cared for extremely well by staff, in very poor conditions at times. Much has been said already about that. We recognise the huge amount of work that staff do on a 24-hour basis to help those small children in their fight for life. However, I have been disappointed at times by the attitude of health professionals to women who have suffered loss. I was told recently that the mother of a stillborn baby had been told that her pregnancy was "unsuccessful". How that is a compassionate way to say "Your baby has died" is beyond me. Much needs to be done to protect and respect people who are bringing children into this world and have to receive devastating news such as that. Ms Ramsey's quotation to the effect that women are still dying in the world because men are in charge should be extended to babies as well. When we had people from the Department talking to the Committee about group B strep, I was horrified by comments made by some of those present on behalf of the Department and by some of the very disparaging comments made about women during that evidence session.

There is much to be learned, not just about the pseudomonas issue itself but about how women who are bereft and have lost a baby during pregnancy or in a neonatal unit are treated. On that point, the new regional women and children's hospital is a huge priority for the House. It is a regional issue. It affects every Member, because all our constituents will be treated, at one time or another, at that unit. It is well over a decade since I learned of the urgency of that need, and it is very disappointing that, at this point, the women and children's hospital has not been completed. I urge the Minister to do everything he can to ensure that the hospital is built and that our women and children have the standard of care to which they are absolutely entitled.

Mr Deputy Speaker: The Business Committee has arranged to meet immediately after the

lunchtime suspension. I propose, therefore, by leave of the Assembly, to suspend the sitting until 2.00 pm. The first item of business when we return will be Question Time. This debate will resume after Question Time, when the next Member to speak will be Mr Gordon Dunne.

The debate stood suspended.

The sitting was suspended at 12.29 pm.

2.00 pm

On resuming (Mr Principal Deputy Speaker [Mr Molloy] in the Chair) —

Oral Answers to Questions

Health, Social Services and Public Safety

Eating Disorders

1. **Mr Rogers** asked the Minister of Health, Social Services and Public Safety what services are currently available in Northern Ireland for treatment associated with eating disorders. (AQO 1837/11-15)

Mr Poots (The Minister of Health, Social Services and Public Safety): Congratulations on getting the number one question.

Research shows that the best long-term outcomes for people with an eating disorder are achieved when they are cared for in the community, close to family and other social support networks. Eating disorder services are, therefore, provided through a stepped care approach, which ranges from early detection and intervention to community-based treatment to specialist inpatient provision. The aim is to provide treatment in the community and to prevent hospital admissions. There are separate eating disorder services for adults, children and adolescents, provided by specialist community-based teams in four health and social care trusts. The Belfast Trust provides those services for the South Eastern Health and Social Care Trust, and those teams include consultant psychiatrists, eating therapists and dieticians.

Adult inpatient treatment is facilitated in existing hospitals, with in-reach support provided by specialist community-based eating disorder teams. That ensures a continuum of care when patients are discharged. Inpatient care for children and adolescents with eating disorders is provided at Beechcroft, the regional child and adolescent mental health inpatient unit, which has a consultant who specialises in the treatment of eating disorders.

Mr Rogers: Thank you, Minister, for your response. Will you detail the cost of referring patients

from Northern Ireland to other jurisdictions for treatment associated with eating disorders?

Mr Poots: The cost is significant when families have to go to other jurisdictions, not just the cost of the facility and the charge that is laid on the Northern Ireland health service but the cost of flying other family members over and keeping them close to the location for visits, and so forth.

Since 2005, £2 million has been invested in the development of community-based eating disorder services — £1 million in 2005-06, £500,000 in 2007 and £500,000 in 2008. Since 2010, inpatient eating disorder capacity has been provided in each trust area, each of which has one to two beds. Those are managed by specially trained medical psychiatric staff, supported on an in-reach basis by staff from the community-based eating disorder teams. That provides a seamless service, which is key to achieving the best long-term outcomes for patients. Aside from that, there has been interest from the private sector in developing facilities in Northern Ireland, and discussions have been ongoing with health and social care (HSC) in that regard.

Mr Hazzard: I thank the Minister so far for his answer. What services are available to assist the families, friends and carers of those who suffer from an eating disorder?

Mr Poots: Families, friends and carers are essential in the process, so when young people in particular are referred to clinics not in Northern Ireland, we will support families by providing travel costs and, indeed, accommodation, and so forth, when they are providing support for the family.

Often, that will be once every two weeks. However, it depends on the advice from the specialist as to how often they will allow the individual to see their family, because at times when there are particular problems, the medical advice is that, perhaps, fewer visits are appropriate; whereas at other times, they are looking for more visits. We work very closely with the experts on that issue.

Ms Brown: I thank the Minister for his answers so far. Following on from the previous supplementary questions, what has the pattern of the number of referrals outside Northern Ireland for the treatment of eating disorders been in recent years?

Mr Poots: Given the size of the population in Northern Ireland, it would be difficult to sustain a specialist unit here, as such a facility would have a relatively small inpatient client base. In the current economic climate, we will not tie up money directly with the development of such a unit, but, as I indicated, the private sector has expressed an interest and has been in discussions with HSC about the number of clients that would be provided for.

It is for clinicians to decide whether individual patients might benefit from care in a specialist eating disorder unit outside Northern Ireland, but the indications are that, over the past number of years, there has been a reduction in extra-contractual referrals to other jurisdictions. That trend is expected to continue as we develop local expertise in the management of complex conditions. That is something that we wish to continue with.

Mr McCallister: The Minister talked about the private sector, so would he be willing to purchase services from that sector if there were problems with waiting lists? Will he indicate whether we have problems with waiting lists and times?

Mr Poots: HSC has been having that discussion with the private sector to establish how many beds HSC would be buying from it if such a unit were established.

We are doing that already, as we are sending young people who suffer from anorexia, and so on, to other parts of the UK, and we are buying those services off the private sector there. So, I would welcome the opportunity to engage in doing that in Northern Ireland.

Special Educational Needs: Autism

2. **Mr Hussey** asked the Minister of Health, Social Services and Public Safety what discussions he has had with the Minister of Education in relation to the reform of the special education needs system, particularly in relation to services for children with autism.
(AQO 1838/11-15)

Mr Poots: The outcome of the special educational needs (SEN) and inclusion review creates further opportunities and, indeed, highlights a pressing need for education and health and social care services to work more closely together for the benefit of our more vulnerable children, including those on the autistic spectrum.

I have met the Minister of Education twice to discuss a number of areas where there is potential to improve services and outcomes for children by working together more closely. Our officials are meeting regularly to discuss the possible impact of the SEN review and to explore the potential for a more joined-up approach to service provision for the vulnerable groups of children, specifically where autism is concerned. I discussed our progress on this with Minister O'Dowd on 17 April, and my Department is leading on the development of a whole-life, cross-departmental strategy for people with autism, which is to be published in May 2013.

All Departments, in particular the Department of Education, and the education and library boards are playing a full and positive role in the development of that strategy. I welcome that.

Mr Hussey: I thank the Minister for his answer, and, again, he has clearly shown that there is a great sense of urgency here. Will he offer some further information about autism having an A* SEN rating, given that 80% of parents of autistic children have said that the lack of support has harmed their children's social and communication skills and 65% have said that a lack of support has affected their children's mental health?

Mr Poots: I need to be careful that I do not cross the Education Minister's boundaries. The outcome of the SEN review has identified the need to work more closely together for the benefit of our vulnerable children. So, I am making it clear to the House today that I want to see the barriers between education and health removed when it comes to the well-being of our community, whether it is for autism or anything else. We will continue to work on that.

My officials meet regularly with their Department of Education counterparts to address the issues that were raised by the SEN review. In our meeting on 17 April this year to discuss a range of issues pertaining to both Departments, it was agreed that our common purpose would always be to ensure the maximum benefit for all our children in their health, safety and social well-being, as well as to maximise their opportunities for development, learning and achieving full potential. We discussed the development of the autism strategy at that meeting, and I welcomed the Department of Education's full engagement with our work.

We will continue to work together as Departments to identify common sense solutions to all the issues that were raised so that we can better use our shared resources to provide better outcomes for our children.

Mr Dunne: Like the Minister, we welcome the progress that has been made on the autism strategy. Will he give us some details on how the voluntary sector will be involved in the development of the strategy?

Mr Poots: The voluntary sector is represented on the autism strategy project board by Arlene Cassidy from Autism NI, Derek Doherty from Autism Network NI, Alan Hanna from Autism Initiatives NI, Shirelle Stewart from the National Autistic Society in Northern Ireland, and Monica Wilson from Disability Action.

As members of the project board, the voluntary sector representatives are required to make decisions and drive the work to develop the autism strategy and action plan; work collaboratively with other members of the project board; contribute to the development of the autism strategy and action plan; promote interdepartmental co-operation; raise awareness about autism; and encourage more integrated services for people with autism and their families and carers. So, representatives of the voluntary sector do have a significant role to play. To date, they have played an essential role in facilitating the pre-consultation engagement events and documenting and reporting on the feedback from those events to the Department of Health, Social Services and Public Safety core team. They have also issued the pre-consultation online questionnaire to stakeholders.

I have recently decided that the autism strategy project board should establish a research committee, and I have written to Arlene Cassidy, chief executive of Autism NI, to invite her to take up the role of chairperson. Mrs Cassidy replied on 30 April, accepting the invitation.

Mr McDevitt: Will the Minister assure the House that there will be adequate day care provision for young adults with special needs who are leaving school this summer?

Mr Poots: That is and has been a very challenging situation for very many years. I am not sure precisely what the Member means by "adequate day care provision". If he is asking whether it will be available five days a week, I very much suspect that that will not be the

case. We face a huge challenge. A lot of people with learning disabilities are living considerably longer, which I welcome. Consequently, they are spending a considerably longer time at many of the facilities. I recognise that a pressure exists there, and we need to work together with the community to identify the best way forward. I know that good work is being done in many local communities to address that, and I encourage more such work to take place in order to help us achieve solutions in the sector.

Social Care

3. **Mr Gardiner** asked the Minister of Health, Social Services and Public Safety for his assessment of the need to reform social care provision. (AQO 1839/11-15)

Mr Poots: In Northern Ireland, like the rest of the UK and Europe, social care provision is coming under pressure for a range of reasons, such as an ageing population, people's increased expectations and the difficult financial climate. Therefore, I have embarked on a three-stage process of reform intended to establish the future direction and funding of adult social care here.

The first stage will be the development of a discussion document, setting out the challenges that the system is facing and aiming to facilitate a public debate around the future of adult social care. I hope to launch the document before the Assembly recess. It will be followed by an extensive consultation phase aimed at giving the people of Northern Ireland the opportunity to respond with their views.

Mr Gardiner: I thank the Minister for his reply to my question. In December's statement, the Minister said:

> *"we need to stop doing things that do not work, challenge out-of-date practices". — [Official Report, Vol 70, No 2, p62, col 1].*

Five months later, has the Minister identified those out-of-date social care practices? If so, what has he done about them?

Mr Poots: Very clearly, we produced the 'Transforming Your Care' document five months ago. The quote was made at that time, and the position has not changed. Over the past number of months, considerable work has been done to develop integrated care partnerships and population plans. A timescale has been set for the delivery of those plans. That will allow us, with the best available evidence, to take the health and social care system forward. It will enable us to challenge those things that are past their sell-by date. We may get criticism for that on occasions and some of the decisions that we will take may be challenged inside and outside this House, but we need to focus clearly on delivering better outcomes in the health and social care system. That can only be done by challenging outmoded practices.

2.15 pm

Ms P Bradley: I thank the Minister for his answers thus far. Will the review of social care address the financial implications, whether for their homes or their bank accounts, for people who are going into care?

Mr Poots: The Dilnot review was carried out across the UK. We will be putting out our own consultation on these issues to identify the public's views. For example, Northern Ireland is at a considerable advantage over the rest of the UK. Sometimes, we hide the good things that we do, but those people who receive care in their homes do so free of charge in Northern Ireland, which is not the case in England and Wales. Some people will challenge us as to why wealthy people, for example, receive carers on a regular basis. Those are hugely sensitive issues, but, nonetheless, they have to be opened up for discussion so that we can identify how we wish to continue.

Mr D Bradley: Go raibh maith agat, a Phríomh-LeasCheann. Comhairle Ba mhaith liom a fhiafraí den Aire cá mhéad airgead a bheidh de dhíth agus ar fáil leis an straitéis a chur i bhfeidhm. In the Minister's estimation, how much money will be needed and available to implement the strategy?

Mr Poots: As regards the money that is needed and the money that is available, we operate the health and social care system on a finite budget with an infinite demand. The money that is needed will greatly outweigh the money that we have, and that would be the case whether I added £1 billion or £2 billion or, probably, even if I added the entire Northern Ireland Executive Budget. That is the reality of the circumstances in which we live.

The amount of money that we get is not as important as how we spend it. We need to spend every penny wisely. We cannot afford to

have waste in the system, but unfortunately it exists. Sometimes, Members will bring things to my attention, and, to be quite honest, I welcome that because I do not know about everything that goes on in the healthcare system. We need to work together as an Assembly to get the best value for money from the resources that we put into our health and social care system.

Causeway Hospital: Accident and Emergency

4. **Mr Dallat** asked the Minister of Health, Social Services and Public Safety to outline his long-term plans for the future of the accident and emergency unit at the Causeway Hospital, Coleraine. (AQO 1840/11-15)

Mr Poots: I want to acknowledge the dedication and commitment of the staff who provide emergency care at the Causeway Hospital. I recognise that all emergency departments, including the one at the Causeway Hospital, are under pressure as a result of demand and the increasing complexity and acuity of care.

A whole-systems approach is necessary if we are to provide safe and sustainable services in the longer term, not just for people in the Causeway area but for the whole population of Northern Ireland. This will be taken forward through a programme of reform, which will be informed by Transforming Your Care. In implementing Transforming Your Care, safety and quality of service provision are my first concern, and work is under way to develop population plans that will require local engagement. Any proposals for a major reconfiguration of services will be subject to full public consultation.

Mr Dallat: I have listened carefully to the Minister. Will he assure the House that Coleraine will continue to have an accident and emergency provision that is worthy of the name, and that the Causeway Hospital does not become the last of the name?

Mr Poots: The population plans are being worked up by the trusts and the commissioning bodies. It is important that what is put to me is a sustainable model for the future. The easiest thing for me to do as a Minister would be to indicate that I will not alter anything in the Causeway Hospital, only for some of the royal colleges to withdraw their services six months, one year or two years down the line and for everyone to cry in horror. I would rather make a decision that will allow us to have a sustainable model of care for the Causeway Hospital. I believe that a sustainable model of care will include an emergency department, and I look forward to seeing the trust's proposals in due course. I will be quite happy to challenge the proposals where I do not think that they will meet the needs of the population that is covered by the Northern Trust.

Mr Campbell: The Minister will be aware of meetings that MPs and MLAs have had not only with him but with senior members of the trust and other professionals in the area. Can he outline what the Northern Trust must do over the next few weeks to ensure a continuation of a safe, sustainable, 24/7 accident and emergency service at the Causeway Hospital?

Mr Poots: First, we should not accept poor or substandard performance. A model of care for the Causeway Hospital that is built on having some substandard facility would not be acceptable to the people who access those services. For example, I have stated that 12-hour breaches should occur only on the rarest of occasions, and I expect a report on why each of those breaches has occurred. I also want to see an improvement against the target that is related to 95% of patients in A&E being discharged or admitted within four hours. The Causeway Hospital has stood up very well against those types of figures.

On the matter of identifying what is a sustainable model, we need doctors with the skills base to deal with the eventualities that will arise at that hospital. Therefore, we cannot support a service where junior doctors deal with life-critical issues. We need to ensure that we have doctors who have the requisite skills to deal with the particular problems that will come to an emergency department. Obviously, the Royal Victoria Hospital is our major trauma hospital, and many people will go directly to that facility. Indeed, where stents are to be applied where people have had heart attacks, they will probably go directly to one of our major hospitals. The Causeway Hospital still provides a whole range of services, such as thrombolysis for stroke patients and many other key services. It is important to ensure that those can be maintained by having the appropriate skills base, and I will need assurances on that.

Mr Allister: The Minister has not brought much assurance to those who suspect that there is

a plan to close the A&E at Coleraine. Indeed, I am not sure whether he or I should be more concerned, but I find myself on the same page as the MP for North Antrim, Ian Paisley, who, this week, said in Westminster —

Mr Principal Deputy Speaker: Question, please.

Mr Allister: — that the Causeway Hospital is going to close. If an MP from the Minister's party finds no reassurance in what he says and does not believe the assurances that it may not close, why should anyone else think otherwise?

Mr Poots: I note that the Member quoted from a certain publication, which, of course, does not always get things right. As the Member well knows, the MP for North Antrim participated in a debate relating to the European working time directive. He highlighted the problem that the European working time directive creates by not allowing doctors, who previously were allowed to do so, to come into Northern Ireland to support services in the Causeway Hospital. I greatly appreciate the fact that the Member of Parliament for North Antrim is putting up a very vigorous campaign very regularly. In fact, he tortures me about the Causeway Hospital. If the Member of this House for North Antrim were in as regular contact, perhaps more would be done for the residents in that area.

Health: Working-class Communities

5. **Mr Easton** asked the Minister of Health, Social Services and Public Safety what additional action his Department can take to promote and improve the health of people within working-class communities, such as the Kilcooley estate in Bangor. (AQO 1841/11-15)

Mr Poots: More than 60% of health-improvement activities funded or undertaken by the Public Health Agency (PHA) are targeted in disadvantaged communities to specific target groups. The PHA, trusts and others are working with other sectors and with disadvantaged communities, such as Kilcooley, to invest in building capacity and in the design and delivery of programmes to improve health and well-being.

Improving health and well-being and reducing health inequalities will continue to be a key priority for my Department, and I have committed in the Programme for Government to increasing the overall percentage of the allocation to public health. However, health and well-being are influenced by a whole range of inter-related socio-economic and environmental factors in daily life, which are often referred to as the social detriments.

My Department and the health and social care system cannot tackle those issues on their own. Therefore, I have been meeting other Executive Ministers to discuss how we can work together to address the detriments of health that are within the Department's remit. The new cross-departmental public health framework that is being developed for consultation will seek to reinvigorate cross-departmental collaborative action to improve the health and well-being of the working class and the most disadvantaged in our society, and the emphasis will be on community involvement in the design and delivery of programmes based on local need.

Mr Easton: Does the Minister agree that it is vital that we improve health outcomes for working-class communities across Northern Ireland, not just in Kilcooley, and that we need a joined-up approach in government to make sure that that happens?

Mr Poots: Absolutely. I have indicated to the House on a number of occasions that people who live within a very short distance of one another can live for nine years less because they come from a poorer community or one that has greater levels of deprivation. We need to address that; we do not need to find it acceptable. Health and well-being are influenced by a whole range of inter-related socio-economic and environmental influences, and we need to work together on those. The new cross-departmental public health framework that is being developed for consultation will help us to reinvigorate cross-departmental collaborative action to improve health and well-being and to tackle disadvantage. The emphasis will be on community involvement in the design and delivery of programmes based on local need.

I am wholly convinced that the wrong start in life will lead to poor educational outcomes, which will lead to poor employment prospects, all of which will lead to health inequalities. There is a vicious cycle that needs to be broken, and we all have a role to tackle that together and to make a difference for people in disadvantaged communities.

Mr Brady: Go raibh maith agat, a LeasCheann Comhairle. Has the Minister given any thought to the impact that benefit cuts under so-called welfare reform will have on communities such

as Kilcooley? Undoubtedly, they will cause more deprivation and more health problems.

Mr Poots: Debt is a problem for many people in our working-class communities. The social services assist many people in those circumstances, but many find themselves in great difficulties and fall into the grip of loan sharks, who are among the most despicable who operate in our communities. Indeed, my ministerial colleague highlighted yesterday the issue of loan sharks who charge interest rates of up to 2,500%. Fortunately, as advertised by people in the House, those no longer exist. In addition, moneys from the Department for Social Development's neighbourhood renewal scheme have been requested for areas to address community issues. We can assist communities to come together and work closely and can help people to identify different ways of doing things to help them not to fall into the grip of loan sharks and get into debt in the first instance.

Mr Durkan: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. Does the Minister's Department prioritise areas of social disadvantage when funding programmes such as for sexual health, where there appears to be a direct correlation between social disadvantage and teenage pregnancies and sexually transmitted infections?

2.30 pm

Mr Poots: The Public Health Agency will be seeking to direct money more closely to areas of disadvantage. Members need to remember and reflect on the fact that that can best be done on the basis of good knowledge. If local communities develop clear facts about real life situations — poor educational outcomes, high proportions of teenage pregnancies, high proportions of young mothers who smoke during pregnancy, and so on — those will encourage us to carry out more work in such areas. Those factors will be prevalent in many communities, so there will be a huge challenge for us. We need to make a difference, and we must work on the issue.

Justice

County Courts: Judges

1. **Mr A Maginness** asked the Minister of Justice, given the proposed increase in the County Courts' jurisdiction, whether consideration has been given to increasing the current complement of County Court judges.
(AQO 1852/11-15)

Mr Ford (The Minister of Justice): The number of County Court judges is a matter for the Northern Ireland Judicial Appointments Commission (NIJAC) to determine, in agreement with my Department. My Department has written to the commission to notify it of the proposals to increase the jurisdiction of County Courts and the district judges' court. I understand that the issue is under consideration by the commission. My Department will fully consider the matter before changes to the jurisdictions are brought into operation.

Mr A Maginness: I thank the Minister for his reply. I emphasise to him that an increasing burden is being put on County Courts, which has to be carried by the judges. Will the Minister report to the Assembly as soon as possible about any discussions he has had with NIJAC on an increase in complement? Will he also consult the judges on the issue?

Mr Ford: I thank Mr Maginness for his question. When the Department receives something from NIJAC, consultation will be necessary, and I give a commitment to keep at least the Committee for Justice informed, which is probably the best way to inform the Assembly. There are significant issues about balancing the workload, looking at the caseload across the court system and ensuring the best possible system to speed up justice, which we have spoken about so often in the Chamber.

Mr Kinahan: Do we know, or will we know in the near future, the cost estimates for those changes?

Mr Ford: Mr Kinahan has asked the inevitable question. In the absence of a specific business case that has been worked through, it is not possible to estimate the costings. The Member correctly highlights the fact that we need to ensure that we provide a justice system that we can pay for, as well as a system that delivers for all of us.

Fines: Imprisonment

2. **Mr Boylan** asked the Minister of Justice whether there has been an increase over recent months in the number of people who have been imprisoned for the non-payment of fines.
(AQO 1853/11-15)

Mr Ford: Imprisonment for fine default is a major challenge for my Department that I am determined to tackle. We need to ensure that only those who need to go to prison do so. In recent trends in fine default receptions, the second half of 2011 actually saw a 5% reduction when compared with the first half of the year. Early figures for 2012, however, show a slight increase. There were 632 receptions into custody for non-payment of a fine in the first quarter of 2012, compared with an average of 544 receptions per quarter across 2011. Although that does not represent a marked increase, the justice system cannot continue to send people to prison for not paying fines.

Mr Boylan: Go raibh maith agat, a Príomh-LeasCheann Comhairle. I thank the Minister for his response. Has he any plans to end the unnecessary and outdated practice of imprisoning people for non-payment of fines?

Mr Ford: I thank Mr Boylan for that supplementary question. I most certainly do have plans. We can all agree that sending people to prison for a few days for non-payment of a fine is a fairly pointless exercise. Indeed, in Dublin on Friday, I was told about people being taken to Mountjoy prison, staying there for a few minutes while the paperwork was done and then being discharged, which clearly achieves nothing. That is why we have instituted arrangements to remind people about having to pay fines, which has resulted in a reduction of 25% or 30% in the number of warrants being issued. That is why, in Newry court, which should be of particular interest to somebody from Newry and Armagh, we have under way the pilot of supervised activity orders. Over 80 supervised activity orders have been made and seven or eight of them have been implemented already. That is a key example of how we are making people do constructive community service rather than go to prison for non-payment of a fine.

We are looking at the wider possibility of how we might introduce a civilian enforcement model, which would require introducing primary legislation here, but would remove from police the burden of chasing fine non-payers and, perhaps, enable a more flexible way of dealing with the offence. We need to look at the full range of options, learning lessons from other jurisdictions that are seeking to move away from the notion that people who default on relatively minor fines go to jail when, otherwise, they would not go near jail.

Mr Durkan: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. Will the Minister give his assessment of how successful the pilot scheme has been, and when we might see it rolled out in other parts of the North?

Mr Ford: I thank Mr Durkan for his question, but I am reticent about giving an assessment of a scheme that has been in operation only since January this year. What is clear, however, is the very fact that a small number of these orders have already been implemented shows that we are keeping a small number of people out of jail for fine default. We will need to ensure that we do the proper research. Work is ongoing with the judiciary and the probation service to identify a second area, after Newry, in which we can roll out the pilot. I hope that that will not be a prelude to Members jumping up all over the House and suggesting their constituency, which tends to happen when we talk about pilot projects. We certainly need to look at how it would work in another area, so that we see what the benefits are and how we could make the scheme operational across Northern Ireland as fast as possible.

Lord Morrow: The Minister intimated the scheme is in relation to sending people to prison. Is that because our prisons are full, it is too costly, or is it because community service is a better way of ensuring that a person does not have a criminal record?

Mr Ford: I thank Lord Morrow for the question. It is of course the case that we know that our prisons are too full. It is also undoubtedly the case that sending fine defaulters to prison for a few days — particularly given the administrative costs and burden of managing that — is far too costly. However, it is not the case that giving somebody a supervised activity order means that they do not get a criminal record. They do a supervised activity order because they have a criminal conviction. It is just the same as receiving a community service order in the first place. It does not suggest that they do not have a record; it suggests that they are disposed of in a more productive and useful way.

Policing and Community Safety Partnerships

3. **Mr Hilditch** asked the Minister of Justice for his assessment of the process undertaken to establish the new policing and community safety partnerships. (AQO 1854/11-15)

Mr Ford: My Department and the Policing Board are working closely to ensure that we have effective partnerships up and running as soon as possible, and I anticipate that the first meetings will be held later this month. As we work towards fully operational partnerships, we have already made a number of significant achievements. They include commencing the provisions in the Justice Act (Northern Ireland) 2011 that create policing and community safety partnerships (PCSPs); the confirmation of a budget for 2012-13 of £5·8 million, provided jointly by my Department and the Policing Board; the appointment of political members and nearly all the independent members across all PCSPs and, indeed, the four Belfast district partnerships; positive engagement with those bodies likely to be formally designated to the partnerships; and the establishment of transitional arrangements to ensure continuity of provision until the partnerships can develop and roll out their own plans.

I look forward to seeing the progress of the partnerships over the coming months. In working towards common goals and co-operating to achieve them, PCSPs will be able to make a real difference on the ground, ensuring that local issues are dealt with and communities have a real opportunity to shape policing and community safety in their areas.

Mr Gardiner: How much has the recruitment process to establish the new policing and community safety partnerships cost?

Mr Ford: I am afraid that I cannot answer the Member's question. He seems to be pursuing me on the same lines as his colleague Mr Kinahan did earlier. The recruitment process is run by the Policing Board and not my Department, and it has responsibility for its administration and cost. I know that it was anticipated that the recruitment exercise that has just been completed would cost significantly less than the one that was carried out last year. However, Mr Gardiner may wish to write to the Policing Board to get the full details.

Mr Lyttle: What does the Minister see as the potential benefits of the policing and community safety partnerships when they are up and running?

Mr Ford: The key issue that we identified in the House — we went through it in great detail as we went through the Bill — was the previously problematic separation between community safety partnerships and district policing partnerships. The Police Service is a partner organisation as well as one that needs to be held to account. The new model gives the opportunity to provide that different way and to integrate the work of the two organisations, so as to avoid the previous duplication that saw similar groups meeting to discuss similar issues at different meetings. The opportunity to bring together councillors, independent members and representatives of the other statutory organisations with an interest in policing and community safety gives us a much better opportunity to plan for the future and to address problems as they arise. The policing and community safety partnerships will also provide the local delivery mechanisms that we need in order to provide what has been highlighted as the key objective: local people producing local solutions to local problems.

Courts: Televised Proceedings

4. **Mr McCallister** asked the Minister of Justice if there are any plans to follow the practice adopted in Scotland and allow part of court proceedings to be televised if all parties are in agreement. (AQO 1855/11-15)

Mr Ford: As I stated in my response to an earlier question for oral answer on this matter, filming in courts in Northern Ireland is prohibited by the Criminal Justice Act (Northern Ireland) 1945 and the Contempt of Court Act 1981. I am aware of the position in Scotland in relation to filming and of the decision last year by the Justice Secretary in England and Wales to relax the ban on filming in that jurisdiction, initially for judgments in the Court of Appeal and, potentially, later in the Crown Court.

Although I have no immediate plans to lift the ban on filming in courts in Northern Ireland, I have asked my Department to monitor the implementation of the proposals in England and Wales and to consider experiences in Scotland and elsewhere. That will allow me to consider whether there are any lessons to be learned and whether a similar move should be made here.

Mr McCallister: I am grateful to the Minister for his reply. Will he pay particular attention to the impact of filming in courts on victims of crime in the review and process of monitoring that he has outlined?

Mr Ford: Undoubtedly, Mr McCallister has raised a key point and one that I have emphasised

previously. The important issues are to see that justice is done, that justice is seen to be done and that the interests of victims and witnesses, especially vulnerable witnesses, are protected in any way in which courts are run. That is why we have instituted arrangements to provide better protection and support for vulnerable witnesses, including the opportunity to give evidence by video link and the segregation of victims and vulnerable witnesses in court buildings. We would have to take those interests into account as key priorities in anything that we did in that area.

It is noticeable that the other local jurisdictions are merely looking at the issue of televising judgements. Those of us who witnessed the scenes of a court hearing in Norway on the news in recent days would see particular difficulties in extending the use of cameras to that sort of level.

Mr Weir: As someone who is not persuaded by the merits of filming in court, will the Member tell me what particular objections the Department has about televising court proceedings?

Mr Ford: I would be interested to hear the views of Mr Weir and other sceptics. I must confess that, as I look at what is happening elsewhere, I am probably more on the sceptic end than the enthusiast end. Clearly, it is not just an issue of what the Department and Minister think. We must consider the views of those who run the court system; the judiciary and the lawyers who appear before them; and organisations that support vulnerable witnesses, such as Victim Support and the NSPCC. We must ensure that we get a proper take on what is needed and what is best for Northern Ireland, as opposed to rushing into something that looks like a knee-jerk following of the route on which England and Wales appear to have embarked.

2.45 pm

Mr Rogers: Have there been any requests from broadcasters to televise court proceedings?

Mr Ford: I thank Mr Rogers for his question and welcome him to questions on justice. If, in the future, he remains so amenable, in comparison with other Members, I will be greatly pleased. To the best of my knowledge, there have been no requests, simply because the current legislation does not permit such filming. I am not sure that broadcasters have even suggested that we move in the same direction as Scotland, or England and Wales. However, we anticipate that they might take an interest in Northern Ireland when they look at what is happening elsewhere.

Magilligan Prison

5. **Mr Dallat** asked the Minister of Justice for an update on the plans to rebuild Magilligan prison. (AQO 1856/11-15)

Mr Ford: There are no plans to rebuild Magilligan prison. An outline estate strategy sets out proposals for the development of the prison estate over the next ten years. These include proposals for the creation of a new medium-security male prison to be located centrally, which would enable the eventual decommissioning of Magilligan prison on a phased basis. I hope to launch a public consultation on the outline estate strategy soon. Any proposals will, of course, be tested through the usual business case and consultation processes.

Mr Dallat: I thank the Minister for his reply. Does he agree that there are many good reasons why Magilligan prison should stay in the north-west? Not least of those is the area's high unemployment, but the prison also delivers excellent rehabilitation programmes.

Mr Ford: I appreciate that Mr Dallat has a constituency interest in the issue. Of course, I expect Members to make such points on the basis of constituency interests or the interests of groups whom they seek to represent. My view is that I must ensure that the estate strategy that we develop meets the needs of the whole of Northern Ireland in a way that helps to promote and maximise our aim of reducing reoffending and provides appropriate, affordable services. On that basis, I acknowledge Mr Dallat's point about the good work being done in Magilligan. However, the prison does that good work in facilities that are not fit for purpose: temporary buildings, Nissen huts, and, in the case of some workshops, rehabilitated farm buildings. Those are not circumstances in which we should provide modern services to rehabilitate offenders, so we must seek to ensure that we have proper facilities elsewhere. However, as the proposals will be out for consultation, it will be up to individuals to make whatever case they wish for how the prison estate should be developed. The issue is how we develop the prison estate; it is not a Magilligan issue. We need to ensure that

we move forward in a way that best meets our outlined aim of reducing reoffending.

Mr McCartney: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. Gabhaim buíochas leis an Aire. The Minister will be aware that his officials were before the Committee last week. Again, I make the point that all of the review of the prison estate must be in the context of wider prison reform. The debate should not be reduced to Magilligan, or not Magilligan. In much the same way, if there is a need for a centrally located prison, the Department should not be pointing to Maghaberry as its site.

Mr Ford: I thank Mr McCartney for that point, and it is a pleasure when the Deputy Chairperson of the Committee speaks as such and not as an MLA for Foyle. As we set in train the changes needed to provide a suitable prison estate for the future, we need to look at difficult issues and take account of the full range of issues that Mr McCartney highlighted.

Mr G Robinson: Does the Minister agree that a failure to rebuild Magilligan prison will mean that his legacy as Justice Minister will be the wiping out of approximately 400 jobs and the decimation of the economy of Limavady and the surrounding area?

Mr Ford: Again, I expect Mr Robinson to speak as an MLA for East Londonderry, but that is not the line that I have to take. I do not see how moving a facility from A to B is wiping out jobs or decimating the economy when the great majority of those employed at Magilligan do not live in Limavady, as he seems to suggest.

The key issue is what the needs of Northern Ireland are and how we best meet those needs for everyone in Northern Ireland, not the narrow local interests of one particular area. Individuals clearly wish to represent their constituency. I have to take a view as to what is best for the justice system for the years ahead.

Mr McClarty: Can the Minister give me an estimate of the cost of rebuilding Magilligan prison on its present site compared to that of a newbuild on a different site and the relocation of prisoners and officers?

Mr Ford: The answer to that reasonable question on the finances is that I cannot give Mr McClarty the detailed costing at this stage, because, for example, we do not know the detailed costing of building a new prison. However, I do know that the amount of building that is required means that it would not be simple to do it on the Magilligan prison site, even if it was the best location.

We are talking about a current prison that has substandard accommodation. It is full of residential blocks that have extremely substandard accommodation for workshops and offices. For example, in the Foyleview unit, which houses prisoners who are out working in the community towards the end of their sentences in semi-open conditions, the occupants are living in temporary buildings. None of that is suitable for a modern prison estate, which is why there has to be substantial rebuilding wherever the location might be.

As I said earlier, the opportunity is there for Members to make their comments as the consultation is carried through. The Prison Service and I will have to judge the overall best balance for Northern Ireland.

Maghaberry Prison: Security

6. **Mr Givan** asked the Minister of Justice what action his Department is taking to ensure the safety of prison staff following the recent attack by prisoners on officers in HMP Maghaberry. (AQO 1857/11-15)

Mr Ford: The safety and security of the staff working in our prisons is a priority for me and for the management of the Prison Service. In the past three years, the number of recorded assaults by prisoners on staff has more than halved. Nonetheless, there is no room for complacency.

In the most recent incident, staff were able to respond to and manage the incident swiftly and successfully, and no serious injuries were sustained. However, assaults on prison staff, the police, healthcare workers or teachers cannot be tolerated, and I know that Members will join me in condemning this assault and extending best wishes to the staff involved.

Tensions are often a fact of life in a prison setting. On this occasion, staff were able to use their training and skills to manage the situation in a professional manner and bring it to a successful resolution. It is worth noting that although around 30 other prisoners were in the immediate vicinity, none of them joined in the assault. In fact, two prisoners provided

assistance to a third member of staff who lost consciousness afterwards.

Mr Givan: What assessment is carried out when it comes to the ratio of staff to prisoners? I ask that because, only for the 30 other prisoners not engaging in this incident, we could have been talking about something a lot more grave. Given that the governor of Maghaberry, Governor Maguire, is now the acting director of operations and there is an acting governor at Maghaberry, is the Minister content with the situation and can he give an assurance that the senior management of Maghaberry prison are able to ensure the safety of the staff who work there?

Mr Ford: I thank Mr Givan for his question, although I suspect that the latter part of it intrudes on one that one of his colleagues wishes to ask.

There was a consultation on the issue of staff central profiling. The Prison Officers' Association (POA) declined to participate in that. Subsequently, POA committees were given the opportunity to comment on the final reports and the proposed staff profiles, but they did not submit written comments.

The governor and senior staff from the different prisons have visited areas of the prison and discussed with staff the issue of management. We have ratios of officers to staff on the landings that are largely comparable with and in many cases are higher — more staff per prisoner — than in our neighbouring jurisdictions. Therefore, there is not a significant issue in that regard. In the past three years, despite an increase in the number of prisoners, the number of such incidents has gone down from 19 to 17 to eight. That is an indication that good work is being done by prison staff and management in dynamic security to ensure that such incidents do not happen with any regularity.

Mr Hussey: The Minister made reference to the reducing number of incidents. How many prison officers have been injured on duty in the past year, and how many have had to retire as a result of injury on duty?

Mr Ford: I do not have the detailed figures that Mr Hussey asks for, although I can write to him with the details of the total number of injured staff. It should be noted that of the three staff involved in that incident, none was injured seriously. Two have returned to work, although I believe that one has taken some further time off. It is clear that although many of the incidents that we are talking about may be difficult and not particularly pleasant, they are not that serious in respect of how staff are treated by prisoners. By and large, they have been managed very successfully.

Mr McGlone: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. Gabhaim buíochas leis an Aire as na freagraí sin. I am relieved to hear that none of the staff was seriously injured in any of those attacks. You, Minister, outlined that some other prisoners became involved to restrain the level of activity and attacks that were continuing. Will you give us assurances that those non-involved prisoners will not be adversely affected as a consequence of what happened, which was totally beyond their control?

Mr Ford: I thank Mr McGlone for that comment. It is not entirely accurate to say that other prisoners restrained those who were engaged in the attack. However, other prisoners provided care for a member of staff who collapsed shortly after the incident. It is my intention to ensure that those who were not part of the difficulty and who did not contribute in any way to the injuries to prison officers should not suffer in any way for it. There are issues that need to be looked at carefully in managing the relationships on a landing immediately after such an incident.

Prisons: Full-body Searches

7. **Mr Lynch** asked the Minister of Justice for an update on the introduction of body scanning equipment to replace full-body searches in prisons. (AQO 1858/11-15)

12. **Mr S Anderson** asked the Minister of Justice for an update on his efforts to establish an alternative to full-body searches in prisons. (AQO 1863/11-15)

Mr Ford: With permission, Mr Principal Deputy Speaker, I will take questions 7 and 12 together. As Members will know, the Prison Service recently conducted a review of full-body imaging scanners for potential use in Northern Ireland prisons. On the basis of that review, and as previously announced, I intend to initiate a pilot of full-body imaging scanners. A range of technologies is available, and the pilot will focus on two of them: transmission X-ray and millimetre wave, with a view to assessing their suitability for use in Northern Ireland's prisons.

Transmission X-ray scanners have not yet been approved for use in UK prisons, and authorisation must be obtained under the Justification of Practices Involving Ionising Radiation Regulations 2004. An application for use in a prison setting is under way in HMP Holme House, although that process will take some months to complete. I am, therefore, examining whether there would be benefit in commencing a separate application in respect of prisons in Northern Ireland. The use of millimetre wave scanners does not require the same level of approval. The Prison Service will, therefore, be able to commence a pilot of those scanners sooner than the pilot of the transmission X-ray scanners. I intend to provide the Justice Committee with further detail on the necessary steps for the piloting of those scanners later this week.

Mr Lynch: Go raibh maith agat, a Phríomh-LeasCheann Comhairle. Gabhaim buíochas leis an Aire. Thank you for your answer, Minister. I sense a note of progress in it. When will the pilot scheme be introduced?

Mr Ford: I thank Mr Lynch for that comment, although I wish that he had sensed a bit more than a note of progress; it is an indication that we are definitely looking at how we can make progress as fast as possible with both technologies and consider their suitability for use in our prisons. I cannot give him a detailed timetable at this stage for how things will proceed, as the transmission X-ray scanners require a validation process that could take some months.

3.00 pm

As I said in my initial answer, the millimetre wave scanners could be moved somewhere more quickly. However, even that will require the acquisition of equipment, training of staff and provision of a suitable area for the scanning to be carried out. I intend to report to the Committee with as much detail as possible this week, which will enable Members to see what the options are.

Mr S Anderson: I thank the Minister for his response. Can the Minister justify permitting and facilitating a group of republican separated prisoners on protest, who make up a micro-percentage of the HMP population in Northern Ireland, to dictate prison security policy to suit themselves with their demand for the introduction of body-scanning equipment?

Mr Ford: No, I cannot, because that is absolutely not what is happening. For the benefit of Mr Anderson and other Members, what we are looking at is a way of avoiding the necessity for full-body searching for all prisoners in all three institutions in Northern Ireland. Full-body searching is not a pleasant process for either those who have to carry it out or those on whom it is carried out. There are technological alternatives that appear to have the potential to be at least as good as full-body searching in identifying attempts to smuggle contraband, which is why we are seeking to look at them.

We are looking at technological alternatives and their potential use for all prisoners in all three prisons. This is not an issue for one group of prisoners; it is an issue for the entire Northern Ireland Prison Service. I believe that all staff and all prisoners would benefit from ensuring that we have safety and security in our prisons in a way that is less demeaning than it currently is for both staff and prisoners.

Private Members' Business

Hospitals: Pseudomonas Incidents in Neonatal Units

Debate resumed on motion:

> *That this Assembly notes with concern the recent interim report on pseudomonas incidents in neonatal units and its recommendation that the development of the new regional neonatal intensive care unit should be expedited as soon as possible; and calls on the Minister of Health, Social Services and Public Safety to bring forward a time frame for the completion of the new regional women and children's hospital. — [Ms S Ramsey.]*

Mr Dunne: I welcome the opportunity to speak on an important and timely issue. The recent pseudomonas incidents in our hospitals were very regrettable. I wish to pass on my sympathies at this traumatic time to all the families who tragically lost loved ones. Given the severity of the outbreak, it is vital that steps were taken swiftly and measures put in place to ensure that the risk of further outbreaks was kept to a minimum.

When the outbreak was first discovered at Altnagelvin in December 2011, three babies were confirmed to be infected. One baby tragically died. The second confirmed outbreak was in the Belfast Trust in January 2012, and there were three further deaths. Screening of babies was then carried out across the Province and confirmed that other babies in other units had pseudomonas in their skin.

As part of the risk management processes, on 22 December 2011, the Chief Medical Officer issued a directive to all trust chief executives and senior officials detailing the necessary course of action to manage the risk from pseudomonas and legionella and emphasising that a team approach should be used for reviews of schemes to identify potential risk areas. The letter also referred to a previous letter from the deputy secretary of health estates dated 1 July 2011, which further detailed how water systems and potential infection risks should be managed. Chief executives of all trusts were asked to provide a statement of assurance that systems were put in place by 31 August 2011.

The main concern relating to the letter of 22 December was the fact that it was written on the Thursday prior to Christmas Day, when most people were on the wind-down to Christmas. The letter should have been marked as an urgent priority, given the serious nature of its contents and the tragic consequences relating to the need to manage the risk of pseudomonas in all trusts.

The findings of Professor Pat Troop's independent Regulation and Quality Improvement Authority (RQIA) report, which was quite rightly initiated and prioritised by our Health Minister, Edwin Poots, have been very valuable and useful in highlighting the risk areas relating to the pseudomonas outbreaks in the various hospitals throughout Northern Ireland. The 15 recommendations will go some way to addressing risk management.

One of the key issues identified in the report and in various Health Committee discussions is that the bacteria causing pseudomonas is found in stagnant water, usually in the last 2 metres of the pipework that comes before the water taps. The risk has been somewhat compounded by the introduction of thermostatic mixing valves, with water at the tap at 41°C. In other countries, hot water is circulated at 70°C. I believe that an engineering solution to mitigate the risk should be progressed as a priority to ensure the safety of all high-risk patients in our health service.

We look forward to the publication of the final report, which is due shortly, and I trust that it will lead to further improvements on the issue.

This recent outbreak has highlighted the need to have modern, fit-for-purpose accommodation that meets the modern-day needs of our population. The new regional women and children's hospital should continue to be a priority for our Minister, and I trust that we will see further investment and improvement in our healthcare infrastructure. I support the motion.

Mr Gardiner: At the outset, I would like to say that the preventable deaths of infants, which occurred as a result of the pseudomonas outbreak, were an appalling and unintended outcome. I believe that more should have been done to deal with the cause of the infection, which was identified in December 2011 as being the hospital taps.

When a meeting of the Health Committee considered the pseudomonas issue on 4 April, I used the opportunity to ask the expert present, Dr Michael Kelsey of the independent review team, to explain exactly where the cause of the problem was located. He told me that the

infection tended to be found in the last 2 metres of the water distribution system. He said that that was due to a number of factors, one of which was the switch to infrared-operated solenoid taps, which were brought in widely and which use thermostatic mixer valves to avoid scalding. So, the infection arose as an unintended consequence of an attempt to solve another problem, which was the scalding of people's hands when the water was too hot. Dr Kelsey said that it seemed that the new solenoid taps appeared to support the growth of pseudomonas, whereas the old-fashioned, lever-type, simpler taps that had fewer plastics and fewer residual volumes with bits of stagnant water left in the supply pipe were less likely to support pseudomonas. It is shocking that something that was designed to solve another problem had such a terrible outcome. The problem is international, and it has also been widely reported elsewhere in the United Kingdom.

When I questioned Professor Troop and her team more closely, it emerged that, on 4 April, not all the taps had been changed. Although I received some reassurance that babies were now safe because they were being bathed in sterile water — a solution that is now happening right across the United Kingdom — I was still unimpressed that such as simple an operation as changing some taps could take so long.

Apparently, although the manufacturers have been approached by the United Kingdom Health Department and have been asked to design a safer tap, an engineering solution has still to be found. We can take some comfort that sterile water is being used with babies in the meantime. However, I am concerned that solutions to so many problems in the health service appear to take so long. I believe that we now need to focus on speedier outcomes to problems that we experience.

Ms Brown: I rise to speak on the motion as a member of the Health Committee. As many of the Members who have spoken already have done, I want to pass on my sympathies to the families of those who have lost loved ones, especially ones so very young. I also pay tribute to the staff of the neonatal units. For all of their experience, they must have found the circumstances and subsequent tragedy to be very distressing.

The interim report on pseudomonas incidents in neonatal units and its recommendations, which were published at the beginning of April this year, will provide little or no comfort to those who have lost loved ones in the cases looked at. However, the rest of us must do all that we can to ensure that no other parents go through a similar ordeal because of pseudomonas.

A first step in that learning process has begun with the review by the Regulation and Quality Improvement Authority. Professor Troop, who headed the review, reported that the measures had been put in place in order to reduce the risk of the spread of infection. It is encouraging that, to date, there have been no further cases of this particular infection, but, of course, we cannot be complacent.

Earlier today, we discussed a motion on patient safety within the health and social care service here in Northern Ireland, and this motion is not entirely unrelated, as we know from the findings in the report and its recommendations.

In her report, Professor Troop detailed that the likely cause of the spread of infection originated from contaminated tap water. Unfortunately, something so seemingly innocuous had a devastating impact. No matter how mundane or seemingly routine, we must ensure that even the most non-technical aspects of healthcare are subject to stringent inspection and review. The safety of patients when in the care of the health service is paramount, and I am pleased that the Minister acted to review the outbreak of this infection and the circumstances that led to the death of the babies.

Recommendation 15 of the interim report, to which the motion refers, states that the development of the new regional neonatal intensive care unit at the Royal Jubilee Maternity Service should be expedited as soon as possible. I, of course, accept that recommendation. As the Minister has advised the Health Committee, he intends to implement all of the recommendations contained in the interim report. I look forward to hearing how that particular recommendation will be progressed.

On 15 December 2011, the Minister announced the beginning of work to the new critical care building at the Royal Victoria Hospital, which includes postnatal beds and a maternity outpatient unit. The rest of the maternity unit is scheduled to be completed by 2014. I hope that the building of the new maternity unit, which is to include the new regional neonatal intensive care unit, is completed earlier, but I recognise

that that is dependent on a number of factors, including available budgetary funds and other building commitments on the Royal Victoria Hospital site. However, all those constraints should not stop us from pressing on urgently. This is too important an issue to do otherwise.

Mr Allister: There is no doubt that these incidents caused great distress when they occurred, above all, of course, to the families, but also to many people who have small children or grandchildren. Those people will have thought of the turmoil brought to those families and of the very great loss that they all suffered. Naturally, therefore, people have been asking questions and looking for answers. Of course, we still do not have all the answers. I trust that by the time the final report is published at the end of May, we will have many of the outstanding answers that we await, because that is imperative if lessons are to be learnt from this. Sometimes, even the holding of an inquiry, necessary as it is, becomes a shield to hold off the answering of questions or, indeed, the asking of questions. That is not always an entirely healthy situation.

With regard to fundamental questions, there is one tangential issue, in a sense. We, or, at least, I, do not even know when the Minister first heard about the outbreak of pseudomonas. I asked him that question in the House when he made one of his statements on the issue, and he did not provide an answer. I then submitted a question for written answer to the same effect, on when he became aware of the outbreak, and I got an answer that did not tell me. The Minister answered:

> *"I was made aware of a pseudomonas outbreak in Altnagelvin Area Hospital by my Department in a submission of 13 December 2011."*

That tells me when the submission was compiled; it does not tell me when he received it or when he became acquainted with the issues. We then had the scenario that it took the following nine days to get a letter out to the other trusts; a letter that many have properly criticised as being in itself inadequate by not referring to the severity of the situation. If that letter arrived in and about the 22 December, no one seems to yet know what then happened to it, where it sat, when it was acted upon or when the first action, if any, was taken on the foot of it. Did it, as some speculate, languish in an in tray over Christmas, or was it actually acted upon? When it was seen that it was inadequate in its content, were further steps taken to plug those gaps?

3.15 pm

Then, there is the issue of the questions that arise about the adequacy of the cleaning operations in our hospitals. I did get an answer from the Minister to a question in respect of that. I asked whether, in the standard process used to check hospital hygiene standards, microbiological tests were routinely carried out as part of that process. In other words, were those tests carried out to identify the presence of bacteria? I must say that the answer to that was disappointing:

> *"Microbiological testing is not routinely carried out by Trusts but is carried out where an infection outbreak is suspected or confirmed."*

Therefore, it is not done until you are aware of the probable existence of an infection. Why is that? Has that changed? Will that change? Is there a cause to change that? Do we not need to be carrying out microbiological testing to make sure that bacteria that give rise to these outbreaks are not already present? Should that not be done on a routine basis? Will that now be done? Those are some of the questions that I think need to be answered.

I did ask the Minister a series of other questions for written answer, none of which were answered, on the premise that an independent review was under way. I trust that that review does answer those questions and, if not, that he will. There are many, many issues still unanswered. Those issues are still very important for the families affected, for the whole community and for the future.

Mr Poots (The Minister of Health, Social Services and Public Safety): I welcome the opportunity to hear the views of MLAs on this motion and, indeed, respond to it. I thank the proposers of the motion for raising the two important issues.

The motion refers to the recent pseudomonas outbreaks. The death of a baby is obviously devastating for those families involved, and, indeed, for the entire family of people who have babies in the neonatal units across Northern Ireland. In those circumstances, when you have a child who is unwell, people become closely unified and quite bonded. I know that many

people felt great pain as a result of that. For me, having to deal with these circumstances and deal directly with the families involved has been the worst experience of my political life. Indeed, telling people that the death of their baby was perhaps avoidable was one of the hardest tasks I have ever had to fulfil. I trust that I do not have to do it again.

Initially, we commissioned an independent review so that we could have answers as quickly as possible. Mr Allister is right, in as far as, sometimes, inquiries can be put up as blockages. People say, "Oh, we have asked for a public inquiry; how long will that take?" We currently have one that stretches back 17 years; those families have been looking for answers for 17 years. I do not think that that would have been acceptable. So, yes, I did introduce an independent inquiry through the Troop review team. The team came back quickly; I gave them a short time frame in which to respond. They have responded, and made 15 recommendations. The team are bringing forward a further report. I encourage Mr Allister, for example, if he has unanswered questions, to put them to the Troop review team, and it will seek to respond to all the things that are relevant and will add value to the overall report. I encourage anyone who has an interest in this subject to make their opinions known to the Troop review team, pose questions to it, seek to ascertain all the answers to their issues and ensure that, as far as possible, we can mitigate the circumstances in order to prevent this happening again.

The interim report was produced publicly on 4 April and it contained 15 recommendations. I accept all the recommendations. Five of them have already been fulfilled. The majority of them will be fulfilled by the end of the month, and work will continue on a smaller number of them to ensure that we bring them to fruition as quickly as possible. Some will require a longer lead-in time, and I will deal with that.

We need to consider the best way forward for neonatal care and high risk, and the governance of all that is very important. I have met the chair and the chief executive of the Belfast Trust to discuss the interim findings. I have put in place measures to strengthen governance in that instance. So, I look forward to the second report from Professor Troop's team, and I will consider its findings with the same diligence and speed that I considered those of the interim report.

The regional women's hospital has been supported by the Assembly, and I consider it a priority. I strongly refute the idea that women die because of men in power. I think it a totally sexist and unacceptable remark. Sadly, women die and, sadly, on occasions, the powers that be let them down. Sadly, that is the case for men as well. People die and the powers that be let them down. Let us be realistic about this. I care very passionately about the people who I serve, and I do not see any difference between men and women in their health needs. We need to respond to them equally.

Ms S Ramsey: Will the Minister give way?

Mr Poots: Yes; I certainly will.

Ms S Ramsey: I made the comment. If the Minister remembers, he will know that I said that, hopefully, it was not the issue here. I was quoting a press release from the World Health Organization. It said that, sadly, women are still dying in the world because men are in charge.

Mr Poots: I say very clearly that it is not because of this particular man. This particular man happens to care very passionately about people in Northern Ireland receiving the best possible care, whether men, women or children. I will seek to ensure that that is the case.

As to the regional women's hospital, in any event, we have a revised project for the critical-care building. Along with the new maternity building, it will permit the completion of the new maternity facilities within the current Budget period. The new facilities have been designed to allow for the required clinical linkages with the children's hospital. Some of those things have been planned for quite some time and, even if I desired to change them, it would probably delay the process considerably. It has been planned for some time that it should be done in this particular way. The element within the critical-care building will be completed by November 2012 and operational by the summer of 2013. The plan for the new maternity building is that it will be completed by December 2015. I have indicated that, if it is possible, we should try to tighten the timescale and deliver it sooner. However, in all honesty, given that we are in the second quarter of 2012, I suspect that, with the best will in the world, if we take any time off the schedule, it will be months; it certainly will not be years. However, I am putting pressure on to ensure that the work is completed as quickly as possible.

The maternity project will have three floors of the critical-care centre and the new purpose-built maternity hospital. The critical-care centre will contain two floors of postnatal, single-room accommodation, that is, 58 rooms, and a maternity outpatient centre. The new maternity hospital element will contain a delivery suite, a midwife-led unit, theatres, an antenatal ward, and neonatology and ancillary accommodation. It will connect to the critical-care centre via a two-storey link bridge. The design team for the new maternity project will be formally appointed, I suspect, within days, if it is not already appointed, and it will make progress on the design of the new building. An enabling works contract to prepare the site for the new maternity building is being prepared, to be commenced on site in July, after the builders' holiday break. That will include the demolition of the existing education building, the realignment of site roads and the diversion of existing services. It is planned to commence the main contract works on site in the second quarter of 2013.

In relation to the children's hospital; the competition for the selection of the design team for the maternity project including site master planning, which identified the optimum location for the proposed children's hospital and how it interfaced with the new maternity building; the critical-are building; and the services and supplies distribution tunnels on the site, the trust has been asked to submit a business case to the Department of Health, Social Services and Public Safety (DHSSPS) by October 2012. The children's hospital can be procured either through capital funding, using the existing design team framework and the contractor framework, which will be established under the maternity project, or through a revenue-based PFI route, using competitive dialogue process.

The estimated timescales for the procurement route are six months for business case approval; around 18 months for the stage involving design, planning, approval, tender and so forth; and a construction period of around 30 months, giving a total of four and a half years. If that can be pulled forward, I would be very happy to do that. If the project is done by PFI it may take longer, but if that is the only way of delivering it, we will have to consider that.

The total cost of the children's hospital would be around £180 million, including the enabling works. The current capital profile does not permit that level of construction of a new children's hospital in the current Budget period. However, I am looking to be innovative about this, to see whether we can secure the funding to deliver it, because I see it as a priority. We are operating our regional children's hospital in very poor conditions indeed; conditions that I do not believe are acceptable in the medium-to-long term.

We have secured funding of £3 million in 2013-14 and £9 million in 2014-15 to commence the project. In order to expedite the project more quickly than currently planned, I would require at this stage another £30 million to £40 million in my capital budget during this Budget period. So, you can be sure that I will be lobbying the Finance Minister to see whether we can identify any other sources of income to ensure that we can move this forward.

The detail and design of the new children's hospital will be dependent on the outcome of the upcoming paediatric services review. Work will shortly begin on scoping the breadth of the review and on its associated timing. That is certainly something that we will want to do.

I will now respond to questions raised by a number of Members. Mr McDevitt asked for an overview of surveillance systems, which is a perfectly reasonable question. The response is somewhat long, so I hope that you will bear with me.

Public health surveillance is a continuous process that involves the collection, analysis and interpretation of data. That data is then disseminated to policymakers, healthcare professionals and other professionals. The primary purpose of the communicable disease surveillance is to produce timely information for action, and the control of communicable diseases involves not only doctors and nurses but individuals from a wide variety of backgrounds, including water engineers and environmental health officers.

Epidemiological surveillance requires a systematic collection of data, and that is done mainly by making use of data that are generated locally and collected centrally; for example, the reporting by medical microbiologists of laboratory-confirmed infections. The Public Health Agency (PHA) receives data from several sources, primarily clinicians, hospital laboratories, consultants in communicable disease control and environmental health officers. Surveillance includes arrangements to fulfil statutory requirements in relation to notifiable diseases, of which there are currently

35. In Northern Ireland we are fortunate to have a tradition of voluntary central reporting of laboratory-confirmed infections, and the PHA routinely publishes data on notifiable diseases, vaccination coverage, avian influenza, brucellosis, gastrointestinal infections, hepatitis, healthcare-associated infections, meningococcal diseases, sexually transmitted infections and TB.

That information is published on the agency's website.

3.30 pm

With regard to pseudomonas, surveillance has been in place since 2000 for bloodstream infections caused by a range of strains of the bacterium. Data on colonisations are not routinely collected at present. The independent review has recommended the establishment of surveillance arrangements for pseudomonas for augmented care settings, including neonatal care, and I have accepted all the recommendations in the interim report. The PHA is working with the Department and trusts to implement this recommendation by the end of October.

Other Members covered a range of issues. I think we covered quite a lot of them in the statement that was made. I encourage Members that should they have issues of particular interest or wish to make representations on behalf of constituents, they do so. I believe that the work that has been done thus far by the Troop review team will be used in Northern Ireland, other parts of the United Kingdom and, indeed, in the Republic of Ireland in how we can do things better.

In the interim, for example, while the new hospital is being built, we have to look seriously at the existing facilities over the next three years. Troop made recommendations, and we will seek to respond by having the appropriate separation, and so forth, within our neonatal wards and by ensuring that the facilities meet the needs safely in that intervening period.

So, I encourage Members to contribute, because the quality of the report will be subject to the input received. I am very grateful that many of the families have already got involved in developing the report and assisting in providing information. I know it is very tough and very hard for them to do that and we greatly appreciate what they have done thus far.

Again, I thank the Members for bringing forward this motion, and it is one that I am very content with and add my support to.

Mr Brady: Go raibh maith agat, a LeasCheann Comhairle. I welcome and support the motion, and I welcome the Minister's presence for the debate. I also welcome the recent interim report and its findings, although it is deeply saddening that such a report had to be carried out due to the death of four babies. I also offer my sympathy to the families affected, and the wider family circles.

The Minister and most Members alluded to the 15 recommendations. It is encouraging that the Minister indicated that those should be implemented as soon as possible. In relation to the motion, however, it is also clear from the pseudomonas report that there is a need for a women and children's hospital. There seems to have been an outstandingly long delay, particularly when that was first mooted going back a number of years and, more recently, in 2005, when funding was, apparently, to be available.

I will go through some of the issues that Members raised. My colleague Sue Ramsey talked about pseudomonas being virtually unheard of previously, and the effects that it would have. Sympathy was also offered to the families. She welcomed the interim report and the 15 recommendations. She talked about the importance of having a women and children's hospital as a regional unit. She quoted the World Health Organization on how women are still dying in the world because men are in charge. She did, I think, qualify that, and the Minister also qualified that it was not his fault. Nevertheless, it was a World Health Organization quote and may have some veracity.

She talked about radical thinking, and the Department of Enterprise, Trade and Investment (DETI) and the Department for Employment and Learning (DEL) being part of the project process to ensure that the women and children's hospital could become a reality. The Minister did not allude to that in his speech, so maybe that is something he will consider even though he did not mention it.

Jim Wells talked about sympathy for the affected families. He said that something might have been done to save a premature baby. We need to ensure that this does not happen again. He talked about the incident in Altnagelvin and the document from the Chief Medical Officer in

December 2012. Not enough was done to deal with the incident and its implications. There was no evidence that such action was taken in parts of the health service estate. He mentioned an incident in Turkey that involved plumbing and said that the last section of plumbing should have been checked. He referred to Professor Troop's interim report and to her team, saying that they were a very professional group of people. He was strangely fulsome in his praise of the Minister — maybe that is not so strange — and how he has since dealt with the situation.

John McCallister expressed sympathy for the families. He talked about the time frame and the memo that was issued. He said that the debate was timely, following the earlier debate on patient safety. He said that no system is in place to detect the seriousness of issues and that time is of the essence in such cases. He spoke about the need for a women and children's hospital and supported a resolution to that. He asked the Minister to deliver on this project. He also said that systems need to be in place, it had been a painful lesson for the health service and a high cost was involved.

Conall McDevitt expressed sympathy for the families. He talked about solidarity with staff and Professor Troop's final report, which will deal with families' experiences and be an acknowledgement of how the Department reacted. He spoke about the interim and final reports and the absence of a regional network and said that he looked forward to the Minister's response. He talked about the lack of a consistent approach and surveillance. He also mentioned the need for surveillance for microbial infection and acknowledges the need for a new facility.

Kieran McCarthy expressed sympathy for the families. He said that it was a damning indictment of neglect. He said that he was glad that the Minister was in the Chamber and hoped that he would accept his responsibilities. He acknowledged the heartbreak of parents and paid tribute to the families who spoke to the review team. He talked about the 15 recommendations in the interim report.

Paula Bradley also extended her sympathy and said that we should try to ensure that lessons are learned for the sake of the families. She talked about the 15 recommendations in Professor Troop's interim report. She rightly praised staff and talked about the working conditions that they have to endure: we should not be proud of those. She welcomed the fact that the new women's hospital project is under way. Again, strangely, she commended the Minister and talked about the interim report's attention being focused in the proper area.

Michelle Gildernew expressed sympathy and talked about the shocking and concerning issue. She said that information may not have been as forthcoming as it should have been. She said that she first heard of the outbreak on 19 January 2012 and talked about the December warnings and the lack of information from the Minister. The source of the outbreak was identified as taps. She welcomed the Minister's statement about implementing the 15 recommendations. She said that the babies had been very well cared for by staff and was disappointed by the attitude of some health professionals. She gave the example of a pregnant woman who lost a baby and how that was dealt with. She also talked about the attitude of some of the professionals, and I concur with that, given the presentation that the Committee received about group B strep.

Gordon Dunne said that it was an important and timely issue, which it is. He expressed sympathy and spoke of the severity of the outbreak. He said that it was vital that steps were taken to limit the outbreak and talked about the screening carried out on the other babies who were affected. He spoke about the directive that was issued on 22 December and the identification of potential risk areas. He mentioned a letter that was issued on 1 July 2011 that stated that systems must in place by 31 August 2011. He also spoke about the usefulness of Professor Troop's interim report.

Sam Gardiner spoke about the preventable deaths of infants and said that this was an appalling outcome. He talked about the review team being questioned about the factors that caused the outbreak, as well as the unintended consequence of the solving of one problem leading to the creation of another. He said that sensor taps were installed to prevent one problem, but, as we were told, they caused another.

Pam Brown expressed her sympathy and paid tribute to staff. She spoke about the interim report and the recommendations, and she said that those were of little or no comfort to the parents affected. She talked about the measures being put in place and said that

although no further cases had been reported, we cannot be complacent.

Jim Allister said that the incident caused great distress to many people and talked about the turmoil for the families concerned; he said that we still do not know all the answers and that it is imperative that the final report at the end of May answer questions. He talked about fundamental questions, such as when the Minister first heard of the outbreak, and said that he had not got satisfactory answers to his questions. He asked whether the letter that was sent out had languished in an in-tray over the Christmas period. He talked about the adequacy of cleaning in hospitals and asked whether microbiological tests were carried out routinely. In answer to the question, we learned that such tests are not done routinely until there is evidence of an outbreak.

The Minister welcomed the opportunity to hear MLAs' views; he again expressed sympathy to those affected by the babies' deaths. He said that dealing with those circumstances was the worst experience of his political life. He said that he commissioned an independent review to get answers quickly and that the team responded quickly. He encouraged Mr Allister to put any unanswered questions to the review team.

The Minister accepts all 15 recommendations, which is welcome, and said that the majority of them will be implemented by the end of this month. He said that measures will be put in place to strengthen governance and that developing a women and children's regional hospital is a priority. He said that he did not necessarily agree with the quote about women in particular. He talked about the new maternity facility that is to be completed and about how it will have linkages with the children's hospital.

The new maternity building is to be completed by 2015, but he said that he will expedite that if possible. He gave some details of the new building and the logistics involved. He said that he will try to be innovative in order to secure funding and that another £30 million to £40 million will be required in the current Budget period. He talked about the paediatric services review and gave details of the complexities of health surveillance and reiterated that all the recommendations in the interim report will be accepted.

Again, I stress that he did not mention the point about DETI and DEL, which my colleague Sue Ramsey raised. However, perhaps he will come back to us on it.

I welcome and support the debate. I think that everyone who contributed offered something constructive.

Question put and agreed to.

Resolved:

> *That this Assembly notes with concern the recent interim report on pseudomonas incidents in neonatal units and its recommendation that the development of the new regional neonatal intensive care unit should be expedited as soon as possible; and calls on the Minister of Health, Social Services and Public Safety to bring forward a time frame for the completion of the new regional women and children's hospital.*

Motion made:

That the Assembly do now adjourn. — [Mr Principal Deputy Speaker.]

Adjournment

Annadale Flats, South Belfast

Mr Principal Deputy Speaker: The proposer of the topic for debate will have 15 minutes. The Minister will have 10 minutes to respond. All other Members who wish to speak will have approximately seven minutes.

Mr McGimpsey: Today, I raise the issue of Annadale flats. The flats, for those who are not aware, are in South Belfast, close to the River Lagan and the Ormeau Road. There are 202 flats in the development, which was constructed by Belfast Corporation in the 1950s. Indeed, it has been a very successful development, because a number of the original residents who moved in in the late 1950s are still there. The issue, however, is that there are periods when such developments, although properly built and looked after, require major investment and refurbishment to make them fit for purpose and habitable.

(Mr Deputy Speaker [Mr Beggs] in the Chair)

I am pleased to see the Minister here and am grateful to him for coming to the debate. It is important to say that when the flats were handed over to the Housing Executive, it attempted to fulfil its statutory obligation as a good landlord to its tenants by ensuring that they were kept in a reasonable state of repair and that defects were properly attended to, as they should be. However, there have been issues with getting the Housing Executive on site and getting it to spend moneys as required. Nevertheless, the flats have been rewired, and new kitchens and double-glazed windows have been put in throughout the complex; issues with heating have also been addressed. There was a pilot scheme for 24 flats, whereby the exterior fabric of the building was completely refurbished, including new pitched roofs. One of the difficulties is that the flats were constructed with flat roofs covered in three-ply felt, which are now long past their useful life and need to be replaced urgently. The roofs are the main issue, although there are ongoing issues around the proper maintenance of the communal areas, and many of the bathrooms are the original ones dating back to the 1950s. Clearly, those issues need to be addressed.

3.45 pm

The first thing that you need to do as a good landlord is to make sure that your property is wind and watertight. If rain is getting in and the roof is leaking, and if water is getting in through ceilings and electrical fittings, and so on, the flats will deteriorate, the building will deteriorate, and it will eventually be lost unless, as a good landlord, you properly maintain your property. The residents of a number of the flats have continually to use basins and buckets to catch the drips of water, which is the issue that I am talking about today.

The flat roofs are long past their sell-by date. I speak as someone who spent a long part of my career as a builder, primarily of residential properties, and I well know the issues around flat roofs, particularly those that were built in that period. The Housing Executive needs to begin an urgent re-roofing scheme for the flats along the lines of the work that has been done for the 24 flats in the pilot scheme.

The flats need sloped roofs that are felted, tiled or slated, with properly constructed rafters and trusses. That allows water to run out of the building rather than into the building, as happens with a flat roof. With a proper pitched roof, the water can run down internal drainage to external gullies. Currently, as water falls on the flat roof, some of it makes its way down into the flats. That is dangerous when it comes into contact with live electrical wires and fittings, and it is also liable to bring down ceilings.

There is also the issue of tenants not being able to get their flats dried out. The flats are cold because there are problems with insulation; I will talk about that in a minute. Cold and damp flats, as we are all aware, are a recipe for poor health. As I said, a number of the residents in the scheme are elderly people who have lived there for many years, and they are vulnerable to cold-related conditions.

The situation is easy to rectify. The Housing Executive agrees that the re-roofing scheme needs to happen. I have written to the Minister for Social Development and he has replied, saying that he wants to do it and plans to do so, if the money is available. I understand that qualification with regard to future investment,

but I am saying that if these roofs are not attended to immediately this summer — the summer being the best time to roof any building — the flats will not stand to endure another winter and we may be liable for an awful lot more than the cost of new roofs. Ceilings are liable to come down into the flats as a result of water ingress. That is why I am appealing today for the roof refurbishments to be put in hand immediately and urgently. The residents cannot wait; they cannot endure another winter.

The refurbishments will allow for proper insulation to be installed in the roof spaces. The flats have no insulation and are extremely cold. The double glazing has helped, but much more work needs to be done. In this day and age, we know that heat loss through an uninsulated roof is one of the prime ways to lose heat in any building or development. If we can get a proper insulation scheme installed, we can warm up the units.

Other investment is required. Bathrooms need to be replaced and communal areas, going back decades, need to be properly refurbished so that callers can access the flats without coming across some of the obstacles that they are likely to find in the halls, such as the lack of light bulbs, which is particularly a problem in winter.

The main cry from the residents of the 202 flats, all of which are fully occupied, is that we get the roof fixed and stop the water coming in. Based on my experience, it is my opinion that it is no longer possible to repair and patch the flat roof. It has been patched and repaired until it can take no more repairs. It has to be replaced, and the simplest, cheapest, most effective and best way of protecting the Housing Executive's very considerable investment in this area is by having proper pitched roofs. Those pitched roofs will solve an awful lot of the problems, and as I said, they will lead on to a much better quality of life and a much better environment for the families who live in this community.

That is my appeal. It is urgent. We need to get this done quickly, and I appeal to the Minister to treat it as an urgent repair rather than as planned maintenance. Hopefully, the capital will come along, because we are now past the position where we can wait any longer. I do not believe that these flat roofs will take us through next winter.

Mr A Maskey: Go raibh maith agat, a LeasCheann Comhairle. I thank Michael for bringing the matter to the attention of the Assembly. I do not want to rehearse all the points that the Member made, but we should remind ourselves of the point that he alluded to that, over the past number of years, a lot of very good work has been on the flats.

The 202 flats were built around 1953, and, thankfully, they are all occupied. Indeed, I understand that there is a quite considerable waiting list of people who wish to move in. That was not the case a number of years ago, but, thankfully, because of the improvement to the broader environment of the area and the general improvement of the flats, there is a greater demand for people to reside there. That guarantees their long-term well-being in the context of the proper refurbishment that might be required. That demand comes quite considerably from the broader ethnic minority communities in South Belfast, and we all know that quite a number live in what is, nowadays, a very diverse constituency, which is a good and healthy thing.

Again, we should remind ourselves that, in recent years, there have been kitchen replacements, window replacements and replacement of central heating with gas heating. I have spoken with the Housing Executive on its plans to carry out further health and safety work on fire doors, and I think that smoke and heat detectors have been wired. All of that is to the good.

I am surprised to hear the Member say that, in some of the flats, water is dripping through virtually as we speak, so I am keen to hear the Minister's response on that point. Having talked to the Housing Executive about that, I understand that, later in the year, work is due to be done on the roofs, and we would all welcome an upgrade and, in fact, any upgrade to any dwelling, particularly in the social housing sector. I thank the Member for bringing the issue to the attention of the Assembly on behalf of the constituents of South Belfast, and I look forward to the Minister's response. I encourage the Minister to try to ensure that the necessary finance will be there to bring the flats up to highest standards, which the tenants quite rightly deserve.

Dr McDonnell: Similarly, I thank my colleague Michael McGimpsey for bringing the issue to the Floor of the House. I am very familiar with the

issue because, over the years, as a GP, I visited many of these flats, rendering help or medical attention to the elderly residents who live there. In recent years, my constituency office has been working with the residents, and we have visited the homes to see at first hand the damage that is repeatedly caused by persistent leaks in the roofs.

Some people have said, and I am sure that you have heard it repeated, that the definition of insanity is doing the same thing over and over again and expecting a different result. However, that is a fitting description of what appears to be happening here. The persistent and continuing internal damage to the Annadale apartments over the years could have been prevented if the flat roofs that are in such poor condition had been replaced with pitched roofs. That has already been well outlined. An attempt was made some years ago to replace the roofs on two of the blocks with pitched roofs. That has been relatively successful, but the rest were never included. The Housing Executive acknowledges that, and, indeed, it was its intention to do all the flats at the time. However, somehow or other, the programme did not happen, and temporary repairs have been carried out to the flat roofs again and again. Although that may be worthwhile or useful in the very short term, it has failed to address a long-term problem, because the flat roofs are not working and, generally, do not work.

I have a lot of sympathy for the staff in the Housing Executive who are trying to deal with this. They are still grasping for reasons to justify why they cannot do the sensible thing and get on with this. As a result, the rational argument against flat roofs has turned into a very unnecessary pitched battle between the residents and the Housing Executive. As I said, I have sympathy with the Housing Executive officials who work at the front line. Indeed, I want to put on record that my office has always found them as efficient as possible in responding to the issues that we raise on behalf of people in the community. I believe that the will is there among the staff to refurbish and renovate the flats if the opportunity and finance arises. However, we are told that the resources to carry that out are simply not there. That argument, dare I say it, just like the roofs, falls flat on its face.

Vast sums of money appear to have been spent over the years on ad hoc repairs and on patching up the roofs. To my mind, that is the equivalent of putting a sticking plaster on a broken leg and hoping that it will be all right on the night. When they saw that this will be a long-term problem, surely the Housing Executive and the Department for Social Development should have found the resources to make a one-off investment to replace the flat roofs, thus saving the public purse thousands of pounds in ongoing repeated remedial work.

I commend the Minister for rolling out the double glazing scheme for Housing Executive properties that are in need of it. It has gone some way to keeping vulnerable people warm — I should maybe say “less cold” — and to reduce their energy bills. However, in spite of that, in Annadale, the bills keep mounting because of the damp and because property has been damaged and destroyed by roofing that just does not work. I know that capital funding is a finite resource and that, year on year, there are more and more demands on it. However, the money must be found and found soon for the people of Annadale if we are to avoid a situation where the Department for Social Development wastes further public money trying, in effect, to reinvent a square wheel.

The press and public have complained of late about the quality of business coming before this House. I contend that this item should never have troubled this Chamber, but not because it is not important. It is important, and people on the ground know that I am deeply concerned about the mess in Annadale flats. However, the solution is so glaringly obvious and so comparatively simple that it should have been sorted out as part of an operational policy long ago, before my colleague had to raise it in this House.

It is not a complex problem. It is not an insoluble problem. I beg the Minister to look at the capital budget, to look to his current and planned projects and see where some money can be found to undertake that one project in that one area and, in so doing, save his Department a considerable sum of money in the future by no longer having to undertake costly running repairs that, in effect, achieve nothing.

4.00 pm

Ms Lo: I, too, thank Michael McGimpsey for bringing the matter to the House. I am aware that the Housing Executive has carried out a number of renovation schemes in recent years in the Annadale flats, such as PVC double glazing and new kitchen installations. I also

welcome the upcoming work on the communal areas, which will introduce new fire doors and make general amenity improvements. However, I have also had constituents contacting me over the past five to six years, particularly those living on the top floors, who have had continuous problems with leaking roofs, which have ruined internal painting and decoration work. In some cases, that has led to the collapse of ceilings. That has obviously impacted on the residents' enjoyment of their homes, and has, at times, been very distressing and caused significant anxiety for those residents and their families.

In fact, the Housing Executive secured a capital fund of approximately £8 million in 2005-6 to carry out work, including external rendering and new pitched roofs. It is a pity that the scheme was only carried out on one block of flats, leaving the remaining blocks with flat felt roofs. I believe that the money was actually returned to the central pot and never used. Those felt roofs are causing a lot of difficulties for the tenants through leaking, and are impacting on their quality of life. Although the Housing Executive anticipates re-felting the roofs of the worst two blocks in October this year through its renovation stream or maintenance stream, it would be more worthwhile in the long run if the Department could allocate some capital funding to have the roofs pitched rather than re-felted.

I appreciate that the planned maintenance works and the efforts of the Housing Executive are making an impact to address the tenants' problems, but it is perhaps not cost-effective or time-effective to schedule remedial works when proper long-term renovation is badly needed. I recognise the tough economic times we are in, and I am very aware that it is perhaps unrealistic to hope that the same amount of capital can be found that was available five or six years ago. However, I think it makes fiscal sense for the Department to find the capital funding for pitched roofs so that it can be dealt with once and for all, rather than patching things up to be replaced in later years.

Mr McCausland (The Minister for Social Development): I thank the Member for bringing this issue to the Chamber, as well as other Members who contributed to the debate. I welcome the opportunity to respond and, indeed, to clarify some of the issues that have been raised this afternoon. I will, of course, try to address all of the points that Members have raised, but I assure you, Mr Deputy Speaker, that I will study the Hansard report and if I have left any questions unanswered, I will write directly to the Members concerned.

There are a total of 202 flats in Annadale, 145 of which are still owned by the Housing Executive, so around three quarters of them are Housing Executive properties and one quarter are owned by others. The flats are in three-storey blocks, apart from one small block of four, which is a two-storey block. All ground floor flats are two-bedroom. The upper floors are a mixture of two-bedroom and three-bedroom flats. They were, as has been said, built in 1953 and, despite what some may have you think, are in a good state of repair, as evidenced by the fact that all of them are occupied. Indeed, there is a substantial waiting list of people who want to live there.

In 2007, all the flats received new PVC window frames when double glazing was installed. More recently, a kitchen replacement scheme was undertaken, with complete kitchen replacement works delivered, including mechanical extraction fans. Previous works included the installation of hardwired smoke and heat detectors and the replacement of solid fuel heating with natural gas. Therefore, as I said, these flats are in good repair and have undergone significant work in recent years.

However, it is not just about what has been done in the past to update the flats. Later this year, each flat will benefit from the provision of new fire doors to enhance the blocks' fire safety and offer greater protection to tenants. A reroofing scheme to replace the existing flat-roof covering will also start later this year. This follows on from work that was undertaken on two of the smaller blocks a few years ago, when the entire roof structures were replaced. Although the reroofing of the remainder of the blocks on that scale is not needed, it will, nevertheless, improve the thermal comfort of the blocks and help residents to keep their heating costs to a minimum, which is something of a priority for us. I am pleased to outline all of that by way of demonstrating our support for residents in these flats. Clearly, residents are happy with what we have been doing, as they are literally queuing up to get into these much-sought-after flats.

Let me now address the issues that some Members raised about the resources that are

available to maintain existing homes. From my first day in office, I made it clear that I would put as much emphasis and support into maintaining existing homes as I would into building new ones. We must not just build more homes; we must improve and protect the ones that we already have.

Whilst we all know that the last Budget from Westminster reduced the capital funding that we relied on to deliver some of our more significant housing improvement schemes, that is not to say that we have sat back and simply done nothing for tenants whose homes need improving. This year, I made £171 million in revenue funding available to the Housing Executive to maintain and improve its stock. That represents an increase of nearly £30 million from the year before I took up office. That increased funding is being used to improve more homes than before, with increased levels of kitchen, heating and other improvement schemes started last year alone. The work to reroof the Annadale flats will be funded from this increased revenue funding.

For homes that require more extensive work — usually referred to as multi-element improvement works — I have already asked the Housing Executive to bring forward a programme that could see such homes improved. So, even though, as I said earlier, our capital budget has been reduced for bigger housing improvement schemes, I am still determined to find a way to fund those much-needed improvements. I will be happy to come back to the Chamber at a later date to advise Members further on that.

I will pick up on a couple of points that Members made. Michael McGimpsey referred to water dripping into flats. I can only say that the Housing Executive has not made me aware of that, but I will contact it to ascertain the extent of the problem. If any temporary repairs are necessary until the roof is replaced later this year, we will ensure that they are undertaken urgently.

Anna Lo referred to "patching up" roofs. Any work, other than something of a temporary nature such as I have just referred to, and certainly the work to be undertaken in the latter part of this year, will be anything other than "patching up". We intend to do a proper job on them. It is certainly not something that you would dismiss just as "patching up". A proper job will be done to make the roofs watertight.

Alasdair McDonnell said that the flat roofs should have been sorted out long ago, and the money should have been found for it. The issue has been around for some time — I think from 1953. My predecessors were in a somewhat better position than I am as regards funding, although we have been able to redirect money towards improvement schemes. It was not possible to take the work forward in the past and, although we now face financial constraints, I indicated that we will undertake work, and the reroofing scheme is programmed to begin in October of this year. It will be a revenue scheme, which will replace the existing flat roof covering with a high-performance felt covering. A high-quality job will be undertaken and the work will be lasting. I can understand the appeal of installing a pitched roof. However, we face a situation in which many other Housing Executive blocks of accommodation across the province have flat roofs. The important thing is not whether a roof is flat or pitched, but whether it is of good quality and watertight and will last. Those are the key issues, and I am assured that the work that will be undertaken later this year will be of good quality and watertight and will last. That is why I referred to the installation of a high-performance felt covering.

I hope that Members will appreciate that, in what I have said, I have demonstrated my commitment to the Annadale flats. I also hope that they will accept that the work that is proposed to be undertaken later this year will ensure that the flats are totally watertight, warmer and better for the residents, and that it will be a lasting job.

I thank all those Members who took part in the debate. I hope that it has been useful in underlining my commitment to improving the homes of the residents of the Annadale flats and all residents across the Housing Executive estate, whether that is through the installation of double glazing or new heating systems, the replacement of kitchens or the carrying out of other necessary improvements.

Adjourned at 4.12 pm.

Written Ministerial Statement

The content of this written ministerial statement is as received at the time from the Minister. It has not been subject to the official reporting (Hansard) process.

Regional Development

A8 Belfast to Larne Dualling: Publication of Notice of Intention to Proceed and Making of Statutory Orders

Published at 12:00 noon on Tuesday 1 May 2012

Mr Kennedy (The Minister for Regional Development): On 14 February 2012, I announced a programme of improvements to our strategic road network over the next four years. The A8 Belfast to Larne Dualling Scheme is one of the projects I identified to take forward, subject to the outcome of public inquiries. Public Inquiries have been held and the Inspector submitted his report in September 2011.

The Inspector recommended that the proposed dual carriageway should be constructed in accordance with the preferred route which is largely online widening, with an eastern bypass of Bruslee and a western bypass of Ballynure.

The Inspector made over 130 recommendations, which include, keeping Church Road open, the removal of the Rushvale Road – Calhame Road link and the provision of agricultural crossing facilities. The remaining recommendations made by the Inspector are relatively minor and typically relate to accommodation works, provision of additional information, or recommendations for the detailed design or construction phase.

Having discussed the Inspector's report with my Department's officials and having given the matter due consideration, I concur with the main recommendations made by the Inspector.

Construction of the scheme, which will provide 14.4 km of new dual carriageway from Coleman's Corner to Ballyrickard Road is expected to commence in June this year. The scheme helps reduce journey times, improves road safety along the A8, and helps the development of the Port of Larne, which is the second largest Port in Northern Ireland.

The scheme should also lead to an increase in demand for local suppliers of construction material as well as give a boost to commercial trade in the surrounding area.

I have asked my Department to publish Notice of its intention to proceed with the scheme and to make the necessary statutory orders.

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