HUMAN RIGHTS INQUIRY

Emergency Health Care

NORTHERN IRELAND HUMAN RIGHTS COMMISSION

Foreword

This is the first national human right inquiry into health care in emergency departments undertaken anywhere in the world. The Inquiry builds on an international model of human rights inquiries to ensure the process was rigorous. The choice of an Inquiry into health care in emergency departments reflected the focus on the issue both politically and publicly. With around 700,000 visits to emergency departments in hospitals in Northern Ireland it is an issue which touches almost everyone's life here.

The Inquiry has been wide-ranging taking evidence from ministers, the Department, the Health and Social Care Board, health and social care trust managers, clinicians and trade unions, key voluntary organisations dealing with complaints and providing advice alongside patients and families who are at the receiving end of the service. We wanted to hear good stories as well as bad and what was working well alongside what needed to improve. The Commission was conscious that emergency care departments are a vital part of a much wider health care system. To that end, we know that the emergency department relies significantly on other parts of the health service including out of hours GP services, minor injury units, and availability of community care services and beds elsewhere within hospitals. Moreover, the setting of policy from within the Department and how services are commissioned and funded both through regional and local mechanisms has a significant influence on how emergency departments work in practice. The Inquiry also examined spending patterns on emergency care and transition monies for the Transforming Your Care initiative to help us understand how money is allocated and spent. The references to documents and other materials in the report cover the period up to completion of the Inquiry but, it is recognised that additional material has been produced since the completion of the report.

The Inquiry seeks to use international human rights standards including the right to health as a lens through which to view emergency department health care. In turn, this incorporates human rights concepts including the right to respect for dignity, responsiveness to need particularly among the most vulnerable, participation and the involvement of people receiving care and treatment in planning and delivery of services.

The Inquiry found examples of human rights violations though we did not receive evidence to suggest such violations were systemic. The Inquiry also wanted to look forward and the report outlines how a human rights based approach to emergency care could assist health and social care trusts in delivering emergency care services. The conclusions and recommendations aim to support and assist those who set policy, commission services and deliver the care, carry their work forward.

The Inquiry relied on the evidence given to us in writing and in person at the eleven public hearings. We are immensely indebted to everyone who participated in the Inquiry. The evidence at the public hearings can be viewed on the Commission's website at www.nihrc.org.

Finally, I would particularly like to thank my colleagues on the panel Marion Reynolds and Paul Hunt, fellow Commissioners and Commission staff for so ably organising and steering the Inquiry to fruition.

Les Allamby
Chief Commissioner

Contents

Introduction

"[T]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…without distinction of race, religion, political belief, economic or social condition."[1] This right is guaranteed in a number of international human rights instruments. The Universal Declaration of Human Rights (UDHR), Article 25 (1) states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family, including…medical care..." and the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12 guarantees the right of everyone to the enjoyment of the highest, attainable standard of physical and mental health.

On 3 June 2014 the Northern Ireland Human Rights Commission (NIHRC) launched a Human Rights Inquiry into Emergency Health Care (the Inquiry). The Inquiry aimed to investigate, and make recommendations on the extent to which the Northern Ireland Executive and other public authorities respect, protect and fulfil the human rights of those seeking emergency care.

More specifically, the Inquiry examined the quality of care, with a particular focus on the right to respect for dignity; responsiveness to need, including the most vulnerable and marginalised members of society; and, the provision of and support for appropriately skilled staff. The Inquiry also considered the provision of appropriate information and the participation of patients and their families.[2]

What is a human rights inquiry?

An Inquiry is one of the most effective strategies available to National Human Rights Institutions (NHRIs) for investigating and drawing attention to pressing human rights issues. It "introduces, exposes and explains a complex situation to the broad community, offering an analysis based in human rights law and providing recommendations for systemic responses".[3]

Internationally, human rights inquiries are endorsed by the United Nations as a method of investigation by NHRIs. The method has been developed over the past twenty years largely in the Asia Pacific region. Human rights inquiries involve evidence gathering; investigation (much of which is carried out in a public forum); analyses of the evidence; and reporting which includes recommendations for action. An Inquiry also has an educative role raising public awareness of the subject matter and the human rights engaged.

In accordance with the Northern Ireland Act 1998, Section 69, the NIHRC "shall keep under review the adequacy and effectiveness in Northern Ireland of law and practice relating to the protection of human rights".[4] For the purpose of exercising this function the NIHRC may conduct such investigations as it considers necessary or expedient.[5]

Why investigate emergency health care?

With over 700,000 total attendances at emergency departments (EDs) each year, almost everyone in Northern Ireland (NI) will have visited or known someone who has needed to use accident and emergency services.[6]

Considerable attention has focused on the failure to meet Ministerial waiting time targets in EDs. The target is that 95 per cent of patients should either be treated and discharged home or admitted to hospital within four hours of arrival in the ED and no

1 Constitution of the World Health Organisation (1946) as amended, available at, <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1> (accessed 14 April 2015).
2 See, NIHRC, Human Rights Inquiry, Terms of Reference at Appendix 1.
3 Asia Pacific Forum of National Human Rights Institutions and the Raoul Wallenberg Institute of Human Rights and Humanitarian Law, *Manual on Conducting a National Inquiry into Systemic Patterns of Human Rights Violation*, (2012), p 5.
4 Northern Ireland Act 1998, Section 69(1).
5 Ibid., Section 69(8).
6 DHSSPS, Emergency Care Waiting Statistics show that attendances have decreased by 0.1 per cent from 727,935 to 727,466 in the five years between 2009/10 and 2013/14. See, DHSSPS/NISRA, 'Northern Ireland Hospital Statistics: Emergency Care' (26 June 2014) key points, available at, http://www.dhsspsni.gov.uk/nihs-emergency-care-2013-2014.pdf.

patient should wait more than 12 hours for a similar outcome.[7]

The targets are regularly breached in NI. In 2013/2014 only 78.1 per cent of new and unplanned review patients were treated and discharged or admitted within four hours, while over 99.5 per cent of the same waited less than 12 hours for treatment.[8] In practice, therefore 3,109 new and unplanned review patients waited more than 12 hours for treatment in 2013/14.[9]

In January 2014, a major incident was declared at the Royal Victoria Hospital due to the large number of patients within the ED. This had followed a period of sustained pressure on the service. Such pressures are not confined to services in Belfast. In January 2015, all five Health and Social Care (HSC) trusts that provide ED services in NI cancelled non-urgent elective surgery in order to tackle demands on emergency hospital care services.[10] The difficulties facing ED services are also not confined to NI. While it is not possible to make direct comparisons it is clear that England, Scotland and Wales have all faced similar difficulties.[11]

In January 2015, it was reported that the figures for waiting times in England had deteriorated to their lowest level for a decade.[12]

Emergency health care has featured in a number of reports over the past few years.[13]

Three of the most significant reviews have been Transforming Your Care – a review of health and social care in Northern Ireland (TYC) published in December 2011,[14] the Regulation and Quality Improvement Authority (RQIA) inspection report on Unscheduled Care in the Belfast Health and Social Care Trust (BHSCT) in April 2014,[15] and the subsequent follow up work[16] and the "Donaldson review" completed in December 2014 examining the application of governance arrangements for ensuring the quality of health and social care provision.[17]

TYC was commissioned in June 2011 by the then Minister for Health, Social Services and Public Safety to provide a strategic assessment across health and social care, examine the quality and accessibility of services and how the services meet the needs of users, carers and the wider community.[18] The TYC review also considered acute care, minor injury units, and GP out of hours services as well as EDs. At the time, the review recorded the findings of a survey where 91 per cent of those surveyed felt that improvement was needed to time spent waiting in accident and

7 The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014, Schedule, Target 7. These targets remained unchanged in the commissioning plan for 2015/16. See, The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2015, Schedule, Target 12.

8 DHSSPS/NISRA, 'Northern Ireland Hospital Statistics: Emergency Care' (26 June 2014) Table 7, available at, http://www.dhsspsni.gov.uk/nihs-emergency-care-2013-2014.pdf. N.B. Only new and unplanned review attendances are included in the measurement of waiting times at emergency care departments. In the year 2013/2014, there were 694, 618 new and unplanned review attendances in NI's EDs.

9 Ibid., Table 10.

10 See, BBC News, 'Northern Ireland health trusts cancel non-emergency operations' (7 January 2015), available at, http://www.bbc.co.uk/news/uk-northern-ireland-30702853 (accessed 15 April 2015).

11 The National Audit Office (NAO) has reported the difficulties with utilising comparable data. See, NAO, *Healthcare across the UK: a comparison of the NHS in England, Scotland, Wales and Northern Ireland* (June 2012).

12 See, BBC News, 'A&E waiting in England worst for a decade' (6 January 2015), available at, < http://www.bbc.co.uk/news/health-30679949> (accessed 15 April 2015).

13 These include: Appleby, J Independent Review of Health and Social Care Services in Northern Ireland (2005); College of Emergency Medicine Reconfiguration of Emergency Care System Services London (2012); College of Emergency Medicine The Drive for Quality- How to Achieve Safe, Sustainable Care in our Emergency Departments (2013); Patient and Client Council Care When I Need It – A report of Urgent Care Services (2013) and Northern Ireland Audit Office; Transforming Emergency Care in Northern Ireland (2008).

14 *Transforming Your Care: A review of health and social care in Northern Ireland* (December 2011), available at, <http://www.transformingyourcare.hscni.net/about/> (accessed 14 April 2015).

15 RQIA, *Final Report of the Inspection of Unscheduled Care in the Belfast Health and Social Care Trust: 31 January to 3 February 2014* (April 2014), available at, <http://www.rqia.org.uk/cms_resources/RVH%20Inspection%20Report%20for%20Publication%20on%20Website_ISBN.pdf> (accessed 14 April 2015).

16 RQIA, *Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust: 12 to 14 May 2014* (accessed 14 April 2015), available at, <http://www.rqia.org.uk/cms_resources/Follow%20up%20Inspection%20Report%20of%20Unscheduled%20Care%20in%20BHSCT_12-14%20May%202014_ISBN.pdf> (accessed 14 April 2015).

17 *The Right Time, The Right Place: an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland* – Sir Liam Donaldson, Dr Paul Rutter and Dr Michael Henderson, (December 2014), available at, <http://www.dhsspsni.gov.uk/donaldsonreport270115.pdf> (accessed 14 April 2015).

18 TYC was conducted by an independent review panel led by the then Chief Executive of the Health and Social Care Board.

emergency including 56 per cent who said a lot of improvement was needed.[19]

The overall conclusion of the TYC review was that a changing model of care was needed, with care being moved as close to home as possible. This entailed for example, introducing services for older people to encourage independence and avoid unnecessary admissions into hospital, provide more community based respite care and other care services, and a greater role for nursing home care.[20] On acute care, re-configuration of the acute hospital network while ensuring urgent care provision is locally available was prescribed alongside proposals to reduce hospital admissions for long-term conditions and end of life care.[21]

The TYC review recognised the changes proposed were fundamental and recommended that transitional funding of £25 million be provided during the first two years of implementation and £20 million in the third year. The review envisaged that after 2014/2015 the new model would be self-financing.[22] The levels of funding envisaged by TYC were not however secured.[23]

The TYC review emphasised the need for a whole systems review. In effect, those running and delivering emergency care services cannot control the numbers coming in and leaving EDs as they rely on the effective use and availability of hospital beds in specialist and generalist wards. The Inquiry focused on ED services, but also recognised the wider context in which these services are delivered.

Following the major incident declared in January 2014 at the Royal Victoria Hospital, the Department of Health, Social Services and Public Safety (DHSSPS) asked the RQIA to conduct an inspection of the ED and Acute Medical Unit at the hospital and facilitate a separate external review of emergency services across Northern Ireland.[24] The RQIA regional review published in July 2014 concluded that there was evidence that actions were being taken leading to improvements in staffing in key areas and improved local systems in the BHSCT but that this was still a work in progress.[25] A number of further recommendations were made. More widely, the RQIA also recommended that a regional task force be established to take forward specific regional projects to improve unscheduled care.[26]

A further follow-up inspection report of the Royal Victoria Hospital ED and Acute Medical Unit by the RQIA was published in November 2014. The report noted again the improvement in staffing levels, but also that the hospital was experiencing challenges in ensuring a smooth flow of patients across the hospital.[27] A number of earlier recommendations had been met in principle.

The report found that one of its recommendations, namely, that staff should be supported to ensure appropriate care and privacy is given and that patients are treated with dignity and respect had not been addressed in the ED.[28] In contrast, the recommendation had been met in principle by the Acute Medical Unit.[29] Issues related to dignity in death and overcrowding had remained unchanged[30] and a recommendation that a system to identify

19 *Transforming Your Care: A review of health and social care in Northern Ireland* (2011), p 99.
20 Ibid., p 135.
21 Ibid., p 140.
22 Ibid., for the full list of proposals see pp 135-141.
23 The HSCB informed the NIHRC that the total actual TYC expenditure was as follows: 2012/13 - £8.83 million; and, 2013/14 - £6.14 million. For 2014/15, the HSCB was allocated £8 million by the NI Executive for TYC but anticipated the actual spend to be 10.82 million with the extra funds coming from HSCB resources (correspondence dated 21 January 2015).

24 NI Executive, Press Release 'Health Minister Edwin Poots today updated the Assembly on the measures he has taken to reassure the public that they can have confidence in the service provided by hospital emergency departments (ED)' (10 February 2014).
25 RQIA, *An Independent Review of Arrangements for Management and Coordination* of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations (July 2014) p 79, available at, <http://www.rqia.org.uk/cms_resources/UnscheduledCare_Report_ISBN.pdf> (accessed 7 May 2015).
26 Ibid., p 95.
27 RQIA, *Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust: 12 to 14 May 2014* (accessed 14 April 2015), available at, <http://www.rqia.org.uk/cms_resources/Follow%20up%20Inspection%20Report%20of%20Unscheduled%20Care%20in%20BHSCT_12-14%20May%202014_ISBN.pdf> (accessed 14 April 2015), Executive Summary.
28 Ibid., p 86.
29 Ibid., p 100.
30 Ibid., p 31.

which patients require a meal and assistance with eating had also not been met by the ED.[31]

The Donaldson review led by Sir Liam Donaldson a former Chief Medical Officer for England examined the governance arrangements for ensuring that quality health and social care is delivered.[32] The review stated that the NI health and social care system does not have fundamental safety problems and is not less safe than other parts of the United Kingdom or elsewhere in the world.[33] The review did, however, conclude that there were longstanding structural elements adversely affecting quality and safety. In particular, the review highlighted that the design of the system of governance needs more careful thought in areas including the role of commissioning, how provision is structured, the relationship between primary, secondary and social care, the distribution of facilities geographically, the flows of funding, the place of regulation, the monitoring of performance and the use of incentives.[34]

Ten recommendations were made in the review including: the re-designing of the commissioning system; that a new costed, timetabled implementation plan for TYC should be introduced quickly; that the regulatory function is more fully developed within health care with routine inspections, some unannounced; the retention of serious adverse incident and adverse incident reporting subject to some modifications; and, measures to strengthen the patient voice.[35] A specific additional recommendation is that an impartial international panel of experts should be convened to recommend the configuration of health and social care to ensure world class standards of care.[36] At the time of writing, the Donaldson review recommendations were the subject of a consultation exercise launched by the Department.

If implemented, the proposals contained in all of the reviews completed to date will undoubtedly impact on how emergency health care is provided in NI. In any change process an examination of the potential impacts on human rights, and in particular, the right to the enjoyment of the highest attainable standard of health is required.

Having completed a scoping exercise in March 2014, taking into account public concern, as well as the ongoing reviews of the health and social care system, the NIHRC concluded that a human rights examination of emergency healthcare was necessary. Although it was evident that the conditions within EDs affected patients' rights to dignity,the impacts on the human right to health were not yet established. Determining the extent to which the NI Executive and other relevant public authorities respect, protect and fulfil the right to health was therefore a principal consideration in the NIHRC decision to launch an Inquiry.

Human rights framework

The principal sources of human rights laws are international treaties. Treaties are written agreements to which the participating States are legally bound. Typically, the implementation of a human rights treaty is overseen by a Committee. The ICESCR, for example, is monitored by the UN Committee on Economic, Social and Cultural Rights (CESCR). The two primary methods by which Committees monitor compliance are the State reporting procedure and the individual complaints procedure. First, the State must submit a periodic report describing its action to implement the treaty provisions. Upon review of this report and after a dialogue with the State, the Committees issue concluding observations that contain both concrete recommendations and a note of general areas of concern or approval. Second, where accepted by the State, a Committee may receive complaints directly from individuals who allege a breach by

31 Ibid., p 87.
32 *The Right Time, The Right Place: an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland* – Sir Liam Donaldson, Dr Paul Rutter and Dr Michael Henderson, (December 2014), available at, <http://www.dhsspsni.gov.uk/donaldsonreport270115.pdf> (accessed 14 April 2015).
33 Ibid., paras 5.1.1 and 5.1.2.
34 Ibid., paras 5.2.1 and 5.2.2.
35 Ibid., p 44- 49 (chapter 6 contains the full set of recommendations).
36 Ibid., p 44.

the State of a treaty obligation. In this way, the Committees issue jurisprudence determining the appropriate application of treaty obligations to the factual scenarios raised.

The concluding observations and the jurisprudence serve as an authoritative statement on how each Committee believes their treaty should be interpreted. In addition to engaging directly with the State, the Committees also formulate and publish general statements concerning the application of treaty provisions. These statements are called 'general comments' or 'general recommendations'. In addition to the treaties and their respective Committees, the Human Rights Council of the United Nations can appoint special rapporteurs who are independent experts appointed to examine particular human rights or themes. There is a Special Rapporteur on the right to highest attainable standard of physical and mental health.

Within Europe, both the Council of Europe (CoE) and the European Union (EU) have addressed the issue of health. The most relevant European treaties are the European Convention on Human Rights (ECHR) and the Charter of Fundamental Rights of the European Union. Unless otherwise determined by the treaty itself, the official monitoring body for the CoE instruments is the Committee of Ministers (constituting representation from each member State). Under the ECHR, the European Court of Human Rights (ECtHR) was also established to consider inter-State complaints and complaints made by individuals against a State Party.[37] Individuals must exhaust any "effective" domestic legal remedies for a violation on one of these rights before taking a case to the ECtHR.[38]

Through the Human Rights Act 1998 (HRA), a majority of the rights and freedoms contained in the ECHR have been given domestic effect. This is the only human rights instrument incorporated directly into UK law. When interpreting the scope and application of ECHR rights, UK Courts must, by virtue of Section 2 of the HRA, take into account judgments and decisions of the ECtHR.

In addition to the international treaties there exist a number of instruments that are collectively referred to as 'soft law'. These documents are not legally binding but they are of strong persuasive value, especially when issued by the treaty monitoring bodies. They assist with interpreting the treaty obligations, and they often serve as precursors to more binding legal obligations.

The human rights treaties and soft law standards that speak most directly to the topic of emergency health care are listed in the table overleaf.

The right to health

The right to the highest attainable standard of health is to be realised progressively over time and the State must use the maximum available resources to fulfil the right.[39]

The CESCR has made clear that the concept of progressive realisation "should not be misinterpreted as depriving the obligation of all meaningful content" but imposes an obligation on States to "move as expeditiously and effectively as possible towards that goal".[40] Any deliberately retrogressive measures taken by the State and concerning the enjoyment of the right to health must be justified by reference to the totality of rights provided for in the ICESCR and in the context of the maximum available resources.[41]

Progressive realisation towards the full enjoyment of the right to health also exists alongside a number of minimum core obligations.[42] These latter obligations refer to minimum essential levels of the

37 ECHR, Article 35.

38 In the case of *Burden v UK,* the ECtHR stated that a remedy which is dependent upon the discretion of the Executive is not an effective remedy. Therefore at present, if the only possible remedy to be obtained by the domestic courts is a declaration of incompatibility under the Human Rights Act 1998 then an applicant could bring their case directly before the ECtHR. See *Burden v UK,* ECtHR, Application No. 13378/05 (29 April 2008).

39 ICESCR, Article 2(1). See also, UN Doc. E/CN.4/2000/4, CESCR, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 12; and CESCR, General Comment 3: The nature of States parties' obligations (art. 2, para 1, of the Covenant) (1990).

40 CESCR, General Comment 3, para 9.

41 Ibid.

42 Ibid., para 10.

Table 1: International, regional and non-binding instruments with relevance to emergency health care

International	
	United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) [UK ratification 1976]
	UN International Covenant on Civil and Political Rights (ICCPR) [UK ratification 1976]
	UN International Convention on the Elimination of All Forms of Racial Discrimination (CERD) [UK ratification 1969]
	UN Convention on the Elimination of Discrimination Against Women (CEDAW) [UK ratification 1986]
	UN Convention on the Rights of the Child (CRC) [UK ratification 1991]
	UN Convention on the Rights of Persons with Disabilities (UNCRPD) [UK ratification 2009]
Regional	
	Council of Europe (CoE), European Convention on Human Rights (ECHR) [UK ratification 1951]
	Charter of Fundamental Rights of the European Union [UK ratification 2000]
	EU Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin
Non-binding International instruments	
	Universal Declaration on Human Rights (UDHR), 1948
	Vienna Declaration and Programme of Action, 1993
	Vienna International Plan of Action on Ageing, 1983
	UN Declaration on the right to development, 1986
	UN Principles for Older Persons, 1991
	UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, 1991
	UN Human Rights Council Resolution 19/20 'the role of good governance in the promotion and protection of human rights', 2012
	CoE, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine)
	WHO Declaration of Alma-Ata, 1978
Non-binding Regional instruments	
	CoE, Committee of Ministers Recommendation No. R (80) 4 concerning the patient as an active participant in his own treatment, 1980
	CoE, Committee of Ministers Recommendation R (97) 17 on the development and implementation of quality improvement systems (QIS) in health care, 1997
	CoE, Committee of Ministers Recommendation R (99) 21 on the criteria for the management of waiting lists and waiting times in health care, 1999
	CoE, Committee of Ministers Recommendation R (2000) 5 on the development of structures for citizen and patient participation in the decision-making process affecting health care, 2000
	CoE, Committee of Ministers Recommendation Rec (2001) 12 on the adaptation of health care services to the demand for health care and health care services of people in marginal situations, 2001
	CoE, Committee of Ministers Recommendation (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder, 2004
	CoE, Committee of Ministers Recommendation Rec (2006) 7 on management of patient safety and prevention of adverse events in health care, 2006
	CoE, Committee of Ministers Recommendation Rec (2006) 10 on better access to health care for Roma and Travellers in Europe, 2006
	CoE, Committee of Ministers Recommendation CM/Rec (2011) 13 on mobility, migration and access to health care, 2011
	CoE, Committee of Ministers Recommendation CM/Rec (2012) 8 on the implementation of good governance principles in health systems, 2012
	CoE, Parliamentary Assembly Recommendation 1418 (1999) 'Protection of the human rights and dignity of the terminally ill and the dying'
	ECRI, General Policy Recommendation 13: on combating anti-gypsyism and discrimination against Roma, 2011
	WHO, Declaration on the Promotion of Patients' Rights in Europe, 1994

right to health that must be ensured and include for example, the adoption and implementation of a national public health strategy and plan of action, devised on the basis of a participatory and transparent process; appropriate training for health personnel, including education on health and human rights; and monitoring of the extent to which the right is realised.[43]

A further minimum core obligation is the duty to ensure that health facilities, goods and services are accessible on a non-discriminatory basis, especially for vulnerable or marginalised groups.[44] The obligation on States to guarantee the enjoyment of the ICESCR rights without discrimination is also commonly referred to as an immediate obligation and is explicitly outlined in Article 2(2) of the Covenant.

The CESCR has stated that "even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes."[45] The Council of Europe Commissioner for Human Rights has also outlined that,

> [e]conomic policy is not exempt from the duty of member states to implement human rights norms and procedural principles. As embodied in international human rights law, civil, political, economic, social and cultural rights are not expendable in times of economic hardship but are essential to a sustained and inclusive recovery.[46]

In practice, the right to the highest attainable standard of health is not an absolute right to be healthy. Instead, it is "an inclusive right extending not only to timely and appropriate health care but, also to the underlying determinants of health" such as adequate food and water.[47]

The CESCR has stated that health facilities, goods and services should be available, accessible, adequate and of good quality. For emergency care this means sufficient quantity of properly trained skilled medical and other staff with care being accessible to all without discrimination, sensitive to cultural, life cycle and gender requirements.[48]

The CESCR has also recognised the importance of people's involvement and participation in their own health-related decision-making and also wider planning of policies and services. This includes those groups who face barriers to effectively engage in consultation processes.[49] The report examines many of the human rights laws and standards relevant to the provision of ED care in the following substantive chapters dealing with quality, accessibility and governance.

The health system in Northern Ireland

The current framework for providing emergency care services

Health Services are provided in accordance with the Health and Personal Social Services (NI) Order 1972 (the Order) and the Health and Social Care (Reform) Act (NI) 2009 (the Act). Article 4 of the Order requires the DHSSPS to "provide or secure provision of integrated health services in NI designed to promote the physical and mental health of the people of NI through the prevention, diagnosis and treatment of illness". This is reinforced by Section 2 of the Act.

Section 3 of the Act requires the DHSSPS to develop policies to secure the improvement of health and social well-being and to reduce health inequalities between people in NI. The DHSSPS must also determine priorities and objectives for health and social care services. These may be revised from time to time and financial resources allocated, taking into account the need to ensure efficiency and effectiveness and set standards for

43 Ibid., paras 10 and 11, and CESCR, General Comment 14, para 43. Other minimum core obligations include the equitable distribution of health facilities, goods and services.
44 Ibid., General Comment 14.
45 CESCR, General Comment 14, para 18. See also, CESCR, General Comment 3, para 12.
46 Council of Europe Commissioner for Human Rights – Safeguarding human rights in times of economic crisis – an issues paper (2012).
47 CESCR, General Comment 14, para 11.
48 CESCR, General Comment 14, para 12.
49 Ibid., paras 11, 23, 34 and 54.

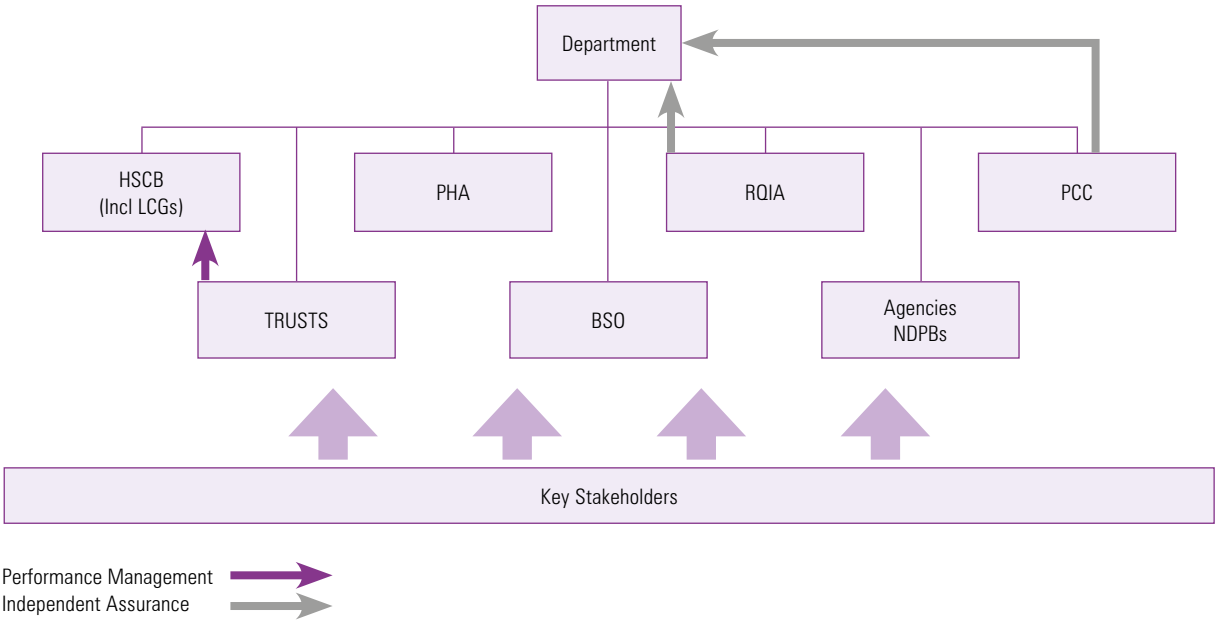
Table 2: Health and Social Care bodies covered in Section 1 (5) of the Health and Social Care (Reform) Act (NI) 2009

Body	Role
Health and Social Care Board	Responsible for commissioning services, management of resources performance and system improvement.
Public Health Agency	Improving health well-being and health protection.
Health and Social Care Trusts	Responsible for service delivery. There are six trusts namely, Belfast, Northern, Southern, South Eastern, Western and the Northern Ireland Ambulance Service health and social care trusts.
Patient Client Council	Provides an independent voice for service users including assisting individuals with complaints.
Business Service Organisation	Provides a range of support services including legal, financial and human resources support.
Regulation and Quality Improvement Authority	Provides independent regulation and inspection for health and social care services.
Special Agencies	Provides specific services for example, the NI Social Care Council to regulate social care staff, the NI Medical and Dental Training Agency and NI Practice and Education Council for Nursing and Midwifery.

the provision of health and social care. The Act also sets out the roles and functions of a number of key agencies within the health and social care system as set out below:

The Act sets out the current structure in which the Health and Social Care Board (HSCB) commissions services while local health and social care trusts and the Ambulance Service delivers the services. Meanwhile, the Act also requires the DHSSPS to

Table 3: The structure of the health and social care system[50]:



50 DHSSPS, *Framework Document* (September 2011), Section 2.1

monitor and hold to account the HSCB and the HSC trusts among others. The structures, roles and responsibilities are set out in a legislatively required Framework Document which was published by the DHSSPS in September 2011. Within this framework the details of health care provision is contained within legal regulations, policy documents and circulars and guidance issued by the DHSSPS. [51]

While the terms of the Inquiry was to examine the rights of those seeking emergency health care, the NIHRC is mindful that EDs do not operate independently from the complex relationships, structures and pressures within the wider health, social and community care system and, at a local level, within the remainder of hospital services to which they are attached. EDs function as part of the health and social care (HSC) trusts in the above structure.

The DHSSPS sets the strategic context for the commissioning of health and social care services through a Commissioning Direction to the HSCB. It may also direct the HSCB as to the performance indicators it should employ in improving the performance of the Trusts. The HSCB is required to produce an annual commissioning plan in response to the Commissioning Direction and is responsible for securing approval for, and implementing, the plan together with any service and budget agreements. The plan is produced following work with local commissioning groups which operate in each trust area.

Health and social care trusts must provide services in response to the commissioning plan, and must meet the standards and targets set by the DHSSPS. The HSCB is responsible for managing and monitoring the achievement by trusts of agreed objectives and targets, including financially to break-even. The HSCB also supports trusts in the discharge of their statutory functions.

There are six HSC trusts in NI. They are:

- Belfast Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service Trust

The first five provide ED services while the Northern Ireland Ambulance Service provides a pre-hospital emergency response to patients, including transporting patients to EDs.

Service standards

Service standards and guidelines help health professionals make best decisions about treatment or care for patients alongside providing other support and provision. A range of bodies set service standards and indicators for health care. For example, the DHSSPS document 'The Quality Standards for Health and Social Care'[52] sets out the quality standards that people can expect from health and personal social services and its 2011 document 'Quality 2020: A 10 year strategy to protect and improve quality in health and social care in Northern Ireland' sets out a ten year direction plan to deliver results for quality in health and social care. Furthermore, the DHSSPS 'Improving the Patient and Clients Experience' document sets out standards that patients can expect in receiving care and services. These include that,

[p]atients and clients have a right to experience respectful and professional care, in a considerate

51 For example see *Quality 2020: A ten year strategy to protect and improve quality in health and social care in Northern Ireland* (2011)

52 http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

and supportive environment, where their privacy is protected and dignity maintained'.[53]

In addition, the National Institute for Health and Care Excellence (NICE) is tasked with providing guidance on current best practice in health and social care, including public health, to the NHS in England and Wales. NICE guidance is reviewed locally for its applicability to NI and, where applicable, is endorsed by the DHSSPS for implementation in HSC.

The DHSSPS is the sponsor department for the Guidelines and Audit Implementation Network (GAIN) which was established in 2007 and develops regional guidelines.

Professional bodies also provide guidelines. For example, the College of Emergency Medicine promotes education, research and monitors standards of emergency care and provides guidance on matters relating to emergency medicine and the Royal College of Nursing helps to shape policies on quality of patient care.

Accessing emergency health care

There are a number of ways in which people may access emergency health care, including:

- Self-referral to an ED (also known as Accident & Emergency or A&E).
- Referral by a GP to an ED.
- Referral by a GP out-of–hours service or a minor injury unit to an ED.
- A 999 call to the Northern Ireland Ambulance Service.[54]
- In NI, EDs are categorised into three types (see Table 4). When the Inquiry commenced, there were eleven Type 1 EDs in NI, and nine in either Type 2 or 3. During the course of the Inquiry, two Type 3 EDs closed.[55] This categorisation is:

Table 4: Provision of Emergency Departments by type as at April 2015

HSC Trust	Emergency Department		
	Type 1	Type 2	Type 3
Belfast	Mater Infirmorium Hospital Royal Victoria Hospital Royal Belfast Victoria Hospital (ENT & RAES) Royal Belfast Hospital for Sick Children		
Northern	Antrim Area Hospital Causeway Hospital		Mid Ulster Hospital
South Eastern	Ulster Hospital	Lagan Valley Hospital Downe Hospital	Ards Community Hospital Bangor Community Hospital
Southern	Craigavon Area Hospital Daisy Hill Hospital		South Tyrone Hospital
Western	Altnagelvin Area Hospital South West Acute Hospital		Tyrone County Hospital

53 'Improving the Patient & Client experience' is a statement produced for DHSSPS by NIPEC in partnership with RCN (2008). The Standards set cover respect, attitude, behaviour, communication, privacy and dignity. http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

54 See DHSSPS, *Audit of Accident and Emergency Activity, PricewaterhouseCoopers LLP*, (September 2007).

55 Armagh Minor Injuries Unit has been temporarily closed from 17 November 2014 and the Whiteabbey Minor Injuries Unit has been temporarily closed from 1 December 2014.

- **Type 1:** consultant-led; reception of emergency care patients, providing both emergency medicine and surgery on a 24 hour basis.
- **Type 2:** consultant-led; reception of emergency care patients; but does not provide both emergency medicine and surgical services and /or has limited opening hours.
- **Type 3:** a minor injury unit (MIU); reception of patients with a minor injury and / or illness; doctor or nurse led.

These services are also complemented by out-of-hours GP services, general care GP services alongside general and specialist hospital services and community based social care services.

How was the Inquiry conducted?

The Inquiry was launched on 3 June 2014. It was the first time anywhere in the world that emergency health care had been the subject of a human rights inquiry. Over 900 posters were distributed across NI to public and community spaces such as supermarkets, bus and train stations, town centre notice boards, libraries, leisure centres, community centres and EDs. Electronic posters and publicity material was distributed to over 600 contacts in the community and voluntary sector, education and training providers, trade unions, health centres and elected representatives. A leaflet distribution exercise was undertaken in ED car parks and extensive use was made of the regional and local print media with advertisements placed in both. Opportunities were also taken to promote the Inquiry on regional and local radio and representatives of the NIHRC took every opportunity to address community sectoral meetings.

A Freephone telephone number was established from 3 June 2014 to 31 July 2014 and arrangements were made to take evidence through a Freepost address and online. A discussion pack for community groups was developed to encourage group submissions through community facilitators. 185 submissions were made through the Freephone, written and online arrangements alongside six contributions from focus groups. The NIHRC is grateful for all of the submissions received which contributed greatly to the work of the Inquiry and enhanced the process.

The Inquiry undertook a review of literature, relevant human rights standards, case law, legislation and policy. It also analysed various statistical and qualitative material on emergency care; and information received from the DHSSPS, statutory bodies, agencies and community and professional groups. An analysis of recent expenditure on EDs was also commissioned in order to assess the trends in financing care in hospital EDs.

The NIHRC also undertook guided visits of observation to EDs to assist understanding of how departments operated and the challenges they face. These were selected randomly. The following guided visits of observation took place:

Tuesday 1 July 2014	Royal Victoria Hospital, Belfast
Friday 4 July 2014	Causeway Hospital, Coleraine
Monday 7 July 2014	Ulster Hospital, Dundonald
Saturday 19 July 2014	Altnagelvin Hospital, Derry/Londonderry
Wednesday 30 July 2014	Craigavon Area Hospital, Portadown
Monday 4 August 2014	Lagan Valley Hospital, Lisburn
Friday 8 August 2014	Bangor Minor Injuries Unit

All of the visits took place during the day except to Causeway and Altnagelvin hospitals which took place in the evening.

During the guided visits the NIHRC was taken through the "patient journey" from presenting at EDs through to discharge. The NIHRC had physical access to all areas of each of the EDs and also had the opportunity to speak with a number of nursing and medical staff.

A panel was set up to listen to evidence presented at public hearings. This was chaired by the Chief Commissioner Les Allamby alongside Marion Reynolds, a Human Rights Commissioner and former social services inspector and Professor Paul Hunt, a former UN Special Rapporteur on the Right

to Health and professor at the School of Law at the University of Essex and former professor of Waikato University in New Zealand.

Eleven public hearings were held from 4 September 2014 to December 2014. The opening and closing hearings and a further hearing were held in Belfast. The opening hearing commenced with evidence from the then Minister for Health, Social Services and Public Safety Edwin Poots MLA and the closing hearing with evidence from his successor Jim Wells MLA. Other public hearings were held in Armagh, Bangor, Ballymena, Coleraine, Downpatrick, Derry/Londonderry, Newry and Omagh. The Inquiry heard from 139 witnesses: 136 of these were in public and three individuals gave evidence in private as they did not want to discuss their personal experiences in a public hearing. A list of those who gave evidence is contained in Annex 2.[56] The public hearings were recorded and are available on the NIHRC's website www.nihrc.org. We are grateful for the evidence provided by all those individuals and organisations as it is their knowledge and experience which has enriched the report. The Inquiry also met Sir Liam Donaldson and his team who were commissioned by the DHSSPS to review governance and accountability arrangements during a period which overlapped with the Inquiry.

Those who wished to submit evidence confidentially were enabled to do so. This strengthened the willingness to engage in the call for evidence and in the Inquiry generally. Except for those witnesses who agreed to do so in open forum at public hearing, Inquiry participants have not been named in this report.

56 N.B. Six individuals gave evidence twice and one individual three times.

1 Quality

The right to the highest attainable standard of health[1] includes a duty to provide facilities, goods and services that are of good quality.[2] It also requires a respectful treatment of patients, family members and carers.[3] The manner in which people are treated in Emergency Departments (EDs) is fundamental to maintaining the right to human dignity and related aspects of the right to health, such as information and participation (including consent), and timeliness. Quality also refers to the conditions in which staff work. Human rights standards require, inter alia, the numbers of appropriately skilled health professionals to be commensurate with the health needs of the population.[4]

Human rights laws and standards framework

Dignity

Respect and protection of dignity is integral to human rights[5], including the right to health.[6] Numerous instruments identify dignity as their founding principle.[7] Within health care settings generally, a person-centred approach is needed to ensure human dignity. The WHO (World Health Organisation) has emphasised the importance of a health system and services "focused … on the person as a whole, whose body and mind are linked and who needs to be treated with dignity and respect".[8] This should be the case during all aspects of a patient's experience, including "diagnosis, treatment and care".[9]

The Charter of Fundamental Rights of the European Union (EU Charter), Article 1 states: "human dignity is inviolable. It must be respected and protected." as both a freestanding provision and a principle that underpins other human rights. The European Court of Justice (ECJ) has indicated the right to dignity is not to be used trivially.[10] According to the official explanations, which provide guidance and must be given "due regard" by the courts:[11]

> the dignity of the human person is part of the substance of the rights laid down [in the] Charter. It must therefore be respected, even where a right is restricted.[12]

Other human rights likely to be engaged by an infringement on dignity, particularly within emergency health care settings, include:

- the right to be free from inhuman and degrading treatment[13]; and,
- the right to privacy, including physical and psychological integrity.[14]

The European Court of Human Rights (ECtHR) has developed caselaw on how dignity manifests within these rights. Although the European Convention on Human Rights (ECHR) does not explicitly refer to it, the ECtHR has stated that "[t]he very essence of the Convention is respect for human dignity".[15]

The ECHR, Article 3 prohibition on inhuman or degrading treatment is absolute. It encompasses a negative obligation to "refrain from inflicting serious

1 ICESCR, Article 12.
2 UN Doc. E/C.12/2000/4, CESCR, General Comment No. 14: the right to the highest attainable standard of health (11 August 2000), para 12(d).
3 A/HRC/7/11, para. 54.
4 CESCR, General Comment No. 14, para 12(d). See, also, UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 80.
5 See for example: Universal Declaration on Human Rights (UDHR) preamble, Articles 1, 22 and 23; International Covenant on Civil and Political Rights (ICCPR) preamble; ICESCR preamble; Convention on the Rights of Persons with Disabilities (CRPD), Articles 1, 3 and 8; Convention on the Rights of the Child (CRC), Articles 23(1) and 39; Charter of Fundamental Rights of the European Union (EU Charter), Articles 1, 25 and 31.
6 CESCR, General Comment 14, para 3.
7 ICESCR and ICCPR, preambles: "Recognising that these rights derive from the inherent dignity of the human person"; and Vienna Declaration and Programme of Action: "Recognizing and affirming that all human rights derive from the dignity and worth inherent in the human person"; and Explanations relating to the Charter of Fundamental Rights, Explanation on Article 1: "The dignity of the human person …constitutes the real basis of fundamental rights".
8 WHO, People at the Centre of Health Care: Harmonizing mind and body, people and systems (2007), p. v. See also, UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 38.
9 WHO Declaration on the Promotion of the Patients' Rights in Europe (1994), para 5.8.
10 EU Network of Independent Experts of Fundamental Rights 'Commentary on the Charter of Fundamental Rights of the EU' (June 2006), p 29.
11 EU Charter, Article 52(7).
12 EU Charter, Official Explanations on Article 1.
13 ECHR, Article 3; ICCPR, Article 7; EU Charter, Article 4.
14 ECHR, Article 8; EU Charter, Article 3.
15 *Pretty v UK*, ECtHR, Application no. 2346/02 (29 April 2002), para 65.

harm on persons within their jurisdiction".[16] The ECtHR has however "reserved to itself sufficient flexibility" to consider the application of Article 3 in other situations[17] including those where:

> the physical well-being of individuals is dependent, to a decisive extent, on the actions by the authorities, who are legally required to take measures within the scope of their powers which might have been necessary to avoid the risk of damage to life or limb.[18]

The ECtHR has held that a "minimum level of severity" must be reached to engage Article 3. This will depend on a number of factors, such as the duration of the treatment, its physical or mental effects, and in some cases, the sex, age and state of health of the individual.[19] Importantly, the treatment can encompass that which:

> humiliates or debases an individual showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance.[20]

The ECtHR has indicated that it may well suffice that an individual is humiliated in his or her own eyes, even if not in the eyes of others.[21] Furthermore, it need not be the intention behind the treatment to debase or humiliate, although this will be a factor for consideration when determining a violation.[22]

The ECHR, Article 8 right to private life incorporates a duty to respect and protect an individual's "physical and psychological integrity".[23] This has been considered in the context of care planning, including a case involving continence support in which the ECtHR stated that human dignity was "engaged when someone who could control her bodily functions was obliged to behave as if she could not."[24] It has also been determined that the quality of one's life and an "undignified" death may fall within the scope of this right.[25]

Patients should be able to die with dignity.[26] The Committee on Economic, Social and Cultural Rights (CESCR) states that there must be 'attention and care for chronically and terminally ill persons, sparing them avoidable pain'.[27] The Council of Europe (CoE) Parliamentary Assembly has identified a number of factors that threaten patients' dignity. These include insufficient access to good pain management; a failure to take into account psychological, social and spiritual needs; and insufficient care and support for relatives and friends of terminally ill or dying patients.[28]

Information and participation (including consent)

Many human rights instruments guarantee patients access to information about their health.[29] The CESCR highlights the duty to "support people in making informed choices".[30] The CoE Committee of Ministers also encourage governments to structure policies and practices in such a way that the health workforce "come to perceive it as their

16 Ibid., para 50.
17 Ibid., para 50; *D v UK*, ECtHR, Application no. 30240/96 (2 May 1997), para 49.
18 *Vasilyev v Russia,* ECtHR, Application no. 32704/04 (17 December 2009), para 115. In *Vasilyev,* the Court found a violation of Article 3 by a hospital for failure to secure to an applicant adequate medical care that contributed to his subsequent disabilities. See, para 152.
19 *Ireland v UK,* ECtHR, Application no. 5310/71 (18 January 1978), para 162.
20 *Pretty v UK*, ECtHR, Application no. 2346/02 (29 April 2002), para 52.
21 *Tyrer v UK*, ECtHR, Application no. 5856/72 (25 April 1978), para 32.
22 *Price v UK*, ECtHR, Application no. 33394/96 (10 July 2001), para 30.
23 Ibid., para 61.
24 *McDonald v UK*, ECtHR, Application no. 4241/12 (20 May 2014). The applicant's care plan had been changed to state that she would be provided with incontinence pads instead of help to access a commode at night. A violation of Article 8 was found for the period of time care was provided contrary to that outlined in the care plan.
25 Price v UK, ECtHR, Application no. 33394/96 (10 July 2001), para 30. para 65 - 67.
26 CESCR, General Comment 14, para 25; WHO Declaration on the Promotion of the Patients' Rights in Europe (1994), para 5.11.
27 Ibid., General Comment 14. See also, CoE, Committee of Ministers Recommendation (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder, 2004, Article 10 provides that States should "ensure that the physical health care needs of persons with mental disorder are assessed and that they are provided with equitable access to services of appropriate quality to meet such needs".
28 CoE, Parliamentary Assembly Recommendation 1418 (1999) 'Protection of the human rights and dignity of the terminally ill and the dying', para 7.
29 CESCR, General Comment 14, para 3. See also, CoE Convention on Human Rights and Biomedicine, Article 10. *R.R. v. Poland,* ECtHR, Application no. 27617/04 (26 May 2011), paras 196-197; UN Doc. CCPR/C/GC/16, Human Rights Committee, General Comment No. 16: The right to respect of privacy, family, home and correspondence, and protection of honour and reputation (Art. 17) (4 August 1988), para, 10. UN Doc. CCPR/C/GC/34, Human Rights Committee, General Comment No. 34: Article 19 Freedom of Opinions and Expression (12 September 2011), para 19.
30 Ibid., para 37.

responsibility to encourage the active participation of the patient" in his or her own treatment. To enable staff to do this, they should be educated on how to be "receptive to patients' needs and to facilitate patients' cooperation".[31]

Ensuring the accessibility of information for patients must not impair their right to have personal data treated with confidentiality. The CESCR identifies that the design of health facilities and services should be such that they promote respect for a patient's privacy.[32] In the case of *Radu v Moldova*, the ECtHR found a violation of the ECHR, Article 8 when a hospital disclosed to a patient's employer detailed information about their health.[33]

Whilst recognising the need to ensure privacy, access to information is nonetheless integral to a patient's ability to give his or her consent. A failure to do so from a mentally competent adult patient prior to treatment may violate that individual's right to physical integrity and personal autonomy.[34] The ECtHR has stated that where treatment involves a risk to a patient's health, appropriate regulations must be adopted to ensure that the consent has been obtained.[35] This must be freely expressed.[36]

In *Glass v UK,* the ECtHR considered the CoE Convention on Human Rights and Biomedicine.[37] This instrument has not been signed or ratified by the UK, but was nonetheless determined to be relevant and legitimate material to inform the court's decision.

Article 5 of the Convention states that:

> [an] intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequence and risks.

According to the Explanatory Report to the Convention, Article 5 "makes clear patients' autonomy in their relationship with health care professionals and restrains the paternalist approaches which might ignore the wish of the patient".[38] An "intervention" is understood in its widest sense to cover all medical acts, including those performed for the purpose of diagnosis and treatment.[39] Free and informed consent is considered to be consent "in the absence of any pressure from anyone"[40] and where information has been provided in 'terms [the patient] can understand'.[41]

The Explanatory Report identifies that while "express" consent may be required for invasive diagnostics or treatment, it is not a requirement for minor medical acts so long as the patient is sufficiently informed.[42] Article 8 of the Convention also provides that where it is not possible to obtain consent because of an emergency medical situation, "any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned".

Timeliness

The right to health requires "timely and appropriate health care"[43] including a "sufficient quantity" of facilities, goods and services to be made available.[44] The CoE Committee of Ministers recognises waiting lists and waiting times to be "quality issues" and encourages efforts to reduce delays as part of

31 CoE, Committee of Ministers Recommendation No. R (80) 4 concerning the patient as an active participant in his own treatment, 1980 (adopted 30 April 1980), Section F, paras 1 and 2.
32 UN Doc. E/C.12/2000/4, ICESCR Committee, General Comment 14: the right to the highest attainable standard of health (11 August 2000), para 12(b)(iv) and para 12(c).
33 *Radu v Republic of Moldova,* ECtHR, Application no. 50073/07 (15 April 2014), paras 27 - 32.
34 *Trocellier v France*, ECtHR. Application no. 75725/01, (dec.) (5 October 2006), 'The Law' para 4. See also, *Pretty v UK*, ECtHR, Application no. 2346/02 (29 April 2002), para 61 and 63.
35 *Csoma v Romania,* ECtHR, Application no. 8759/05 (15 January 2013), para 42. See also, *Trocellier v France*, ECtHR. Application no. 75725/01, (dec.) (5 October 2006), 'The Law' para 4.
36 *Glass v UK,* ECtHR, Application no. 61827/00 (9 March 2004), para 81 – 82.
37 Ibid.
38 Convention on Human Rights and Biomedicine, Explanatory Report, para 34.
39 Ibid.
40 Ibid., para 35.
41 Ibid., para 36.
42 Ibid., para 37.
43 CESCR, General Comment 14, para 11.
44 Ibid., para 12(a).

quality assurance.[45] Where waiting times policies exist, it is recommended that access to treatment is based on transparent criteria "that address the risk of deterioration both in clinical and quality of life terms".[46]

The ECtHR has been reluctant to rule "*in abstracto*"[47] on access to treatment within particular timeframes so as not to impose an "excessive burden" on governments and public authorities, bearing in mind "the unpredictability of human conduct and operational choices which must be made in terms of priorities and resources".[48] Having said this, the ECHR, Article 2 does include a positive obligation to take appropriate steps to safeguard life.[49] This can extend to, for example, "the provision of emergency services where it has been brought to the notice of the authorities that the life or health of an individual is at risk on account of injuries sustained as a result of an accident".[50] In *Şentürk v Turkey*,[51] the ECtHR held that the denial of appropriate health care due to a "flagrant malfunctioning of … hospital departments", one aspect of which included a delay in treatment, violated Article 2.

The provision of appropriately skilled health care staff

Health care staff play an indispensable role in the realisation of the right to health.[52] The UN Special Rapporteur on the Right to Health explains that:

> [p]olitical, legal, economic, social or cultural pressures that may conflict with human rights mean that [staff] sometimes have to make decisions in their daily practice which have profound human rights implications.[53]

A good quality health system needs a minimum number of health professionals.[54] The numbers of trained staff should be commensurate with the health needs of the population, subject to the principle of progressive realisation and resource availability.[55] Medical practitioners and other health professionals must meet "appropriate standards of education, skill and ethical codes of conduct".[56]

To achieve such a workforce, the training curriculum must educate on the relationship between health and human rights.[57] The Special Rapporteur has outlined the minimum content of staff training to include:

> the right to health; the health-related human rights of vulnerable groups, such as women, children and people with disabilities; and their own human rights relating to their professional practice… [It] should also always include practical instruction in how to implement a human rights approach in clinical practice, including how to maintain respect for the inherent dignity of all patients, resist institutional or societal pressure to commit violations, identify violations, empower patients or colleagues to defend their human rights, and promote accountability in relation to known or suspected abuses, as well as minimizing risks of reprisals.[58]

45 CoE, Committee of Ministers Recommendation R (99) 21 on the criteria for the management of waiting lists and waiting times in health care, 1999, para 3.
46 Ibid., para 5
47 *Şentürk v Turkey,* ECtHR, Application no. 13423/09 (9 April 2013), para 95.
48 *Furdik v Slovakia,* ECtHR, Application no. 42994/05 (2 December 2008), 'The Law' para 1. cf. *Vasilyev v Russia,* ECtHR, Application no. 32704/04 (17 December 2009), paras 149-152.
49 *L.C.B v the United Kingdom*, ECtHR (9 June 1998), para 36.
50 *Furdik v Slovakia,* ECtHR, Application no. 42994/05 (2 December 2008), 'The Law' para 1.
51 *Şentürk v Turkey,* ECtHR, Application no. 13423/09 (9 April 2013), para 97.
52 UN Doc. A/60/348, Special Rapporteur report 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (12 September 2005), para 8.
53 Ibid., para 9.
54 UN Doc. A/60/348, Special Rapporteur report 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (12 September 2005), para 54.
55 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 80.
56 CESCR, General Comment 14, para 35. See also, among others, paras 12(a), 12(d) and 36.
57 Ibid., para 44(e).
58 UN Doc. A/60/348, Special Rapporteur report 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (12 September 2005), para 15. In addition to the groups identified by the Special Rapporteur, vulnerable groups include the marginalised, such as the poor, unemployed persons and refugees. CESCR, General Comment 14, para 37; CoE, Committee of Ministers Recommendation Rec(2001)12 on the adaptation of health care services to the demand for health care and health care services of people in marginal situations, part V, para 3. Specific comments have also been made with regard to the Roma and Traveller communities. CoE, Committee of Ministers Recommendation Rec (2006)10 on better access to health care for Roma and Travellers in Europe, part IV, para 5.

Domestic framework

The following sections extract some of the core obligations of the DHSSPS and health authorities in ensuring the quality of the health system and, in particular, emergency health care, and examine establishment within:

- Domestic laws and standards;
- Regional strategies and plans; and
- HSC trusts and institution specific policies, education and training.

Domestic laws and standards

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003 ('the 2003 Order'), Article 34 requires the Health and Social Care Board (HSCB) and each health and social care (HSC) Trust to:

> put and keep in place arrangements for the purpose of monitoring and improving the quality of: (a) the health and personal social services which it provides to individuals; and, (b) the environment in which it provides them.

There is no restriction on the type of service or environment to which Article 34 relates. It can therefore apply to EDs.

The 2003 Order does not define 'quality'. However, its meaning may be determined from regional health and social care (HSC) standards. These include the Department for Health, Social Services and Public Safety (DHSSPS) Quality Standards for Health and Social Care ('the Quality Standards') and the DHSSPS Patient and Client Experience Standards ('the PCE Standards'), are broadly in keeping with the human rights principles identified in this chapter (see Table 5).

HSC organisations are required to be "committed to human rights, as identified in human rights legislation and United Nations Conventions."[59] There are also specific references to dignity, information and participation (including consent), timeliness and the provision of appropriately skilled health care staff.

The PCE Standards recognise as a founding principle that "patients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained."[60] The Quality Standards require "relevant, accessible information to support and enhance service user and carer involvement in self-management of their health and social care needs."[61] It is also recognised that "currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery." Finally, each organisation is required to ensure "appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff."[62]

There are, however, a number of gaps in the referencing of human rights in domestic law. The operational meaning of "dignity" is often lacking within both the Quality Standards and the PCE Standards. It is therefore difficult to ascertain how "dignity," including dignity in death, can be put into effect, especially in the challenging environment of an ED. Unlike other care environments, such as nursing or residential homes, there are at present no dedicated minimum care standards that give further detail on how to benchmark people's dignity experiences within the context of an ED (see also findings in Chapter 3).

Both the Quality and PCE Standards acknowledge the collection, usage and storage of personal information as an aspect of confidentiality. But how this can be achieved in oral communications with patients and the need to ensure that health care facilities are designed to promote privacy could be better set out. There is also no explicit requirement to ensure timely health care services in the specific criterion of the standards. Although Ministerial waiting time

59 DHSSPS, Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, March 2006, criterion 7.3(c).

60 DHSSPS, Improving the Patient & Client Experience, November 2008
61 DHSSPS, Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, March 2006, criterion 5.3.3(a)
62 DHSSPS, Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, March 2006, criterion 4.3(j)

targets for EDs exist,[63] ensuring timely treatment and requiring that, where they exist, waiting time policies address the risk of deterioration in clinical and quality of life terms' could be usefully included.

The Quality Standards are to complement existing professional and care standards. They are described as "the absolute minimum to ensure safe and effective practice."[64] But the nature of the duties placed on HSC providers by the PCE Standards is less clear. Perhaps because the duty in Article 34 of the 2003 Order is written in terms of 'quality improvement,' the manner in which each of the PCE standards are to be met is, for the most part, presented in terms of progressive development.

For example, the standard "Privacy and Dignity" suggests that all elements of patient dignity can be achieved at some point in the future: "this standard *will be* recognised when staff members ensure all environments where care is provided protect the privacy and dignity of patients and clients" [emphasis added]. As such, it does not acknowledge aspects of dignity that are absolute and must be achieved immediately to comply with human rights law.

Table 5: Extracts from DHSSPS Quality Standards and Patient, and Client Experience Standards against key right to health elements of quality.

Quality: Right to Health elements				
	Dignity	**Information and participation (including consent)**	**Timeliness**	**The provision of appropriately skilled health care staff**
DHSSPS Quality Standards	Underpinning Values: 'dignity and respect;' 'promotion of rights'; 'privacy;' 'confidentiality'	Underpinning values: 'choice and capacity;' 'empowerment;'	No specific criterion. (Recognition on p. 3 "Currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery and ease of access")	4.3(j) [the organisation] has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with: - Departmental policy and guidance; - professional and other codes of practice; and - Employment legislation.
	5.3.1(a) & (b): person-centred approach	5.3.1(f): effective and efficient procedures for obtaining informed consent for examination, treatment, care		4.3(l): requirement for appraisal and supervision systems for staff
	6.3.2(a): ensure all service users treated with dignity and respect and that privacy is protected and promoted	5.3.3(a): relevant, accessible information to support and enhance service user and carer involvement in self-management of their health and social care needs		4.3(m): requirement for appropriately funded training plans and programmes
	6.3.2(e) ensure that individual service user information is used for the purpose which it was collected, and that such information is treated confidentially	5.3.3(b) requirement to actively involve service users and carers in the development, implementation, audit and review of care plans and pathways		4.3(n) a workforce strategy that, inter alia, ensures workforce development to meet current and future service needs in line with Departmental policy and available resources

63 The Health and Social Care (Commissioning Plan) Direction (NI) 2014, Schedule, para. 7.
64 DHSSPS, Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, March 2006, p.2.

Quality: Right to Health elements				
	Dignity	**Information and participation (including consent)**	**Timeliness**	**The provision of appropriately skilled health care staff**
		6.3.2(c) requirement to ensure information, where appropriate, is provided in a number of formats		5.3.1(f): properly maintained systems, policies and procedures for the protection of health, welfare and safety of staff; and awareness raising and staff knowledge of reporting arrangements when poor practice and/or unsafe practice or care comes to light
		6.3.2(d) requirement to incorporate the rights, views and choice of individual service user into the assessment, planning, delivery and review of his or her treatment or care […]		8.3(g): the organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and media
		8.3(e) requirement for clear communication principles for staff and service users		8.3(e) requirement for clear communication principles for staff and service users
		8.3(f) requirement for clear information principles for staff and service users		8.3(f) requirement for clear information principles for staff and service users
DHSSPS PCE Standards	Under 'Respect:' demonstrated by "an organisational culture where respect for the individual is valued";	Under 'Respect:' demonstrated by "patients and clients being actively involved in decisions regarding their care"	No explicit reference within the text of the standards	Under 'Attitudes:' demonstrated by "organisational structures and processes that enable staff to take sufficient time to show positive attitudes to patients and clients"
	'Privacy and Dignity:' "all HSC staff protect the privacy and dignity of patients and clients at all times"	Under 'Behaviour:' demonstrated by "Staff seeking patient and client consent when appropriate"		Under 'Communication:' demonstrated by "staff undertaking learning and development activities relevant to communication"
	Also: Under 'Privacy and dignity:' demonstrated by "staff ensuring that personal information is collected, utilised and stored in a way that maintains confidentiality	'Communication:' "all HSC staff communicate in a way which is sensitive to the needs and preferences of patient and clients"		Under 'Privacy and dignity:' demonstrated by "staff receiving training and development relevant to their needs to support the maintenance of patients' and clients' privacy and dignity
		Under 'Communication:' demonstrated by "staff giving clear, correct information using appropriate language		
		Under 'Communication:' demonstrated by "staff involving carers and family members where appropriate"		

Regional strategies and plans

Quality 2020

Quality 2020 and its implementation plan are the core DHSSPS strategy documents on quality in the health care system, including EDs.[65] Various objectives within the documents pledge to strengthen staff education and training, as well as the ways in which health care teams work.[66] Dignity, information and participation (including consent) and timeliness are also evident, although more detail could be included. For example, the "vision" and "values" of treating patients with respect and dignity are apparent, but it is not always clear how this will be progressed.

The centrality of patient participation is indicated within the values of "empowerment" and "involvement." Commitments to promote and encourage partnerships between staff, patients, clients and carers to support decision making[67] and to collaborate in developing individual care pathways[68] are also included. There is an absence of any reference to patients' informed consent and no commitment to monitor and improve the adequacy of information provision, which is integral to patients' involvement.[69] It is important to note that the DHSSPS core document on personal involvement does, however, include a principle on "information and communication," noting that "timely, accurate and user friendly information… are key to the success of PPI activities."[70]

Finally, timeliness is implicit within the overarching vision on "effectiveness," within Quality 2020. This is expressed as "the degree to which each patient and client receives the right care, at the right time in the right place, with the best outcome." It could, nevertheless, be progressed by a commitment within the objectives setting out how policies to achieve timeliness, such as waiting time targets, will be monitored and reviewed.

The Quality 2020 implementation plan is important since it has a potential to remedy in some respects the strategy's lack of detail on patient dignity, information, and timeliness. But information on how many of the strategy's commitments will be taken forward has not yet been included, and some areas of the strategy are dependent on scoping projects being completed.[71] The Plan also notes "[g]iven the very significant pressures on the HSC system in 2012/13 and the following two or three years it is proposed to limit the number of projects to be commenced in each year to no more than five, as far as possible."[72]

The Commissioning Plan

The Commissioning Plan,[73] developed by the regional Board in consultation with the Public Health Agency, is also central to the delivery of 'quality' health care. It sets out the HSC services intended to deliver on "Ministerial Priorities and Objectives" for the forthcoming financial year. Among a range of indicators of performance on emergency care clinical

65 DHSSPS, Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland, November 2011.
66 See for example the objectives under Strategic Goal "Strengthening the Workforce" and "Integrating the Care".
67 DHSSPS, Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland, November 2011, Objective 2 of Strategic Goal 'Transforming the Culture.'
68 DHSSPS, Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland, November 2011, Objective 9 of Strategic Goal "Integrating the Care.
69 This may, however, be covered in the detail of 'best practice standards,' which the strategy states "will be established for informing patients, clients and carers based on what has been successful elsewhere" (see DHSSPS 'Quality 2020' under Objective 2 of Strategic Goal "Transforming the Culture"). To the Commission's knowledge these have not yet been developed. In March 2015, the PHA published a leaflet entitled, 'Setting the Standards – Personal and Public Involvement (PPI)' containing standards, performance indicators and values on PPI. The leaflet contains five standards relating to: leadership; governance; opportunities and support for involvement; knowledge and skills; and measuring outcomes, and is available at, <http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf> (accessed 7 May 2015). Further, on consent, after the draft Inquiry report, the DHSSPS noted the DHSSPS, Reference Guide to Consent for Examination, Treatment or Care (March 2003), available at, http://www.dhsspsni.gov.uk/consent-referenceguide.pdf (accessed 8 May 2015).

70 DHSSPS, Guidance on Strengthening Personal and Public Involvement in Health and Social Care 2007, Circular: HSC (SQSD) 29/07, under Principle 8.
71 See Quality 2020 Implementation Plan, May 2012, p.10 (http://www.dhsspsni.gov.uk/quality_2020_implementation_plan.pdf [accessed 22/12/2014])
72 Ibid, p.11.
73 The Commissioning Plan sets out how services being commissioned "will deliver safe, effective and high quality care" (The Health and Social Care (Commissioning Plan) Direction (NI) 2014, para. 1(4))

quality, key priorities for emergency health care in 2014-15 included:[74]

- from April 2014, 95% of patients attending any Type 1,2 or 3 ED are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any emergency department should wait longer than 12 hours; and,
- by March 2015, 72.5% of Category A (life threatening) calls are responded to within eight minutes, 67.5% in each LCG (Local Commissioning Group) area.

Given the Ministerial target on ED waiting times, it is perhaps not surprising that the draft Commissioning Plan commitments for "acute services (non-specialist)" are geared toward improving the timeliness of service provision within EDs and related services. As well as developing an "Unscheduled Care Improvement Plan" (UCIP), the regional commissioning priorities in this respect relate to timely GP services, earlier discharge for inpatients, and bringing services in line with the relevant average peer benchmarks for efficient and effective service provision.[75]

Importantly, each priority has the potential to impact on the quality of patient experience. As the draft Commissioning Plan notes: "Services which respond on a 'same or next day' basis, are safer and higher quality, provide a much better patient experience...".[76] The Commissioning plan also includes "Personal and Public Involvement" as an "opportunity and enabler," setting out how this will be embedded in the commissioning, design and evaluation of services.[77] However, the services identified appear to focus more on public involvement and personal feedback mechanisms, rather than the participation of patients in decision-making about their health.[78]

HSC trusts and institution specific policies, education and training

Many HSC trust policies (including those provided by the Northern Ireland Ambulance Service Trust (NIAS)) relate, at least in some way, to the human rights aspects of quality. For example, the Belfast Health and Social Care Trust (BHSCT) 'Patient Privacy and Dignity Policy'; 'Promotion of Continence Policy (Adults)'; and its 'Food, Fluid and Nutrition Policy;' or the Northern Health and Social Care Trust (NHSCT) 'Nutritional Care and Food Safety for Hospital Adult Inpatients' and 'End of Life Care for all Critical Care Patients.' But these policies do not typically focus on the specific context of EDs. There are, however, exceptions, including:

- The Altnagelvin Area Hospital's 'Patient's Charter':[79] derived from the hospital's Unscheduled Care Improvement Programme, and based on feedback from staff, the Charter sets out six commitments including: "we [staff] will speak up for patients and challenge any decision that may hinder [patient] care"; "we would treat every patient as we would our own families;" and "we will introduce ourselves to each of our patients and explain the what, whys and when's of their care;"
- The Causeway Hospital's 'Emergency Department Standards'[80]: developed in consultation with staff, sets out ten commitments including: we will always "be polite and courteous to patients, relatives and colleagues;" "ensure privacy and dignity;" "encourage family participation and involvement in patient care." The standards

74 The Health and Social Care (Commissioning Plan) Direction (NI) 2014, Schedule, targets 7 & 8 respectively
75 HSCB / PHA, Draft Commissioning Plan 2014/15 (Draft - 24 March 2014), p.77; the draft regional commissioning priorities for 'acute services (non-specialist services)' are set out at pp. 75-76.
76 HSCB / PHA, Draft Commissioning Plan 2014/15 (Draft - 24 March 2014), p.74.
77 HSCB / PHA, draft Commissioning Plan 2014/15 (Draft - 24 March 2014), p.496.
78 For example, the Plan states: "[…] all commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work, from ensuring that input and feedback from service users and carers underpins the identification of their commissioning priorities, to involving service users and carers in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements." (HSCB / PHA, Draft Commissioning Plan 2014/15 (Draft - 24 March 2014, p.496).
79 WHSCT, Altnagelvin Hospital, Patient Charter, 2014.
80 Causeway Hospital Emergency Department, Emergency Department Standards (undated).

also set out actions for "service improvement," "equality, diversity and rights," "quality," "health, safety and security," and "communication."

In addition to these policies, the HSC trusts provided copies of the equality and / or human rights training offered to health care staff. Among the human rights training materials reviewed, the Human Rights Act 1998 tended to be a principal focus but it was not apparent from the documents provided if international human rights instruments had been covered in any detail, (other than by the Belfast Health and Social Care Trust (BHSCT), which includes a section on the UNCRPD).[81] There was also generally no reference to the right to health within the documents provided by the trusts.[82] Moreover, none of the training documents provided applied human rights standards to the ED setting.

Overall, there appeared to be a degree of variance in both the type and content of policies and training documentation provided to the Inquiry by the HSC trusts and the NIAS. While, in certain circumstances, these differences may have been warranted, it was not always apparent that the degree of variance was required or indeed beneficial. For instance, the development of a regional human rights training programme would help ensure a consistent level of human rights education for all HSC, including ED staff; and the initiatives undertaken by two EDs to produce a department specific charter or standards could be usefully shared with, and, if appropriate, adopted by others. The apparent inability to ensure positive initiatives and good ideas are rolled out in practice across trusts is a recurring theme gleaned from the evidence provided to the Inquiry (see findings in Chapter 3).

81 One Trust noted that the documents provided related to generic human rights training for all bands of staff, which is tailored depending on the audience (response to draft report dated 5 May 2015).

82 An outline of "Developing a Disability and Human Rights Approach to Health and Social Care: Master Class" 23 January 2012 was provided by the WHSCT.

Findings: Domestic framework

International human rights standards require a domestic framework of legislation and policies that ensure quality of people's experiences within healthcare, including ED settings. Based on the information reviewed as part of the Inquiry, the NIHRC found that:

- The core legislation and DHSSPS standards on quality include important elements of the right to health, for example, explicit references to dignity, information and participation, timeliness and the health workforce are included.
- While these are not dedicated ED standards, they do apply to ED settings.
- Areas for improvement, some of which could be addressed through the development of dedicated ED minimum standards (see further in Chapter 3) include:
  - Greater clarity in the operational meaning of 'dignity' within ED settings;
  - More emphasis on ensuring privacy in oral communications with patients and how this can be achieved in a busy ED environment;
  - Much greater emphasis in documentation, such as Quality 2020 and the HSCB Commissioning Plan, on personal participation of patients in specific health care decisions (e.g. explicit references to informed consent, and to the importance of monitoring information provision to patients);
  - Development of the Quality 2020 implementation plan, which appears to have been limited due to financial pressures;
  - Greater sharing of initiatives and policies across trusts, for example, only two EDs provided dedicated ED Charters / standards (the Altnagelvin

Patients Charter and the Causeway ED Standards);

- Development of trusts human rights training documentation to include explicit references to the right to health, as well as examining how human rights training might be tailored to the ED setting.

Quality in practice – Inquiry evidence

Dignity

Person-centred care

When the public addressed the issue of dignity, they more typically attributed concerns to the ED environment rather than the attitude of staff. For example, one witness reported a lengthy trolley wait, described as "psychologically extremely painful," but stressed that staff were "very good", as his case study demonstrates:

Case Study 1: An undignified environment

During May and June 2014, Richard Watson visited Causeway Hospital ED three times, due to chest pains and breathlessness. On each occasion, Richard sensed that staff were "run off their feet." He described a crowded environment with people waiting on trolleys and chairs. Recalling his second attendance, Richard said there was no access to pillows or painkillers:

"I requested a pillow because I suffer from arthritis and I'm on medication for it. I found it extremely uncomfortable. I had to keep getting off the bed because I couldn't get comfortable and eventually Janet [Richard's partner] made me a pillow out of her coat and a towel she had with her, you know, something to just try, but nothing was done"

"I requested painkillers and other stuff, the doctor did say he would get the nurse to get some […] but […] I didn't get it […]."

Richard's partner Janet also recalled relying on other patients and relatives to get water: "during the night I went to the vending machine and it wasn't working; I looked around but some of the patients and relatives told me where there was a water machine."

When asked how he felt treated by the doctors and nurses, Richard replied: "very good, […] you could actually see they did what they could; they spent as much time as they could because they had to rush off to do somebody else […], there was compassion I felt from the nurses, definitely"

In his 'Statement of Experience' to the Inquiry, Richard recommended: "More beds in the hospitals. The ED can't cope and they cannot materialize beds that aren't there."

Other participants also raised concerns about delays in receiving pain relief, lack of pillows and blankets, and no access to food and fluids. Some described a sense of embarrassment that private communications – either about the patient's own care or the care of another – could be overheard in crowded departments. Inadequate assistance with personal care needs was also, at times, reported. For instance, one member of the public stated that her sister was soiled when she arrived at ED at 12.30pm and remained unchanged at 5am. There were also reports of night-time transfers from EDs to other wards or hospitals, which caused distress and uncertainty. These accounts replicated findings

from the RQIA[83], the PCE Standards[84] and the '10,000 Voices' survey.[85]

Senior managers of the HSC trusts and clinicians communicated that patient dignity is a core focus of their work:

> when we come to work each day we strive to provide good quality care for our patients; and by that I mean we focus on safe and timely care, treating people fairly, with dignity and respect […] (Lead Consultant: Craigavon & Daisy Hill).

There was an indication of plans already in place and actions taken to address some of the concerns raised. An improvement in the provision of meals and drinks is a regional priority emerging from monitoring of the PCE Standards.[86] A requirement to have more pillows and blankets available in EDs was reported in response to the '10,000 Voices' survey,[87] as were local actions regarding pain relief.[88]

One notable initiative highlighted by the South Eastern Health and Social Care Trust (SEHSCT) was the employment of two housekeepers[89] to help in the provision of pillows, blankets, meals and fluids:

> At the Ulster Hospital we didn't have a housekeeper and some of the feedback we received from users was […] we didn't have enough stock or stores of pillows, blankets, "I really wanted a cup of tea" […] So we have appointed two housekeepers who work across the seven day service [to] make sure the environment is safe; they have got the time to do the cup of tea when it's required. [It] has made an absolutely fantastic improvement in the patient experience, but not only for the patient, also for the nurses on the floor because when they go to the cupboard they get the bit of kit that they need; it's stocked and already there (clinical manager, SEHSCT).

Despite the good work, it was also apparent that more was required to improve the dignity of patients in EDs. In its follow-up inspection of the Royal Victoria Hospital ED, the RQIA has continued to note that provision of - and assistance with meals - and drinks was a concern, with nursing staff having limited participation in delivery of meals due to workloads, and no drinks provided during the dinner and tea mealtime service.[90] Some clinicians have also identified pain relief as an area that requires ongoing improvement:

> something that would be more easily rectified and improved would be in and around our pain management of patients, and that's pain assessment at triage, […] so that the patient is given appropriate pain relief at the initial point of contact and then pain reassessment; it's no good giving pain relief if you're not going to go back and reassess and we have plans in place to review those procedures currently. (ED Manager: Lagan Valley & Downe Hospital).

Concerns regarding patient dignity were largely attributed to overcrowding or a lack of facilities. But this was not universally the case and perceived staff attitudes were sometimes criticised. For example, a tetraplegic witness told of arriving at Dungannon Minor Injuries Unit needing her catheter changed. The witness described how staff told her that her catheter could not be changed at the minor injuries unit but perceived an unwillingness from staff to help

83 For example, RQIA, *Final Report of the Inspection of Unscheduled Care in the Belfast Health and Social Care Trust: 31 January to 3 February 2014* (April 2014), p. 20-21. Available at, <http://www.rqia.org.uk/cms_resources/RVH%20Inspection%20Report%20for%20Publication%20on%20Website_ISBN.pdf> (accessed 7 May 2015).

84 For example, see p. 15 of the Public health Agency, Patient Client Experience Standards Annual Report: April 2012 – March 2013.

85 For example, see p. 28 of the PHA / HSCB, Ten Thousand Voices: Patient Client Experience '10,000 Voices' Annual Report, June 2013 – July 2014: "Almost a quarter of the respondents for Emergency Departments felt that others could overhear their personal information or what was happening with them, while receiving care in the treatment area and even on the point of entry to the department when having to check in at reception. This could be partly due to the design and layout of an emergency department, which tends to have cubicles separated only by curtains."

86 Public health Agency, Patient Client Experience Standards Annual Report: April 2012 – March 2013, p. 65

87 The HSCB and PHA Annual Quality Report 2013/2014, p. 66

88 The PHA / HSCB, Ten Thousand Voices: Patient Client Experience '10,000 Voices' Annual Report, June 2013 – July 2014, under "Local actions."

89 Note that in response to the RQIA inspection, the BHSCT has also employed a housekeeper, but this is noted as a temporary position (see The RQIA, Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust, 12 to 14 May 2014 (published November 2014), p.29).

90 The RQIA, Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust, 12 to 14 May 2014 (published November 2014) p. 33.

at all, and found staff comments "very cutting". This treatment was made worse for the witness when staff directed her to the local out-of-hours only to find it closed.

Case study 2: perceiving a lack of kindness

Jackie Dempsey attended Antrim Area Hospital ED in April 2014. She attended with a friend after visiting her GP. She was unable to speak properly or swallow. She stated:

"I have been a nurse for 23 years and, really, I wished I hadn't gone to Antrim […]; the triage nurse was very factual; my friend had gone to park the car; I was having bother speaking; we asked for some water from the water bottle that was sitting next to us […]; so belligerently, I have to add, the nurse gave me the water, which then enabled me at least to speak for myself to some degree."

"[She] triaged me that I need to go to majors [for more serious triage categories]; got in a wheelchair, got taken around the corner and then was confronted by what I know now was the emergency department consultant who waved her hands around in the air, told me I was the wrong colour code and, because I was upright, I really didn't need to go to the majors and she said, "not that that matters to you what colour you are"; but that did matter to me because it either meant I was going to be seen more rapidly or I was going to sit for hours. And that was what happened. I couldn't speak, so I couldn't voice my opinion[…]."

When the doctor attended, Jackie explained: "The [Locum Registrar] was quite rude […]; he told me to sit in a way maybe that Barbara Woodhouse would have spoken to a dog."

"There was no communication; I didn't know whether I was being kept in, whether I was being sent home, whether I was just going to die where I was sitting because that's what I felt was going to happen at that point."

Jackie explained that eventually a decision was taken to admit her to a ward, but as she waited for that decision:

"many people walked by in uniforms, not one came near any one of us […];there was absolutely no compassion to any one of us and there certainly wasn't any kindness."

In her 'Statement of Experience' to the Inquiry, Jackie made a number of recommendations for change, including:

"People waiting in the ED are frightened and a little bit of kindness, should it be just a kind word, is required. A little bit of kindness can go a long way. People realise the ED is very busy and unpredictable but these are basic things."

It is noted that the Annual Report of the PCE Standards finds polite, professional, friendly, and welcoming staff are key areas of compliance. But there is evidence of 'bluntness' or 'disinterest' from other surveys.[91]

When staff voiced concerns about patient dignity, this typically related to a patient who had received a "decision to admit" but for whom no bed had yet been found. The staff confirmed public evidence, as well as RQIA inspection findings,[92] that during busy periods space constraints and overcrowding compromised patient privacy in the provision of personal care needs, medical examinations, and the provision of personal information.

Moreover, we received considerable evidence that difficulties experienced in this respect were exacerbated for people with particular needs, including older people, those with physical disability,

91 SHSCT, Annual Quality Report 2012-13, p.45; See also NIAS Trust, Patient Client Experience Standards: Monitoring Report Quarter 4, January – March 2014, p. 13, where the Trust states that, as well as regional priorities, it has prioritised staff attitude in taking forward the PCE Standards.

92 E.g. The RQIA, Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust, 12 to 14 May 2014 (published November 2014), Executive Summary.

and people presenting in mental health crisis (more detailed evidence on the experiences of particular groups is presented in 'Accessibility'). For example, one consultant who contacted the call for evidence noted particular concerns about privacy for people with dementia, who, often unaware of the crowded environment, may remove items of clothing or blankets. Similarly, it was felt that "psychiatric patients" would receive "a better level of care if we weren't so crowded and had more privacy."

Overall, the sense from staff evidence to the Inquiry was that problems associated with maintaining patient dignity would not be resolved in the absence of structural changes:

> We've also opened a new emergency department at Antrim hospital that provides the space and facilities to meet both patient and staff needs, these facilities make it much easier to provide privacy and dignity to patients and families and in particular to meet the needs of vulnerable groups such as children and the elderly (Chief Executive, NHSCT).

> An environment that was designed more than 20 years ago for half the number of patients is very limited in personal areas like toilets and showers and bathrooms and all of that so the staff while doing remarkably well, I think at times would feel that their ability to provide privacy and dignity to the level that they would wish to do, and would wish to see their patients receiving, can be challenged (Clinical Leads, Causeway Area Hospital ED)

Evidence from community and voluntary sector organisations, professional bodies and trade unions suggest that waiting time targets in particular undermine dignity. A drive to meet targets according to UNISON has led to the "objectification" of patients. The Royal College of Nursing (RCN) echoed this view, stating that language associated with targets, such as "trolley waits," had "dehumanised". The challenges of respecting and protecting dignity were also attributed to the absence of standards to assist ED staff: "There is no physical standard either in terms of space or facilities to protect dignity in waiting times. […] [We hear] the language of patient experience, dignity, waiting times – it's an important language, but it needs articulating in human rights terms" (UNISON).

End of life care

Dignity in death was reported as lacking by the RQIA in its January 2014 inspection of the Royal Victoria Hospital.[93] Its May 2014 follow-up report noted that this remained "unchanged" within the ED, although improvements had been made in the Acute Medical Unit.[94] Evidence presented to the Inquiry suggests concerns about this are not limited to the Royal Victoria Hospital. One member of the public reported that after her husband died at Altnagelvin Hospital ED, the family was asked if 'they minded moving him next door to an old plaster room'. Another, who attended Craigavon Area Hospital ED with her mother, reported a "total lack of compassion […] shown to my mother during her last hours." Suspecting that their relative may have been left alone while passing away, another witness reported the difficult and lasting impact this had.

Collectively, this evidence conveyed the significance of 'end of life' care, including loved ones' perceptions of interactions with staff and the extent to which care and sensitivity is communicated.

A number of staff also reported concerns about 'end of life' care with one senior consultant, who contacted the Inquiry's call for evidence, stating that 'dignity in death is a scarce commodity' in an ED. Another consultant indicated the view that end of life

93 The RQIA, Final Report of the Inspection of Unscheduled Care in the Belfast Health and Social Care Trust, 31 January to 3 February 2014 (published April 2014), p. 21: "There is little dignity, even in death. The inspection team was informed that when a patient dies in the resuscitation room, and the resuscitation space is needed, the deceased patient is either placed to the side of the room and screened off, or transported to another cubicle within the ED. This poses dignity and privacy issues for the family who wish to pay their respects. It may also cause distress for those patients who had witnessed the deceased person being moved within the ED."

94 The RQIA, Follow up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust, 12 to 14 May 2014 (published November 2014), p. 31 and p.54.

patients are not prioritised: '[the HSC Trust] don't see it as a priority bed because the patient is going to die anyway.' Particular concerns were highlighted for older people at the 'end of life' who were transferred inappropriately from nursing homes to ED.

Giving evidence, the Clinical Director for Emergency Care at the SEHSCT stated:

> I remember very clearly somebody coming in, in the last year or so, dying within 15 minutes of arriving and the family being very upset by the fact that they were being brought from a nursing home they had been present in for 12 years to the ED, when it was quite clear that half the family went to the nursing home thinking they were going to spend the last minutes with [their relative] to find that [they] had been transported [to the ED].

One consultant participant in the call for evidence felt that liaison with GPs had lessened the incidence of inappropriate transfers of older people from nursing homes occurring, but the SEHSCT indicated a "large body of work" still needed to be done in this respect.

Addressing dignity in death, Minister Wells stated that he is "[…] committed to ensuring that the maximum dignity is afforded to people in need of services at the end of their lives […]." The Minister referred to the development of links between the Unscheduled Care Taskgroup and palliative care services, which may have the potential to impact on the numbers of 'end of life' patients inappropriately arriving in ED.[95] Some also spoke of initiatives to address 'dignity in death'. For example, the SEHSCT Chief Executive, explained:

> […] we had a complaint three to four years ago where we had a death in ED of a man who was terminally ill with cancer and his wife fed back through a complaint her experience of that. On the back of that we took the learning from that and have introduced a new policy – at that time, before the sort of board SAI [Serious Adverse Incident] process – and on the back of that we introduced a new policy where end of life patients will either bypass or go through ED extremely quickly.

The Assistant Director of Nursing, Patient Safety and Quality Experience at the PHA gave evidence about an "improvement group" considering, "quiet rooms and viewing rooms" for those who have died in the EDs. This, she stated, is being taken forward by staff, as well as patients and carers. The importance of initiatives to improve dignity in death within the ED was apparent in the evidence of Alzheimer's Society NI, whose representative stated: "[…] that feeling that somebody you loved had a bad death where they were in the wrong place […]; it's a terrible thing to live with afterwards […] the end of your life is as important as the beginning and the middle." Likewise, the Chief Executive of Age NI spoke of the importance of improvement in 'end of life' care to ensure older people can "live well and, if I may say, die well, that is with those around them, that it's not strangers and to do that needs a lot of training and investment in [home and community] settings."

Findings: Dignity

To ensure respect and protection of the right to human dignity, a person-centred approach within health care settings is required.[96]

The NIHRC found that:

- Staff are striving to maintain patient dignity in an often challenging and crowded environment. But evidence to the Inquiry, including reported instances where assistance with personal care needs has not been provided, no pain relief, and no access to food and fluids, points to the types of circumstances in which there is a risk of human rights violations occurring (see in

95 On 14 January 2015, the Chief Nursing Officer, in evidence to the Northern Ireland Assembly Health, Social Services and Public Safety Committee, referred to a "Marie Curie initiative" to give more out-of-hours support "[…] to help to keep that person at home with appropriate care and treatment" and that these extra out-of-hours posts would "be in place from the end of this month".

96 WHO, People at the Centre of Health Care: Harmonizing mind and body, people and systems (2007), p. v. See also, UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 38.

particular, the rights to private life ECHR, Article 8; ICCPR, Article 17)

- While interactions with staff were often reported to have been positive, person-centred care was, at times, undermined by a perceived disregard, lack of attention or kindness from health professionals.
- 'Dignity in death' should involve, *inter alia*, support for patients' social and spiritual needs and care and support for friends and family.[97] But Inquiry evidence suggests that the provision of care and support to maximise dignity for 'end of life' patients and their friends and family is not always prioritised within EDs.
- Older people receiving 'end of life' care are at times inappropriately transferred from nursing homes, or other community care settings, to EDs. It was generally felt that greater investment in, development of, and training of staff within, community and home services was required to help avoid this occurring.

Information and participation (including consent)

Positive experiences of ED described by members of the public often related to information provision. One person reported that staff 'great at explaining why they were keeping [the patient] immobilised'. Another recalled 'they told me at all times what they were doing and why […]'. If information about waiting times was available in the ED, the public unanimously reported it as being helpful. This is important because a lack of information about waits was also a common a source of frustration. "[S]taff seemed to disappear for ages and didn't give you an estimate as to when you were going to be seen".

Some patients, family members and carers noted a lack of accessible information about their health condition and after care. This was particularly the case with regard to mental health issues (the detail of this evidence is discussed further in Chapter 2). There was also at times a reported lack of communication with patients and relatives, and poor information provision about how the ED works. Comments provided through the call for evidence included:

Felt in the dark most of the time.

Information not flowing through to the patient.

With no one coming, you don't know, and there's a degree of fear.

Doctors talked to each other over the top of me and I felt very much like a number not a person.

Staff so busy, not speaking to me.

A number of people highlighted concerns about information provision in relation to bad news. Some stated they were not informed about the seriousness of a condition at all. Others criticised how the news was given:

The delivery of this distressing information was very factual. Following the diagnosis, TIA [a type of 'stroke'], it impacted him negatively – [he experienced a] week of depression.

Providing information in an accessible and sensitive manner is important to aid people's understanding, but it is also central to their empowerment and participation. As one witness explained: "There was no communication […]; I was invisible". The public commonly recounted not feeling involved in their care and there was a particular focus on the perceived failure to listen to or involve family members. Typical comments from the call for evidence included:

The frustration of not being listened to when you are the voice of somebody who is unwell and incapable of speaking;

I felt like I was continuously alerting them to the fact that my mother was deteriorating and they kept responding that they were waiting for a bed;

97 See CoE, Parliamentary Assembly Recommendation 1418 (1999) 'Protection of the human rights and dignity of the terminally ill and the dying', para 7.

Trying to be involved – not to be running all doctors down – but these doctors were aloof, you know, if we think you're not going to make it we'll make that decision.

For staff, the ability to communicate well with a patient is dependent on the level of crowding within the ED. According to the Lead Clinician at the Royal Victoria Hospital ED:

Communication is not only integral but vital to every time we deal with a patient and their family, [but] it's not always easy to do if you're trying to shimmy in next to another trolley [...]

Representatives of the HSC bodies noted that concerns about information provision and communication had already been identified through monitoring, such as the '10,000 Voices' survey and the HSC trusts' complaints processes. The PHA, Assistant Director of Nursing, Safety, Quality and Patient Experience stated:

[…] patients are telling us they're very frustrated at having to wait so long but in fact when you start to read into the stories […] it's not so much about the wait but the actual communication throughout that wait, not knowing what's going to happen to them next […]. Relatives and patients are telling us in their stories that that's a very fearful time for them because they don't know what's happening so, again, that was a key issue we've picked up with the trusts […].

Improvements have been made, for example, all EDs have signs indicating "the length of wait and what patient's should do [while waiting]" (Assistant Director of Nursing, Patient Safety and Quality Experience, PHA). However, there was evidence these signs do not always work or are not being utilised consistently.[98]

Annual Quality Reports for 2013/14 from the HSC trusts highlight actions on information provision. For example, the BHSCT states that:[99]

i) We are developing information leaflets to explain the processes in our emergency departments.
ii) Waiting times will be better displayed and more frequently updated.
iii) A process has been established to review patients on an hourly basis to coincide with the hourly ward round with the Nurse-in-charge and Consultant.

Both the '10,000 Voices' Annual report and the PCE Standards report set out regional actions to address information provision and involvement by patients and family or carers in their care. The former has found that while most patients feel involved in decisions about their care some indicate "I was just told how it was going to be." The report states that:

[t]his may reflect the care in ED where due to the nature of the presenting condition, at times treatment and care must be led by healthcare professionals because of the urgency to deliver lifesaving and emergency measures.

In response to '10,000 Voices', areas for action have been identified. These include:

- Developing staff skills to enable them to support patients to articulate an understanding of their condition and treatment using appropriate communication methods.
- Empowering members of the public to take responsibility for their own personal health and to work alongside clinicians in equal partnership.
- Integration of person centeredness into pre – registration health care programmes.

98 Observation visit 01.07.14

99 BHSCT, Annual Quality Report 2013/14, p. 44.

- Ensuring organisational culture supports person centred practices.
- Care planning and involvement of patients when it is possible.
- Asking patients do they understand the treatment /care plan.[100]

As a result of survey findings, the PCE Standards report identifies four regional priorities three of which centre on information and communication: (1) staff introductions (2) name and designation badges except where deemed inappropriate (3) roles and responsibilities of the team and frequent communication with patients and carers.[101]

Each of these initiatives, if successfully implemented, will undoubtedly improve information and help empower patient participation. But each will take time to implement. Calls for more information "on what's going to happen" and on waiting times; to listen to and communicate; and, to provide information in a "dignified and truthful manner" were among the recommendations made by patients, family members and carers who provided evidence.

Findings: Information and participation (including consent)

Access to information in terms that the patient can understand is integral to the right to health and to free and informed consent.[102] The NIHRC found that:

- The evidence suggests that staff often sought to ensure that information about health conditions and the treatment process was fully explained to patients, family members and carers. But there were occasions when insufficient or no information was communicated. This suggests that the active participation of patients, family members and carers is not always encouraged in EDs.
- Staff reported levels of over-crowding within EDs and the corresponding need to prioritise medical care compromise their ability to communicate well.
- Screens displaying information about waiting times in EDs are a positive development, but these screens are not utilised consistently or they do not always work.

Timeliness

Availability of services

There was an overwhelming view that an improvement in services is required to ensure timely health care within EDs. There was also recognition that this is, however, generally needed throughout the health care system. The Northern Ireland Chair of the CEM stated:

> […] my experience [of regional escalation plans] to date is a lot of that is focused on what the emergency department can do and what we need now is to see how the rest of the system respond to the pressures within the system that are being expressed in the emergency department.

The problem of timeliness was often attributed to patient flow – the movement of patients in and out of the ED. Improving this was generally said to require greater co-ordination between all services; community care, unscheduled care, and inpatient hospital services. As one Nurse Consultant from the Royal Victoria Hospital ED suggested:

> […] the overcrowding issue isn't going to be improved by moving to a new environment; it's a different building albeit a much nicer building than we're being accommodated in at the minute. The issues of overcrowding have to be addressed by our inpatient colleagues, by our GP colleagues,

100 The PHA / HSCB, Ten Thousand Voices: Patient Client Experience '10,000 Voices' Annual Report, June 2013 – July 2014, p. 24

101 Public health Agency, Patient Client Experience Standards Annual Report: April 2012 – March 2013, p. 25. See also the "Hello My Name is" campaign endorsed by the PHA/HSCB in its '10,000 Voices' Annual Report (The PHA / HSCB, Ten Thousand Voices: Patient Client Experience '10,000 Voices' Annual Report, June 2013 – July 2014, p. 5 & p.21).

102 Convention on Human Rights and Biomedicine, Explanatory Report, para 34; As already noted in this chapter, failure to ensure consent may violate the right to physical integrity and personal autonomy (Trocellier v France, ECtHR. Application no. 75725/01, (dec.) (5 October 2006), 'The Law' para 4. See also, Pretty v UK, ECtHR, Application no. 2346/02 (29 April 2002), para 61 and 63).

by our community colleagues and ourselves all working together […].

The importance of patient flow was conveyed by the President of the College of Emergency Medicine (CEM) as follows:

There is only a certain amount of capacity that is sensible to build into an emergency department. The analogy I make is that if the bath is overflowing you either need to turn the tap off or unblock the plug hole you do not need a bigger bath – and so simply building larger and larger emergency departments hides the problem rather than solves the problem. The problem is not one necessarily of fixed capacity it's of flow through the system and the way to optimise flow I'm afraid requires a more system wide approach […]. [For every patient that is on a trolley] not only is the care of the patient in the emergency department compromised but care of patients yet to arrive in the emergency department is already being compromised by the lack of that flow. […] All the Royal Victoria Hospital has shown is a particularly acute example of where that (system flow) isn't currently happening.

Similarly, the Patient Client Council (PCC) stated that improvements in people's ED experiences required a "system- wide approach." Noting that EDs are "not right" for people in mental health crisis, those with long term conditions and the frail elderly, it called for a joined up approach in the development of Minor Injury Units, and GP out-of-hours services. Professional and voluntary organisations also emphasised that service improvements beyond the ED were required to address patient flow. Age NI stated, in its view, community based preventative services could reduce ED attendances by approximately 29%. It therefore called for more investment to realise the vision of Transforming Your Care (TYC). A need to reassess the numbers and availability of inpatient beds, to discharge patients promptly and safety, and to build GP networks for the provision of community care was expressed by the British Medical Association (BMA, NI Chair).

Similarly, the Director of the RCN called for the establishment of more alternatives to ED:

Somebody […] in the system made [the ED] the front door and I think our members would say it is not the fault of the people of Northern Ireland that they arrive at our emergency department, they wouldn't be there if there were alternatives.

The Inquiry was informed about initiatives aimed at improving the situation including the development of an Acute Medical Unit where patients can be admitted for assessment without needing to go via the ED. This is in operation at various departments including the Royal Victoria Hospital ED, the Ulster Hospital Dundonald ED, the Altnagelvin Hospital ED, with a similar model recently introduced at Craigavon Area Hospital.[103] It was reported to be an appropriate facility to assess patients who can be seen "in not just as time critical a fashion as the emergency department" (Consultant Lead, Altnagelvin Hospital ED).

The NHSCT referred to the development of "discharge lounges" on both ED sites, including as part of a new Medical Assessment Unit at Antrim Area ED. These were described as comfortable areas from which patients can leave hospital safely, it was said to free up beds and reduce the occurrence of discharge late in the evening. There were also references to co-located GP and out-of-hours services to assess and treat those not in an immediate emergency who might, otherwise attend the ED. But this had not been as successful as hoped. The Lead Clinician at Altnagelvin Hospital ED stated that GPs haven't been able to take up 30% of the workload, which meant he suggested reports about patients attending the ED who shouldn't be there "are probably overblown."

In the Western Health and Social Care Trust (WHSCT), a new way of working with minor injuries

103 DHSSPS Press Release: 'New Medical Assessment Unit will ensure appropriate and timely patient care' 16 December 2014 http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-december-2014/news-dhssps-161214-new-medical-assessment.htm (accessed 11/01/15).

units was highlighted. The Chief Executive of the NIAS stated:

> we have the minor injury pathway in place in Omagh […] the trust advises us that they are ready to accept these patients and it is safe to bring them there […] we have the protocol already in place operating in the west and we stand ready now [if] it's safe to take them to an alternative centre, we […] will apply the regional protocol in that area.[104]

Minister Wells suggested minimum alcohol pricing as a method to address over attendance at ED. In his view, "if a lot of our community would address their alcohol dependency the demands on A&E would drop dramatically and we could easily live within our unscheduled care targets." There was little evidence, however, from the clinicians, professional bodies or representatives of the HSC trusts that alcohol use was a major cause of overcrowding in the ED.

While the HSCB noted particular difficulties associated with alcohol misuse within EDs, it did not recognise a sizable proportion of those routinely presenting to have alcohol taken. The Director of Commissioning stated: "I'm not sure I recognise that reach; it may be some attendances have an alcohol element at certain times on certain days […]." He then continued to point out the importance of:

> distinguishing between those who genuinely have some sort of alcohol dependency […] from those that have just consumed too much at a particular point in time during the week and trying to see whether it is possible safely and appropriately to put in place a mechanism, which keeps those patients safe and effectively cared for but perhaps avoid them from being overly disruptive in an A&E department.[…] actually, when you look at the realities and the difficulties of putting in place models like that [alternatives to ED] there are some people who turn up having had too much alcohol who have an underlying health condition, who have maybe bumped their head or whatever, and the risk is obviously of missing that, if you simply put them in some alternative facility. Having said that […], this is a consistent theme that is raised; it is an issue of concern to the public and therefore it is an issue of concern to us and we will continue to explore opportunities in that regard.

Notably, in recent evidence to the NI Assembly, the HSCB referred to a pilot project, planned for March 2015, "that will focus on diverting patients who otherwise would have presented at the Royal or Mater emergency departments, offering minor injury and sobering services for patients under the influence of alcohol." [105]

Waiting times

The Ministerial waiting time target (set out at earlier) has never been met by all EDs in any of the months since its introduction in 2007. The most recent five-year trend shows progressive improvement against the 12-hour target, with 3,109 (0.4%) people waiting over 12 hours at emergency care departments in 2013/14, 772 (19.9%) less than the number in 2009/10.[106] At the same time, however, there has been a decline in performance against the four-hour target, with 542,541 (78.1%) people either treated and discharged, or admitted within four hours in 2013/14, compared to 585,402 (84.5%) in 2009/10.[107]

Emergency care waiting times have featured heavily in media reports, particularly in recent

104 Note that on 17 November 2014 Armagh Minor Injuries Unit was temporarily closed as part of the requirement upon the Southern Trust to save £2.9 million in the 2013/14 financial year. The Trust sates that it will close until the end of March 2015 and that "Around four patients an hour currently attend the Armagh Minor Injuries Unit, and the Trust is confident that these patients can be accommodated at other Trust facilities" (see http://www.southerntrust.hscni.net/about/2878.htm [Accessed 11/01/15).

105 14 January 2015, Michael Bloomfield, Director of Performance and Corporate Services, HSCB. Evidence to the NI Assembly Health, Social Services and Public Safety Committee.

106 "In 2013/14, 3,109 (0.4%) […] attendances waited over 12 hours at emergency care departments, 772 (19.9%) less than the number in 2009/10 (3,881, 0.6%) and 2,451 (44.1%) less than the number in 2012/13 (5,560, 0.8%)" (Northern Ireland Hospital Statistics: Emergency Care (2013/14), p.10.

107 Northern Ireland Hospital Statistics: Emergency Care (2013/14), p.10).

months.[108] During the first week in January 2015, all HSC trusts cancelled some non-urgent elective surgery, to cope with demands on ED.[109] Waiting time statistics suggest greatest pressure in meeting the target is being experienced in the winter period (from December to March).[110] Statistics covering October to December 2014,[111] show a decline in performance against the four-hour target at Type 1 EDs, from 75.4% of patients being either treated and discharged, or admitted within four hours, in October 2014 to 73.5% in December 2014. In terms of the 12-hour target, performance during this period "improved or remained similar in all Type 1 emergency care departments, with the exception of the Ulster which more than doubled from 22 in October 2014 to 45 in December 2014."[112] Provisional data across all trusts for February 2015 shows a substantial decline in performance from December 2014, with:[113]

- a total of 624 people waiting over 12 hours compared to 380 in January 2015, and 92 in December 2014
- 67.3% seen within the four-hour target; compared to 71.4% in January 2015, and 73.5% in December 2014.

According to this data, both the Royal Victoria Hospital ED and the Antrim Area Hospital ED performance on the four-hour target is less than 60%; and greatest numbers waiting over 12 hours in February 2015 were in the RVH ED (n= 243), the Ulster ED (n=210), the Mater ED (n=80), and Antrim Area ED (n=80).

The prioritisation of the waiting time target by the DHSSPS, and the heavy reliance on them in media reporting means their utility must be a key issue of consideration. It is generally recognised that people waiting lengthy periods in an emergency department are at greater risk of coming to harm. For example, in evidence to the Northern Ireland Assembly Health, Social Services and Public Safety Committee, the Chief Medical Officer, Dr Michael McBride has stated: "[t]here is absolutely no doubt that people who are sick and wait more than 12 hours come to harm".[114] For some of those providing evidence to the Inquiry, waiting time targets are, therefore, a robust indicator of quality:

> […] the time a patients spends in an emergency department, particularly that 12-hour standard, is a very direct indicator of quality; it's not a dignified experience for anybody to spend 12 hours in the ED department" (Michael Bloomfield, HSCB).

Nevertheless, many people have stressed that targets should not be a sole indicator. For example, Minister Wells maintained that:

> there's much more to the quality of the services than just time limits or performance targets, we must remember that behind every one of these statistics there is a person, often a very vulnerable person who deserves respect and compassion[…]

Prioritising waiting time targets was noted by the Chief Executive of the SEHSCT to be part of a "top down" "clock based" system. He stated that over the last four years a new performance system had been developed in the SEHSCT based on:

> The first parameter is safety – is the service up to standard? Not based on a very simple clock based target but how do you test it against standards which are relevant for that service so for instance in emergency medicine we use the College of

108 See for example, BBC News, 'Northern Ireland health trusts cancel non-emergency operations,' 7 January 2015 http://www.bbc.co.uk/news/uk-northern-ireland-30702853 (accessed 11/01/15); BBC News, 'NI Hospitals: Emergency Numbers spike by 7.5% says Michael McBride', 11 January 2015 http://www.bbc.co.uk/news/uk-northern-ireland-30768173 (accessed 11/01/15); BBC News, 'A&E Waits in England 'Getting Worse'', 18 December 2014 http://www.bbc.co.uk/news/health-30415390 (accessed 11/01/15);

109 Ibid.

110 For example, DHSSPS, Emergency Care Waiting Time Statistics (October – December 2014), 29 January 2015, Hospital Information Branch, Table 9, p. 23.

111 DHSSPS, Emergency Care Waiting Time Statistics (October – December 2014), 29 January 2015, Hospital Information Branch.

112 DHSSPS, Emergency Care Waiting Time Statistics (October – December 2014), 29 January 2015, Hospital Information Branch, p. 13.

113 DHSSPS, Provisional Figures for January and February 2015 http://www.dhsspsni.gov.uk/index/statistics/hospital/waitingtimes/waitingtimes-emergency.htm (accessed 25.03.15)

114 Chief Medical Officer, Dr Michael McBride, 14 January 2015, Northern Ireland Assembly Health, Social Services and Public Safety Committee.

Emergency Medicine standards to test whether we're delivering the service safely. We benchmark around those, we participate in national audits. The second area is […] around [Quality] which is about what could we do better at, what could we improve […] and the third area […] is test the experience, and I don't mean just in terms of user satisfaction, but what is the user's experience of how we deliver care. Do we do it in the right way, do we respect their dignity, do we respect their privacy, do we communicate well – all the things which are core to human rights and quality of care.

Other HSC trusts also gave evidence of monitoring beyond waiting time indicators. The Lead Clinicians in Craigavon Area hospital ED and Daisy Hill hospital ED recounted that:

We're focusing in on things like pain relief for example; that is a theme we have picked up on in our complaints process […]. So we are starting now to put things in place that have a much more robust means of monitoring how we're doing against quality; I think previously that focus may have been more on the quantitative side so I would like us to do more in relation to the qualitative side.

There were some witnesses, however, who rejected the notion that the four-hour waiting time target had any proven benefits for patients at all. The Clinical Director, Emergency Care SEHSCT suggested: "As much as the four-hour target has been lauded across the world, there's no evidence whatsoever that it improves the outcome for individual patients." For some, it was primarily to serve a political purpose:

New Zealand for example uses a six hour target, which is more sensible, as it allows more time for communications – that's a personal opinion. For Governments they serve a purpose; as a clinician, it's quality for me, I'll take five hours if needs be (Clinical Director, Royal Victoria Hospital).

Those measures are Ministerial targets, the 12 [hour] one I think's a must do as far as I'm concerned, no-one should lie on a trolley for 12 hours, you cannot say that's quality care in any society. The four-hour one […] I think we should have a debate around that as we go forward […] (Chair, Northern Local Commissioning Group)

Crucially, from the evidence given to the Inquiry, it was not apparent how the utility of the four hour and 12 hour waiting time target for EDs in Northern Ireland had been determined. In recent evidence to the Northern Ireland Assembly Health, Social Services and Public Safety Committee, the Health and Social Care Board stated that "[…] the targets were introduced in Northern Ireland, taking account of clinical advice."[115] But, according to the DHSSPS, there are no documents setting out the basis for these particular waiting time targets in Northern Ireland. In a letter to the Commission, Minister Wells states:

The 4 and 12 hour waiting time targets were first introduced in Northern Ireland by the late Paul Goggins, MP the then Minister for Health, Social Services and Public Safety through Priorities for Action, in June 2006 [….]. These key targets have remained in place in each subsequent iteration of Ministerial priorities for Emergency Department performance. […] these targets are based iteratively on clinical evidence, strategic policy and performance management measures etc. […] It remains my view that these targets, whilst only one part of a wider assessment of safe and high quality healthcare are nonetheless key elements to ensuring effective urgent emergency care across NI (date 10 February 2015)

While acknowledging the four and 12 hour waiting time targets are performance measures in place across the United Kingdom (UK), the Minister highlighted that measurement of the 12 hour target

115 14 January 2015, Michael Bloomfield, Director of Performance and Corporate Services, HSCB.

between Northern Ireland and England differs.[116] The DHSSPS emergency care waiting time statistics caution against direct comparisons between Northern Ireland and the rest of the UK, noting that "the way in which emergency care services are delivered differs between UK jurisdictions" and it is "currently liaising with colleagues in England, Scotland and Wales to clarify any differences between the emergency care waiting times reported for each administration."[117]

An increase in the number of indicators the HSCB must use to monitor ED attendances suggests recognition by the DHSSPS of the need to monitor beyond the four and 12 hour target.[118] Moreover, the Emergency Department Collaborative under the auspices of the PHA's 'HSC Safety Forum' have also developed indicators.[119] These are based on clinical consensus with some linked to CEM standards (although it is not clear if the full suite of indicators have been adopted by all EDs). The HSCB/ PHA's Annual Quality Report does, however, highlight positive outcomes against the severe sepsis indicator:

> […] following 12 months of engagement and improvement through the collaborative, by mid-2013, NI exceeded the CEM standards on early management of severe sepsis. A 'point in time' audit, conducted by all HSCTs in spring 2014, demonstrated that this improvement had been maintained.[120]

Overall, from the Inquiry evidence, while there was general agreement that people waiting over 12 hours in an ED are unlikely to experience good quality care, there was less consensus on the utility of the four-hour target.

Findings: Timeliness

A sufficient quantity of health facilities, goods and services is essential to ensure timely health care.[121] The NIHRC found that:

- Delays are often due to the limited availability of 24/7 facilities, inpatient and non-hospital based services outside EDs. Moreover, while various initiatives aimed at improving the situation were identified, these, at times, appeared to be dependent on individual HSC Trust or EDs.
- The 'emergency care waiting time target', introduced in 2007, can be said to form part of a quality assurance process to reduce delays in EDs. While the target has never been consistently achieved by all Type 1 and 2 emergency care departments, the five year trend shows progressive improvement against the 12 hour target.
- At the same time, overall performance against the four hour target has declined.
- Inquiry evidence points to a lack of consensus on the utility of the waiting time target, particularly the four-hour component.[122] There was also no evidence that the utility of the target (as opposed to outcomes against it) is reviewed. It was therefore not possible to determine if the waiting time target is based on transparent

116 Letter from Minister Wells to the Chief Commissioner 10 February 2015, "In Northern Ireland, as with the 4 hour target, the timing of the patient journey in ED begins at their presentation to the Department and the clock continues to run until they are admitted or discharged. In England, the waiting time commences once a clinician has made a decision to admit to hospital." See also NHS England, 'Emergency Care Weekly Situation Report', 3 April 2014 at p. 9 where the relevant 12 hour waiting time measure for Type 1, 2 and other EDs is defined as "Total number of patients who have waited 4-12 hours in A&E from decision to admit to admission" and "Total number of patients who have waited over 12 hours in A&E from decision to admit to admission."

117 DHSSPS (Information Analysis Directorate) *Emergency Care Waiting Time Statistics (January - March 2015)*, p47, available at, http://www.dhsspsni.gov.uk/ecwt-q4-january-march_2015.pdf (accessed 11 May 2015).

118 See the Health and Social Care (Indicators of Performance) Direction (NI) 2014, Schedule, Indicators A9 and B2 to B11. The development of indicators is in keeping with Objective 5 of Quality 2020 to "develop a set of effective and measurable quality targets to monitor safety, effectiveness and patient client experience."

119 http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum/emergency-department (accessed 11/01/15).

120 HSCB / PHA Annual Quality Report 2013/14, p. 35.

121 CESCR, General Comment 14, para 11

122 That: "95% of patients attending any Type 1, 2 or 3 ED are either treated and discharged home, or admitted, within four hours of their arrival in the Department."

criteria that address the risk of deterioration in clinical and quality of life terms.[123]

- Other time-sensitive indicators, as well as qualitative data accounts are being used by EDs to monitor quality. But it was not apparent if these are routinely used across all EDs.

The provision of appropriately skilled health care staff

Provision

Members of the public conveyed a general view of EDs as under staffed and overworked:

I would like to see more staff and doctors at patient level; I honestly believe things would have been a lot better for me.

The medical staff were overworked and coped well under the demands as the A&E department was overcrowded.

The staff reinforced these views using terms such as "swamped" "demoralised" "burn out" "stretched" "distressing" and "frustrated"[124]. One nurse recalled being solely responsible for eight cubicles in the ED. Describing this as "horrendous", she recalled "crying a lot" and "worrying that things were not done safely." Another reported that at times there is only one nurse responsible for six beds. Although expressing awareness about the importance of patients' rights, such as the effective communication, it was felt that due to pressured conditions staff are required to focus on maintaining safety:

As it's so busy, patients' right to know what's happening – communication – is the biggest area of complaint. Staff [are] trying to facilitate clinical needs – [we're] so worried about maintaining this. My heart breaks for patients waiting in a corridor for hours – I get the anger of family – staff are very demoralised.

A lack of permanent consultant posts and middle grade doctors was also reported as a significant concern. For example, in the BHSCT some staff indicated that EDs are employing locums at great cost to the Trust:

Consultant medical cover is too low. Last year there were five consultants, from next week there will be one emergency consultant.[…] A new locum is expected from England. This will cost £140 an hour…

We don't have enough of middle grades; a consultant overnight isn't needed all the time and its difficult to deliver but what we do need is middle grades and enough of them and properly supported and valued;

It was felt that the difficulties in retaining permanent middle grade posts is due to the pressure and lack of care they are afforded: "Some of those folk had to take time off because [they are] so incredibly overworked". The NIAS also reported difficulties ensuring adequate staffing levels within the ambulance service. There was an acceptance that staff were, at times over-burdened, and a recognition that some had been working through their rest periods.

HSC Trust representatives and ED clinicians largely supported these views. For example, in the WHSCT, it was stated that "below our senior tier [of emergency medicine consultants] we rely mostly on locums" (Lead Clinician, SW Acute). When giving evidence the Trust reported a significant overspend partly related to this (Chief Executive, WHSCT; and Deputy Chief Executive). Further, the RBHSC identified that while staffing levels had improved on the back of two reviews, recruitment of general paediatric nurses, paediatric emergency care nurse practitioners and middle grade medical paediatric staff was the main resource issue for the ED. This was reported as having follow-on effects upon staff training.

123 CoE, Committee of Ministers Recommendation R (99) 21 on the criteria for the management of waiting lists and waiting times in health care, 1999, para 3

124 Note that this was mostly regarding the Royal Victoria Hospital ED and the Mater Infirmary Hospital ED, but one staff participant also referred to experiences in Antrim Area Hospital and Causeway Area Hospital.

More generally, it was noted that the demands of emergency medicine rendered it unattractive for many as a speciality. On this, the CEM called for more "ethical" contracts:

> What the college argue is there should be a proportionality between out of hours work and annual leave entitlements because the reason that people find it unattractive to work Saturdays and in the middle of the night and lots of weekends is because of the opportunity lost to spend time with family and friends […]. If you can link in some way annual leave to out of hours work what you then allow the person to do is say yes I spend fewer weekends, fewer Saturday nights or such with the family, but overall I have just as much quality family time with my friends and family as people who work in more normal office hour based contracts. The whole point about this is it should be an ethical contract rather than an identical contract and if we were to do that we would undoubtedly reverse the drain of doctors away from emergency medicine both in terms of enhanced recruitment and more importantly probably, enhanced retention (President, CEM).

The skills mix within EDs was another area identified as a concern for both clinicians and nursing staff. It was stated that "regionally and nationally" there is no recognised workforce planning tool for emergency nursing, which makes it difficult for EDs to justify the staff they need (Lead Nurse, Antrim Area Hospital). In this respect, the work of the Chief Nursing Officer (CNO) in commissioning the NI Practice and Education Council for Nursing and Midwifery (NIPEC) to develop a framework for an emergency care nursing career pathway, as well as plans to review and evaluate emergency care nurse staffing levels was welcomed (RCN). However, the RCN reported:

> Our slight concern about that is that we will need the trusts and indeed the Health and Social Care Board to actually buy into that piece of work because if we have come up with a framework we need to ensure that is then implemented.

In its evidence, the BHSCT stated it was "very proud" of the development of the Advanced Nurse Practitioner role within the Royal Victoria Hospital ED, but it was also acknowledged that this role is "quite costly to educate […] and we do need our medical colleagues to provide the supervision and training, which is very difficult when they're already stretched in other areas." (Director of Nursing and Patient Experience, BHSCT).

It was further noted that ED staffing is not only about nursing and clinical roles: "[…] Administrative roles are extremely important, [such as] the patient tracker […] that can free up clinical staff […]; we really do need to think who can deliver what elements of care" (ED Manager, Antrim Area Hospital). Both the HSC trusts and the NIAS referred to the establishment of a 'Hospital Ambulance Liaison Officer' (HALO), although this post does not exist in all EDs:

> we have them at Antrim, Craigavon, the Royal and the Ulster and these are officers who would work with the crew arriving on scene and more importantly with the ED department themselves in trying to ensure that where there are acute patients coming that they know they're coming in […] each ED department has an arrival screen which will show there is ambulance traffic en route so they can anticipate what traffic is coming to emergency departments, they can work to create capacity in the floor and they can also work to create capacity by organising discharge from wards to allow the patient flow to be improved (Director of Operations, NIAS)

Inquiry evidence suggested that rural areas experienced particular difficulties attracting permanent middle grade doctors and this had forced rural EDs to devise local solutions. Co-located GP and out-of-hours services, close working relations between physicians and surgeons across other parts of the hospital, and a combined medical and surgical assessment unit were referred to, as examples of working differently to address the identified problems.

Finally, there was a view that increased staffing would not in itself resolve the difficulties in EDs, As the Director of the RCN explained:

you can put in temporary staff to deal with the influx that you have got in that environment but that is not what is required. The ED is not a department for providing nursing care or any kind of care to patients; they were never designed to do that and therefore whilst some may think that when you put 40 extra nurses into our emergency departments, that's it sorted, but it isn't it sorted at all […] we need to understand who are all the people that are coming […], did they need to be there? When they are assessed, what are the assessments like? Are we admitted people appropriately? Are we discharging people too early? Those are all questions that need to be asked about […] are we truly running a 24/7 service?

Training

A number of staff described positive experiences of education including of induction packages and mandatory courses, such as child protection and vulnerable adults training. However, others noted that "getting time to attend" even mandatory training had been difficult. One participant in the call for evidence reported:

[there is] no opportunity to go to training due to short staff. People are behind on mandatory training and because they're so overworked there is no inclination for extra training.

It was also reported that overcrowding had impacted negatively on training for junior and middle grade doctors, as consultants had less time to supervise.

When asked about human rights training, a number of staff indicated that it was either implicit or mainstreamed within other training programmes:

[…] fundamental to nurses and nursing and I suppose anyone in the care environment are the core principles of human rights […]. Probably the different […] specialist practice courses that the staff go on there's elements of human rights brought into that (Nurse Manager, Altnagelvin).

Others felt that while the delivery of technical training for medical staff was "simple," human rights training "is a challenge" (Clinician, Antrim Area Hospital ED). An Equality Manager for the SEHSCT noted that specific human rights training had been developed, but frontline staff found it difficult to attend, particularly those in ED. For this reason, an e-learning module had been developed: "[…] between April and September when we implemented it we have seen a 19% increase in the number of staff who've gone through equality and human rights training." Another Equality Manager noted, uniquely, that for staff in the SEHSCT: "[…] human rights training is mandatory in terms of induction and for the three yearly review."

A review of the HSC trusts' Annual Quality Reports have demonstrated various initiatives and plans for staff training and development, although it was not explicitly stated if this included those working in the ED. For example, the SEHSCT notes a commitment to build knowledge and skills of quality improvement in staff as part of its drive to foster a "culture of continuous quality improvement (CQI)." This adopts a "[…] 'bottom up' approach to CQI, by empowering frontline staff to articulate and measure their own, service specific indicators for safety, quality and patient/client experience."[125] The Southern Health and Social Care Trust (SHSCT) records that "Professional staff (e.g. nurses, doctors, AHPs, social workers etc.) also continue to be supported in completing their Continuing Professional Development and/or meeting the requirements of Revalidation, as applicable within their profession."[126] The BHSCT reports on a "Step-Up Project" to educate specialist trainee doctors in "modern concepts of leadership and quality improvement skills."[127]

A clinical manager at the SEHSCT recalled that workshops for staff to give feedback and develop solutions to the outcomes of the '10,000 Voices'

125 SEHSCT, Annual Quality Report 2013/2014, p.5.
126 SHSCT, Annual Quality Report 2013/2014, p.39.
127 BHSCT, Annual Quality Report 2013/2014, p.55.

survey had been provided. Others referred to mandatory clinical and safety training, noting that in a busy ED setting clinical training might have to be prioritised:

> […] it's not that we negate the importance of it [but] it would be fair to say that within an A&E a lot of the training is very focused on the clinical need, you know resuscitation and elements of that. (ED Manager, Altnagelvin).

In its evidence UNISON suggested that funding cuts had a significant impact on the delivery of training.[128] This view was illustrated by the example of the SHSCT, where reportedly a letter was sent to staff cancelling some training. For UNISON, this raised the question "where are we going to get the human rights and equality training from" (UNISON).

Findings: Provision and training of health care staff

A good quality health system requires a minimum number of health professionals.[129] The NIHRC found that:

- There is a general view that EDs are typically understaffed.
- Recruiting and retaining middle grade doctors, and ensuring sufficient skill mix among nursing staff was a concern.
- Evidence of progressive improvement included recruitment of Advanced Nurse Practitioners, the development of the Emergency Nurse Practitioner role, and work on an 'emergency care framework.'
- Non-medical staff, such as patient-trackers and Hospital Ambulance Liaison Officers, have been recruited to assist in freeing up clinical staff. But this was not apparent on a permanent basis in all EDs.
- Human rights training was often reported as implicit or mainstreamed within other training programmes. Where delivered, this covered many core human rights standards and principles, particularly those derived from the ECHR. But it was not apparent that the right to health was included.[130]

128 In its response to the draft report, one Trust noted for clarification that "the Trust's mandatory Equality Training and Human Rights Training Programme is ongoing and is reported annually to Trust Board and the Equality Commission" (dated 6 May 2015).

129 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 80.

130 CESCR, General Comment 14, para. 44(e): training and the curriculum should educate on the relationship between health and human rights including, inter alia, the right to health.

2 Accessibility

The right to the highest attainable standard of health includes a duty to provide facilities, goods and services that are accessible.[1] Maintaining the principle of equality and ensuring non-discrimination is of fundamental importance to guaranteeing that Emergency Departments (EDs) are accessible.[2]

This requires refraining from practices that may distinguish, exclude, restrict or preference patients on the basis that they are members of a particular group, where there is no reasonable and objective justification.[3] It also means that when such practices are identified, positive steps must be taken to eliminate them.[4] In addition, accessibility is dependent upon preventing the conditions within EDs and staff attitudes, which may have the effect of causing or perpetuating the marginalisation of patients belonging to groups that are at risk of experiencing inequalities.[5]

It is vital that EDs monitoring processes seek to gather data on accessibility and use of service, in particular by including the views of such groups and ensuring that the collected data is disaggregated.[6] Finally, human rights standards also require that health professionals be trained to both recognise and respond to the specific needs of such patients.[7]

1 ICESCR, Article 12; UN Doc. E/CN.4/2000/4, CESCR, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 12(b).
2 ICESCR, Article 2(2) and Article 12; CESCR, General Comment 14, paras 12(b)(i) and 18; CESCR, General Comment 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2) (2 July 2009). See also, ICCPR, Article 26; CoE Convention on Human Rights and Biomedicine, Article 3; and taken in conjunction with the relevant substantive right, ECHR, Article 14, and EU Charter, Article 21.
3 CESCR, General Comment 20, para 13.
4 Ibid, para 8.
5 Ibid.
6 Ibid., paras 36 and 41. See also, UN Doc. E/CN.4/2006/48, 'Report of the Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (3 March 2006), para 49(b); UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 93; UN Doc. E/CN.4/2005/51, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (11 February 2005), paras 59-60.
7 CESCR, General Comment 14, para 37.

Human rights laws and standards framework

Non-discrimination and equality

Refraining from discrimination

The International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 2(2) taken together with the right to health, prohibits discrimination in law or in fact in the development and delivery of healthcare within an ED. The International Covenant on Civil and Political Rights (ICCPR), Article 26 explicitly requires the law to "prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground".

Discrimination constitutes,

> any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of the right to health.[8]

The concept of discrimination includes "laws, policies or practices which appear neutral at face value, but have a disproportionate impact" on the enjoyment of the right to health by persons belonging to particular groups, also known as indirect discrimination.[9]

The prohibited grounds are not limited and have been identified by the Committee on Economic, Social and Cultural Rights (CESCR) to include, "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status

8 CESCR, General Comment 20, para 7.
9 Ibid., para 10(b). The European Court of Human Rights (ECtHR) has also made clear that the Convention's non-discrimination provisions extend to cases of indirect discrimination. For example, in *Thlimmenos v Greece*, the Court declared that Article 14 is engaged when States 'fail to treat differently persons whose situations are significantly different'. See, *Thlimmenos v Greece,* ECtHR, Application No. 34369/97 (6 April 2000), para 44.

(including HIV/AIDS), sexual orientation and civil, political, social or other status".[10]

It is important to note that differential treatment will not be deemed discriminatory under any of the standards if the acts or omissions of the relevant health authority are "reasonable and objective".[11] The CESCR directs that the concept of a reasonable and objective justification will entail,

> an assessment as to whether the aim and effects of the measures or omissions are legitimate, compatible with the nature of the Covenant rights and solely for the purpose of promoting the general welfare in a democratic society. In addition, there must be a clear and reasonable relationship of proportionality between the aim sought to be realised and the measures or omissions and their effects.[12]

That said, a lack of available resources is not a reasonable and objective justification, "unless every effort has been made to use all resources that are at the State party's disposition in an effort to address and eliminate the discrimination, as a matter of priority".13 The CESCR stresses that,

> many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information.[14]

Eliminating and preventing discrimination

In the event of identifying discrimination, health authorities are under an immediate obligation to "adopt the necessary measures to … diminish and eliminate the conditions and attitudes which cause or perpetuate" it.[15] The approach must be "active", typically requiring a comprehensive range of measures.[16] Eliminating discrimination may also require the adoption of "temporary special measures".[17] The CESCR notes that special measures are "legitimate to the extent that they represent reasonable, objective and proportional means to redress *de facto* discrimination and are discontinued when substantive equality has been achieved".[18]

In addition, the health authorities are under an immediate obligation to "adopt the necessary measures to prevent … the conditions and attitudes which cause or perpetuate" discrimination.[19] This will include measures that

10 CESCR, General Comment 14, para 18. The ICCPR, Article 26 refers to the grounds of "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

11 CESCR, General Comment 20, para 13. See also, UN Human Rights Committee, General Comment 18, para 13; and *Thlimmenos v Greece,* ECtHR, Application No. 34369/97 (6 April 2000), para 44.

12 CESCR, General Comment 20, para 13. In considering what amounts to a 'reasonable and objective' justification, the ECtHR accords to the State a degree of discretion, known as the 'margin of appreciation'. The scope of the margin will vary 'according to the circumstances, the subject-matter and the background'. While the Court has regarded the margin to be wide in the context of economic or social strategies, discrimination on certain grounds, such as sex, race, disability and sexual orientation, among others, will result in that margin being greatly reduced. See, *Eweida and Others v United Kingdom,* ECtHR, (Applications nos. 48420/10, 59842/10, 51671/10 and 36516/10) (15 January 2013), para 88; *Stummer v Austria,* ECtHR, Application no. 37452/02 (7 July 2011), para 89. See also, *Ruszkowska v Poland,* ECtHR, Application no. 6717/08 (1 July 2014), para 54; *X and Others v Austria,* ECtHR, Application no. 19010/07 (19 February 2013), para 99; *Nachova and others v Bulgaria,* ECtHR, Application no. 43577/98; 43579/98 (6 July 2005), para 145; *Glor v Switzerland,* ECtHR, Application no. 13444/04 (30 April 2009), para 84.

13 CESCR, General Comment 20, para 13.

14 CESCR, General Comment 14, para 18.

15 CESCR, General Comment 20, para 8. See also, CESCR, General Comment 3: The nature of States' parties obligations (1990), para 1. Other human rights standards which support this obligation include: ICCPR, Article 26; CoE Convention on Human Rights and Biomedicine, Article 3; and taken in conjunction with the relevant substantive right, ECHR, Article 14, and EU Charter, Article 21. In the case of the ECHR, the most likely rights to be engaged are the right to privacy (Article 8), the right to be free from inhuman and degrading treatment (Article 3) and the right to life (Article 2). The ECtHR has reasoned that a violation need not be found of the foundation right in order to find a violation of the prohibition on discrimination and it will be sufficient if the facts of the case fall within the ambit of the foundation right to engage Article 14. See, *Case "relating to certain aspects of the laws on the use of languages in education in Belgium" (Merits),* ECtHR, Application no 1474/62; 1677/62; 1691/62; 1769/63; 1994/63; 2126/64 (23 July 1968), 'Interpretation adopted by the Court' para 9; *Eweida and Others v United Kingdom,* ECtHR, (Applications nos. 48420/10, 59842/10, 51671/10 and 36516/10) (15 January 2013), para 85.

16 CESCR, General Comment 20, para 39.

17 Ibid., paras 38 and 39. The concept of 'temporary special measures' is sometimes referred to as 'affirmative action'. See, Human Rights Committee, General Comment 18: Non-discrimination, para 10. For a general discussion on the different terminology, see the CEDAW Committee, General Recommendation 25: on temporary special measures, para 17. See also, the EU concept of 'positive action', for example, EU Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, Article 5; CoE, Committee of Ministers, Recommendation Rec(2001)12, Appendix, Part I, part 5.

18 CESCR, General Comment 20, para 9. The CESCR has noted that such measures will exceptionally need to be of a permanent nature.

19 Ibid., para 8. Italics added.

address the underlying social determinants of health[20] and a plan of action that seeks to prevent discrimination by giving particular attention to vulnerable and marginalised groups.[21] The health authorities must pay "sufficient attention to groups of individuals which suffer historical or persistent prejudice."[22]

To further safeguard against discrimination, health authorities should provide equal access to healthcare facilities, goods and services, and ensure that they are culturally appropriate.[23] These obligations are subject to the principle of progressive realisation and should be understood alongside the various group specific human rights laws and standards.[24] Accessibility requires health facilities, goods and services to be in safe physical reach, especially for vulnerable or marginalised groups ('physical accessibility'). This includes ensuring, for example, adequate access to the ED building for persons with disabilities.[25] Accessibility also refers to the right to seek, receive and impart information and ideas concerning health issues ('information accessibility').[26] This includes ensuring, for example, the provision of age-appropriate information to children presenting at ED.[27] A culturally appropriate ED will be "respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements."[28]

Monitoring inequality

To monitor inequality, indicators and benchmarks within national strategies, policies and plans should be disaggregated on the basis of the prohibited grounds of discrimination (see also 'Governance' chapter).[29] In light of the contextual nature of vulnerabilities and the practical difficulties in gathering accurate disaggregated data, the UN Special Rapporteur on the right to health has recognised the possibility of prioritising some disaggregated data above others in certain situations.[30] At a minimum, however, the Special Rapporteur urges disaggregation of health data on grounds of sex, race, ethnicity, rural/urban and socio-economic status.[31] Furthermore, "individuals and groups of individuals, who may be distinguished by one or more of the prohibited grounds, should be ensured the right to participate in decision-making processes" concerning the measures taken to address discrimination.[32]

20 Ibid., and CESCR, General Comment 14, para 4.
21 CESCR, General Comment 20, para 38. See also, CESCR, General Comment 14, para 43(f).
22 CESCR, General Comment 20, para 8. The failure, for example, to adopt a gender-sensitive approach to health is a violation of Article 12. See, CESCR, General Comment 14, para 52.
23 CESCR, General Comment 14, para 12(b)-(c).
24 There are numerous human rights laws and standards that pertain to particular groups. Some examples applicable to ED include: all information and communication pertaining to the provision of health care should be accessible through sign language, Braille, accessible electronic formats, alternative script, and augmentative and alternative modes, means and formats of communication (UN Doc. CRPD/C/GC/2, CRPD Committee, General Comment 2: Accessibility (art. 9) (22 May 2014), para 40); measures should be taken to address language barriers for ethnic minorities including the provision of both interpretation and translation services, avoiding the use of family members (CoE, Committee of Ministers, Recommendation CM/Rec(2011)13 'on mobility, migration and access to health care' (16 November 2011), paras 13, 15 and 16); all health professionals should be aware of the entitlement of migrants to use the health system irrespective of legal status (CoE, Committee of Ministers, Recommendation CM/Rec(2011) 13 'on mobility, migration and access to health care' (16 November 2011), para 11 and CoE, Committee of Ministers, Recommendation Rec(2001)12 'on the adaptation of health care services to the demand for health care and health care services of people in marginal situations' (10 October 2001), Appendix, Part I, para 2); and, health mediators should be recruited to provide liaison between health personnel and managers and Roma (ECRI General Policy Recommendation 13: on combating anti-gypsyism and discrimination against Roma (adopted 24 June 2011), recommendation 7(b)). Further instruments of general application include: UN Principles for Older Persons (adopted by UN General Assembly resolution 49/91 of 16 December 1991); and the UN General Assembly Resolution 46/119, 'The protection of persons with mental illness and the improvement of mental health care' (17 December 1991).
25 CESCR, General Comment 14, para 12(b)(ii). See also, UNCRPD, Article 9.

26 CESCR, General Comment 14, para 12(b)(iv).
27 UN Doc. CRC/GC/2003/4, CRC Committee, General Comment 4 (1 July 2013), para 39(b).
28 CESCR, General Comment 14, para 12(c).
29 CESCR, General Comment 20, para 41.
30 UN Doc. E/CN.4/2006/48 'Report of the Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (3 March 2006), para 49(b).
31 UN Doc. E/CN.4/2006/48 'Report of the Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (3 March 2006), para 49(b).
32 CESCR, General Comment No. 20, para 36; UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 93. See also UNCRPD, Articles 3 and 4; CRC, Article 12; CEDAW, General Recommendation 24, para 31(a); Vienna International Plan of Action on Aging (1983), para 61 (Recommendation 9); CoE, Committee of Ministers Recommendation Rec(2006)10 on better access to health care for Roma and Travellers in Europe, part IV, para 4; CoE, Committee of Ministers Recommendation CM/Rec (2011)13 on mobility, migration and access to healthcare (16 November 2011), para 28; UN Doc. E/CN.4/2005/51, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (11 February 2005), paras 59-60; CERD, General Comment 27: Discrimination against Roma (2000), para 34.

Finally, the health authorities should regularly assess whether the measures chosen to address discrimination are effective in practice.[33] Such an assessment should consider both the steps taken and the results achieved.[34]

Training to ensure awareness and responsiveness by health care staff

The duty to prevent discrimination also includes a requirement that training programmes are provided for health care staff to ensure that they can recognise and respond to the needs of vulnerable or marginalised groups.[35] The duty to prevent discrimination also includes a requirement that training programmes are provided for health care staff to ensure that they can recognise and respond to the needs of vulnerable or marginalised groups. In the 2009 concluding observations, the CESCR recommended that the State undertake,

> training programmes for doctors and health-care professionals about the State party's [ICESCR] obligations, as well as with regard to the prevention and treatment of dementia and Alzheimer's diseases.[36]

Domestic framework

The following sections extract the core obligations of the DHSSPS and health authorities in ensuring the accessibility of the health system and, in particular, emergency health care, and examine the extent to which these are established within:

- Domestic laws and standards;
- Regional strategies and plans; and
- HSC trusts and institution specific policies, education and training.

Domestic laws and standards

Refraining from discrimination

In Northern Ireland (NI), it is unlawful to discriminate in the provision of healthcare on the grounds of sex,[37] sexual orientation,[38] race,[39] religious belief,[40] political opinion[41] and disability.[42] No equivalent legal provision appears to exist to prohibit such discrimination on grounds of birth, property, health status, or age,[43] although these grounds will be covered where there is an interference with one of the substantive rights protected under the Human Right Act 1998.[44] The Northern Ireland Executive (NI Executive) has, however, committed to extend age discrimination legislation to the provision of goods, facilities and services, thereby including the provision of healthcare, in its Programme for Government 2011-2015.[45] On 19 February 2015, the NI Executive announced plans to bring forward a consultation document on the issue in the near future.[46]

Eliminating and preventing discrimination

Domestic legislation places obligations on health authorities to be cognisant of inequality. The trusts for example, are under a broad duty by virtue of

33 CESCR, General Comment 20, para 36.
34 Ibid., para 41.
35 CESCR, General Comment 14, para 37. Other human rights laws and standards state that this should include, where relevant, training on: a gender sensitive approach, including gender based violence (CEDAW Committee, General Recommendation 24 (1999), para 31(f)); a child-friendly provision of services, along with maternal and children's health (UN Doc. CRC/C/GC/15, CRC Committee, General Comment 15 (17 April 2013)); geriatric illness (Vienna International Plan of Action on Aging (1983), para 60; UN Doc. CEDAW/C/2010/47/GC.1, CEDAW Committee, General Recommendation 27 (19 October 2010), para 45); disabilities (UNCRPD, Article 25(d); UN Doc. E/CN.4/2005/51, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (11 February 2005), para 55); barriers for migrants in accessing health care, such as discriminatory assumptions about suitable treatment (CoE, Committee of Ministers Recommendation CM/Rec(2011)13 'on mobility, migration and access to healthcare' (16 November 2011), Appendix, Guidelines, para 14 and 25); and, an assessment to ensure that staff possess the necessary psychosocial qualities to enable work with young children (UN Doc. CRC/C/GC/7/Rev.1, CRC Committee, General Comment 7 (20 September 2006), para 23).
36 UN Doc. E/C.12/GBR/CO/5, CESCR, 'Concluding observations on the UK' (12 June 2009), para 34(a).

37 Sex Discrimination (NI) Order 1976 (as amended), Article 30. This includes discrimination on the grounds of gender reassignment, see Article 4A.
38 Equality Act (Sexual Orientation) Regulations (NI) 2006, Regulation 12.
39 Race Relations (NI) Order 1997 (as amended), Article 21.
40 Northern Ireland Act 1998, Section 76.
41 Ibid.
42 Disability Discrimination Act 1995 (as amended), Section 19.
43 Age discrimination law covers employment and vocational training only. See, Employment Equality (Age) Regulations (NI) 2006.
44 See Human Rights Act 1998, Schedule 1.
45 NI Executive, Programme for Government 2011-2015, Commitment 38 (p 10).
46 OFMdFM, Press Release 'McCann and Bell announce way forward for new age discrimination legislation' (19 February 2015). The consultation is to include legislation protecting persons aged 16 years and over.

the Health and Social Care (Reform) Act (NI) 2009, Section 21, to exercise their functions "with the aim of reducing health inequalities between, those for whom it provides, or may provide, health and social care."

Further, the Northern Ireland Act 1998 ('NI Act 1998'), Section 75(1) places a statutory duty on all health authorities, when carrying out their functions, to, "have due regard to the need to promote equality of opportunity" on nine grounds, namely, between: persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; persons with a disability and persons without; persons with dependents and persons without; and, men and women. The Disability Discrimination Act 1995 ('DDA 1995'), Section 49A[47] further requires the health authorities, when carrying out their functions, to "have due regard to- (a) the need to promote positive attitudes towards disabled persons; and (b) the need to encourage participation by disabled persons in public life." The list of groups to which the Section 75(1) duty applies is narrower than the specific groups identified by the ICESCR Committee and Special Rapporteur, omitting for example, rural/urban, health status and socio-economic status.

Pursuant to the NI Act 1998 and the DDA 1995, health authorities must each adopt an Equality Scheme and a Disability Action Plan detailing to the public how they propose to meet their Section 75 and Section 49A duties.[48] The Equality Commission for Northern Ireland (ECNI) is obliged to keep under review the effectiveness of the Section 75 and Section 49A duties and offer advice to the authorities.[49] Since 2010, the ECNI has recommended that each authority also produce an action based plan to tackle inequalities informed by an inequalities audit.[50]

The Equality Scheme, Equality Action Plan and Disability Action Plan therefore serve as the primary medium through which the health authorities convey what measures they are taking, directed both at procedure and outcome, to prevent discrimination and promote equality. Other documents, which may include actions towards addressing inequality, include commissioning plans, corporate plans, national strategies and annual quality reports as demonstrated below.

There is recognition by the NI Executive of the need to address health inequality. This is directed both towards the social determinants of health[51] and the delivery of health care.[52] For example, Priority 2 of the Programme for Government commits the NI Executive to tackle disadvantage and address health inequalities.[53] In turn, the Department for Health, Social Services and Public Safety (DHSSPS)'s Ministerial Priorities for 2014/15 direct the Health and Social Care Board (HSCB) to "… reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention", priority (a), and "ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively," priority (g).[54] One target attached to priority (a) impacts directly on EDs and is the requirement that,

> [b]y March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC (health and social care) acute hospital settings undertaking regionally

47 As amended by the Disability Discrimination (NI) Order 2006.
48 Northern Ireland Act 1998, Schedule 9, Section 4(1) and Disability Discrimination Act 1995, Section 49B (as amended by the Disability Discrimination (NI) Order 2006).
49 NI Act 1998, Schedule 9, para 1; Disability Discrimination Act 1995, Section 49A (as amended).

50 ECNI, *Section 75 of the Northern Ireland Act 1998: A guide for public authorities* (April 2010), p 46.
51 For example, NI Assembly, Committee for Health, Social Services and Public Safety, *Review of Health Inequalities Report* (2012?), p 3 states: "the main social determinant of health is poverty".
52 For example, Quality 2020, p 7.
53 See also, NI Assembly, Committee for Health, Social Services and Public Safety, *Review of Health Inequalities Report* (2012?), p 3 states: "the main social determinant of health is poverty".
54 The Health and Social Care (Commissioning Plan) Direction (NI) 2014, part 3(g).

agreed Structured Brief Advice or Intervention programmes.[55]

In addition, the 'Indicators of Performance' related to this priority include a requirement to monitor the "[n]umber of A&E presentations due to self-harm".[56] Concerning priority (g), the legislation explains that the Commissioning Plans must ensure that the DHSSPS's statutory responsibilities to vulnerable groups are met.[57]

The NI Executive's strategic framework, 'Making Life Better: 2013-2023' also incorporates the reduction of unequal health outcomes within its vision and aims.[58] However, it is the three Departmental 'Service Frameworks', relating to older persons, persons in mental health crisis and persons with learning disabilities that identify the most comprehensive list of specific standards that patients and their families of these vulnerable groups can expect of the health and social care (HSC) system.[59] A few of these standards relate specifically to the ED setting and the issues discussed within the context of the current Inquiry.

The table below lays out the standards relevant to ED within the three Service Frameworks, and the Department's accompanying rationale.

Table 6: DHSSPS Service Frameworks

Title	Standard	Rationale
Service Framework for Mental Health and Wellbeing	51: Self Harm – Assessment and early intervention A person who has self harmed should have any physical injuries dealt with as a matter of urgency and be offered preliminary psychosocial assessment when first presenting to services. If presenting either a risk to themselves or others they should be referred and assessed by age appropriate specialist mental health services immediately in line with NICE guidelines. Anyone presenting to A&E who does not immediately require access to specialist services will be provided with a specific follow-up appointment scheduled within 7 days, i.e. Card Before You Leave scheme.	Preliminary psychosocial assessment to establish physical risk and mental state assessment in a respectful and understanding way, taking account of emotional distress as well as the physical distress will help to identify motives for the act and associated problems that might be amenable to intervention at a later stage.
Service Framework for Older People	34: End of Life Care Planning for Older People with Advanced Dementia. Older people with Advanced Dementia should be identified through existing Primary Care Dementia Registers. These individuals should have the Gold Standards Framework prognostic indicators applied and where appropriate End of Life Care Plan should be agreed.	Often, acute illness occurs at night. In these situations, an on-call doctor may have to make a difficult decision about whether to admit the person to hospital. A decision to admit to hospital will often be made because of a lack of any prior knowledge of the individual with dementia, their stage of illness and the most appropriate approach to their care. This can lead to the distressing and relatively common situation where a person with advanced dementia is transferred to the acute hospital where they then die in unfamiliar surroundings. The presence of an Advance Care Plan for individuals with Advanced Dementia would inform the approach to their end of life care and give a framework for an End of Life Care approach most in keeping with that individual's best interest.

55 Ibid., Schedule (Target 3).
56 The Health and Social Care (Indicators of Performance) Direction (NI) 2014, Schedule (A.10).
57 The Health and Social Care (Commissioning Plan) Direction (NI) 2014, part 3(a). See, for example, the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.

58 DHSSPS, *Making Life Better: 2013-2023,* Chapter 4.
59 The NIHRC notes that a fourth Service Framework on Children and Young People is in development.

Title	Standard	Rationale
Service Framework for Older People	40: Early Identification to Maximise Independence Older people with health problems should be identified early to maximise independence and reduce crisis. Treatment and care should be delivered in the most appropriate setting.	Older people should always access high quality secondary care services when required. However many emergency admissions to hospital could be avoided by more timely intervention and support in the community which is better for older people and reduces unnecessary pressure on hospitals. In addition many patients remain in hospital unnecessarily because they are waiting for equipment or community care service.
Learning Disabilities Service Framework	19: All people with a learning disability should have equal access to the full range of health services, including services designed to promote positive health and well-being.	Most people with a learning disability do not require specialist services to address their health needs but many will require a range of reasonable adjustments to help them make use of … health services... . Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as: … fast tracking arrangements when appropriate (e.g. in A&E Departments) Performance Indicator: 1. All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability.

Monitoring inequality

The NI Act 1998 further requires that the health authorities' equality schemes specify the arrangements in place for "assessing" compliance with the Section 75 duties and the likely impact of policies on the promotion of equality of opportunity, as well as monitoring any adverse impact of policies adopted by the authority.[60] Alongside these assessment requirements are obligations to specify arrangements for consultation[61] and staff training.[62] The ECNI additionally recommends that collated data should be disaggregated by Section 75 categories enabling the identification of multiple identity issues and the development of inequality indicators.[63]

The primary arrangements for assessing compliance with the Section 75 duties identified in the health authorities' equality schemes include management and accountability structures, the audit of inequalities, equality action plans (including indicators and timescales) and the annual equality progress reports.[64] Arrangements for assessing policies adopted by health authorities include two levels of equality review, namely, screening and an equality impact assessment (EQIA).[65]

60 Northern Ireland Act 1998, Schedule 9, para 4(2)(a)-(c),
61 Ibid., Schedule 9, para 4(2)(a)-(b).
62 Ibid., Schedule 9, para 4(2)(e). The Disability Action Plan should stipulate similar procedural arrangements to those stated within the Equality Scheme for meeting the Section 49A duties and include action measures. See, Disability Discrimination Act, Section 49B (4) (as amended by the Disability Discrimination (NI) Order 2006); and ECNI, *A short guide to the public sector equality and disability duties* (October 2014), p 6.

63 ECNI, *Section 75 of the Northern Ireland Act 1998: A guide for public authorities* (April 2010), pp 25 and 49. See generally, ECNI, *Section 75 of the Northern Ireland Act 1998: Monitoring Guidance for Use by Public Authorities* (July 2007).
64 This follows ECNI advice, see generally ECNI, *Section 75 of the Northern Ireland Act 1998: A guide for public authorities* (April 2010).
65 Ibid., pp 13, 40, 54-55; ECNI, *Section 75 of the Northern Ireland Act 1998: Practical Guidance on Equality Impact Assessment* (February 2005), p 4.

Regional strategies and plans

Eliminating and preventing discrimination

In addition to the HSCB equality and disability action plans, there exists a range of regional strategies and plans that set out measures aimed at improving the health situation of particular groups. These include the: 'UK Strategy for Rare Diseases'; 'Bamford (Mental Health and Learning Disability) Action Plan 2012-2015'; 'Autism Strategy (2013-2020) and Action Plan (2013-2016)'; and '10 year Strategy for Children and Young People in NI 2006-16'.

In terms of emergency care, however, the pre-eminent directions at the regional level can be found in two HSCB commissioning priorities. First, the HSCB draft Commissioning Plan 2014/15 identifies as a regional priority the "expan[sion of] substance misuse liaison services to achieve the Commissioning Direction target for a 7-day service in all appropriate HSC acute settings."[66] Second, the draft Commissioning Plan requires the Local Commissioning Groups (LCGs) to "improve psychiatric liaison services" reflecting TYC recommendation 57 (which calls for a consistent pathway for urgent mental health care).[67]

Concerning the local action, the Belfast, Northern and Southern LCG plans adopt the specific target that access to psychiatric liaison services from EDs should be ensured within a "maximum 2 hours response time."[68] The Western LCG Plan refers to a "timely response"[69] and the South Eastern LCG Plan notes the issue is a "work in progress" and will be reviewed within the 2014/15 commissioning plan year.[70]

Regional guidelines also exist to assist staff in the provision of emergency care to particular groups. These include the 'Making communication accessible guidelines' and the 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedure Guidance (Sept 2006)'.

Monitoring inequality

There exists a NI wide "minimum dataset" which specifies what staff must record when a person attends ED. This includes the recording of age, sex, ethnicity and postcode (the latter should indicate rural/urban status).[71] A further drop down menu relating to the 'detail of the incident' includes the ability for staff to record self-harm and overdose attendances. Importantly however, there was no requirement for staff to record race or socio-economic status; two categories the Special Rapporteur has advised should be recorded as a minimum.[72]

The HSCB equality action plan recognises the need to improve the Section 75 information base and to this end contains an action to,

[e]stablish arrangements for collecting and analysing equality data to improve the central data base available within the Health and Social Care Board within the constraints needed to preserve confidentiality.[73]

The HSCB/Public Health Agency (PHA) '10,000 Voices' survey also seeks to collect information pertaining to the respondent's sex, age and ethnicity. The annual report presents the number of surveys returned by these categories but does not present a further breakdown of the respondent's experience along these lines.[74]

Concerning the participation of vulnerable groups, the HSCB facilitates regional steering groups on

66 HSCB/PHA, *Commissioning Plan 2014/15* (draft - 26 January 2015), p 79. See discussion on Ministerial Priorities above.
67 Ibid., p 107; Transforming Your Care: A review of health and social care in Northern Ireland (December 2011), p 139.
68 Ibid., pp 201, 266 and 426.
69 Ibid., p 495.
70 Ibid., p 339.

71 *Minimum Dataset for Emergency Departments, version 2.0* (February 2013), p 2.
72 It is noted that the patient's race will often be captured within the ethnicity category but that there often confusion between the two disaggregates; and that the symphony recording system used by most EDs (with the exception of the SEHSCT) allows staff to insert supplementary information in free response boxes.
73 HSCB *The Audit of Inequalities Action Plan 2013-2018,* (July 2013) p 8.
74 PHA/HSCB, *Patient/Client Experience: '10,000 Voices' annual report, June 2013-July 2014*, p 15.

particular issues where the views of service-users can be fed in to the wider HSC system. These include the Regional Self-Harm Group (and the wider Reference Group) and the Regional Ethnic Minority HSC Wellbeing Steering Group.

An example of a structural mechanism to assist in the assessment of measures taken to address discrimination is the DHSSPS 'Equality and Human Rights Steering Group' (EHRSG), which serves as a forum for discussion and dissemination of information between equality leads across health and social care.[75]

HSC trusts[76] and institution specific policies, education and training

Eliminating and preventing discrimination

In addition to the trusts' equality and disability action plans, there exists a range of local strategies and plans that set out measures aimed at improving the health situation of particular groups. These include the Belfast Health and Social Care Trust (BHSCT) Traveller Health Strategy and the Southern Health and Social Care Trust (SHSCT) Race Equality in Health Action Plan.

The trusts' equality and disability action plans include the following commitments in terms of emergency care:

- Maintain the 'Multi-Cultural and Beliefs' handbook to ensure that reflects current migration trends (all five ED trusts);
- Work with Trust service areas to identify key issues to address in preparation for extension of Age Discrimination Regulations (all five ED trusts);
- Increase accessibility to information, the Trust will increase the number of documents produced in an Easy-read format and to ensure that this information is readily available in an online Easy-read library (all five ED trusts); and,
- Contribute to Regional Support Services Review Task and Finish Group established to scope and review sign language communication support services (all five ED trusts).

The 'Patient Charter' produced by Altnagelvin Hospital ED singles out older people, stating, "[w]here appropriate, we will prioritise the needs of our elderly patients".

Monitoring inequality

The trusts jointly produce an audit of inequalities known as the 'Emerging Themes Document' which provides baseline data on which measures to address inequality can be based. The process for the audit of inequalities is presented as an examination of,

> (a)n extensive range of information sources including complaints received, customer surveys, monitoring information, research documents, annual reports, corporate plans, statistical information and health needs assessments.[77]

The trusts' commit to annually review and maintain the compendium document.[78] In addition to the minimum dataset that all EDs are required to record, the Inquiry was informed that the Royal Victoria Hospital ED recording system has two additional tabs related to particular groups. The tabs are designated as "special needs this attendance" and "special needs permanent". The categories within the recording system are set out in the following tables:

75 Email correspondence between the DHSSPS and NIHRC (10 February 2015). The EHRSG is chaired by the DHSSPS and meets on a quarterly basis.
76 EDs are not the responsibility of the NIAS.
77 See for example, NHSCT, *Trust Equality Scheme S75 Action-based Plan: Period 1 May 2014 - 30 April 2017,* p 3.
78 Ibid., p 22 (Action 15).

Table 7: Royal Victoria Hospital ED recording system - Special needs this attendance

Special Needs This Attendance	
- No special needs	
- Spinal board patient	
- Alcohol screen	
- Elderly/Frail	
- Flu like Symptoms	
- Hearing Loss	
- Private Room	
- Sight Problem	
- Speech Problem	
- Walking Aid	
- Wheelchair	
- Young Children (Accompanied by)	

Table 8: Royal Victoria Hospital ED recording system - Special needs permanent

Special Needs Permanent	
- Impaired hearing	
- Impaired mental status	
- Impaired mobility	
- Impaired sight	
- Other	

The BHSCT's Annual Quality Report 2013/14 notes that since December 2013, the Trust has recorded waiting times in EDs for patients referred to mental health.[79] The other trusts annual quality reports did not provide any information on the monitoring of this local commissioning priority.

Like the HSCB, the five trusts recognise within their equality action plans areas of concern related to the monitoring system. These include, "low levels of complaints received from the deaf and hard of hearing community" and "a need to improve ethnic monitoring of services".[80] To address these issues, the trusts commit to the following respective actions:

- promote the Regional complaints DVD: 'Complaints Procedure: A Guide on How to Complain'; and,
- continue to roll out ethnic monitoring to key information systems such as … PAS (Patient Administration System).[81]

In addition, the SHSCT and the Western Health and Social Care Trust (WHSCT) note the more general need to improve monitoring of Section 75 groups. The SHSCT equality action plan states that an "absence of an effective monitoring system makes it difficult to plan and respond to the changing needs profiles of the population" and adopts as an associated action:

- develop[ing] mechanisms to monitor and evaluate the uptake of services by Travellers and other BME communities.[82]

The WHSCT equality action plan notes the specific need to improve monitoring in the Acute Services Directorate, leading to the following action:

- identify 1 pilot area for developing S75 monitoring in Acute Directorate. Work with S75 groups to ensure systems are appropriate in particular for LGBT people, people with learning disability and people with sensory impairments.[83]

The trusts' also facilitate a selection of local steering groups on particular issues in which service-users are involved. Examples include the Carer Reference Groups/Carer Steering Groups and Disability Steering Groups.

Training to ensure awareness and responsiveness by health care staff

The trusts' 'equality leads' train senior managers and staff involved in policy development on the equality screening and EQIA process.

79 BHSCT, *Annual Quality Report 2013/14,* p 27.
80 See for example, BHSCT, *Trust Equality Scheme S75 Action-based Plan: Period 1 May 2014 – 30 April 2017,* pp 17-18.

81 Ibid.
82 SHSCT, *Trust Equality Scheme S75 Action Based Plan: Period 1 May 2014 – 30 April 2017,* p 18.
83 WHSCT, *Equality Action Plan: 1 May 2014 – 30 April 2017,* p 21.

Information provided by the trusts along with the annual equality progress reports, indicated that some level of equality training was mandatory for all staff in all trusts, whether that manifested as face-to-face training by the equality leads (BHSCT), the 'Discovering Diversity' e-learning programme (WHSCT; SHSCT),[84] or part of initial staff induction training programmes (Northern Health and Social Care Trust (NHSCT); South Eastern Health and Social Care Trust (SEHSCT)).

There are additionally a number of group specific trainings available for HSC staff. Safeguarding children and vulnerable adult training appeared to be mandatory across the trusts. Other training programmes available to various degrees within the trusts include topics such as: deaf awareness; sight loss awareness; autism awareness; mental health; dementia; traveller health; cultural competency; British Sign Language; inclusive communication; working well with interpreters; and providing Human Rights Act 1998 compliant health care to destitute persons.

Finally, a number of in-house leaflets and documents are available to ED staff. These include the 'Multi-Cultural and Beliefs' handbook and the 'Disability Etiquette' booklet.

Findings: Domestic framework

International human rights standards require a domestic framework of legislation and policies that ensure accessibility of healthcare, including ED provision.[85] Based on the information reviewed as part of the Inquiry, the NIHRC found that:

- The Human Rights Act 1998 prohibits discrimination in the provision of health care on all grounds if one of the substantive rights (e.g. right to privacy, freedom from degrading treatment, right to life) has been engaged. Outside of this context, no legislative prohibition on discrimination appears to exist concerning the provision of health care on grounds of birth, property, health status or age. There is however a commitment by the NI Executive to amend discrimination legislation on grounds of age;
- The domestic framework for eliminating and preventing discrimination on Section 75 grounds is well developed. There is no equivalent framework for promoting equality beyond these grounds;
- There is recognition of the need to improve the monitoring of the uptake of health care services, including presentations at emergency departments. The regional dataset does not include certain categories regarded as a minimum by the Special Rapporteur.

Accessibility in practice – Inquiry evidence

Refraining from discrimination

Behaviours and attitudes

Some family members of older patients expressed concern and felt that their relatives had been deprioritised, at times deliberately, on the basis of age. Comments included the impression that their relative was "left", "dismissed", "neglect[ed]" "wrote off" or "last priority in a long list". Age NI held the "very strong" belief that there is "institutionalised ageism in health and social care".

One 84 year-old witness recounted how ED staff had not accepted her version of events leading to her injury. Staff repeatedly asked her "Did you fall in the bathroom?/Did you fall in the kitchen?" despite being told what had happened. The witness stated that she felt "like [staff] treated me according to my birth certificate and treated me like a dog... The staff were not concerned with me."

84 See, <http://www.diversity.hscni.net/> (accessed 2 March 2015). The course flyer states, 'The goal of the programme is to promote positive staff attitudes to diversity and to encourage and promote appropriate behaviour in keeping with the letter and spirit of equality legislation', available at, <http://www.diversity.hscni.net/pdf/course_flyer.pdf> (accessed 2 March 2015).

85 CESCR, General Comment 14 para 12(b); ICCPR, Article 26.

The public provided examples of positive and negative approaches by staff when treating dementia patients. One witness perceived that a "casual and indifferent attitude" by staff contributed to the "distress, anxiety and confusion" of her 86 year-old mother. In another case, a relative described how staff were "very good" at speaking to their father and asking his permission. It was thought particularly important that he was not made to feel like a "second-class citizen".

A number of members of the public and community and voluntary organisations also reported that patients presenting to ED with self-harm and attempted suicide experienced negative attitudes from staff and a dismissal of the psychological pain that is being expressed.[86] Comments from patients included:

- There was no compassion;
- I got the impression they were annoyed;
- I was given the impression that they did not believe that my problem was worthy of intensive emergency care, although I had nearly died;
- I feel like I am treated differently because 'I did it to myself'. I am made to feel as if I am not worthy of treatment at the emergency department.

A representative of the organisation the NI Association for Mental Health (NIAMH) reported hearing that pain-relief had been denied to a person presenting with self-harm:

> One colleague who is a nurse described somebody being sutured without pain relief for quite a deep cut - this kind of punishment of somebody who has self-harmed rather than addressing their physical distress. I think the experience is so difficult in A&E for people with mental health issues, particularly people who self-harm, that people will not go to A&E or they won't go to certain A&Es… The A&E they will go to is co-located with a mental health service which is open on the weekends and which will do assessments … it's much less stigmatised.

NIAMH distinguished NI from the rest of the UK by pointing to the absence of a regional anti-stigma campaign.

Some positive experiences were however also identified. A group submission from Contact NI's User Advocacy Group highlighted their awareness of some good practice at the Ulster Hospital and the Royal Victoria Hospital. Additionally, one public email noted,

> there are members of staff, particularly some of the Ulster hospital A&E nurses who knew exactly how to deal with me, have shown sympathy and provided non-judgmental care and support to me when I most needed it.

Contact NI stressed the "deeply imbued myth" held by the public and clinicians that "persons who self-harm never go on to die by suicide" when in reality "self-harm is the greatest predictor of a death by suicide across the rest of the life cycle". One patient described being told by an ED consultant "if [you] wanted to kill [your]self, [you] would just go and do it".

Patients and relatives of patients with less common conditions reported responses of disbelief and laughter by health care staff. For example, one relative recounted how his daughter with Addison's disease overheard staff saying "haha, adidas disease". Another patient described that,

> because the nurse laughed at my latex allergy I felt that it was as if I wasn't there. I didn't want to ask anything else in case they made fun of me - I was scared.

These responses often had serious consequences, either physical or emotional, for the patients concerned. The patient with a latex allergy described experiencing an allergic reaction and later requiring CPR (see case study 6). The Inquiry

86 The '10,000 Voices' annual report similarly identified that "[s]tories received reflect the need for some staff to become more aware of their attitude when caring for patients with mental health issues in unscheduled care areas." See, PHA/HSCB, Patient/Client Experience: '10,000 Voices' annual report, June 2013-July 2014, p 37. Between Apr '13 - Mar '14, 5983 people presented to NI EDs with self-harm. See, PHA, NI Registry of Self-Harm Annual Report 2013/14, p 13.

also heard how the experience of another patient in 2007 had left him reluctant to attend ED today:

Case study 3: impact of a lack of knowledge and compassion shown to a patient with cerebral palsy

Tony O'Reilly, who has cerebral palsy, was taken to Altnagelvin Hospital by ambulance in June 2007 experiencing severe pain. The following account is based on Tony's evidence to the Inquiry and 'Statement of Experience'.

Arriving around 3am on a Saturday night, he was taken to a room to be interviewed:

"I was asked had I taken any alcohol, was I on drugs. I explained to the nurse that I hadn't taken any alcohol and that as a general rule I don't drink and that I wasn't on any drugs. Then she asked me, 'yes, but what drugs have you taken and what alcohol have you been taking'. I explained that I have cerebral palsy and I again explained I had taken no drugs or alcohol. 'So you have taken nothing' she questioned me."

Tony explained that he had experienced this before in other contexts and informed the nurse that it was a common misunderstanding experienced by persons with cerebral palsy.

"I knew for a fact that the nurse did not believe me. I also knew that the person with her in white looked at me disbelieving … I was rather dishevelled, I accept that, but I had been in bed. It wasn't as if I was out on a pub crawl. I had taken no drink."

"I … viewed it as an interrogation … I didn't feel any compassion or empathy on the part of the medical people at that point. I felt I was being accused of something and found guilty. What I was being found guilty of I'm not quite sure."

Tony explained that he was sent back to the waiting room about 3.20am and refused the offer of pain relief due to his concerns over the source of the pain.

"Throughout all of this I was in tears. I was in agony… I recognise that A&E is A&E and in hindsight I maybe shouldn't have been there but I was in such a state… The nurse came out to [the waiting room] to ask me to keep quiet. [I bit my bottom lip and held my breath, letting the air out slowly] to try to keep the pain away. I know all the rules about how to behave in an A&E … not to be whingey or too demanding as the doctors have other things to do".

He was taken to a trolley bed at 8am. While lying on the bed, Tony needed to take a deep breath which caused him to let out a yell.

"It wasn't a big howling yell because I managed to control it as [I was very conscious of other people around me]. One of the nurses shouted 'shut up and stop that nonsense'".

A male nurse who Tony described as kind gave him two slices of toast and a cup of tea. When the doctor arrived, he told Tony that spasms associated with his condition could be more severe with age. He was given painkillers and told after a couple of days he would be fine. Tony went home.

"My issue is not that they didn't … give me the right treatment… My issue is that in my experience there was a lack of compassion, a lack of understanding that when you go to an A&E situation at 3am in the morning from your own bed … you're vulnerable, at your most weakest point… At the time I actually thought I was going to die … because the pain was so severe. Bar one male nurse, nobody showed any compassion, any understanding. They never even asked me about my pain, where it was located. I know they were all convinced I was on drugs or drinking alcohol."

In Tony's 'Statement of Experience', he described the impact of his 2007 visit to ED,

"I have had four episodes of a similar nature since this incident. I have never gone back to the ED due to my experience. I have given instructions to my family that if it is a choice between going to an ED and dying, then let me die."

When asked by the Inquiry, Tony recommended to staff:

"Talk to me, ask me at least where the pain is… When I say I have cerebral palsy, believe me. Why would I lie? … I still have cerebral palsy today because I've had it since I was born… Do your best to believe the patient and if the patient gives guidance and says, 'oh, I'd like this' but maybe the doctor knows best in the sense of 'no this is the treatment', that's fine but listen, listen to the patient."

The common plea from patients and relatives of patients with less common conditions was for healthcare staff to "listen to the patient". Representatives from the Rare Disease Partnership stated that "the real experts are the patients and families themselves" and emphasised the need for "a change of culture to recognise … the patient voice is important".

Carers NI also stressed the importance of listening, this time to the patient's carer at ED. The organisation identified that some carers report feeling a lack of recognition and being treated like an "irritant, rather than … a resource" when engaging with HSC staff. Carers NI stressed that carers are often experts in the cared for person's behaviour and prefer to be viewed as "partner providers" of care. It was further speculated that a lack of engagement by staff with the carer may emanate from a misunderstanding of the DHSSPS guidance on patient confidentiality and whether they could involve carers.

Some staff also identified the critical role of families in the care of patients with particular needs in ED. For example, the nurse consultant for the Royal Victoria Hospital and the Mater Hospital told the Inquiry that staff should "take [their] lead" from families.

The Bryson Charitable Group (Bryson) emphasised that while there are a lot of very good staff, the Roma and Traveller communities still felt they were "regarded differently" by frontline healthcare staff, including in ED, which made them feel "intimidated" and "discriminated against" by the healthcare system. The need for "cultural sensitivity" was stressed by a Traveller representative who reported suspicious attitudes from staff if patients could not identify a fixed address.

Conditions

Some staff identified that older persons wait the longest in ED (Royal College of Nursing (RCN); WHSCT). Information provided from the WHSCT demonstrated that nearly all patients over 75 years waited longer than four hours.[87] The RCN described the waiting times as a "sad indictment" and called for older persons needs to be "prioritised", cross-referencing the more positive situation with children.

Staff gave examples of having to treat older persons on trolleys "in full view of everyone else". The "undignified" nature of such treatment was exacerbated for one member of staff by the fact that older people more commonly have their chest and "tummies" examined.[88]

Concerns were also identified in relation to older persons arriving at ED from nursing homes on their own. The SEHSCT noted the "information vacuum" that can result (ED lead) while the WHSCT described a recent Serious Adverse Incident

87 Seamus McGirr, Director of Clinical Development GMCSU training powerpoint, *'The Western Trust_Altnagelvin Hospital. Non-elective systems and processes review: December 13'. Analysis based on Trust data over two years.*

88 See also, RQIA, *Review of the Care of Older People in Acute Hospitals* (March 2015), recommendation 8, which states, "[f]urther work is required by all trusts to ensure that ward environments are more suitable and supportive for older people, taking into account the issues raised in this report and individual hospital reports."

(SAI) where the resident with dementia left the ED before being assessed by clinicians (Medical Director). In addition, Age NI called for quality standards for EDs to prevent vulnerable older persons being transferred in a taxi alone in the middle of the night.

The Chief Executive told the Inquiry,

> It seems to happen in the middle of the night or at weekends … I think that practice should just stop, particularly if that person has dementia … We believe that [it occurs] to free a bed …. [One example is where a] person was brought back to [Meadowbank Residential Home], not even in an ambulance but in a taxi, with no support and no one with that individual and we think that that is bad practice and there should be some quality statements around [EDs] to say what can't happen.[89]

As identified in the 'Quality' chapter, senior staff members also raised concerns about instances where nursing home residents had been transferred to ED shortly before death (ED lead SEHSCT; ED consultant BHSCT).

Additional concerns were expressed by staff and community and voluntary sector organisations about older persons in the context of dementia patients.[90] The ability of staff to take time with a dementia patient was considered particularly important in mitigating the stressful effects of the hospital environment and preventing further deterioration. Comments on the difficulties faced by dementia patients included:

- long periods of time increase [their] agitation, increase distress, not able therefore to have their medication on time, and also, more importantly, their hydration needs met. (Age NI)
- [they] can't hail people, maybe [their] timing is not right … [they] can very easily be isolated. (Alzheimer's Society)

Some staff expressed frustration at the lack of time and/or resources available to care appropriately for older people and particularly those with dementia.

Members of the public and community and voluntary organisations also expressed concerns about access for wheelchairs and provision for persons with visual or hearing impairments in ED. One patient described how being prevented from taking her wheelchair in the ambulance increased her sense of vulnerability. She explained the importance of her wheelchair: "it was my legs, it was my dignity". Within the ED itself, some patients identified that there was a lack of space for wheelchairs. For one patient, the feeling that she would be blocking other patient's passage prevented her from sitting in her wheelchair during the 24 hour wait, opting to lie on a less comfortable trolley bed. Another patient in a wheelchair explained that chairs located in front of the reception desk had prevented her from holding a discrete conversation with staff concerning her catheter.

Practical difficulties reported by blind and partially sighted persons at ED included finding a seat, being aware of predicted waiting times, accessing the toilet and getting the attention of staff when assistance was needed. Comments from patients and relatives included:

- No consideration for my deafness or poor eyesight… I found the whole experience very frightening and unsettling. I was left to my own devices and only had help during that first night in A&E by the lady who was beside me on a trolley.

89 On 1 April 2015, the BBC reported that 8 senior ward sisters had written a letter to the RVH Director for Trauma and Orthopaedics (dated 23 March 2015), expressing their concerns about older patients being transferred from the Royal Victoria Hospital to the non-emergency Musgrave Park Hospital at night. This was noted to be contrary to the BHSCT's policy which directs that older patients should only be transferred prior to 7pm and after a prior check is carried out to ensure an available bed in the receiving hospital. See, BBC News, 'Nurses say night-time hospital transfers are an 'abuse' of elderly', (1 April 2015), available at, http://www.bbc.co.uk/news/uk-northern-ireland-32137526 (accessed 8 April 2015).

90 See also, RQIA *Review of the Implementation of NICE Clinical Guideline 42: Dementia: Overview Report* (June 2014), pp 24 which states, "[p]eople living with dementia and their carers … shared their experiences of attending hospital emergency departments and wards. While some people did have a positive experience, the majority of those who attended found the experience to be mostly negative."

- She felt discriminated against because of her blindness… Was in a room where nobody would come and ask for her... When triage nurse called her, she didn't know where to go.

The Royal National Institute of Blind People (RNIB) also spoke of a lack of accessible written information, such as large print or braille and suggested that tactile maps directing patients to the toilets or vending machines could improve the situation.

Case study 4: lack of provision for a blind patient and a perceived lack of care from nursing staff

During 2013, Sam Kilpatrick, who is blind, visited the Lagan Valley Hospital and the Royal Victoria Hospital EDs due to migraines. Sam described his experience at Lagan Valley Hospital ED after his GP sent for an ambulance:

"I was put on a trolley in a room of my own immediately. I was given no buzzer to call for assistance. A doctor came and took blood after 20 minutes and then left for two hours. I needed to go to the toilet but I was in a private room and I had no way of alerting a nurse. I had to ring Lagan Valley Hospital reception on my mobile and get put through to casualty in order to speak to someone."

"A nurse came and asked why I did not have a white cane. I said that I did but I can't find my way about the ED. She asked why I had not brought the cane. I said that it was no good to me in the hospital."

Sam found this line of questioning "unreasonable" and said, "it was not clear what [the nurse] expected that the white cane would do – that it would be like a magic wand?"

After the nurse took Sam to the toilet, he asked her if she could look in on him approximately every 20-30 minutes. Sam explained:

"She said that she could not guarantee this and that they were very busy. I asked for assurances that someone would come by but no guarantees were given. This made me not want to go back to the ED again. The nurse's manner was not nice. A different nurse did pop her head in 20 minutes later. The doctor came back after 3 or 4 hours. I was not offered any food or water during this time. I was not able to move off the trolley at any time."

"I felt generally hurt by the manner in which I was treated, and that I didn't have any dignity. I felt that I couldn't trust them and that they were not looking out for me. This experience makes me dread going to hospital."

Sam described how on another occasion his medical treatment "was the same" at the Royal Victoria Hospital ED as in the Lagan Valley Hospital ED but that the "manner [of the staff] was much better". Sam continued, "at the Royal Victoria Hospital ED they do not provide a buzzer either but they were much nicer. They regularly checked on me to make sure I was alright and to ask if I needed anything. A nurse came out and waited for a taxi with me."

"I try not to use the Lagan Valley ED anymore even though it is much closer. At the Lagan Valley Hospital ED there is no provision for disabled people. In my opinion they are not cared for at the ED. I [felt] my blindness … was not taken into consideration in the Lagan Valley ED. They have not thought about it."

Sam recommended to the Inquiry that "nurses … show more care, more dedication and more common sense."

One member of the public described how her deaf father had received "excellent" care from a minor injuries unit: "staff made sure that he understood what was happening. The also made sure I was aware of everything they were doing for my father."

The Inquiry received reports of a lack of sign language interpreters to assist deaf persons at ED. The Equality lead for the NHSCT noted that the trusts were working to improve this issue.

The Rare Disease Partnership identified issues around diagnosing rare diseases in the health system, including ED and referred to the 2012 Patient and Client Council (PCC) 'Experience of Diagnosis' report findings that,

> 30% of respondents had waited between one and five years for a diagnosis. 81% had emergency admissions between the onset of symptoms and diagnosis. 34% had at least one misdiagnosis before the correct diagnosis was reached. 20% had begun treatment that was not appropriate for the rare disease.[91]

To assist staff in treating patients with rare diseases, the Rare Disease Partnership suggested: placing a "red flag" on the electronic care record; developing an information hub; and establishing specialist care coordinators who could ultimately fast track patients into wards, avoiding ED. The Partnership welcomed the DHSSPS 'statement of intent' around a NI Implementation Plan for Rare Diseases. At the time of writing, a draft implementation plan had recently completed public consultation.[92]

Importantly, community and voluntary organisations stressed that there are typically plenty of opportunities or significant scope for health professionals to engage with persons experiencing a mental health crisis (Contact NI; NIAMH). The Managing Director of Contact NI noted in particular the opportunities to prevent suicide in young people under 25 who present with self-harm:

> the WHO have backed this figure, that [for] those in the teens and early twenties age category it takes up to 200 suicide attempts for a suicide death to occur … [that is] 200 opportunities to intervene and intervene effectively.

The Director of Social Care and Children for the HSCB informed the Inquiry that between June 2013 and July 2014, about 12,000 persons presented to NI's EDs in mental health crisis and as such it was a key issue to which they were paying due regard. The Director of Social Care and Children noted that based on anecdotal evidence, the two-hour target for persons who present to ED in mental health crisis to be seen by specialists was "by in large … being met". The BHSCT was the only trust to provide figures on the two-hour target in its Annual Quality Report 2013/14, stating that from December 2013 to March 2014, 80% of patients referred to mental health were seen within two hours and 90% seen within four hours.[93]

Despite this, a number of community and voluntary organisations and patients expressed concern that persons presenting to ED with a mental health crisis did not always have access to specialist assessment and that where they did, waiting times could be long.[94] One mental health advocate described how when accompanying a patient to ED, "the self-harm and thoughts of suicide were treated in exactly the same way as if we'd gone in with an injured toe".

Some staff also expressed concerns about the long waiting times. Comments included:

- After waiting hours on a doctor to see them they then must wait on the mental health team. This is not reasonable.
- One group I have great sympathy for, are the relatively few patients with serious mental illness requiring detention... It seems to me that this small group can have long waits in an ED while they are assessed by the relevant professionals.

91 PCC, *Experience of Diagnosis: Views of patients and carers of diagnosis of rare disease in Northern Ireland* (February 2012), para 4.2.
92 DHSSPS Consultation document, *Providing High Quality Care for people affected by Rare Diseases - The Draft Northern Ireland Implementation Plan for Rare Diseases* (27 October 2014). Consultation period 27 October 2014 - 19 January 2015.

93 BHSCT, *Annual Quality Report 2013/14,* p 27.
94 See also, PPR, *Time to Listen; Time to Act: Holding Mental Health Services to Account* (March 2014), p 5.

One member of the public told the Inquiry how their relative had left ED during a waiting period and died by suicide later that day. This resulted in a SAI, discussed within the 'Governance' chapter.

Case study 5: delay in specialist care for a patient in mental health crisis

The following account is based on Johnny's sister Julie's evidence to the Inquiry:

Johnny was reported missing in the morning. He was found by the Police Service of Northern Ireland (PSNI) later that day at 6pm with "slit [...] wrists" and taken to Belfast City Hospital ED. Due to Johnny's "habit of walking out", Julie telephoned the ED reception asking them not to let him leave before family could arrive.

Julie stated that despite "the hospital classif[ying] Johnny as high risk they still let him go out for a smoke and get food unsupervised". "The hospital stitched Johnny up but I don't think they looked after his mental health. He was there until 1am and he should have been sectioned under the [Mental Health (NI) Order 1986] but this never happened. They couldn't section him until another doctor signed him off … the doctor never arrived to do this and Johnny left without [receiving] the help that he needed."

On leaving Belfast City Hospital, Julie described how Johnny had gone to the Lagan Valley Hospital to seek help but that "they didn't help him either and [have] since told me that they don't have any records of him ever being there".

Julie told the Inquiry that "despite all his attempts for help [and] all the time he spent in A&E," Johnny died by suicide later that day.

A number of patients, staff and community and voluntary sector organisations expressed concerns about the lack of privacy for persons experiencing mental health crisis, such as self-harm and attempted suicide, presenting to ED. One patient told the Inquiry,

> you have to go up to the glass to tell the receptionist the reason why you are there. This is difficult because everyone can hear what you are saying; I don't know how to explain it. I now ask to write down the issue instead of explaining it verbally where everyone can hear. I have had to ask for the door to triage to be closed. Staff and those on the other side can hear what is being said. The staff will pull the curtain closed, which allows for a physical examination to be discreet; however, it does not allow privacy for talking.

It was suggested that some kind of screen to separate the waiting area from the area where you give personal details could help address this issue or that a cubicle should be used. One staff member identified the importance of the limited number of cubicles with doors on both sides, approximately two of the 23, at the Mater Hospital.[95]

As evidenced in case study 5, concern was expressed by some relatives of patients in mental health crisis about a lack of supervision while waiting in ED. Other patients described frustration at being overly supervised by staff. For example, one patient stated,

> I have been told that because I have arrived with self-harming behaviour I cannot leave the department on my own and there is no one to take me outside. I believe this statement has made me even more agitated than I was in the first place.

The PSNI identified that 21% of all persons reported missing were from hospitals and predominantly EDs. The Mater, Royal Victoria, and Altnagelvin hospitals ranked first, third and fourth on the list of locations from which people are most frequently

95 A PHA guidance leaflet published in March 2015 advises persons presenting to ED in mental health crisis, "[y]ou don't have to tell the [ED] receptionist the reason you are attending if you prefer not to. You can say that you prefer to tell the nurse." See, PHA, 'Improving the lives of people who self-harm' leaflet (4 March 2015). Available at, http://www.publichealth.hscni.net/publications/improving-lives-people-who-self-harm (accessed 1 April 2015).

reported missing.[96] The PSNI raised resource concerns in the context of tracking missing patients and the need for new guidelines detailing the appropriate organisational actions to be taken when a patient in mental health crisis goes missing. It was noted that discussions between the PSNI and the BHSCT's adult ED are ongoing, but there was no suggestion that this local engagement was being rolled out across the trusts (Chief Inspector, PSNI).[97]

The Inquiry was also informed of the practical difficulties faced by both the Roma and Traveller communities due to low literacy levels. This resulted in difficulties understanding signs and embarrassing situations when patients are asked to fill out forms in the public waiting room. One Traveller representative stated,

> [staff assume] you can read your name on that sign there, [so they've] no need to actually call your name out … It disempowers the Traveller people. (Bryson)

Carers NI informed the Inquiry that ED attendance often marks a "turning point" in the care relationship because it can represent a change in the level of care required. The organisation warned that staff should not assume carers can "gear up" for a higher level of care upon discharge. To assist with identifying variation in needs as well as making "hidden carers" known to the HSC system, it was recommended that all potential carers presenting to ED whether accompanying the cared for person or as patients themselves, should be given information on the right to a 'carer's assessment'.

Findings: Refraining from discrimination

Any treatment of persons belonging to a particular group with the intention or effect of impairing their enjoyment of the right to health on an equal basis with others will amount to discrimination in the absence of a reasonable and objective justification.[98] Based on what people said to the Inquiry, the NIHRC found that:

- Concerns were expressed by members of the public about dismissive attitudes from staff towards older people, sometimes including a perception of deliberate de-prioritisation.
- Patients presenting with self-harm perceived ED to be a hostile environment, detecting a lack of compassion and annoyance from staff. The Inquiry was informed that these attitudes may at times be reflected in the medical treatment administered. Co-locating EDs with mental health services may lead to a reduction in negative attitudes from staff.
- Patients with less common conditions reported negative experiences from staff, including feeling laughed at. The core complaint was that staff did not listen to the patient which at times appeared to result in improper medical treatment. This impacted upon the patients' willingness to attend ED in the event of future emergencies.
- Concerns were expressed by staff and community and voluntary organisations about residents of nursing homes presenting alone to ED. These related to accessing relevant information and the risk of patients with dementia leaving.
- Concerns were expressed by a community and voluntary organisation that older persons, particularly those with dementia, are being transferred alone at night in taxis.

96 PSNI, *Missing persons from A&E: Information for the Northern Ireland Human Rights Commission* (1 December 2014) (ppt). Data represents the time period Feb 2013 - Oct 2014. The PSNI also expressed concern to the Inquiry about the upward trend in numbers of persons reported missing from the Mater Hospital and the Royal Victoria Hospital over the data period, and the limited police resources.

97 The BHSCT provided the NIHRC with 'Guidance for staff on problems or suicidal ideation who leave the emergency department' and informed that the document was active but due for further review after PSNI input (email correspondence 5 February 2015).

98 CESCR, General Comment 20, para 13.

- Older persons appear to wait the longest in ED.
- In order to treat patients with dementia appropriately, staff and patients identified that extra time was required.
- A reported lack of physical provision for blind and partially sighted persons, such as buzzers and braille information, made EDs difficult to navigate. The experiences of persons with sensory impairments could be improved by regular communication from staff; mixed reports were received concerning this behaviour.
- While acknowledging ongoing initiatives to address the issue, there is a lack of sign language interpreters across HSC.
- The HSCB reported that the two hour target within which persons presenting to ED in mental health crisis should be assessed by specialists was mostly being met. However, staff with recent experience of ED and some members of the public were of the opinion that waiting times for specialist assessment remained long. Only the BHSCT had statistics on the two hour target in their Annual Quality report.
- Concerns were expressed by staff, patients and community and voluntary organisations at the lack of privacy at reception and during triage for patients presenting in mental health crisis.

Eliminating and preventing discrimination

The Director for Acute Hospital Services from the NHSCT identified a commitment to support patients with particular needs at ED by adopting a time sensitive approach to limit anxiety (Director Acute Hospital Services NHSCT). Senior staff from other trusts highlighted that ED staff can draw on the support of specialist staff within the wider Trust team, such as child protection nurses and the nurse consultant for dementia (Director of Primary Care, Older People and Executive Director of Nursing, SEHSCT).

The HSCB informed the Inquiry that efforts were ongoing to ensure that where appropriate persons could bypass ED and be directly admitted. The Director of Commissioning commented that substantial progress had been made on this issue, highlighting in particular its appropriateness for the older population.

The Unscheduled Care Task Group has adopted the care of frail older people as a work stream.[99] One initiative seemingly hastened by recommendation 3 of the RQIA regional review[100] is the establishment of the 'BCH Direct' admission service for the over 75s in the BHSCT. The service aims to provide an alternative assessment pathway for frail older persons who do not require the services of ED and can be accessed by GPs via a dedicated telephone line. In November 2014, the Minister noted that initial feedback on phase 1 of the project had been "very positive".[101] A recent news report from 9 February 2015 indicated that the BCH-Direct unit may have experienced capacity issues.[102]

The WHSCT reported that the culture was to admit older people as soon as possible (Nurse Manager SWAH ED). Where older persons presented to ED with a fall but could return home, staff would liaise with Derry City Council to request that an assessment of the home for suitability, for example

99 Unscheduled Care Task Group Update No 1 for Regional Coordinating Group (18 November 2014). Available at, http://www.dhsspsni.gov.uk/index/unscheduled-care/unscheduled-care-01.htm (accessed 14 April 2015).

100 QIA, *An Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations,* (July 2014), p 92 (Recommendation 3).

101 Written Statement to the Assembly by Health Minister Jim Wells – The work of the Unscheduled Care Task Group - 19 November 2014.

102 BBC News 'Continuing Pressures on Belfast A&E units' (10 February 2015), available at, <http://www.bbc.co.uk/news/uk-northern-ireland-31334539> (accessed 12 February 2015). Data available from the BCH-Direct's immediate predecessor OPTIMAL7 showed that during its first ten weeks of operating (3 March and 11 May 2014), 133 phone calls were received from GPs regarding admission, of these: 93 older persons were directly admitted, 32 were redirected to ED/DMAU for clinical reasons, and 8 were redirected to ED for capacity reasons. See, Wigam, I., Heaney, M., O'Kane, M. (BHSCT), *Evolution and Innovation - Hospital Care for the Acutely Ill Frail Elderly'* (May 2014) (ppt.), statistics relate to 3 Mar- 11 May 2014, available at, <http://www.rqia.org.uk/cms_resources/Hospital%20Care%20for%20the%20Acutely%20Ill%20Frail%20Elderly_Presentation.pdf> (accessed 28 January 2015).

to ensure that mats are not loose, and automatic lights and handrails installed (Medical Director).

The SEHSCT and the NHSCT referenced using the 'butterfly scheme', while the WHSCT used a 'purple folder' to identify dementia patients to staff. The NHSCT in particular highlighted a number of additional measures, such as: the role of 'dementia champion' held by nurses or health care assistants responsible for leading new learning and supporting staff on how to communicate with patients; dementia friendly signage; a welcoming environment for carers and relatives to ensure stability; and access to quieter single rooms at Antrim Area Hospital. The NHSCT's Assistant Director of Acute Hospital Services considered that the butterfly scheme had been a "good success" and that dementia champions had made a "significant contribution". The NHSCT further identified that they had signed up to the CEM clinical audit on 'assessing for cognitive impairment in older people' (Clinical lead).

The Inquiry was also informed that trusts were in the process of testing a patient passport, a document carried by patients with (in the first instance) communication difficulties containing information on their needs that could be presented to ED staff on arrival (SEHSCT; NHSCT; Rare Disease Partnership). The Rare Disease Partnership spoke of favourable reports and that the cohort being tested "seem to like it", as well as identifying its potential future use for persons with long term conditions. However, the Partnership also noted that the passport manifests in different formats and expressed that the inclusion of the HSCB logo on the front helps ensure staff give it appropriate weight. In addition, one witness with a rare disease reported a negative experience on presenting to ED with a patient passport:

Case study 6: mixed acknowledgment of a patient passport for a patient with rare disease

Daryl Couples has to attend ED regularly due to a number of medical conditions which include an allergy to latex. As Daryl's condition can result in seizures or black outs, she carries with her a patient passport to help her communicate to staff. Daryl told the Inquiry the detail of one particular occasion in 2013 when she attended the Ulster Hospital after becoming unconscious following a cut to her thumb.

"I showed [the reception staff] my passport… it tells you all the information on the back. They didn't really take it into consideration."

"They took all my notes down so I didn't have to explain too much but they didn't say about the allergies, I had to tell them, you know, there's another bit to [the passport but] they never said nothing, they just handed it back to me."

Daryl explained what happened once called by the triage nurse:

"I told [the nurse] about the passport. Then [the nurse] went away and got gloves and [I said], 'I'm allergic to latex. Make sure they are latex free'. She started to laugh at me. Then she looked at my thumb and just told me to wait outside again to see the doctor."

Shortly after leaving the ED, Daryl's "face started to swell up". She told the Inquiry that she did not want to return to the Ulster deciding to go to the Royal Victoria Hospital ED instead. She explained what happened there:

"I showed them my passport, the guy there was very very good. He took time with me and

explained everything to me. I then went round to see the doctor straight away … [The doctor] said 'I've never seen anything like it… how do we cope with this', so I told him what to do… go on the computer [to the condition website]… He came back with his iphone and told me what he actually did on the computer and said it was very very good information I gave him… He kept me in overnight. They had to work on me ... [gave me] CPR… I didn't know this at that stage. [The doctors] told me."

Daryl recommended to the Inquiry:

"Look at the patient passport and give me time to explain. If [staff] don't understand I can try to explain, although this is not always possible due to seizures, this is why the patient passport is there."

A number of trusts identified a mental health pathway at triage and 24/7 access to psychiatric services. For example, the Clinical Director for Emergency Care for the SEHSCT stated that over the past six to seven years the Trust has "positively discriminate[d]" in favour of persons in mental health crisis by placing them at a higher triage category. The Clinical Director described how patients in mental health crisis are now seen on average faster than other patients and subject to a triple assessment in terms of medical need, mental health need, and risk of absconding. The Inquiry was told that the measure was "controversial at the time but [that] it has been effective."

The Medical Director for the WHSCT commented generally that persons experiencing mental health crisis are "often badly managed" at ED. In his opinion, decisions tended to centre around whether or not a person should be admitted to a mental health unit or enabled to go home rather than focusing on the "whole range of options in between". He identified that the WHSCT had recently forged links with the community psychiatric nursing team to provide Altnagelvin Hospital with 24/7 rapid assessments of patients. The Nurse Manager for the South West Acute Hospital ED identified the benefit of having psychiatric nurses co-located with the ED but noted that the service hours during which this facility can be accessed, presently 9am - 10.30pm, could be improved in line with the practice at Altnagelvin Hospital.

While one community and voluntary organisation did recognise an apparent improvement across the trusts in on-site access to psychiatric assessment, the issue of waiting times remained and the quality of assessments was questioned. A representative from the organisation Participation and the Practice of Rights (PPR) stated,

[w]e've had varying reports about the quality of the psychiatric assessment, that they are a bit rushed. As far as we are aware those assessments should take up to two hours whereas we are hearing they can be very very short … that is backed up from the Royal College of Psychiatrists as well who are concerned about the quality of assessments at A&E.

Staff from the Royal Belfast Hospital for Sick Children (RBHSC) explained that a care-pathway exists for children up to 14 years who present with self-harm and that this generally means admittance.[103] The RBHSC also identified that they "generally have good support" from the 'crisis and assessment intervention team' (CAIT). The Inquiry heard how the establishment and availability of CAIT at all hours has made a significant difference for ED staff. The RBHSC ED consultant described that the Child and Adolescent Mental Health Service (CAMHS) "can be difficult" for acute presentations but that CAIT has "bridged the gap to some degree".

103 This was identified as in accordance with the NICE guidelines.

Some trusts mentioned implementing the 'Card Before You Leave' (CBYL) scheme. The Inquiry was informed that this initiative was developed in liaison with the Belfast Mental Health Rights Group (BMHRG) and involves giving patients deemed suitable to return home a written appointment for a full psychiatric assessment within 24 hours. The BMHRG stressed the importance of the card as "it keeps [patients] in the system" but noted inconsistencies in how it is implemented across the trusts. These concerns centred on patients not receiving the card,[104] receiving differing formats of the card, telephone follow-up instead of appointment cards, and a lack of Trust monitoring as to the numbers of cards issued (BMHRG). The Inquiry notes that the WHSCT was the only Trust to give statistics on the number of people referred and the uptake of the CBYL scheme within its 2013/14 annual quality report.[105]

The BMHRG suggested that it would be helpful for a designated person to go into each Trust and ensure that the scheme was implemented uniformly.

A number of staff referred to the accessibility and increasing uptake of the telephone interpreting service across the HSC system EDs for patients that did not speak English. Positive comments included:

- At any stage we can access the big word (Clinical lead, SHSCT)
- We have timely access to interpreters (Clinical lead, Antrim Area Hospital)
- The interpretation service - It has won national awards (Equality lead, SHSCT)

Bryson however, suggested that the service did not facilitate the Romani language, noting that the general lack of Romani interpreters in Belfast's EDs contributed to the intimidation felt by Roma when accessing the health care system. While family members were sometimes used, Bryson noted that this raised privacy issues for the patient.[106] More positively, Bryson spoke of the resources provided by the BHSCT to fund 'community mentors' designed to educate the Roma community on the HSC system in NI.

The Medical Director at the WHSCT told of his serious concerns about the homeless population which led to the subsequent proactive approach taken by the WHSCT to their treatment in ED. He noted that homelessness was often linked with chronic alcohol use and that the presentation of homeless persons to ED permitted staff a "brief window of opportunity to connect their ill-health with their risky alcohol behaviour" as well as the opportunity to provide any necessary primary care. The Inquiry further heard how the WHSCT has embedded an "alcohol liaison nurse" within ED to assist staff with patients whose attendance is linked to alcohol. The Medical Director identified that such an approach can result in a ten-fold reduction of subsequent attendances at ED. A similar emphasis was not detected within the other trusts despite the related 2014/15 ministerial direction and regional priority.[107] The HSCB informed the NIHRC that reliable statistics were not available on the numbers of alcohol-related attendances at ED.

When asked by the Inquiry what advice they would give to generalist EDs concerning children, staff at the RBHSC regarded a "separate waiting area as vital" and highlighted the importance of paediatric nurses and play specialists. In addition to the specific ED at the children's hospital, the Inquiry was informed that Antrim Area, Altnagelvin[108] and South West Acute hospitals' EDs have dedicated children's areas. Staff from the NHSCT

104 BMHRG gave evidence that a survey conducted in March 2013 identified no one receiving a 'card before you leave'.
105 WHSCT, *Annual Quality Report 2013/14,* p 12.

106 Human rights standards recommend that the use of family members as translators should be avoided. See, CoE, Committee of Ministers, Recommendation CM/Rec (2011)13 'on mobility, migration and access to health care' (16 November 2011), para 16.
107 See discussion above in 'Domestic framework' section.
108 During the Inquiry, NIHRC Commissioners and staff visited Altnagelvin Hospital and noted that there was no separate waiting room for children but that there was a family waiting room with a soft couch and some toys (note of visit dated 19.07.14).

expressed that they were "particularly pleased how [the Antrim Area Hospital ED] was designed for children", noting its small seats, colourful play area and dedicated staff team which includes the rotation of paediatric nurses (Director of Acute Hospital Services). The dedicated area was also described as enabling staff to forge better links with the paediatric team (Clinical lead, NHSCT).

In some cases, staff identified that resourcing constraints had resulted in a reduction in the provision of tailored services for children. For example, the WHSCT commented that while the South West Acute Hospital ED does have separate cubicles for assessing children, "currently due to staffing shortages that is not operational" (ED Nurse Manager, South West Acute Hospital). The SHSCT also noted the previous existence of a separate ED facility for children at Craigavon Area Hospital which has since closed due to staff shortages. Children in the Trust area are now directed to the Paediatric Ambulatory Unit which according to the Chief Executive has "enormously helped the flow and care" to young children. The Inquiry was told that the Unit is staffed by advanced nurse practitioners.

Both the SEHSCT and the WHSCT identified that children would be prioritised at triage, and that arrangements existed with paediatric teams, whereby GPs and ED staff could acquire direct admission for children in need. For the SEHSCT this was described as via a 'rapid response team' during the hours of 9am-5pm. The Medical Director suggested that extending the hours for this service would be beneficial.

Finally, a Nurse Manager for the South West Acute Hospital ED stated that the WHSCT was the only Trust to employ safeguarding clerical officers operating live checks on children deemed to be vulnerable upon presenting to ED, although other trusts reported that such checks are completed appropriately.[109] Further initiatives mentioned included the facilitation of schools visits and 'teddy bear clubs' designed to alleviate the stress of children at ED (RBHSC; NHSCT).

Carers NI further recounted positive experiences in the WHSCT. For example, prior to the introduction of the electronic care record, the organisation told of how one carer was given written medical notes on his two disabled sons to assist him in communicating information when presenting to Altnagelvin Hospital ED. This was described as "hugely reassuring" for the man who was additionally given a "fast pass card" to alert staff to the fact that his son's treatment was time sensitive.

Findings: Eliminating and preventing discrimination

Steps must be taken to prevent, diminish and eliminate the conditions and attitudes that cause or perpetuate discrimination.[110] Based on what people said to the Inquiry, the NIHRC found that:

- Efforts to address long waiting times for older people at ED were apparent through the BHSCT's direct admission initiative 'BCH-Direct' for over 75s. Initial demand for the pathway appears to be high.
- Trusts appeared to operate either the 'Butterfly Scheme' or the 'purple folder' system to assist staff in identifying patients with dementia. Staff viewed the approach positively.
- The 'patient passport' initiative to assist persons presenting to ED with communication difficulties was described as being in its formative stages and regarded as a positive development. Concerns were however raised about staff not paying due regard to the passport. An inconsistent

109 Information provided by BHSCT to NIHRC after draft Inquiry report (dated 5 May 2015).
110 CESCR, General Comment 20, para 8.

approach may have hindered its effective implementation to date.

- There was recognition at senior staff level of the value of early treatment for persons presenting to ED in mental health crisis. Efforts were referenced by trusts to create greater links with specialist mental health services and where this was available staff affirmed the benefits. Staff and the community and voluntary sector noted scope exists for further improvement.
- The 'Card Before You Leave' scheme which instructs that a patient presenting with mental health crisis is given a written appointment with specialists before leaving ED was regarded as critical. Concerns were raised, however, about inconsistencies in its implementation.
- There were positive comments from staff about the accessibility of the telephone interpreting service; however, there was a lack of professional interpreters for the Roma population.
- A proactive approach to addressing the health needs of the homeless population and persons presenting with chronic alcohol use was described by the WHSCT. The primary initiative identified was the embedding of an 'alcohol liaison nurse'.
- Specialist staff regarded a separate children's area as vital. While dedicated children's areas were available in a number of hospital EDs, this did not appear to be the case in all.

Monitoring inequality

The equality leads in each of the trusts informed the Inquiry that their role is to provide advice, support and training[111] to the Trust on Section 75 and Section 49A duties. The equality leads identified their individual Trust teams as being small in size. As such, the importance of mainstreaming equality and the adoption of a collaborative approach to maximise efficiency was emphasised.

The equality leads identified that the screening process was the primary tool through which their work was embedded into the trusts' ED operations and emphasised the importance of being involved by the persons responsible for the development and monitoring of policies at an early stage. For example, the Head of Equality for the NHSCT remarked, "you could be brought in at any stage to screen but our mantra is, from the beginning involve us in that process". The SEHSCT and the NHSCT informed the Inquiry of positive early engagement in relation to the decision to change the operating hours of Lagan Valley Hospital ED and the design stage of Antrim Area Hospital ED respectively.

On the whole, the equality screening process was presented positively by the leads, particularly when compared to human rights screening (see 'Governance' chapter for further discussion).[112] Equality Managers from the SEHSCT noted:

- we have a very robust policy screening process … for all policies, proposals and procedures
- if we identify some impact around equality, we can go to the ongoing screening, and if we are identifying red, amber, green, and looking at moving from amber to a red, we will then upscale to an EQIA and that seems to fit very neatly with the equality world.

The Equality Manager for the SHSCT did, however, reference the commitments (in all the trusts' equality action plans) to review the screening template and develop a best practice EQIA template. This was based on the need to provide greater contextualisation for staff:

that assessment tool … [and] the support and guidelines, [we] want to make that much more

111 For example, screening training and the e-learning module on equality (SEHSCT).

112 A human rights section was added in 2008 to the equality screening template.

transparent … it has to be contextualised and we have to give real examples, we are big organisations … and we are complex, but we have to try and get that guidance, to try and illustrate as best we can how that tool can be used in different areas of the service.

The equality leads also identified mechanisms by which they could feed equality concerns in to the trusts' senior management structures.

Some staff in leadership and equality promotion roles identified moving towards a proactive and inclusive approach in terms of involving persons from vulnerable or marginalised groups in the decision-making process. Comments included:

- We are constantly looking for and asking groups to feed the research in so that informs us because if we know what the issues are that makes for better policy development (Equality Manager, SHSCT)
- Have a very extensive community voluntary sector and a very large number of groups … who represent the public voice so there are real opportunities there… that's absolutely the direction of travel that the organisation wants to go in (Director of Primary Care, Older People and Executive Director of Nursing, SEHSCT)
- It's a collaborative arrangement with lots of stakeholders to inform commissioning … service monitoring and service re-design and more recently we're moving to the notion of co-production. So the mental healthcare pathway that has just been published was absolutely co-produced with service users … . (Director of Social Care and Children, HSCB).

Comment from community and voluntary organisations on the involvement of particular groups in decision-making processes was however, less favourable. In particular, concerns were raised about the involvement of persons with experience of mental health crisis and older people.

While Youthlife reflected positively: "we're all working together and I feel my voice is being heard and that I'm informing the decision-makers";

NIAMH and the BMHRG identified a contrasting experience. Interestingly, NIAMH referred to the desire for a process of co-production, something also referenced by the HSCB (above), but from the perspective that this did not presently occur. The Head of Policy & Public Affairs for the organisation stated,

I do not see a good quality of engagement or results for us … Its [also] really important to look at how the State invests in supporting people with mental health issues to directly engage in the policy and commissioning process …. [p]eople are at the point because they've had such difficult experiences of consultation that they are now saying we want to co-produce policy and services, we've gone past consulting and engaging and dialogue.

Age NI also expressed cynicism about the consultation and participation process under Section 75 which it stated, "tends to be almost a tick box, tokenism" exercise. Psychological and practical barriers to meaningful engagement from older people included:

- Preconceived opinions on the possibilities of older people to meaningful engage and the perception of older people as dependent and vulnerable; and the lack of options [for] older people who have hearing loss, sight loss, confined to bed or older people from minority communities (Age NI).

In addition, the Inquiry heard from organisations concerned about the involvement of particular groups. For example, the RNIB identified accessibility challenges with the '10,000 Voices' project; an initiative specifically designed to gather the patient's experience of HSC. This was described as being due to incompatibilities between the online home screen for the project and the screen readers used by blind and partially sighted people. The Director told that Inquiry that other arrangements put in place did not remedy his concerns:

[i]t's not the same to be honest, it requires a different communication about the project…. From my constituency's' perspective, the value of '10,000 Voices' has been diminished by not planning that aspect of accessibility into it from the beginning.

Finally, in keeping with the needs identified in the equality action plans, some community and voluntary organisations identified a lack of data collection and disaggregation. Age NI commented,

I suppose our argument is if you don't know your population how can you plan; when I asked regarding older people presenting at A&E the Department couldn't tell me. This goes across the whole health and social care in general – we just don't have the data.

Senior staff and equality leads did, however, recognise the importance of data collection and breakdown into specific categories. The Head of Equality for the NHSCT suggested that for some ED staff benefit would be derived from explaining the importance of data collection and disaggregation:

[o]ur ethnic monitoring project gives a very good example that when you talk to staff about the importance of getting the information … whenever you provide the right information to service users and they can see the benefits of gathering the information, it improves considerably. … I think it just needs a little bit of focus and a little bit of support to gather the information.

The Equality Manager for the SHSCT expressed the opinion that staff recording was improving but that an environment also needed to be created where people feel comfortable to fill monitoring data in. The lead further anticipated the publication of the 'Ethnic Monitoring Guide' as a catalyst toward improvement and identified work done through the Racial Equality Forum on "standard classifications".

Findings: Monitoring inequality

To determine the impact of actions on vulnerable or marginalised groups, collected data should be broken down into standard specific agreed categories.[113] In addition, the views of vulnerable or marginalised groups should be sought.[114] Based on what people said to the Inquiry, the NIHRC found that:

- While the equality leads regarded the screening process itself as fairly robust, they identified the need to give staff real examples within screening, EQIA templates and guidance. This is an action within the trusts' equality action plans.
- Trust staff identified wide interaction with service users from particular groups. This perception was not, however, shared by some voluntary and community organisations representing persons in mental health crisis and the older people. A shared desire identified among some staff and community and voluntary organisations was that of policy co-production.
- The online version of the '10,000 Voices' survey was not accessible to blind and partially sighted persons.
- Some community and voluntary organisations expressed frustration at the lack of disaggregated data.
- Senior staff recognised the importance of data collection and disaggregation. There was the suggestion that attitudes of ED staff towards data collection would be improved if the reasons for collection were explained.

113 CESCR, General Comment 20, para 41.
114 Ibid., para 36.

Training to ensure awareness and responsiveness by health care staff

Based on the information provided, it was not possible to determine the number of ED staff who participated in equality training or the comprehensiveness of training undertaken. However, some statistics were available for the Directorates within which ED fell. For example, the BHSCT reported that 11% of staff from the Unscheduled and Acute Care Directorate had received the mandatory face-to-face training since 2011;[115] and the NHSCT reported that 18% of staff in the Acute Services Directorate had participated in mandatory equality training as of January 2014.[116] More generally, the recent decision of the WHSCT to make the e-learning programme mandatory was reported to result in a significant increase in the uptake among Trust staff between 2012/13 and 2013/14.[117] As with the screening assessment tool, the Equality Manager for the SHSCT emphasised the need to contextualise equality training for staff working in the different departments. She commented,

> [t]here are the broad tenets that we need to give staff about prejudice, discrimination … but then its back to the bespoke training that we need to roll out in certain areas of the service so that people get it because they can relate to it.

Information provided by the BHSCT, indicated that as of end of March 2014, 64% and 62% of ED staff had received vulnerable adults training and child protection training respectively.[118]

A number of members of the public and health care staff expressed the need for increased training for ED personnel on identifying and dealing appropriately with persons experiencing mental health crisis. For example, a group submission from Contact NI's Service User Advocacy Group noted that this was crucial to remedy a gap in knowledge among staff on the process around detainment and prevent the use of uninformed comments. Concerning the '10,000 Voices' annual report finding that "some staff need to be more aware of their attitude when caring for patients with mental health issues", the PHA/HSCB stated that a regional action is that:

> [i]nformation received from '10,000 Voices' will be integrated into training programmes and will be aligned with and inform regional improvement work streams in the provision of Mental Health Services.[119]

Concerning children and young persons in mental health crisis, senior staff with the RBHSC noted the need for both medical and nursing ED staff to obtain additional training (ED sister; ED consultant). RBHSC staff linked this need with an increase in children presenting with mental health concerns since the upper age limit was raised to under 14 years and the particular need in light of the possibility that it will be raised again to under 16 years. The Inquiry heard that the RBHSC are already discussing what training issues that will involve (ED consultant). Contact NI expressed the need for training on when and how to engage support to offset a reticence within health care staff to discuss with parents the state of their child's mental health.

On another positive note, the Inquiry heard how two persons who experienced mental health crisis

115 BHSCT, 'Mandatory Equality Training Summary from 2011' (Information pack provided to NIHRC, Document 4.6 (dated 31.07.2014)). Percentage of Directorate staff information: email correspondence between NIHRC and BHSCT (dated 27.04.15). Correspondence included information on Trust efforts to increase compliance with the requirement for attendance at equality training.

116 NHSCT, *Annual Progress Report on Section 75 of the Northern Ireland Act 1998 and Section 49A of the Disability Discrimination Order (DDO) 2006: 1 April 2013 - 31 March 2014,* p 18. Nb. This was 12% lower than the Trust's target figure of 30% by March 2013.

117 See, WHSCT, *Equality Commission for Northern Ireland: Public authority Annual Progress Report, April 2013 - March 2014,* p23; and, WHSCT, *Equality Action Plan: 1 May 2014 - 30 April 2017,* (Action 20).

118 BHSCT, 'Mandatory Training Activity for Available Staff - April 2014' (Information pack provided to NIHRC, Document 4.1, dated 31.07.14).

119 PHA/HSCB, *Patient/Client Experience: '10,000 Voices' annual report, June 2013-July 2014,* p 37.

had subsequently participated in the recording of a staff training DVD. Further, information provided by the SEHSCT reported that two ED staff had been trained as trainers on the management of self-harm,[120] while the BHSCT noted the possibility for doctors at the Royal Victoria Hospital to avail at each changeover of ED specific mental health training. The BHSCT also reported the availability, as required, of training to "empower ED staff to use the Risk Assessment Tool/Matrix and Pathway" for patients experiencing mental health crisis.[121]

Despite the wide number of training programmes available, the Inquiry also heard requests from members of the public for further training on the identification of and appropriate behaviour towards persons with sensory disabilities and dementia,[122] as well as appropriate behaviours towards persons with HIV and rare diseases.

In their evidence to the Inquiry, the NHSCT identified that staff had undertaken a "considerable programme of training" on recognition and care for dementia patients (Assistant Director Acute Hospital Services). In addition to medical staff, this included training of porters, cleaning and catering staff to increase their sensitivity. (Director Nursing and User Experience). The Equality lead for the Trust also reported the involvement of service-users with learning disabilities in training for staff.

In line with the international human rights standards, materials from the 'working well with interpreters' training pack used by trusts advises that "friends, relatives or other persons should not be used as interpreters unless in an emergency, or for very routine administration tasks such as setting up an appointment".[123]

Finally, community and voluntary organisations were identified as having involvement in the design of staff training. Two examples include the RNIB Visual Awareness training,[124] and the HSC LGBT Staff Forum in the LGBT e-learning module.[125]

Findings: Training to ensure awareness and responsiveness by health care staff

The duty to prevent discrimination within HSC requires that training is provided to staff to ensure they can respond to the needs of vulnerable and marginalised groups.[126] Based on what people said to the Inquiry, the NIHRC found that:

- There is a wide range of equality and particular group training and resources available to HSC staff, often developed with the assistance of service-users.
- While all staff were likely to have received some level of equality training, most ED staff did not appear to have availed of the more in-depth equality or particular group training on offer. Work pressures on staff made it difficult to find the time to attend (see 'Quality').

120 SEHSCT, 'Human rights inquiry into Emergency Health Care' (16 July 2014, revised 28.7.14). (Information pack list provided to NIHRC, p3).
121 BHSCT, 'Mental Health Training in ED Royal Victoria Hospital'. (Information pack provided to NIHRC, Document 3.7, dated 31.07.14).
122 A recent RQIA review similarly noted, "[p]eople told reviewers that staff not being aware a person had dementia was a major contributing factor to the overall negative aspect of their experience" and that "[p]eople expressed the view that simply knowing that someone has dementia is not enough. Staff must also be properly trained in how to interact with and manage someone diagnosed with dementia." See, RQIA *Review of the Implementation of NICE Clinical Guideline 42: Dementia: Overview Report* (June 2014), pp 24-25. In addition, a March 2015 RQIA report recommended that "[s]taff should receive additional training appropriate to the patient's needs such as delirium, dementia and challenging behaviour." See, RQIA, *Review of the Care of Older People in Acute Hospitals* (March 2015), recommendation 4.
123 WHSCT, 'Working with interpreters' training ppt. (Information pack provided to NIHRC, p 756).
124 SEHSCT, *Implementation of the Equality and Good Relations Duties under Section 75 Northern Ireland Act 1998: Progress Report by the South Eastern Health and Social Care Trust, 1 April 2013 - 31 March 2014,* p 20.
125 NHSCT, *Annual Progress Report on Section 75 of the Northern Ireland Act 1998 and Section 49A of the Disability Discrimination Order (DDO) 2006: 1 April 2013 - 31 March 2014,* pp 15-16. E-learning module is available at, <http://www.lgbtelearning.hscni.net> (accessed 2 March 2015).
126 CESCR, General Comment 14, para 37.

- An extensive training programme for staff concerning appropriate behaviour towards patients with dementia was described by the NHSCT.
- The public and staff expressed the need for further training for ED staff on how to deal with adults and children presenting in mental health crisis.

3

3 Governance

The good governance of health systems is an essential component of the right to health.[1] Its requirements include the right to health recognised in law and a national health strategy and action plan.[2] More detailed provisions establishing what people can expect from various health services and facilities should also exist,[3] as well as quality improvement and patient safety policies.[4] People have a right to participate in health decision-making and, to enable this, a health information system and a culture of transparency should be ensured.[5] Accountability is a crucial health governance component. It requires, at least, a system by which realisation of the right to health can be monitored, internally and independently reviewed, and findings actioned.[6] Where violations of the right to health have occurred, access to independent judicial or other effective remedies are required.[7]

Human rights laws and standards framework

Legislation, strategies, codes of conduct etc.

The right to health must have "sufficient recognition" in the national legal system.[8] The Special Rapporteur on the right to health firmly indicates that this should at least mean its explicit articulation within law.[9] Additionally, the adoption of a national health strategy and action plan is a minimum core obligation under the right to health.[10] The strategy and plan should be based on epidemiological evidence and address the health concerns of the whole population.[11] As such, the Special Rapporteur advises that a "health situational analysis informed by suitably disaggregated data" is carried out.[12]

On the basis of this evidence, the national health strategy and action plan should be drafted to include defined objectives[13] with associated time frames[14] that are underpinned by human rights. The strategy should indicate the resources available to attain the identified objectives based on their most cost-effective use.[15] In the words of the Special Rapporteur, a "process for prioritizing competing health needs" is required, along with a "detailed budget … attached to the plan".[16]

Importantly, the relevant human rights framework that underpins the strategy and plan should include the overlapping good governance principles of "accountability, transparency and independence of the judiciary".[17] To adhere to the spirit of these principles, the Special Rapporteur identifies that the plan should include "effective coordination

1 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 55.
2 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 36.
3 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 106.
4 E.g. CoE, Committee of Ministers Recommendation No. R(97) 17 'on the development and implementation of quality improvement systems (QIS) in healthcare'; CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006)
5 CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), Appendix, Guideline 9; see also the WHO Declaration of Alma-Ata, (September 1978), Article 6; on information, see e.g., UN Doc. CCPR/C/GC/34, Human Rights Committee General Comment No. 34: Article 19 Freedom of Opinions and Expression (2011), para 19.
6 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 65.
7 E.g. ICCPR, Article 2(3); UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 59. See also, ICESCR, General Comment No. 9 on the Domestic Application of the Covenant (1998), para 2;
8 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 36.
9 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 105. Additionally, the ICESCR Committee considers that the incorporation of the Convention itself into the domestic legal order is likely to enhance the scope and effectiveness of remedial measures for victims of violations of the right to health. See, ibid., para 60.
10 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 43 (f) and 52.
11 Ibid., para 43(f).
12 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 94.
13 Ibid., General Comment 14, para 53.
14 Ibid., para 56; UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 96.
15 Ibid., General Comment 14, para 53.
16 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 96.
17 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 55.

mechanisms, reporting procedures …, evaluation arrangements, and one or more accountability devices".[18] Disaggregated right to health indicators and corresponding national benchmarks should accompany defined objectives.[19]

States should also ensure "more detailed provisions clarifying what society expects by way of health related services and facilities".[20] This would include for example, provisions on the quality of care.[21] The Rapporteur is not directive on what form these provisions should take and suggests they could reasonably manifest as "laws, regulations, protocols, guidelines [and] codes of conduct".[22] Although, some human rights provisions recommend additional standards are implemented.[23] Provisions should be evidence based.[24] Importantly, to protect people's right to health, States' are required to regulate the activities of third parties, including independent health care providers.[25]

The Council of Europe (CoE) Committee of Ministers emphasises that "patient-safety" is the underpinning philosophy of quality improvement.[26] As such, it should be the cornerstone of all quality improvement policies.[27] Further, the Department and relevant public authorities should ensure "a coherent and comprehensive patient-safety policy framework" is developed.[28] This framework should: promote a culture of safety at all levels of health care; take a proactive and preventive approach in designing health systems for patient safety; make patient safety a leadership and management priority; and emphasise the importance of learning from patient safety incidents.[29] It also recommends the "systemic design of safe structures and processes," facilitating, where possible, "voluntary, anonymous and confidential" reporting.[30]

Crucially, to fulfil the positive obligation required by the right to life,[31] States must enact regulations compelling hospitals to adopt measures, and take appropriate steps, for the protection of patients' lives,[32] and establish an appropriate regulatory framework for the provision of emergency services.[33] While States are ensured a "wide margin of appreciation" in determining the detail of its regulations, developing jurisprudence indicates this must be sufficient to ensure the system's proper organisation and effective functioning.[34]

Participation, information and transparency

The Committee of Ministers identify that "listening to patients and citizens should become a constant concern for the whole health care system at all

18 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 96. The Special Rapporteur notes elsewhere that the health system must be 'effective and integrated; it should be more than a bundle of loosely coordinated vertical interventions for different diseases', see UN Doc. E/CN.4/2006/48 'Report of the Special Rapporteur on the highest attainable standard of physical and mental health, Paul Hunt' (3 March 2006), para 8.
19 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), paras 52, 53 and 57. [sic. Para 58 - benchmarks are a requirement by paras 52 and 53].
20 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 106.
21 Ibid.
22 Ibid.
23 See for example, CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000).
24 CoE, Committee of Ministers Recommendation No. R(97) 17 'on the development and implementation of quality improvement systems (QIS) in healthcare', para 1.
25 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para. 51.
26 CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006), preamble.
27 Ibid., para i.
28 Ibid., para ii.
29 Ibid.
30 Ibid, para iii(c) and Appendix, para 1; see also para iii listing six components of safety reporting systems, namely, that it is non-punitive; independent of other regularity processes; encourages reporting by health personnel; enables analysis of adverse events and reporting at local, regional and national levels where necessary; includes public and private sectors; and facilitates service user involvement.
31 ECHR, Article 2; see also ICCPR, Article 6
32 E.g. Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 104; Oyal v. Turkey (App. No. 4864/05) 23 March 2010, para 54; Senturk v. Turkey (App no. 13423/09) 9 April 2013, para 81.
33 Furdik v. Slovakia (App no. 42994/05) 2 December 2008.
34 Furdik v. Slovakia (App no. 42994/05) 2 December 2008; Asiye v. Turkey (App no. 24109/07) 27 January 2015; Press release ECHR 027 (2015), 27.01.2015 (judgment in French).

administrative levels."[35] Importantly, participation should occur not only in the formulation of the health strategy and action plan[36] but in "all health-related decision-making at the community, national and international levels".[37] This includes, wherever possible, public participation at the problem identification and policy development,[38] as well as at implementation and accountability stages.[39] Participatory rights in this respect include health workers. [40]

The Special Rapporteur directs the establishment of institutional arrangements for the participation of all relevant stakeholders.[41] And the CoE Committee of Ministers recommends institutional arrangements that include legal structures and policies promoting public participation, along with the involvement in the management of different health structures and facilities.[42] Relevant policies should be disseminated, monitored and updated, and a democratic process followed for selecting public members on decision-making structures including health boards and advisory bodies.[43] Particular effort should be made to seek participation of "individuals and groups of individuals, who may be distinguished by one or more of the prohibited grounds",[44] as well as other vulnerable or disadvantaged communities[45] (as also discussed in Chapter 2).

The right to health and the right to freedom of expression[46] incorporate a right to "seek, receive and impart information and ideas" concerning health issues.[47] Access to health information not only enables effective participation in the decision-making process but empowers individuals to "promote their own health …, claim quality services, monitor progressive realisation, expose corruption [and] hold those responsible to account".[48]

To ensure this, and progress a culture of transparency, the relevant public authorities must "proactively put in the public domain" health information that is of public interest and "make every effort to ensure easy, prompt, effective and practical access" to it.[49] The information should include the main health problems in the community and methods of preventing and controlling them.[50] Quoting the World Health Organisation (WHO), the Special Rapporteur further details that,

35 CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), Appendix, Guideline 9; see also the WHO Declaration of Alma-Ata, (September 1978), Article 6; UN Declaration on the right to development, Preamble and Articles 1(1), 2(1) and 2(3); UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 54
36 Ibid., General Comment 14, paras 43(f) and 54.
37 Ibid., para 11. See also, CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000); and, ICCPR, Article 25 and UN Doc. CCPR/C.21/Rev.1/Add., Human Rights Committee, General Comment 25 (27 August 1996), paras 5-8.
38 Ibid., Recommendation R(2000)5, Appendix, Guidelines, para 4.
39 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 41; CoE, Committee of Ministers Recommendation No. R(97) 17 'on the development and implementation of quality improvement systems (QIS) in healthcare', para 3.
40 Ibid., Paul Hunt, para 84; Recommendation No. R(97) 17, para 3.
41 Ibid., Paul Hunt, para 41. See also, para 92, and the UN Declaration on the right to development, Article 8.
42 CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), preamble and Appendix, Guidelines, paras 9 and 10.
43 Ibid., Appendix, Guidelines, paras 2 and 9. See also Appendix, Guideline, para 10 on the establishment, operation, and ensuring transparent and open relationships between, civil society organisations and public authorities.
44 UN Doc. E/C.12/GC/20, ICESCR Committee, General Comment 20: Non-discrimination on economic, social and cultural rights (2 July 2009), para 36.
45 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 43(f); UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 41.
46 UDHR, Article 19; ICCPR, Article 19(2).
47 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 12(b).
48 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 40.
49 UN Doc. CCPR/C/GC/34, Human Rights Committee General Comment No. 34: Article 19 Freedom of Opinions and Expression (2011), para 19. See also, Ibid., Paul Hunt, para 40; UN Doc. A/68/362, 'Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression' (4 September 2013), para 76.
50 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 44(d).

a well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.[51]

Accountability

A transparent distribution of responsibilities for health decision-making[52] is important to evaluate how HSC bodies have discharged their duties towards the system.[53] Accountability is said to be one of the most important yet least understood concepts within human rights.[54] It entails three essential and interrelated dimensions: (1) monitor (2) review and (3) remedial action.[55] This is a cyclical process aimed at assessing progressive realisation, and core minimum obligations, of the right to health as well as redress for mistakes made.[56]

Monitor

Accountability mechanisms designed to ensure progressive realisation of the right to health must include capacity to monitor conduct, performance and outcomes within the health system.[57] Failure to monitor realisation of the right to health will result in a violation of the right to health.[58] A compulsory aspect of monitoring includes the systematic collection of data in accordance with right to health indicators.[59] Indicators have three identifiable purposes: they help evaluate progress over time, identifying problems and successes; facilitate rights-holders to hold the State to account for the discharge of their responsibilities (although notably, deteriorating indicators do not guarantee a breach); and, finally, they facilitate international comparisons.[60]

Review

The right to an effective remedy requires adequate mechanisms to review the substance of a complaint.[61]

An independent judicial system to establish the cause of death of people under the care of health professionals is also an essential element of review. The ECtHR requires:

[…] an efficient and independent judicial system by which the cause of death of an individual under the responsibility of health professionals can be

51 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 68(c).

52 CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), Appendix, Guideline 4; CoE, Committee of Ministers Recommendation CM/Rec (2012)8 'on the implementation of good governance principles in health systems' (12 September 2012), Tool 1, Attribute No. 1 - Accountability.

53 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), paras 65.

54 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 65 and 99.

55 Commission on Information and Accountability for Women's and Children's Health 'Keeping Promises, Measuring Results', World Health Organisation, September 2011.

56 Ibid., paras 99 and 101. See also, CoE, Committee of Ministers Recommendation No. R(97)17 'on the development and implementation of quality improvement systems (QIS) in health care' (30 September 1997).

57 Ibid., para 65.

58 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 52.

59 See OHCHR, 'Human Rights Indicators: A Guide to Measurement and Implementation', United Nations, 2012. Note that in 2011, the Equality and Human Rights Commission published a list of indicators on the right to health that follow the Rapporteur's suggested structure, process, outcome framework (ECHR, 'Human Rights Measurement Framework: Prototype panels, indicator set and evidence base' (2011), Chapter 10, available at, http://www.equalityhumanrights.com/sites/default/files/documents/humanrights/HRMF/hrmf.pdf). See also, UN Doc. E/CN.4/2006/48, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (3 March 2006), paras 52-60.

60 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), paras 43(f) and 56; UN Doc. E/CN.4/2006/48, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (3 March 2006), para 35; CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care' (24 May 2006), para vi; Vienna Declaration and Programme of Action (1993), para 98.

61 Council of Europe, 'Guide to Good Practice in Respect of Domestic Remedies (adopted by Committee of Ministers, 18 September 2013), p.12; See also R.R. v. Poland (no. 27617/04) 26 May 2011, para 184 (a case concerning termination of pregnancy) in which the court notes that "there may also be positive obligations inherent in effective "respect" for private life […]" including ensuring a regulatory framework to adjudicate on health disputes.

established, whether they are working in the public sector or employed in private structures […].[62]

This should also apply to any alleged deficient response to an emergency resulting in death[63] and, in exceptional circumstances, if the victim has not died but "suffered serious injuries as a result of illegal acts perpetrated against them."[64] To be effective, there must be a prompt examination of the case without delay.[65]

Review also requires routine internal *and* external review of health system monitoring data to determine if the State's core commitments are being met, and whether particular aspects of the right to health have improved. .[66] This is described as a learning process that involves identifying and recommending remedial action.[67] Importantly, the emphasis should be on determining 'what works, so it can be repeated, and what does not, so it can be revised'.[68] Review processes should be effective, transparent, and accessible and include an independent element.[69] On the latter, the UN Special Rapporteur notes that independence within accountability mechanisms can be weak, "sometimes the same body provides health services, regulates and holds to account."[70]

Remedial action

Remedial action concerns the right to an effective remedy in individual cases.[71] The CESCR directs the DHSSPS to provide any victim or group victim of a right to health violation with 'access to effective judicial or other appropriate remedies'.[72] The latter may legitimately include administrative remedies, provided they are "accessible, affordable, timely and effective".[73] An effective remedy is typically interpreted as requiring the characteristics of independence and impartiality.[74] It is further appropriate to establish an "ultimate right of judicial appeal from administrative procedures".[75] Reparations made to victims of right to health violations may take the form of 'restitution, compensation, satisfaction or guarantees of non-repetition'.[76]

For the ECtHR, a remedy must include both mechanisms to review the complaint's substance (see above) and for granting relief, but it is generally not proscriptive on the type of relief required.[77] In cases concerning the right to life, efficient and independent scrutiny of the case should be sufficient to ensure accountability,

62 Senturk v. Turkey (no. 13423/09) 9 April 2013, para 81; see also Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 104; Oyal v. Turkey (no. 4864/05) 23 March 2010, para 54; Furdik v Slovakia, (no. 42992/05) 2 December 2008;

63 *Furdík v Slovakia*, ECtHR, Application no. 42994/05, Decision on Admissibility (2 December 2008), 'The Law', concerning an alleged deficient response by an air ambulance service in relation to the applicant's daughter who died as a result of a mountaineering accident; *Dodov v. Bulgaria,* ECtHR, Application no. 59548/00 (2008), para 80.

64 Oyal v. Turkey (no. 4864/05) 23 March 2010, para 55.

65 Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 117; Senturk v. Turkey (no. 13423/09) 9 April 2013, para 82.

66 See Commission on Information and Accountability for Women's and Children's Health 'Keeping Promises, Measuring Results', World Health Organisation, September 2011, p. 7.

67 See Commission on Information and Accountability for Women's and Children's Health 'Keeping Promises, Measuring Results', World Health Organisation, September 2011, p. 7.

68 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008),para99.

69 See UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 100 noting that "An institution as complex and important as a health system requires a range of effective, transparent, accessible, independent accountability mechanisms"; See also Commission on Information and Accountability for Women's and Children's Health 'Keeping Promises, Measuring Results', World Health Organisation, September 2011, p. 16 recommending that States consider independent reviews of data.

70 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 101.

71 UDHR, Article 8; ECHR, Article 13

72 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 59. See also, ICESCR, General Comment No. 9 on the Domestic Application of the Covenant (1998), para 2; UN Doc. A/HRC/25/27, 'Report of the UN High Commissioner for Human Rights on the role of the public service as an essential component of good governance in the promotion and protection of human rights' (23 December 2013), para 16; ICCPR, Article 2(3).

73 ICESCR, General Comment No. 9 on the Domestic Application of the Covenant (1998),, General Comment 9, para 9.

74 See for example, UN Doc. CCPR/C/21/Rev.1/Add.13, Human Rights Committee 'General Comment 31: The nature of the general legal obligation imposed on States Parties to the Covenant' (26 May 2004), para 15.

75 UN Doc. E/C.12/1998/24, ICESCR Committee, 'General Comment 9: The domestic application of the Covenant' (3 December 1998), para 9.

76 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 59.

77 Council of Europe, 'Guide to Good Practice in Respect of Domestic Remedies (adopted by Committee of Ministers , 18 September 2013), p.12.

if appropriate, by health professionals for their actions.[78] Civil redress and disciplinary measures, without recourse to the criminal law, may satisfy the requirement for an effective remedy if violation of the right to life is not caused intentionally.[79]

Implementing, where possible, necessary changes in response to collecting, collating and reviewing health system data is also an important remedial action.[80] This may include, for example, reallocating resources to ensure maximum health benefits, greater support for programmes that are working well, and adopting improvement measures to address what is not working.[81] Moreover, in examining States' compliance with the right to life, the ECtHR has observed that learning from deaths investigations should be promptly disseminated to staff to prevent repetition of error:[82]

> […] apart from the concern for the respect of the rights inherent in Article 2 of the Convention in each individual case, more general considerations also call for a prompt examination of cases concerning death in a hospital setting. This is because the knowledge of facts and possible errors committed in the course of medical care should be established promptly in order to be disseminated to the medical staff of the institution concerned so as to prevent the repetition of similar errors and thereby contribute to the safety of users of all health services.

Commentary on a recent case suggests the extent to which such an investigation enables learning by the wider health system may also be factor in determining a breach of Article 2.[83]

Domestic Framework

The following sections extract some of the core obligations of the DHSSPS in the governance of the health system and, in particular, emergency health care, and examine the extent to which these are established within the domestic legal and policy framework. Although not a comprehensive list, these core obligations include:

- the right to health recognised in law
- a national health strategy and action plan underpinned by human rights
- A regulatory framework to ensure effective system functioning, including more detailed provisions applicable to emergency health care
- Quality improvement and patient safety policies
- Participation in health-related decision-making
- An effective accountability framework.

Legal recognition of the right to health

The statutory basis for the domestic health system and its associated services, including those provided within emergency departments (EDs), is contained primarily within the Health and Personal Social Services (NI) Order 1972 (the 1972 Order) and the Health and Social Care (Reform) Act (NI) 2009 (the 2009 Act). Entitlements related to ICESCR, Article 12 and its associated jurisprudence are also included. The 2009 Act, Article 2 (1) (a) states:

> The Department shall promote in Northern Ireland an integrated system of –
>
> (a) Health care designed to secure improvement
>
> ii) In the physical and mental health of people in Northern Ireland, and

78 E.g. Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 117; Oyal v. Turkey (no. 4864/05) 23 March 2010, para 54.
79 Senturk v. Turkey (no. 13423/09) 9 April 2013, para 83; Furdik v Slovakia, (no. 42992/05) 2 December 2008
80 ICESCR, Article 2(1); CoE, Committee of Ministers Recommendation No. R(97) 17 'on the development and implementation of quality improvement systems (QIS) in healthcare', para 1; UN Doc. A/HRC/RES/19/20, Human Rights Council Resolution 19/20 'The role of good governance in the promotion and protection of human rights' (25 April 2012), preamble; CoE, Committee of Ministers Recommendation CM/Rec(2012)8 'on the implementation of good governance principles in health systems' (12 September 2012), Tool No 1, 'Attribute 10'.
81 See Commission on Information and Accountability for Women's and Children's Health 'Keeping Promises, Measuring Results', World Health Organisation, September 2011, p. 7.
82 Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 117.
83 Asiye v. Turkey (no. 24109/07) 27 January 2015, ECtHR Press Release (official judgment in French only). For commentary, see Quenivet, N 'Euro Rights Blog: Emergency Health Care and Article 2' 10 February 2015 http://eurorights.net/euro-rights-blog-emergency-health-care-and-article-2-echr/ (accessed 20.03.15).

iii) In the prevention, diagnosis and treatment of illness.

In furtherance of this (and any other statutory provision relating to health care), the Department is required to provide, or secure the provision of, health care.[84] This accords with the "[…] the right to a system of health protection",[85] required by the right to health. Importantly, as in ICESCR, Article 12, the 2009 Act and 1972 Order explicitly reference both physical and mental health.[86] Nevertheless, because neither explicitly includes the right to health, it is not sufficiently recognised in national law.

A national health strategy and action plan

Together, the "Making Life Better"[87] and "A Healthier Future"[88] strategies most closely correspond to the right to health requirement for a national strategy and action plan. Moreover, their overall focus in investing in, and improving, people's health and wellbeing means undoubted potential to impact on emergency health care.[89] According to the CESCR, the national health strategy and plan should have certain features, as set out in Table 3.2. As this demonstrates, the majority of features are contained within the "Making Life Better" strategy, but less apparent within a "A Healthier Future".

84 Health and Social Care (Reform) Act (NI) 2009, section 2(2)
85 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 8.
86 Health and Social Care (Reform) Act (NI) 2009. Section 2(1)(a)(i); Health and Personal Social Services (NI) Order 1972, article 4(a).
87 DHSSPS 'Making Life Better: A Whole System Strategic Framework for Public health 2013-2013', June 2013.
88 DHSSPS 'A Healthier Future: A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025', December 2004.
89 Explicit references to emergency health care are also included, for example, "A Healthier Future" refers to improving access to different forms of emergency care, and "Making Life Better" to training for emergency department health professionals on interventions relating to substance misuse, suicide prevention and mental health promotion (see respectively DHSSPS 'A Healthier Future: A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025', December 2004, Policy Direction 7, p.48; and DHSSPS 'Making Life Better: A Whole System Strategic Framework for Public health 2013-2013', June 2013, p.78).

Table 9: Right to health features of the national health strategy and plan

	Are the required features within a 'Making Life Better' or "A Healthier Future" documents? (NIHRC analysis)	
Required right to health features (CESCR, General Comment 14)	**"Making Life Better"**	**"A Healthier Future"**
Defined objectives with associated timeframes	Yes (18 outcomes with associated actions, commitments and timeframes identified)	Yes (See section 8 "making it Happen"; but not always clear if commitments expressed in text are visionary or also "actions")
Underpinned by human rights	Partially (The right to health is explicitly included; but it is not apparent how human rights define the strategies objectives strategies substance)	Partially (Some references to human rights but no explicit reference to any particular human rights or instrument; not apparent how human rights have informed the strategy's substance)
A health situational analysis	Yes (Summary included in Annex A)	Yes (References to data on the health situation of the population included at points throughout document)
Disaggregated right to health indicators and benchmarks	Partially (Annex B includes high level indicators and baselines; but no requirement to disaggregate on prohibited grounds of discrimination)	No
Process for prioritising competing health needs	Yes (Proposes 'social gradient' approach, adopting universal actions with intensity of implementation proportionate to need / vulnerability p.22)	No
Detailed budget	No (Broad funding arrangements at p.12 and p.130 but detailed budget not included)	No (Objective on resourcing delivery included at p.106, but budget absent)
Effective co-ordination mechanisms	Yes ("Whole system approach" for implementation referenced at pp.10-11; other strategies referenced throughout; More detailed governance arrangements outlined in Part 3).	Partially (Plans for delivery set out at p.98 but detail not apparent)
Reporting procedures	Yes (p.11-12; and p.128-129)	Partially (Plans for reporting set out at p.98 but detail not apparent)
Evaluation arrangements	Yes (Overall activity to be reported on annually; high-level indicators to serve as proxy measures towards achieving outcomes – see p.12 and p.129).	Partially (Plans for three year review of five year implementation plans set out at p.98, but detail not apparent)
Accountability devices	Yes (Included in Part 3 on governance and implementation)	Yes (Plans for the role of HPSS bodies referenced at p.98 but detail of accountability arrangements not apparent)

The development of "A Healthier Future" in advance of the Review of Public Administration may explain why it falls short on meeting several of the required features of a national strategy (particularly on co-ordination, reporting, and evaluation arrangements).[90]

The subsequent "Making Life Better" represents a significant improvement. However, it is not apparent how objectives have been defined by human rights, nor is a detailed budget included. Its indicators and benchmarks include important social determinants of health but there is no requirement to disaggregate on the prohibited grounds of discrimination.[91] This makes it difficult to monitor the strategies impact on particular groups and develop evidence on which targeted actions can be based. Finally, while both strategies contain objectives with timeframes, an action plan is not included within the document. Nor is there a framework law to operationalise implementation, which States should consider adopting.[92]

A regulatory framework to ensure effective system functioning

System planning

Overarching frameworks to ensure the effective health system functioning, including for EDs can be located within, inter alia, the DHSSPS Quality Standards[93], and its Framework Document.[94] The latter establishes the structure, roles and statutory responsibilities of all HSC bodies, including in service planning, which is integral to the effective functioning of emergency care. The requirement on the HSCB to produce an annual commissioning plan is described as one:[95]

> […] at the core of the key working relationship that translates the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services […].

Although commissioning is described as a cyclical "end to end" process,[96] certain tasks should complete within each cycle for commissioned services to function effectively. This includes the Department securing "[…] resources that enable the health and social care system to satisfy the population's need for high quality, accessible services,"[97] publishing its Commissioning Plan Direction, and the HSCB developing an annual Commissioning Plan. In this process, trusts should provide services to meet the Plan, setting out viability via "Service and Budget Agreements."[98] As discussed in Chapter 1, the draft Commissioning Plan for 2014/15 included regional priorities for EDs (under "acute services – unplanned), with corresponding detail and actions within LCG plans.[99]

While recognising the context of significant financial difficulties in 2014/15, the fact the Commissioning Plan remained in draft throughout much of 2014/15, and consequently, "Trust Development Plans" too, [100] suggests the

90 For example, it states "[…] there would be one [implementation [plan] for each Board area although this will be reviewed in light of the outcome of the Review of Public Administration" (DHSSPS 'A Healthier Future: A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025', December 2004, p.98).
91 The first annual report confirms that disaggregation is not occurring in practice (apart from some reporting by gender and social deprivation), see DHSSPS, 'Making Life Better: Monitoring the wider social determinants of health and wellbeing – key indicators and baselines 2014, June 2014; see UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 57.
92 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 56.
93 DHSSPS, 'Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, March 2006.
94 DHSSPS, 'Framework Document', September 2011.
95 DHSSPS, 'Framework Document', September 2011, p.18.
96 DHSSPS, 'Framework Document', September 2011, p. 33.
97 DHSSPS, 'Framework Document', September 2011, p. 25.
98 DHSSPS, 'Framework Document', September 2011, p. 18.
99 See HSCB 'Commissioning Plan 2014/15 – Draft 24 March 2014' (and also draft January 2015 http://www.hscboard.hscni.net/publications/Commissioning%20Plans/%2026%20Jan%202015%20Draft%20Commissioning%20Plan%202014-15%20PDF%205MB.pdf (accessed 16.03.15)).
100 Confirmed via email communication with HSC Trusts during November and December 2014. Through TDPs, HSC Trusts communicate to the HSCB the financial viability of the services it considers necessary to meet commissioning priorities and flags those areas where additional monies are required.

regulatory framework is not working as it should.[101] Moreover, difficulties for 2015/16 planning may be apparent in so far as the Departmental Commissioning Plan Direction 2015, to direct the plan for 1 April 2015 to 31 March 2016, was not available until early March 2015.[102] While maintaining a focus on improving ED performance,[103] the DHSSPS 2015/16 budget does not allow for the funding of new service developments in, *inter alia*, unscheduled care and TYC transitional funding.[104] This suggests tighter regulatory frameworks are required to ensure effective functioning of EDs in 2015/16.

Hospital measures to protect patients' lives

The ECtHR has not been specific on the types of measures hospitals should adopt to protect patients lives. But they must ensure effective functioning especially when the system is pressured.[105] To help address ED crowding, and ultimately safeguard life, CEM recommends "hospital wide escalation plans."[106] Escalation plans were provided to the Inquiry by all HSC Trusts, including the NIAS. When initially provided (July 2014) some were still in draft form but either said to be operational or an older plan was being applied.[107] The content of the plan varies considerably across trusts, some of which may be justified by the local set-up. But differences in escalation levels[108] and plan breadth[109] makes regional co-ordination, where required, less likely. Notably, the HSCB has published a revised "Regional Unscheduled Care escalation Plan" one principle of which includes establishing consistency across trusts in determining levels of escalation.[110] Trusts are to review escalation arrangements against the plan.[111]

More detailed provisions on emergency health care

More detailed provisions regarding different health-related services help clarify what people and staff delivering the service can expect.[112] These provisions may take various forms including laws, standards, and protocols.[113] Various documents, although not always specific to emergency health care, are applicable to emergency services and facilities. For example, there are the DHSSPS Quality standards[114] and the DHSSPS "Service Frameworks," which include standards for different areas of, or particular groups within, health and

101 A review of commissioning arrangements has recently been announced – see DHSSPS Press Release, 27 January 2015, http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-january-2015/news-dhssps-270115-wells-report-presents.htm (accessed 19.03.15)

102 Given "official seal" by the Department on 6 March 2015; whereas the Commissioning Plan Direction 2014 was "sealed" on 13 November 2013.

103 NI Executive, 'Budget 2015-16', p. 95.

104 NI Executive, 'Budget 2015-16', pp.93-94. Information provided by the DHSSPS to NIHRC in response to the draft report (dated 8 May 2015) notes the HSCB plans to submit a bid for TYC financial support in the June 2015 Monitoring Round, which is subject to Ministerial approval.

105 Asiye v. Turkey (no. 24109/07) 27 January 2005; ECtHR Press Release (judgment in French).

106 The Royal College of Emergency Medicine, Crowding in Emergency Departments, Revised June 2014 http://www.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/College%20Guidelines/; also The Royal College of Emergency Medicine, Exit Block in Emergency Departments: 6 Month Review, February 2015, http://www.collemergencymed.ac.uk/Shop-Floor/Policy/Exit%20Block (accessed 16.03.15)

107 The Belfast Trust provided an "Escalation Plan (Paediatric)" April 2011, an "Acute Escalation Plan (Adult)" September 2013, and an "Unscheduled Care Escalation Plan – draft July 2014" (this was finalised by December 2014); The Northern Trust an "Acute Capacity Escalation Plan" (undated); South Eastern Trust was the only Trust that provided "Hospital-wide Escalation Plans" for each of its acute hospital sites, each in draft in July 2014 but finalised in year; the Southern Trust a "Trust Escalation Framework – Achieving the 4 Hour Standard" (undated); the Western Trust provided a "Policy for Patient Flow and Escalation – draft version October 2015;" NIAS a "Resource Escalation Action Plan (REAP Plan) – draft version 5.4, June 2014.

108 For instance, the South Eastern, Southern and Northern Trusts' plans are three tiered; whereas the Belfast and Western Trusts' plans contain four levels.

109 Some plans were hospital wide, others Trust wide or applying to acute services, and one appeared to be ED specific (what Ed staff should do "if there is a risk that patients will breach the 4 hour standard").

110 HSCB, 'Regional Unscheduled Care Escalation Plan – updated November 2014, p.1; see also RQIA, 'An Independent Review of Arrangements for management and Coordination of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations', July 2014, Recommendation 1.

111 HSCB, 'Regional Unscheduled Care Escalation Plan – updated November 2014, p.1.

112 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 106.

113 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 106.

114 DHSSPS, 'Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS', March 2006.

social care.[115] Moreover, the Guidelines and Audit Implementation Network (GAIN), commission regional guidance applicable to EDs,[116] and, since 1 April 2006, National Institute for Health and Care Excellence (NICE) guidance is reviewed by DHSSPS for local application.[117] Notably, NICE recently consulted on draft "safe staffing guidelines for A&E departments."[118]

Importantly, the DHSSPS has a statutory mandate to develop regulations and "statements of minimum standards."[119] The former relate to establishments and agencies listed in the 2003 Order and may make provision for, inter alia, the services and facilities to be provided.[120] The listed bodies relate primarily to independent health care providers rather than statutory providers of acute hospitals. This means that the one private Type 3 ED (Minor Injuries Unit) in Northern Ireland is governed by specific set of regulations[121] and acute hospitals, in which the overwhelming majority of EDs are located, are not. The Quality 2020 strategy includes an objective to "establish a framework of clear evidence-based standards and best practice guidance."[122] There are, however, no commitments either within legislation or Quality 2020 to develop minimum care standards for acute hospitals, including emergency departments. Human rights law does not explicitly require "Minimum care standards" for emergency care, and the collective of provisions already mentioned may set out what people can expect from acute services and facilities to some extent.[123] But the absence of a single, comprehensive set of care standards makes it difficult to ascertain minimum obligations in emergency health care settings and it is consequently problematic to clarify what people can expect. As discussed further below, it also creates an accountability gap.

Quality Improvement Policies

Regional and HSC Trust policies for improving the quality of emergency health care are much better developed than those establishing minimum obligations. This corresponds with the directing legislation, which introduced a statutory duty to establish arrangements for "monitoring" and "improving" quality.[124] The DHSSPS Quality 2020 represents the core strategy on quality improvement. As recommended by human rights standards,[125] its core vision includes patient safety.[126] Further, Transforming Your Care was premised on identifying quality improvements in all aspects of health and social care services, including emergency care.[127] It makes proposals regarding acute and urgent services to achieve, *inter alia*, "Balancing local and central demand with quality and safety."[128]

At a local level many policies and plans pertain to quality improvement. For example, each HSC Trust is committed to developing an "Unscheduled

115 See http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards-service-frameworks.htm (accessed 19.02.15).
116 For example, most recently for EDs: 'Regional Guidelines for the Supply of "Take-Home Medication" from Northern Ireland Emergency Departments' December 2014. Guidelines available on http://www.gain-ni.org/index.php/audits/guidelines (accessed 24.03.15).
117 See DHSSPS website on 'Safety, Quality and Standards' at http://www.dhsspsni.gov.uk/sqsd-guidance-nice-guidance (accessed 24.03.15).
118 See http://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/nice-safe-staffing-guidelines (accessed 24.03.15); Anticipated publication date is May 2015 (see http://www.nice.org.uk/guidance/indevelopment/gid-sgwave0762 (accessed 24.03.15)),
119 The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003, Article 23 and 38 respectively.
120 The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003, Article 23(7)(a); see Article 8 for the list of establishment and agencies.
121 Independent Health Care Regulations (NI) 2005
122 DHSSPS, 'Quality 2020: A ten-year strategy to protect and improve health and social care in Northern Ireland, November 2011, objective 7.

123 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 106
124 The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003, article 34(1).
125 CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006), preamble
126 "Safety – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them" (DHSSPS, 'Quality 2020: A ten-year strategy to protect and improve health and social care in Northern Ireland, November 2011, under 'A Vision for Quality').
127 HSCB, Transforming Your Care: A Review of Health and Social Care in Northern Ireland, December 2011, p. 3.
128 HSCB, Transforming Your Care: A Review of Health and Social Care in Northern Ireland, December 2011, p. 109.

Care Improvement Plan"[129] and to auditing against "18 Unscheduled Care Key Actions", which were issued by the DHSSPS in 2007 to improve A&E waiting times.[130] Trusts also develop various other, more detailed improvement plans in response to inspections by regulatory and professional bodies, or systemic reviews.[131] For instance, recent inspections of unscheduled care by the RQIA prompted a Belfast Trust Quality Improvement Plan,[132] with trusts producing implementation plans in response to regional recommendations.[133]

The development of these plans is an overwhelmingly positive indication of a commitment to improve the quality of emergency care services. There are, however, structural gaps impacting on effective accountability (discussed below).

A Patient Safety Policy Framework

Quality 2020 represents the core strategic framework for patient safety superseding the DHSSPS Safety First document.[134] As recommended by human rights guidance,[135] it includes an emphasis on learning, pledging to promote: "a culture of innovation and learning that creates more quality-focused attitudes and behaviours among HSC staff." A myriad of related guidelines, procedures and reports designed to encourage safety related activity exist, including guidelines for incident reporting, feedback and complaints processes, internal and external review mechanisms, regional learning letters, and complaints reports.

Of particular importance is the DHSSPS guidance on how to classify adverse incidents[136] and the HSCB procedure regarding "Serious Adverse Incidents [SAIs]".[137] The latter includes criterion to help determine when an adverse incident is an SAI, and for deciding the nature of investigation. Importantly, it distinguishes the SAI process as an administrative one that may run in parallel but is separate from criminal or disciplinary action, as recommended by the CoE to encourage learning.[138] However, there are areas for improvement. For example, there is little clarity on the processes each HSC organisation should follow to detect SAIs. Additionally, service user and family involvement in both reporting incidents and in SAI investigation lacks emphasis within the HSCB procedure, noting only an opportunity to contribute to the latter "as is felt necessary". Although, importantly, in January 2015 a guide for HSC staff on engaging with service users and family regarding SAIs was published. [139]

A review of "adverse incident management," which will include the SAI process, within each Trust has been ordered.[140] This will consider:

129 See the Local Commissioning Group Plans within the PHA and HSCB 'Commissioning Plan 2014/15 – Draft 24 March 2014'. All HSC Trusts provided a UCIP to the Inquiry, save for one which had developed instead a "sustainability plan."
130 Letter to Trust Chief Executives from Hugh Mullen, Director of Performance & Provider Development Designate, DHSSPS, 29 June 2007. (provided by email from HSCB 27.01.15)
131 For example, the Northern HSCT developed Phase 1 and Phase 2 Improvement Plans in response to the report of the "Turnaround and Support Team", which was commissioned by the DHSSPS to determine changes required to accelerate improvement in unplanned care ('Turnaround Support for the Northern Health and Social Care: Report of the Turnaround and Support Team' undated, and the Phase 1 and Phase 2 Improvement Plans, provided to the Inquiry by the NHSCT).
132 Updated 22/08/2014 by the Belfast Trust in Section 8 of RQIA 'Follow-up Inspection Report of Unscheduled Care in the Belfast Health and Social Care Trust, 12 to 14 may 2014', November 2014.
133 See the 'Unscheduled Care Update for Regional Coordinating Group, Update Number 1' at http://www.dhsspsni.gov.uk/index/unscheduled-care/unscheduled-care-01.htm (accessed 19.02.15). For the regional recommendations see, RQIA, 'An Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations, July 2014.
134 Indicated by DHSSPS to NIHRC by email on 24.02.15.
135 CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006), preamble.

136 DHSSPS,' How to Classify Adverse Incidents and Risk: Guidance for Senior Managers Responsible for Adverse Incident Reporting and Management', April 2006; see p. 1, defining an adverse incident as: "any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."
137 HSCB, 'Procedure for the Reporting and Follow up of Serious Adverse Incidents', October 2013.
138 Recommendation Rec(2006)7, preamble, para iii(a) and (b) stating that the reporting system for patient safety should be non-punitive and independent of other regulatory processes.
139 The Guide was developed by the HSCB and PHA working in collaboration with the RQIA, the PCC and the HSC Trusts (see 'A Guide for Health and Social Care Staff: Engagement/Communication with the Service User/ Family/Carers following a Serious Adverse Incident', January 2015).
140 See DHSSPS Press http://www.dhsspsni.gov.uk/statement080414 (accessed 11.03.15)

> […] the appropriateness of Trusts' systems for identifying Serious Adverse Incidents by considering their current arrangements for reporting and handling adverse incidents, litigation cases and complaints. This will involve RQIA sampling cases from the adverse incidents, complaints and litigation systems and reviewing Trusts' systems for identifying, where appropriate, these cases as SAIs.

Although RQIA's report is awaited, recommendations arising from Sir Liam Donaldson and colleagues' governance review urge an adverse incident reporting policy to ensure learning from less serious harm, and a process for incident reporting by patients.[141] And, importantly, the forthcoming report of the Inquiry into Hyponatraemia-related Deaths may include the reporting and reviewing of adverse clinical incidents within trusts.[142]

Additionally, routine review of deaths in ED, and of illnesses and injuries presenting is an important safety activity. Documents provided to the Inquiry shows "Mortality and Morbidity" (M&M) policies agreed or in development within the Belfast, Southern and Western HSC Trusts, with each holding dedicated emergency department M&M meetings. While the Northern Trust does not have an M&M policy, it stated (by email on 20 August 2014) that the Chief Executive "has initiated a governance review […] to ensure best practice in all aspects of governance and in particular Mortality and Morbidity." The SE Trust also does not have an M&M policy, but indicated that M&M review occurs at monthly Audit meetings attended by medical staff. It noted:

> ED has moved to a format of adverse incident reporting on a monthly basis whereby reflective learning is generated and practices and policies are adopted and changed. The traditional Mortality and Morbidity format was not considered meaningful in ED as patients started their journey in ED but on-going management was completed by another clinical team. (Written submission received by email 22.10.14)

Although regional variation in M&M policy and practice is clearly apparent, the former Minister has pledged to ensure "phased regional implementation of a Mortality and Morbidity Review System".[143]

Mechanisms to ensure public participation

A statutory duty of public involvement and consultation, commonly known as "Personal and Public Involvement" (PPI), exists in sections 19 and 20 of the 2009 Act. The former requires HSC Bodies to promote information about the health and social care for which they are responsible, to obtain information about people's needs and the efficacy of that care, and encourage and assist people to (a) avail of that care in an appropriate manner and (b) maintain and improve their own health and wellbeing. It also requires the health and social care bodies to prepare a consultation scheme. Section 20 requires, *inter alia*, that consultation schemes show arrangements to consult the PCC, recipients, or potential recipients of care, and carers about planning and decisions affecting the provision of care, and any proposals for change.

Associated DHSSPS guidance includes core values and principles for HSC bodies on PPI promoting it as an integral "way of working".[144] In keeping with human rights, PPI should be "part of organisational planning and management processes including

141 Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' December 2014, Recommendation 6. Note that although the relevant RQIA report had not been published, a draft was made available to Sir Liam Donaldson and colleagues to inform their findings (see p.6 of Sir Liam Donaldson and colleagues' report).

142 See 'Revised List of Issues – Department of Health' under "Actions of Doctors, Nurses and Trusts" (http://www.ihrdni.org/revised_loi_08_08_13.pdf (accessed 24.03.15).

143 DHSSPS Press Release, 8 April 2014, http://www.northernireland.gov.uk/news-dhssps-080414-poots-announces-actions (accessed 11.03.15).

144 See Part 8 of the DHSSPS Circular: HSC (SQSD) 29/07 'Guidance on Strengthening Personal and Public Involvement in Health and Social Care', September 2007; see also DHSSPS Circular: HSC (SQSD) 03/2012 'Guidance for HSC Organisations on Arrangements for Implementing effective personal and public involvement in HSC', 20 September 2012 including, inter alia, monitoring arrangements.

budgets, workloads and training plans";[145] there should be a focus on creating opportunities for representative involvement and engagement with marginalised groups;[146] and timely, accurate and user friendly information is prioritised.[147]

A core focus of the DHSSPS Guidance is on gathering people's feedback and viewpoints. This is reflected in related documentation, such as the HSCB/PHA PPI Strategy,[148] the Regional and LCG Commissioning Plans, as well as existing consultative mechanisms. On the latter, there is, for example, the '10,000 Voices' project, which gathers patient / service user feedback regarding their experiences via survey; the 2014/15 commitment to deliver a "regional survey of inpatient and A&E patient experiences",[149] and the development of ED "Values and Principles", which will be informed by public consultation.[150] Many of the domestic frameworks discussed in this chapter on, for example, quality improvement, patient safety, resource planning, and monitoring also include varying degrees of, or commitments to, participation.[151]

Complementary statutory provisions established the PCC, an independent statutory body whose functions includes representing the interests of and promoting the involvement of the public.[152] As recommended by human rights guidance[153], it must undertake research into the best methods for consulting and involving the public in health and social care matters, as well as publish an annual report of its activities.[154]

There are fewer references in the legislation and DHSSPS guidance to public participation in health management, or to ensuring health boards, committees, and advisory bodies include democratically appointed public members.[155] This is not to say participatory governance does not, or cannot, occur in practice. For example, the Regional Forum to coordinate and monitor PPI across the HSC system includes services users and carers on its membership, and Quality 2020 has a "Governance Model" that includes community representation on its steering group,

145 Under Principle 3, DHSSPS Guidance. For applicable human rights guidance on favourable fiscal conditions for civil society participation and training of health professionals see CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), Appendix, Guidelines, para 10 and 11 respectively.

146 Under Principle 5, DHSSPS Guidance. For applicable human rights guidance see e.g. UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 43(f); UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 41.

147 Principle 8, DHSSPS Guidance. For human rights standards see e.g. UDHR, Article 19; ICCPR, Article 19(2); on human rights guidance see UN Doc. A/HRC/25/27, 'Report of the UN High Commissioner for Human Rights on the role of the public service as an essential component of good governance in the promotion and protection of human rights' (23 December 2013), para 21; UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 40.

148 PHA/HSCB 'Valuing People, Valuing their Participation: A Strategy for Personal and Public Involvement for the Public Health Agency and Health and Social Care Board', March 2012. Note each HSC body, including each trust, is responsible for developing and implementing its own PPI strategy (as highlighted by the SEHSCT in response to the draft report 6 May 2015, in which its own PPI strategy was noted – see SEHSCT, 'Involving You: Personal and Public Involvement Strategy 2012-2015).

149 Health and Social Care Commissioning Plan Direction (NI) 2014, standard / target 25.

150 See DHSSPS Press Release, 19 November 2014 http://www.northernireland.gov.uk/news-dhssps-191114-health-minister-updates (accessed 16.03.15)

151 E.g., the DHSSPS Framework Document contains a chapter on "Personal and Public Involvement" (PPI) noting people "must be properly involved in the planning, delivery and evaluation of their services" (p.38); and PPI is emphasised as a continued commitment by the DHSSPS in the NI Executive Budget 2015/16 (p. 96); Note, however, recent recommendations "to strengthen the patient voice" by Sir Liam Donaldson and colleagues (Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' December 2014, Recommendation 10).

152 Health and Social Care (Reform) Act (NI) 2009, section 16, and 17(1)(a) and (b).

153 Among other matters, publication of an annual report on the progress of citizen participation and developing research programmes to ascertain most-effective means of participation in health decision-making is recommended (see CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), Appendix, Guidelines, para 11).

154 Health and Social Care (Reform) Act (NI) 2009, section 17(5)(a) and Schedule 4, para 11(1) respectively.

155 CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000), preamble and Appendix, Guidelines, paras 9 and 10; and 2 and 9 respectively.

and a "Stakeholder Forum." [156] But it is less likely to become embedded if not explicit within the directing laws and guidance. Notably, in March 2015, the PHA published the five new PPI standards of Leadership; Governance; Opportunities and Support; Knowledge and Skills; and Measuring Outcomes. While not explicit on requiring public participation within the structures of HSC boards and committees, it states:[157]

> HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.

Finally, although information provision is core to PPI, information provided to the Inquiry notes "there is no single Health and Social Care accredited advice and information service" in Northern Ireland.[158]

An effective accountability framework

Monitoring

Various indicators to monitor ED performance exist and, as set out in Chapter 1, both the range and nature is progressively improving. In 2014, there were ten statutory indicators for monitoring ED attendances compared to only two in 2012,[159] and the 2014/15 draft Commissioning Plan notes continued development and expansion of quality indicators by the 'regional collaborative in Emergency Medicine'.[160] Qualitative monitoring is also evident with a priority "to improve the design, delivery and evaluation of health and social care services through public involvement, and the 2014/15 Ministerial target to deliver an inpatient and ED patient experience survey".[161]

Further monitoring[162] containing qualitative dimensions includes complaints scrutiny, collation of patient feedback including through the '10,000 Voices' project, surveys pursuant to the PCE Standards, and less formal activities within EDs to gather patient and staff views (such as in Causeway ED to inform its ED Standards). EDs also undertake monitoring against a "minimum dataset",[163] as well as recommended clinical indicators,[164] and the regional "18 Unscheduled Care Key Actions", which were introduced in 2007 to help achieve the four and 12 hour waiting time targets.[165]

Although further dialogue between HSC bodies, clinicians, human rights practitioners, and stakeholders is required to explore if these are suitable right to health indicators, all are potentially important for benchmarking and examining progressive realisation.[166] Nevertheless, distinguishing what is absolutely required from that which can be progressively improved is difficult in the absence of standards establishing a "minimum basket" of core obligations for emergency health care.

Review

In terms of review in individual cases, a new HSC complaints procedure was introduced in April 2009 encompassing a "single tiered" mechanism with

156 For the Regional PPI Forum, chaired by the PHA, see the DHSSPS 'Framework Document', September 2011, p.39, and the PHA/HSCB 'Valuing People, Valuing their Participation: A Strategy for Personal and Public Involvement for the Public Health Agency and Health and Social Care Board', March 2012; for Quality 2020 see DHSSPS, 'Quality 2020 Governance Model', October 2012.
157 HSC, 'Setting the Standards: Personal and Public Involvement: Involving You, improving care', Standard Three – Opportunities and support for involvement.
158 Information submitted by PCC email dated 16.10.14
159 Same as currently written (fn.436)
160 HSCB, 'Draft Commissioning Plan 2014/15', 24 March 2014, p.524.

161 See, respectively, the Health and Social Care (Indicators of Performance) Direction (Northern Ireland) 2014, Indicator E1; and the Health and Social Care Commissioning Plan Direction (NI) 2014, Standard / target 25
162 There are many monitoring mechanisms not considered here including those for measuring the discharge by external bodies of contracts and Service Level Agreements.
163 Provided to the Inquiry via BHSCT by email dated 9 July 2014
164 See indicators developed by the "Emergency Department Collaborative" via the PHA "HSC Safety Forum" http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum/emergency-department (accessed 18.03.15).
165 Documents provided to the Inquiry by the HSCB email 27.01.15.
166 See CESCR, General Comment No. 14, para. 52: Violations of the obligation to fulfill the right to health occur through, inter alia failure to "monitor realization of the right to health […], for example, by identifying rights to health indicators and benchmarks."

a right of appeal to the NI Ombudsman.[167] The efficacy of this, including development of a regional mechanism to receive user feedback, is subject to ongoing review by a "HSC Complaints Policy Liaison Group."[168] The NI Ombudsman consists of two statutory offices, the NI Commissioner for Complaints and the Assembly Ombudsman.[169] The NI Assembly recently approved proposals for a Bill to combine into a single "Northern Ireland Public Services Ombudsman" (NIPSO).[170]

The proposals include, *inter alia*, provision for the office to investigate of its own initiative.[171] The NI Ombudsman's Annual report notes that health and social care complaints submitted to his office are rising annually, with an increase of 46% (117) on the previous year, totalling 38% of all complaints received for 2013/14.[172]

On scrutiny of deaths occurring in ED, all deaths resulting from any cause, other than natural illness or disease, for which the deceased had been seen and treated within 28 days of death must be reported to the coroner.[173] Guidance on reporting arrangements to the Coroner and other relevant bodies for deaths and "untoward harm" is contained within multiagency "Memorandum of Understanding"[174] and Departmental "Guidance on Death, Stillbirth and Cremation Certification."[175] Notably, planned implementation of a regional "Mortality and Morbidity Review System" is intended to "act as an additional safeguard to ensure that deaths are appropriately reported to the Coroner."[176] And the development of proposals, with DFP and DoJ, for a new independent system to review deaths complementing the work of the Coroner has also been announced.[177] Finally, important lessons regarding the reporting of deaths to the Coroner may be included in the forthcoming report of the Inquiry into Hyponatraemia-related Deaths[178]

Review of health system monitoring data occurs internally by various means including, for example, through collation and analysis of complaints and compliments by EDs, Trusts and at regional level; ED specific surveys against the PCE Standards, and EDs' internal review of the "Minimum Dataset" outputs.[179] However, a recent examination of

167 See DHSSPS, 'Complaints in HSC: Guidelines for Resolution and Learning, April 2009.
168 Information provided to the Inquiry by DHSSPS, Document 52-14 (date unknown). Complaints handling is also encompassed in RQIA's 2014/15 review of HSC Governance (DHSSPS Document 52-14). RQIA is also planning a review of the HSC complaints procedure in 2017-18 (RQIA, 'Three Year Review Programme, 2015-18', p.13).
169 See the Ombudsman (NI) Order 1996; the Commissioner for Complaints (NI) Order 1996.
170 Hansard Official Report, 16 September 2013 at http://www.niassembly.gov.uk/assembly-business/official-report/reports-13-14/16-september-2013/#8 (accessed 24.03.15).
171 For the proposals see Committee for the OFMDFM, 'Report on the Committee's Proposals for a Northern Ireland Public Services Ombudsman Bill' Volumes One and Two, 27 June 2013.
172 'Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints 2013-2014', p.30
173 Coroner's Act (Northern Ireland) 1959, Section 7.
174 Memorandum of Understanding: Investigating patient or client safety incidents (unexpected death or serious untoward harm): Promoting Liaison between the Health and Social Care, Police Service of Northern Ireland, and the health and Safety Executive for Northern Ireland, March 2013 http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf (accessed 18.03.15); Note that as well as independent judicial system to investigate deaths of patients in the care of the medical profession, ECHR, Article 2 (right to life) may require the same where victims have serious injuries as a result of illegal acts perpetrated against them (e.g. Oyal v. Turkey (no. 4862/05), 23 March 2010, para. 54).
175 DHSSPS, August 2008.
176 DHSSPS Press Release, 8 April 2015, http://www.dhsspsni.gov.uk/statement080414 (accessed 18.03.15).
177 DHSSPS Press Release, 27 January 2015, http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-january-2015/news-dhssps-270115-wells-report-presents.htm (accessed 18.03.15)
178 See 'Revised List of Issues – Department of Health' under "Actions of Doctors, Nurses and Trusts" (iv) Are there now more reports to the Coronial Service than before? (http://www.ihrdni.org/revised_loi_08_08_13.pdf (accessed 24.03.15); and 'Revised List of Issues' http://www.ihrdni.org/revised_loi_14-02-12.pdf (accessed 24.03.15).
179 In meetings with both the Belfast and Southern Eastern Trust it was noted that different levels of review occur at daily, weekly and monthly intervals. Moreover, the HSCB noted that "there are a wide range of regular, consistent indicators of quality and safety. Including those contained in HSC organisations Annual Quality Reports. In addition, there is regular monitoring and reporting of Hospital Standardised Mortality Ratios, Healthcare Associated Infections, [and] Waiting Times […]" (response to draft report dated 6 May 2015).

health system governance has noted that internal review processes lack coherence:[180]

The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor level.

The overarching context and structure in which review occurs is contained within the DHSSPS Framework Document.[181] With the exception of some tasks allocated to the PHA, the central internal reviewer of health system performance is primarily the HSCB. It must monitor and report to the Department on trusts' performance,[182] and assess if targets and other priorities are being met, escalating concerns to DHSSPS where appropriate.[183]

Notably, although the four dimensions for "holding the system to account" – corporate control; safety and quality; finance; operational performance and service improvement[184] - are important right to health constituents, assessing furtherance of the right to health is not explicit.[185] Transparency is also not reflected.[186] Therefore, routine monitoring information must be passed from trusts to the HSCB (and on to the Department),[187] but the circumstances in which this should (or should not be) publicly available are not apparent from the document.[188]

Various bodies can potentially carry out an "external review" role. For instance, the Northern Ireland Audit Office can conduct health system audits, and the NI Assembly Health Committee has undertaken a "Health Inequalities" review.[189] For events of public concern, the Minister may establish an inquiry.[190] The Inquiry into Hyponatraemia-related Deaths is an important example of this occurring.[191] Importantly, there is a statutory health and social care regulator, the RQIA that can conduct reviews, investigations, and, in specified circumstances, inspections of statutory acute hospitals,[192] and the recent reviews of "unscheduled care" in the BHSCT and regionally were conducted by it.[193] Moreover, a programme of unannounced infection prevention and hygiene inspections of hospitals are conducted by the RQIA pursuant to the DHSSPS regional action plan for the prevention and control of healthcare-associated infections.[194]

Notwithstanding these mechanisms, legislative provision for external review could be enhanced. For example, in terms of reviews, investigations and inspections of statutory acute hospitals by the RQIA, there is no clear statutory provision requiring these to occur routinely. Moreover, independence is potentially jeopardised by the

180 Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' December 2014, at Recommendation 8.
181 Note that the DHSSPS Framework Document often uses the term "monitoring" to refer to what is sometimes monitoring and sometimes more correctly described as review i.e. monitoring the performance data and reporting on same to the Department.
182 DHSSPS, Framework Document, September 2011, p. 53; also Section 8 of the Health and Social Care Reform Act (Northern Ireland) 2009. Note that the Department is ultimately accountable for effective functioning of the system, and each HSC body locally through its Board of Directors (p. 42).
183 See DHSSPS, Framework Document, September 2011, pp.53-54.
184 DHSSPS, Framework Document, September 2011, p.41.
185 For the centrality of this in review see Commission on Information and Accountability for Women's and Children's Health 'Keeping Promises, Measuring Results', World Health Organisation, September 2011, p. 7.
186 See UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 100 respectively, noting that "An institution as complex and important as a health system requires a range of effective, transparent, accessible, independent accountability mechanisms."
187 DHSSPS, Framework Document, September 2011, p.54.
188 The HSCB reported that "the majority of monitoring information is sourced directly from Trust IT systems. This is publicly reported at monthly HSCB Board meetings and is published on the HSCB website" (response to draft report dated 6 May 2015).
189 Thompson, J. 'Health Inequalities – Review by Committee for HPSS', NI Assembly Research and Information Briefing Paper, 20 September 2012.
190 Inquiries Act 2005, replacing provision for inquiries in the Health and Personal Social Services (NI) Order 1972, Article 54 and Schedule 8.
191 The Inquiry into Hyponatremia-related Deaths was established under the Health and Personal Social Services (NI) Order 1972, Article 54, since replaced by the Inquiries Act 2005.
192 For review, investigation and inspection of statutory providers of health and social care see Article 35 of the Health and Personal Social Services Quality, Improvement and Regulation) (NI) Order 2003
193 RQIA, 'Final Report of the Inspection of Unscheduled Care in the Belfast Health and Social Care Trusts 31 January- 3 February 2014', April 2014; RQIA, 'An Independent Review of Arrangements for management and Coordination of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations', July 2014
194 DHSSPS, 'Changing the Culture 2010: Strategic regional action plan for the prevention and control of healthcare-associated infections in Northern Ireland', January 2010, p.3.

Department's power to require compliance by RQIA of any directions it gives on the exercise of its functions.[195] Notably, Sir Liam Donaldson and colleagues' review of HSC governance notes RQIA has "no real tradition" of regulating healthcare provision and recommends greater development of this to include routine inspections focusing on patient safety, clinical effectiveness, patient experience, clinical governance and leadership.[196]

Further, in relation to the independence of external review mechanisms, concern that the Inquiries Act 2005 Act (which is Westminster legislation) makes it impossible to establish truly independent inquiries have been continually raised[197] including by the UN Human Rights Committee noting, in relation to conflict related deaths, it:[198]

> […] is concerned that instead of being under the control of an independent judge, several of these inquiries are conducted under the Inquiries Act 2005, which allows the Government Minister who is responsible for establishing an inquiry to control important aspects of that inquiry.

More generally, external and independent review is underemphasised within the overarching DHSSPS Framework Document. The role of RQIA and PCC in providing independent assurance is briefly referenced[199] and there is no mention of the other crucial processes, such as external review of complaints, investigation of deaths, "whistleblowing" procedures, audits by statutory bodies sponsored by or outside of the DHSSPS, or provision for inquiries. Reviews by non-statutory bodies, such as the CEM, are also not encompassed and therefore not effectively located in the accountability structure.

Remedial action

Victims of violations of the right to health must have access to effective judicial or other appropriate remedies.[200] In Northern Ireland, as the right to health is not incorporated within domestic law, there is no direct legal remedy for right to health violations. There are, however, a range of processes to seek redress including by way of complaint to the trusts and externally to the NI Ombudsman, medical negligence claims via the civil courts, or prosecution via the criminal courts where offences are alleged. The DHSSPS Safety First document recognises a core aspect of safety being:

> An organisational commitment to providing an explanation of what happened, an apology, a reassurance of speedy remedial treatment, and, where appropriate, financial compensation.[201]

But on financial compensation, the NI Ombudsman, can recommend but not award it and, if required, complainants must seek enforcement via the courts.[202]

195 Article 6(2) of the Health and Personal Social Services (Northern Ireland) Order 2003.
196 Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' December 2014, Recommendation 5.
197 The Commission has raised these concerns because, pursuant to Section 5(1) and (3) of the Act, the Minister sets out the inquiry terms of reference and may alter them subsequently at any time if he or she considers the public interest so requires (e.g. NIHRC, 'Submission to the UN Human Rights Committee on the United Kingdom's Seventh Periodic Report on compliance with the ICCPR', p.13)
198 UN Doc. CCPR/C/GBR/CO/6, CCPR 'Concluding Observations of the Human Rights Committee, United Kingdom of Great Britain and Northern Ireland', 30 July 2008, para. 9
199 DHSSPS Framework Document, p.56.

200 E.g. UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 59.
201 DHSSPS, 'Safety First: A Framework for Sustainable Improvement in the HPSS', March 2006, p.22.
202 A recent Court of Appeal decision on the authority of the NI Commissioner for Complaints to recommend financial payment in cases concerning individual health care providers is currently the subject of an appeal to the Supreme Court (see JR55 v. Northern Ireland Commissioner for Complaints [2014] NICA 11)

Importantly, in terms of redress, the Minister had committed to a statutory "duty of candour" stating:[203]

> Patients, service users and the public have a right to expect that when [mistakes happen], they will be communicated with in an honest and respectful manner and that every effort will be made to correct errors or omissions, and to learn from them to prevent a reoccurrence.

Remedial action also entails implementation of learning from deaths investigations,[204] and other internal and external reviews. In the context of emergency care, there are various implementation mechanisms including through the development of "Quality Improvement Plans" by trusts, learning reports and newsletters from HSCB reviews of adverse incidents, local and regional complaints reports, PHA reports of the '10,000 Voices' project and PCE standards surveys, and the more recent establishment of a DHSSPS 'Task Group' to drive forward recommendations from recent external reviews. But implementation of, and responsibility for, learning is said to derive from a "complex interweaving" of roles between the HSCB, the PHA and the DHSSPS, which is oriented overly "toward performance management."[205]

In terms of enforcement, following reviews, investigations, or inspections of statutory acute hospitals, RQIA can make recommendations for quality improvement,[206] and recommend "special measures" if services, in its view, are of unacceptable quality or there are significant management failings.[207] Any special measures recommended by RQIA in this regard are for the Department to take.[208]

RQIA also has the power to issue "improvement notices" to, *inter alia*, a Health and Social Services Board, or a Trust if there is failure to comply with a statement of minimum standards.[209] This can potentially apply to an ED for which a Trust is responsible. However, although various standards and audit tools may apply to an ED, including the DHSSPS Quality Standards, there are at present no dedicated ED minimum standards. It is also not apparent from the legislation how an "improvement notice" relating to an ED can be enforced in the event a Trust fails to comply with its requirements. In contrast, listed care providers, such as nursing, residential homes, and independent hospitals are registered, regulated, and inspected by RQIA against minimum standards, which are dedicated to the relevant care setting and can be considered by RQIA in, for example, registering the provider, and any proceedings for cancellation of, or applying conditions to, its registration.[210]

Acknowledging weaknesses in the regulation of statutory acute services, the Minister recently announced, *inter alia*:[211]

203 DHSSPS Press Release, 27 January 2015, http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-january-2015/news-dhssps-270115-wells-report-presents.htm (accessed 18.03.15). A "duty of candour" was recommended by Sir Liam Donaldson and colleagues' review of governance, see Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' Recommendation 6.

204 Asiye v. Turkey (no. 24109/07) 27 January 2005; ECtHR Press Release (judgment in French); Byrzykowski v. Poland (no. 11562/05), 27 June 2006.

205 Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' at Recommendation 7.

206 Under its general duty to encourage improvement in the Quality of Services (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003, Section 4(2)(b)).

207 See Article 35 (1), (4) and (5) of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) order 2003.

208 "In its report, the Regulation and Improvement Authority may recommend that the Department take special measures in relation to the body or service provider in question with a view to improving the health and person social services for which it is responsible or the way the body, service provider or other person (…), is being run" (Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003, Article 35(5)). Information provided by DHSSPS to NIHRC in response to the draft report (dated 8 May 2015) notes that responsibility for ensuring RQIA recommendations are addressed rests with the Board of the relevant Arm's Length Body and the Department does not decide whether or not recommendations are pursued.

209 Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003, Article 39(1) and (2); for minimum standards, see Article 38.

210 See Articles 8 (on regulation), Article 12 (on registration), Article 38 (on minimum standards); Article 39 (on Improvement Notices), Article 21 (on Urgent Procedure for Cancellation).

211 DHSSPS Press Release, 27 January 2015, http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-january-2015/news-dhssps-270115-wells-report-presents.htm (accessed 18.03.15).

- Speeding up the roll out of unannounced inspections of acute hospitals
- New policy proposals to review the 2003 Order with a view to introducing more robust regulation of acute services;

Findings: Domestic framework

Various governance components are required by international human rights standards, some of which have been considered here.[212] Based on the information reviewed for the Inquiry, the NIHRC finds that:

- Many of these requirements are being met, for example:
  - A national health strategy that contains many of the required right to health features exists;
  - There are numerous quality improvement policies and plans for unscheduled care, moreover, the overarching DHSSPS Quality 2020 includes patient safety as a core aim;
  - Various mechanisms to encourage patient safety activity also exist;
  - A revised HSCB regional escalation plan to address overcrowding and ultimately protect patients' lives has been published with trusts now required to review local plans against it;
  - Many elements of public participation are recognised in legislation and overarching DHSSPS guidance;
  - Indicators to monitor health system performance, including within EDs, are progressively improving and
  - A 'duty of candour' to strengthen openness within the health system, is promised.
- Nevertheless, concerns and / or gaps include:
  - The right to health is not recognised in law and, consequently, there is no direct legal remedy for right to health violations;
  - There are signs that the commissioning process, essential for the effective planning and function of ED services, is not working as it should;
  - The core content of hospital wide escalation plans, recommended to address overcrowding and protect patients' lives, vary considerably across trusts making regional collaboration difficult (although with the revised regional plan, local plans should be redeveloped);
  - There is no single, comprehensive set of standards to clarify what people can expect from acute services and facilities, including within EDs;
  - SAI guidance is weak on guiding responsible persons within EDs on how to detect serious incidents;
  - There is no incident reporting mechanism for patients, and, (beyond NIMDTA trainee surveys), no routine anonymous reporting mechanism for staff;
  - Participatory governance is not sufficiently included in the statutory provisions and overarching DHSSPS guidance on 'PPI';
  - While there are various bodies outside the health system that could potentially fulfil an external review role, provision for the Department to give direction to the RQIA in respect of its functions potentially impacts independence.
  - There is no clear statutory provision compelling the health regulator, RQIA, to undertake routine inspections of statutory acute hospitals; while acknowledging the DHSSPS Quality Standards applicable

212 Summarised in the introduction to this chapter at page 74

to various HSC settings, there are no dedicated ED minimum standards to inspect against;[213]

- In terms of enforcement, any "special measures" recommended by RQIA would appear to be for the Department to pursue; and it is not apparent from the legislation how failure by a Trust to comply with an "improvement notice" in relation to an ED is actioned.

Governance in practice – Inquiry evidence

Integration of right to health / human rights-based approach

Inquiry participants stated that human rights discourse is rarely explicit among the HSC bodies, but the language of policies is often "on the same terms". For example, it was noted that values within the PCE Standards are drawn from human rights. Nevertheless, it was felt unhelpful that different terminology is used: "when you actually look at [the '10,000 Voices' project] they're the same values, the words are different so I think we've got to stop using different words […]" (NI Ombudsman). In this respect, a health constitution or charter was suggested to help integrate human rights. Citing the NHS Constitution as an example, Professor Derek Birrell, University of Ulster, stated that: "it's possible then to trace [the rights within] to what is relevant to Accident and Emergency provision […]."

Among some senior representatives of the HSC system, explicit reference to human rights was feared to encourage litigation, distracting time and resource from patient care. Reluctance to directly reference International Conventions was reported, for example, by Minister Wells:

> Whilst implicit in much of what we do are basic fundamental human rights of dignity and quality of care I think that's best done through a more general, you know, 'we want to do what's best for our people' rather than enshrining it within any constitution where immediately it becomes a litigant's charter, and where people will, at the drop of a hat, unfortunately, use scarce resources by suing us for what they believe is a fundamental breach of their human rights, which may be a resource issue rather than any intent to do down a particular community or section of the community […].

For others, it was felt human rights should not be forced on health professionals, who often see rights as integral to their work. The Chief Executive of the SEHSCT said that while human rights ought to be embedded in "judging success" and as part of the core values of the health system:

> We do believe it is explicit. I wouldn't have a problem with it being a written framework if that makes it more explicit. I suppose the issue I would have is that won't necessarily make a frontline health care worker do it more; I think it is when they own it as a part of their values […]. And I think sometimes our staff would reel a little bit about it being an obligation, a human rights obligation, because they see it and want it to be a part of their values. When I spoke to an Emergency Nurse Practitioner in ED she said 'I do it because it is good quality care, it's the values at the core of my professional practice, it is how I want to deliver quality care.

Similarly, the Chief Executive of the HSCB said "I think it is much better for the culture of the organisation if we can naturally introduce [rights] […]." Voluntary organisations sensed this fear, as NIAMH stated, HSC bodies view rights in "a maybe statutory, regulatory, protectionist kind of way, [rather than] a positive way they can talk to people they provide services to […]."

But Alzheimer's Society observed that "the word rights has been problematic for some" because

213 Information provided by the Department in response to the draft report (dated 8 May 2015) notes the RQIA has been working with the Department on an appropriate standards template for piloting unannounced inspections in acute hospitals, and these inspections are currently being piloted.

people are uncertain about practical application. A representative from the SEHSCT suggested that tools to help take a human rights approach beyond a compliance model might be helpful:

> We have had a lot of discussion around this recently and we do think there is probably room for something else in between because […], for example, if we identify some impact around equality we can go to the ongoing screening and if […] we're moving from an amber to a red we will then upscale to an equality impact assessment but when we're identifying similar issues in terms of human rights we're having that debate, where do we go with this and it seems to be in the compliance model; you're really going straight to legal advice, and that's not how we've actually operated because a lot of professionals on the ground, they do appreciate if you mitigate as you go and you're identifying those issues that that's a better model for us really as well, and we don't often end up going to take legal advice" (Equality Lead, SEHSCT).

For UNISON, while Trusts have "good people with the right knowledge and skills" to embed human rights, they are generally "ignored [and] not included in senior decision making processes." Evidence from some trusts suggested otherwise. For example, the NHSCT Head of Equality stated she regularly attends Senior Management Team and Trust Board meetings. And the BHSCT's commitment to develop a human rights strategy in 2015/16 was described by its Equality lead as recognition that human rights should be "enshrined through everything we do".

The Chief Executive of the SHSCT felt a human rights-based approach (HRBA) could help navigate financial crisis: "by thinking about human rights you protect the vulnerable […], so I think focusing on human rights in this very difficult financial climate will guide us to make the right decisions." Positive examples of a HRBA were also relayed, including by the HSCB who noted that some human rights treaties, such as the UNCRC and UNCRPD, had become embedded in areas of its work, accepting there was still work to do on others:

> […] I think that some of the Convention rights are better embedded than others if I'm really honest, so the UNCRC for example […] is a fundamental plank around the strategies we have developed and the services we have developed. But more recently I think I can point to two examples where we're absolutely looking at commissioning decisions based on a rights based evaluation or a rights based framework; and I would refer to our recent work on the review of statutory residential homes, for example, where we absolutely took Convention rights and looked at how they would impact on our processes for considering the future of that area of service provision. We've also embarked on a piece of work […] in the area of sensory disability where we are developing a rights-based commissioning framework […] [based on UNCRPD]. So […] I think we can point to examples where we are beginning to embrace those rights in our work (Director of Social Care and Children's Services, HSCB)

Findings: Integration of right to health / human rights-based approach

A human rights-based approach to health prioritises realising the right to health and other human rights in health policies and programmes.[214] Based on what people said to the Inquiry, the NIHRC found that:

- Within health policy and discourse human rights are rarely explicit, although values and principles might be on similar terms;
- Explicit references to human rights are feared by some to encourage litigation and distract from quality care;
- For others, human rights are integral to the work and core values of health professionals; imposing rights via explicit obligations might

214 On a human rights based approach to health see, for example, OHCHR/WHO, 'A Human Rights-Based Approach to Health' at http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf (accessed 25.03.15).

"push staff away";

- But a shift in emphasis was apparent, with commitments to develop a HRBA by the BHSCT, examples of embracing rights in the work of the HSCB, and beliefs being expressed that human rights can benefit health governance, particularly in financial crisis;
- It was felt that HSC bodies require help to embed human rights as an approach, as opposed to a "compliance model";
- A health constitution or charter was suggested as one possible solution.

Quality Improvement and Patient Safety

Three interrelated themes captured the Inquiry evidence regarding quality improvement and patient safety in the emergency care setting: mechanisms to implement, including coordination; the organisational culture to embed these; and the leadership and support perceived.

Mechanisms

Participants cited many different mechanisms to improve quality and patient safety. Those commonly referenced by Trusts included the process for reporting and reviewing SAIs, the "adverse incident" reporting process, and Morbidity and Mortality (M&M) reviews. Clinicians described the SAI process a crucial learning tool at the "more extreme end" of learning and highlighted other mechanisms, such as "Serious Event Audit" (SEA) analysis, as facilitating learning in a "quicker timeframe" for incidents that do not constitute an SAI (e.g. Lead Consultant, RVH & Lead Consultant, Mater ED).

M&M review was acknowledged as a crucial mechanism to learn from deaths and conditions presenting at the ED. However, one Trust reported due to resource constraints, there are difficulties enabling staff to attend and it was also reported that not all Trusts held dedicated ED M&M reviews.

Numerous less formal improvement mechanisms were relayed including review of "untoward incidents" by clinicians in the SEHSCT, twice daily safety briefings at the RVH ED, and thrice daily meetings to assess pressure within ED sites in the SEHSCT. Complaints, patient feedback, including through the '10,000 Voices' project, and staff appraisals were also commonly cited as important learning mechanisms. Three trusts additionally talked about an external body, ALAMAC, as a "critical friend" to help identify improvements.

Co-ordination to enable shared learning was described as occurring on two levels, internally within each trust and regionally across all trusts. Its importance was described by one caller to the Inquiry: "ED is different than any other speciality as there are so many factors affecting the patient journey; we have to work with and communicate with those interfaces". But it was generally felt this could be improved. For example, the RBHSC reported at times being overlooked in regional learning projects. And the RCN talked about missed opportunities in the "Nurse of the Year" awards: "year after year [the] awards step up nurses […] and nobody goes could we do that anywhere else."

Others said that although individual services had "got it right", this was not replicated across the system. A new project promoting communication by email and text in the WHSCT was cited by the RNIB, and the PSNI noted an interagency protocol for persons leaving ED without treatment. Although operational in the BHSCT, regional consensus had proved difficult. Similarly, on "rolling out" the "Card Before You leave": "in different Trusts [its] implemented differently" (PPR; BMHRG). Responsibility for disparity was said to be corporate: "equality managers get it, so the difference between the trusts is the extent to which that has been absorbed within the

organisation." (RNIB). Indeed, Trust Equality leads described "a collaborative approach" as a core tool in their work.

For RCN, it is "a commissioning responsibility" to replicate services that are "tried and tested." When asked about coordination, the HSCB cited various mechanisms including regional audits of the "18 Unscheduled Care Key Actions," regional and local commissioning arrangements, the establishment of an ED patience experience group, and the Emergency Care Summits facilitated by the RQIA. Although it was noted not all initiatives work, or are affordable regionally (SELCG), the LCGs cited examples, such as the "roll out" of a project for GPs to manage routine skin conditions (NLCG), and a primary care pathway for thrombosis (WLCG). But from its reviews, RQIA felt learning is not systemic: "our view really was that not all of the examples were known about across the system."

Findings: Quality Improvement and Patient Safety – mechanisms

Coherent and co-ordinated quality improvement and patient safety mechanisms are recommended for health systems.[215] Based on what people said to the Inquiry, the NIHRC found that:

- Many processes were cited and welcomed as important Quality Improvement and Patient Safety mechanisms;
- There are practical difficulties for EDs in finding the time and resources to enable staff to learn (for example, engaging in M&M reviews);
- Various mechanisms for regional coordination at the "top" of the system were cited, but there was evidence that good practices are not always "rolled out" on the ground. [216]

Culture

Staff and public participants commonly discussed perceptions of organisational culture. In the latter case, people reported feeling fearful of making concerns known, as one witness explained: "I would rather not kick up a fuss because […] things could get worse". Describing experiences of seeking answers, callers talked about "barriers up and doors closing," "closing ranks," feeling "fobbed off" and "worn down," and believing concerns were "swept under the carpet." One witness, who gave evidence about his own experience and on behalf of the "Action on Medical Negligence Association" (AMNA), called for a "duty of candour" as outlined in the following case study.

Case Study 7: Calling for duty of candour

Witness Eamon Duffy explained that following an experience in A&E in 1997 he set up AMNA: "The basic thesis was that people who are damaged by an adverse event are then punished more or less for the rest of their lives because they're iatrogenic victims, and therefore they are to be feared, to be seen as hot potatoes not to be dealt with and that's the real problem […]. So our main agenda is basically a duty of candour."

Eamon talked about his most recent A&E experience in Craigavon Area ED in February 2010 following a fall in which he sensed a "hostile" atmosphere from medical staff: "I

215 CoE, Committee of Ministers Recommendation No. R(97) 17 'on the development and implementation of quality improvement systems (QIS) in healthcare'; CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006)

216 See UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 57, on co-ordination, "A health system, as well as the right to the highest attainable standard of health, depends on effective coordination across a range of public and private actors (including non-governmental organizations) at the national and international levels." Paragraph 57, on co-ordination, further states that co-ordination is crucial between various sector and departments, within the Department of Health, and in policy making and service delivery.

thought at the time I was mistreated because I was in fact claiming to be a victim of iatrogenic neglect and that had coloured and tailored all that happened […]." He also mentioned codes or labels in his medical notes that he believed were intended to indicate he was "a threat" or "imagining things."

When asked what should be done differently, Eamon said: "[…] most of the time doctors think of candour as telling their colleagues or somebody else up the line but not telling the patient, they've no family involvement at all." He felt Serious Adverse Incidents rarely involve family and "[…] if you look at the […] matrix risk register [for SAIs] you'll find […] it mentions all sorts of other professionals and administration staff, but the patient is not mentioned." Noting improvement is the SAI procedure, Eamon stated it's "still not satisfactory from the patient's point of view."

Eamon explained that AMNA does not wish to "demonise" doctors who, he felt, do a "difficult job in very difficult circumstances" but rather "a collaborative relationship so that when I meet a health professional we're meeting on the same level ground"

Notably, in a statement to the NI Assembly on 27 January 2015, the then Minister reiterated a commitment to introduce a statutory duty of candour.[217]

Indeed, those who talked about SAI or other investigation procedures, often reported feeling excluded or not having sufficient information to be meaningfully involved: "I didn't know what [an SAI] was; […] didn't get enough information about the review from the Trust, certainly no written information"(PPR/BMHRG).[218]

Evidence from the Trusts indicated efforts to improve family engagement in SAIs: "[…] we do try to make contact with the family at a very early stage […] in the past couple of years I think we have got better at that process" (Assistant Director, ED SHSCT).[219] And concerns of family members in this respect were being acted upon by the HSCB who explained that, with the PCC and RQIA, it is:

> […] changing the documentation that requires families to be told absolutely explicitly at the outset that the care of them or their loved one has been reported as a serious adverse incident and the reasons for that, seeking their views on the extent to which they wish to be directly involved […]

Others described a lack of communication even after treatment and care had been found "amiss". One caller, who first learned there would be an inquest almost three years after the death of a loved one in the ED, told how the Trust communicated with the media but not family:

> [The inquest was] over a year ago and we still never heard anything from the Trust at all. When they put it in the paper that they were studying the report and recommendations and it would be their intention to speak with the family, we would have expected to receive some communication.

Staff callers from some EDs felt management did often not reciprocate openness. For example, one clinician reported a proactive approach following M&M meetings: "we fire anything up

217 Oral Statement to the Assembly by Health Minister Jim Wells MLA, 27 January 2015, available at http://www.dhsspsni.gov.uk/statement270115 (accessed 11 May 2015).

218 A recent HSCB "SAI Lookback" exercise across all EDs, spanning 2009 to 2013, reveals 24 out of 83 SAIs in which the patient / family was not advised, 2 cases of a delay in informing the patient / family, and 7 cases where it's not known if they were informed 'Emergency Department Serious Adverse Incidents (Sai) Lookback Exercise (2009-2013) Findings' (http://www.dhsspsni.gov.uk/sailookback accessed 11.03.15).

219 On the day following oral evidence by the SHSCT to the Inquiry, it was reported that, in the case of Peter McAneney, who died weeks after an ear operation at Craigavon Area Hospital in 2012, the Trust only reported an SAI seven months following his death when the Coroner contacted the Trust to request the report, (BBC News, 'Peter McAneney's family criticise Southern Health Trust over his death', 18 September 2014; http://www.bbc.co.uk/news/uk-northern-ireland-29243794 (accessed 25.03.15)).

[to management] that is a concern, nothing gets pushed sideways" but there was rarely a response. Several callers said that Adverse Incident (known as 'IR1') forms are regularly completed including for overcrowding, dignity in death, injuries, shortness of staff, missing breaks, and patient privacy. However, some mostly from two EDs (the Royal Victoria Hospital and the Mater Hospital) said "we don't ever hear back."

"Fear", "cover-up", and "bullying" was reported by staff primarily in relation to two Trust areas during the call for evidence, Belfast and Northern HSC Trusts, although on the latter this related mostly to pre-2013. One caller stated that staff had been actively discouraged from completing IR1 forms and others were fearful about highlighting concerns, believing they would be viewed as "trouble makers." It was also noted: "there is no mechanism to fill out IR1 form anonymously". There was, however, "great optimism" reported following the RQIA and other reviews. Signs of improvement conveyed included new leadership positions, daily de-briefs and ward rounds, and staff meetings, which one caller described as "getting our say back, […] being a voice for our patients." While welcomed, disappointment was expressed that change had not occurred sooner: "it didn't matter what we said about patient dignity or needs."

Mixed views were reported by organisations on whether a "culture of bullying" exists. UNISON said it is endemic across all trusts, with the Royal Hospitals Branch representative highlighting this as a barrier to engagement:

> Whenever there is a culture of bullying it's very, very difficult, if not impossible, to engage with staff to get them to freely come forward with their ideas, their concerns and progressive methodology. Instead, what we have is a system of fear where people are afraid to report the issues and the concerns. Hopefully that's less than what it was a few months ago, unfortunately I believe that it's still ongoing.

RCN felt, although not universal, bullying occurred in most EDs, while the BMA felt there was "room for improvement." The Chief Executive of the RCN explained:

> In all of our dealings […] I have never met a "bad" person and I think that some of the people whose behaviours are being perceived as totally unacceptable, as reported they are totally unacceptable, […] are to a degree, and this is not an excuse, a victim of circumstance […] the most important thing is how many four and 12-hour breaches have we got […]. The problem is it totally disempowers nurses; it certainly disempowers team leaders [and] ward managers

Likewise, UNITE described: "an intolerance which leads to pressures and perceptions of bullying and it's all symptomatic" of pressures in a busy ED.

Trust representatives generally stated that bullying does not occur or that, if it does, it is not systemic. The BHSCT acknowledged lessons to be learned from the recent RQIA review, especially: "[the] need to keep staff engaged at all times." NHSCT representatives cited an "open door" approach and an increase in its SAI reports reflecting an improved "culture of openness." Disconnect between experiences of staff and management was recognised by the WHSCT: "[…] in our desire to achieve [… the waiting time target] some members of staff may well feel intimidated or bullied or harassed," and, in response, it had established "Beyond the Grapevine", a project with dedicated sessions in which frontline staff have the opportunity to share information, ideas or escalate concerns directly with the Trust's Director of Nursing.

Minister Wells cited the DHSSPS "whistleblowing" policy as supporting openness. The NHSCT Chief Executive outlined that it is neither in an individual nor an organisation's interests to be anything less than open. In that context, he took whistleblowing to be a failure of the system because "you should have already known about the

problem because people should have already come forward and again I have never seen an altruistic whistleblower." Others felt media reporting could result in staff feeling "publicly pilloried" (MD BHSCT) and "the press see SAIs as being almost […] as a tool that's used in disciplinary hearings" (Minister Wells). Notwithstanding that separate disciplinary processes may occur, focusing "on who did what wrong" was felt not "conducive to openness" (HSCB).

Findings: Quality Improvement and Patient Safety Mechanisms – culture

An open culture of safety should be promoted at all levels of health care comprising, *inter alia*, safe structures and processes for reporting and where possible voluntary, anonymous and confidential mechanisms.[220] Based on what people said to the Inquiry, the NIHRC found that:

- Perceptions of a closed culture commonly existed among public and some staff participants.
- There was a sense from the public that openness is encouraged within the health profession, but not in relation to patients or family.
- Some staff reported openness among colleagues, but this is not reciprocated by management.
- On the existence of bullying, a disconnect was apparent between staff/ organisations representing staff and Trust representatives with the former commonly stating it was endemic or apparent in most EDs, and the latter that it is not systemic.
- In this respect, some felt bullying was not intended but rather symptomatic of behaviours that can occur in a busy ED;
- Recent improvements in culture were noted, but problems remaining included narrowly focused media reporting, and lack of anonymous reporting mechanisms for staff.

Leadership

Many Trust representatives attributed openness to medical leadership and close working relationships between staff and management. The SHSCT reported managers are regularly "on the shop floor" and, in the WHSCT, it was said: "[…] you'll find no other hospital where the [Deputy] Chief Executive will wander through your Department a couple of times a day." And the CE of the Northern Trust stated "to produce a management model […] that puts […] doctors in more responsible positions" is work ongoing for the Trust.

Staff to the Inquiry's "call for evidence" reported good support among the ED team: "the senior sisters are very approachable and consultants are good at voicing concerns". It was described as an "honour" to work with ED staff, with one caller reporting "tremendous camaraderie". But, at least in relation to two EDs, leadership above clinical level was generally not perceived: "we have a great environment where it works; it stops at a level above us [staff] and that's very disappointing". Others from the same EDs said that senior management are visible only when "there's trouble" and felt "they shouldn't just be managers when times are bad." It was hoped this would improve with actions derived from external reviews, but changes in leadership had "only started" and, at the time of the call for evidence, it was felt "not possible to comment on how communication with management will work."

220 CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006); see also on the centrality of transparency for public participation CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000); and UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008).

Findings: Quality improvement and patient safety mechanisms – leadership

Patient safety should be a leadership and management priority in which a culture of learning is emphasised.[221] Based on what people said to the Inquiry, the NIHRC found that:

- ED staff reported support among colleagues and leadership from supervisors at clinical level, but some reported a lack of leadership above this;
- There was however optimism from staff following external reviews and evidence that this was improving.

Effective functioning of the system

Protocols including escalation

Callers reported various guidelines available to help ensure the proper running of the ED and, generally, these were said to be accessible and helpful:

[there's] every guideline under the sun […] for how to treat conditions, how quickly treatment should be provided, how quickly antibiotics should be provided, different conditions have different guidelines […] we work towards the guidelines, they are useful.

However, it was indicated, "there is nothing much on the clinical side". As such, a gap in guidance was perceived in relation to "treating patients with respect". Some callers explained that Trust wide and corporate policies exist but there is "nothing specific for A&E". As a result, staff are often "left to their own professional judgement."

Some from two EDs (the Royal Victoria and Mater Hospital) reported lack of final agreement on guidelines for hospital wide escalation.[222]

Overcrowding due to lack of bed space was described as an often-predictable occurrence for which protocols are required. Clinicians from these hospitals said they had developed their own "internal escalation policy" to lessen risk. This was based on "time to triage; numbers in resus; total number of patients in the ED; and the longest wait for four or more patients." At the time of the call for evidence, it was reported to have been in "red alert" since March 2014 with little response from management. One caller stated that, unless escalation plans are agreed and followed, adverse outcomes attributed to overcrowding would be a matter of "corporate conscience."

At the final public hearing in December 2014, Minister Wells cited agreement on "a regional emergency care escalation plan" as an important development. And SE Trust representatives talked about formal escalation plans already in place within its hospitals, which include "triggers" for diverting ambulance arrivals to other hospitals. Moreover, an electronic "dash board" showing real time status of each ED was described by the NIAS:

[…] one big benefit of that kind of intelligence and application of the intelligence has been the significant reduction in bypasses [diverting ambulance arrivals to other hospitals] […]; last year I believe we had two […]; we have reduced them down to near never events.

Similarly, the SHSCT explained how appropriate capacity planning within its EDs aimed to avoid escalation, including ambulance diverts: "[…] we know [if] we have to make some capacity; bypassing […] usually just leads to the other department [being] overcrowded in 24 hours time."(Dr B S Trust).

221 CoE, Committee of Ministers Recommendation Rec(2006)7 'on management of patient safety and prevention of adverse events in health care'(24 May 2006)

222 The BHSCT notes "an extant escalation plan had been in place however it was in the process of being revised. The revised plan was tested on 2 occasions and implemented in December 2014 (BHSCT response to draft report dated 5 May 2015).

Findings: Effective functioning of the system – protocols, including escalation

Regulatory frameworks should exist to ensure effective functioning of emergency services, and this should include hospitals adopting measures to protect patients' lives.[223] There should be more detailed provisions regarding specific health related services and facilities. Based on evidence to the Inquiry, the NIHRC found that:

- A lack of ED specific guidelines for ED staff on how to treat patients with dignity and respect was reported;
- Although all trusts provided some form of escalation plans to the Inquiry, a lack of agreed "hospital wide escalation" protocols, and action from management against same, was reported in relation to two EDs;
- Witnesses from other Trust areas reported escalation plans in use that had facilitated effective ED functioning.

Resource planning

Participants generally reported planning for emergency care was not as effective as it could be. Among clinicians, it was felt emergency services are treated as secondary: "Unscheduled care remains the poor relation to scheduled care […]" and it "is the Cinderella of the system." One clinician suspected Commissioners (the HSCB) are having difficulty understanding how to adequately plan for it: "[elective care] has facts and figures […]; unscheduled is a very different beast and some […] are finding it very difficult to understand". Professor Derek Birrell cited problems in the wider commissioning process noting he'd "seen criticisms" that the Board undertake a "rubber stamp function," rather than adequately appraising local and service needs.

The evidence, as well as budgetary data provided to the Inquiry, shows difficulties in practice. For instance, the Chief Executive of the WHSCT stated it had a "very significant overspend" at month five of its 2014/15 financial year and attributed this, in part, to getting "the emergency care pathway right." The HSCB explained that within trusts overspend should only occur in one of two scenarios: "(a) we understated the needs of patients and/or (b) a Trust is incurring more costs than it should" to meet need, and said when overspend occurs in year it can be difficult to respond. But it was explained that services trusts cannot afford are highlighted in a "Trust Development Plan" at the start of each financial year (NLCG). Rather than instructions to "balance the books", HSCB should "take commissioning decisions and tell [trusts] what not to deliver" (Deputy CE WHSCT).

In light of this evidence, the Commission asked for budgetary data to be provided by HSC bodies to the Inquiry. Analysis of resource allocation to, and spending on A&E services, indicates that, indeed, allocated resources are being used for this purpose (save for underspend in one year, 2011/12, by the BHSCT) (see Table 10). And, in fact, Table 10 shows overspend by trusts on A&E as a percentage of the allocated budget has grown from 11.3% in 2011/12 to 17.7% in 2012/13, and 19.6% in 2013/14.

223 Asiye v. Turkey (no. 24109/07) 27 January 2015, ECtHR Press release (official judgment available in French only); Furdik v Slovakia, (no. 42992/05) 2 December 2008; Senturk v. Turkey (no. 13423/09) 9 April 2013.

Table 10: Variance in spend compared to allocated resource(%)

Trust	2010/11	2011/12	2012/13	2013/14
NI	N/A[224]	11.3	17.7	19.6
Belfast	4.2	-2.5	2.3	7.4
Northern	15.8	22.9	36.9	39.3
Western	22.7	20.1	20.2	21.0
Southern	9.5	11.5	28.0	44.7
South Eastern	N/A	17.4	15.0	4.7

Moreover, A&E expenditure both as a percentage of trusts overall spending (Table 11), in nominal terms (that, is in simple case terms without taking inflation into account) (Table 12), and adjusting for inflation (Table 13)[225] has generally increased.

Table 11: A&E Expenditure as a % of Total Trust Expenditure

Year	Western	Belfast	Northern	South Eastern	Southern	All Trusts
2010/11	1.4	1.3	1.6	2.3	1.6	**1.6**
2011/12	1.3	1.3	1.7	2.2	1.7	**1.6**
2012/13	1.3	1.2	1.9	2.5	1.8	**1.6**
2013/14	1.3	1.3	1.9	2.2	1.9	**1.7**
2014/15 (p)	1.4	1.4	M	M	1.9	**M**

(p = projected figures; m = missing data)

Table 12: Nominal Spending on A&E (£000s)

Year	Western	Belfast	Northern	South Eastern	Southern	All Trusts	Increase (%)
2010/11	6,617	14,004	9,321	11,289	7,792	**49,023**	**-**
2011/12	6,695 (1.2%)	14,571 (4.0%)	10,334 (10.9%)	11,529 (M)	8,463 (8.6%)	**51,592**	**5.2**
2012/13	6,848 (2.3%)	14,633 (0.4%)	11,421 (10.5%)	12,998 (12.7%)	9,471 (11.9%)	**55,371**	**7.3**
2013/14	7,220 (5.4%)	15,856 (8.4%)	12,080 (5.8%)	12,398 (-4.6%)	10,209 (7.8%)	**57,763**	**4.3**
2014/15 (p)	7,998 (10.8%)	18,158 (14.5%)	12,846 (6.3%)	12,401 (0.0%)	10,660 (4.4%)	**62,063**	**7.4**

(p= projected figures; m = missing data)

224 Not available due to absence of allocated budget data in South Eastern Trust.

225 Shown in 2013/14 prices using the latest Treasury GDP deflators https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-december-2014-autumn-statement

Table 13: Real Spending on A&E (£000s)

Year	Western	Belfast	Northern	South Eastern	Southern	NI	Increase (%)
2010/11	6,974	14,759	9,824	11,898	8,212	51,667	-
2011/12	6,932	15,087	10,700	11,937	8,763	53,419	3.4
2012/13	6,974	14,902	11,632	13,238	9,646	56,392	5.6
2013/14	7,220	15,856	12,080	12,398	10,209	57,763	2.4
2014/15 (p)	7,834	17,785	12,582	12,146	10,441	60,787	5.2

(p = projected figures)

On the one hand, this is an indication that spending is perhaps keeping up with demand. But consistent, sizable and increasing overspends by trusts on A&E budgets are a serious concern. Allocations routinely below actual spend raise questions about the extent to which services are *planned* to meet demand, how overspend is funded, and whether shortfalls will be met in future. Minster Wells confirmed the additional £5m to emergency care for the last quarter of the 2014/15 derived from "monitoring round" surpluses.[226] Moreover, documents provided by one Trust shows aspects of its ED winter planning dependent on "in-year bids".

Inquiry participants gave various reasons to explain why, despite stable or growing resources, additional in-year monies are required. Reported elsewhere in this report, these included a lack of bed capacity in the wider hospital system, the costs of locum recruitment to fill understaffed consultant posts, and difficulties discharging safely to the community. The scale of reliance on locums[227] is apparent from the budgetary data provided to the Inquiry. This shows expenditure totalled £6.5m in 2013/14, representing a real-term increase of 25.3% on the previous year.

Table 14 shows total expenditure has increased each year over the period.[228] There was a particularly substantial rise in 2013/14 of 27.6% (Table 14) in nominal spending, and 25.3% in real terms (Table 15), due to large increases in locum spending by the BHSCT and to a lesser extent the SHSCT.

Table 14: Nominal expenditure on Locums (£000s)

Year	Western	Belfast	Northern	South Eastern	Southern	Total	Change
2010/11	1,214	101	549	1,707	790	4,360	N/A
2011/12	1,062	402	1,094	1,264	839	4,661	6.9%
2012/13	1,040	189	1,283	1,775	776	5,062	8.6%
2013/14	968	1,421	1,249	1,623	1,199	6,461	27.6%

226 See also DHSSPS Press Release, 19 November 2015, http://www.dhsspsni.gov.uk/index/statements-minister/statements-minister-2014/statement191114.htm (accessed 20.03.15)

227 See also recent news item in which the Director of the RCN is critical of the amount of monies spent on hiring agency nursing staff and Locums (Irish News, 'Nursing chief accuses NHS managers of failing to employ adequate staff', 24 March 2015, hard copy).

228 In response to draft report, 6 May 2015, the SEHSCT stated, "an explanation as to why costs are higher in South Eastern Trust may be due to the Trust having 3 [EDs] (more than any other Trust), therefore, more Locums are needed to cover 3 sites of Ulster, Lagan Valley and the Downe Hospitals."

Table 15: Real Expenditure on Locums (£000s)

Year	Western	Belfast	Northern	South Eastern	Southern	Total	Change
2010/11	1,279	106	578	1,799	833	4,595	N/A
2011/12	1,100	416	1,133	1,308	869	4,826	5.0%
2012/13	1,059	191	1,306	1,808	790	5,155	6.8%
2013/14	968	1,421	1,249	1,623	1,199	6,461	25.3%

Highlighting a £3m overspend on the trusts £7m budget for its EDs, the SHSCT noted " some of that expenditure is because of a shortage of certain key workforce such as some of our consultant staff [and] some of our middle grade staff […]."

Participants called for greater financial investment in community care to help, among other things, more effective discharge from ED and fewer attendances in the first place. UNISON stated that monies saved "at the expense of acute side of health provision" had not been reinvested in the community. In this respect, many felt the vision articulated in TYC presented a way forward. However, implementation was felt stymied by a lack of political leadership and funding:

> [We're required] to save £17m and yet the Parties round that table will castigate us for any pound, any bed, any post that we take out of a service in a particular area. And that creates great difficulties for us as public sector leaders – 'find 17 million but don't do it on my patch.' We need a political system that will give us the leadership to make the changes we need to make and to create that new system (Chief Executive SEHSCT)

Data provided by the HSCB to the Inquiry shows that in 2013/14 and 2014/15 spend for TYC has not, or was not projected to match allocations.[229]

Moreover, a NI Assembly Written Answer reveals that, up to 2013/14, the shift in funding from hospital to community based services has focused (importantly) on the "resettlement" from hospital to community in the area of mental health and learning disability, but not other services.[230] Sir Liam Donaldson and colleagues' recent review of health governance recommends a new costed, timetabled TYC implementation plan, reporting "a widespread feeling that [it] is simply not being implemented".[231]

Minister Wells highlighted to the Inquiry progress in some areas, such as the "Integrated Care Partnerships" and establishment of four "Health Care Hubs." But said little monies had been allocated to the Department in 2014/15 for implementing TYC: "you're constantly trying to fire fight to keep services within their budgets and […] you're trying to keep the TYC plate spinning." The NI Executive Budget 2015/16 allocates no transitional funding to DHSSPS for TYC.[232] Age NI felt under investment in TYC was ill-judged: "[we] need to invest to […] release savings in the future; low level preventative services can reduce attendance at [EDs] by in and effect around 29%."

229 Letter from HSCB dated 21 January 2015 indicating that in 2013/14 there was £3.35m slippage on TYC monies and this was distributed to Trusts to assist with pressure on mainstream services; for 2014/15 it is noted that the NI Executive only allocated £8m for TYC but the HSCB contributed funding making the total budget allocation £13.10m; at the date of letter, the HSCB anticipated £10.82m of this being spent on TYC, with an underspend of £2.28m "to be deployed to the 5 HSC Trusts in their notional capitation shared to assist with financial pressures."

230 NI Assembly, AQW 40240/11-15, 15 January 2015. In 2012/13 £11.4m and in 2013/14 £13.6m (totalling £25m) was allocated to "Mental Health and Learning Disability – Resettlement".

231 Sir Donaldson, L, Dr Rutter, P, and Dr Henderson M 'The Right Time, the Rights Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland,' p.14 and recommendation 3 respectively.

232 NI Executive Budget 2015-16, p. 93 (http://www.northernireland.gov.uk/budget-2015-16.pdf accessed 08.03.15).

Findings: Effective functioning of the system – resource planning

Proper resource planning is required to ensure effective system functioning.[233] Planning should take account of population needs, and the right to health elements of "maximum available resources" and "non-retrogression."[234] Based on the budgetary data provided and what people said to the Inquiry, the NIHRC found that:

- In the view of some clinicians, and the HSCB is struggling to understand how to plan effectively for unscheduled care.
- Budgetary data shows overall expenditure on ED has increased from 2010/11 to 2013/14, as has Trust spending per ED attendance.
- Increasing overspend by trusts on ED raises questions about whether services are planned to match need, and also long-term planning requirements.
- One Trust reported that an overall overspend in its budget at the end of month five in the 2013/14 fiscal year is due, in part, to it ensuring its emergency care services are safe.
- And reliance on in-year surplus raises questions about sustainability.
- As does under investment in TYC, which risks under-development of community and other services intended to reduce ED pressures.

Participation in health decision-making

Organisations generally described some level of engagement with the HSC bodies including the Trusts, the HSCB or with the LCGs (e.g. Age NI, NIAMH, Contact NI). PPR talked about "participation standards" it had developed to monitor participation in a HSCB Project to implement the "Card Before You Leave": "they did start to listen and improvements were made." However, there appeared to be less engagement at ED level. For example, Carer's NI reported its carer reference groups "don't feel very well tied into the [A&E] process." The Director of Contact NI said "a deep sea culture change" is required to embed the voice of service users. And 'PPI' was said to centre on the development of consultation plans rather than public participation: "Northern Ireland doesn't actually do very well in terms of public and user participation" citing, in contrast, "co-production" adopted in Scotland whereby services are run by professionals and "users by experience" (Prof. Birrell).

When asked about participation in health care, HSC bodies typically referred to consultation processes and surveys to gather service user views. Many examples were given. For instance, the SEHSCT described consultation and engagement with the wider public on the reduction of ED services at Downe hospital, the Chief Executive of the WHSCT said the LCG regularly consults "right across the geography" regarding any proposals for change, and clinicians referred to consultation with user groups regarding the design of SW Acute hospital. The Northern LCG noted that while it seeks to mainstream participation in its work, it had been under-emphasised, and therefore was not sufficiently apparent, within its local commissioning plan. A barrier to participation at all levels, the PCC noted the absence of a Northern Ireland single Health and Social Care accredited advice and information service.

In terms of service user feedback, the '10,000 Voices' project was cited, as well as other

233 Asiye v. Turkey (no. 24109/07) 27 January 2015, ECtHR Press release (official judgment available in French only)

234 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000); UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008); also ICESCR, General Comment No. 3: On the Nature of States Parties Obligations.

mechanisms, including surveys undertaken pursuant to the PCE Standards; a survey about ED improvements conducted by the Belfast LCG and West Belfast Partnership; the development of an "ED Patient Experience Survey" by the DHSSPS, and the PCC research "Care When I Need It." Some ED managers, and the NIAS, highlighted getting patient feedback is a challenge due to the emergency nature of the service. As such, emergency services need to: "get feedback from people who have been in our system and […] proactively [go] out and […] involve the community as far as we can in changes" (Assistant Director HR, NIAS).

There was, however, less evidence of direct participation by the public in governance of the health system. As one ED manager aptly explained:

> I think we've invested a lot of resources and energy into retrospective views of our service so we have lots of systems around complaints and giving compliments, looking back when things go wrong, how we do that; what we haven't invested enough in is the looking forward and engaging with our community in how we develop services into the future. […] I think where we need to move forward is how we begin to engage and have our community residents involved in how we take services forward in the future and that's where I think we haven't really cracked it yet […] I think the more that our community do that in partnership with us then the more we've designed a service around what they need

When asked, several participants felt the role of Non-Executive Directors could be enhanced in representing community views at Trust Boards. Minister Wells stated this to be "an interesting idea" that he would "like to take back and consider". The CE of the Northern Trust indicated that although systems "don't necessarily [exist] to allow them to truly represent the public" it would be an "interesting extension" to the Non-Executive Director role.

Closer to participatory governance, an "ED Service User Group" was mentioned by both the HSCB and WHSCT. The PHA said there was little doubt health care governance was still "top-down" but described the '10,000 Voices' project as an important first step because the results will directly "shape policy." Indeed, the HSCB said, "a comprehensive action plan is being fed into the commissioning process" from its findings.

Organisations representing staff typically called for more engagement in health care decision-making with RCN noting that staff often feel disempowered. Representatives of the Allied Health Professionals reported its members feeling overlooked, particularly regarding the ED: "they're outside the ED and report to their Head of Service and […] their concerns can get lost." And the NIAS described having "fought very hard" to be engaged at the right decision-making levels. Clinicians from the BHSCT described improvements following the RQIA inspection report: "as a clinician I feel more empowered now […] For the first time, we're starting to integrate [with management]." But some ED clinicians still reported no direct involvement in regional commissioning decisions, "they don't come to the grassroots to hear or see some of the initiatives that we think could make a big, big difference." (Lead Consultant, Antrim Area Hospital ED).'[235] Although one described:

235 The NHSCT notes that "the Trust has established a new senior structure which ensures Clinicians are integral to the decision making process" (response to draft report dated 6 May 2015).

An awakening at Commissioning Board level that there needs to be more input into emergency care and that professionals who are working in the area are well placed to give advice" (Clinical Director Emergency Care, SEHSCT).

Findings: Participation in health decision-making

Public participation, including participatory governance, is an essential right to health governance component and, integral to this, health related information should be ensured.[236] Based on what people said to the Inquiry, the NIHRC found that:

- Many positive examples were given of consultation with the public regarding changes to health care services, as well as mechanisms to gather service user feedback.
- Northern Ireland has no single Health and Social Care accredited advice and information service.
- There was evidence that participatory governance in health care is developing, but it was generally less apparent than consultative mechanisms and surveys.
- There were calls for greater engagement with ED staff in commissioning, and for enhancement of the role of Trust Board Non-Executive Directors.

Accountability

Monitoring

When asked about measuring quality of care, Trust representatives and clinicians commonly said monitoring occurs beyond the "four and 12 hour" waiting time targets. For example:

[…] during shifts you're looking at how people are spoken to, how they're communicated to, how they're addressed, how the staff are engaging with them, do they know what's happening next in terms of their journey of care in the department, are they getting pain relief, are they being respected in terms of are the curtains closed when they're being examined […] (ED Nurse Manager, Altnagelvin)

Altnagelvin ED also highlighted a researcher "embedded" to identify trends in attendance and disseminate learning to the community. Some clinicians accepted that, historically, monitoring had been quantitative but gathering of qualitative patient experience data was improving.

Nevertheless, organisations, at times, reported monitoring of its services by the HSC bodies was still: "a little arm's length, it's very numbers oriented, tad performance indicators and targets driven" (Contact NI). Clinicians agreed monitoring of "Service Level Agreements," such as for the design and build of the new ED at Antrim, tended to remain quantitative. Age NI indicated data was often not sufficiently disaggregated to monitor the experiences of particular groups. It highlighted the importance of gathering data by age group, particularly for those over 85 years, by disability, and minority ethnic status stating: "if you don't know who your population are […] how on earth can you plan". An Equality lead for one of the trusts recognised: "our colleagues within the [ED] would say […] they're priority is to deal with the clinical issues but I do think a focus on [gathering data] would be very useful".

236 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000); CoE, Committee of Ministers Recommendation R(2000)5 on the development of structures for citizen and patient participation in the decision-making process affecting health care (24 February 2000); on information, e.g. UN Doc. CCPR/C/GC/34, Human Rights Committee General Comment No. 34: Article 19 Freedom of Opinions and Expression (2011), para 19; UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para 40.

Many of the mechanisms cited to ensure quality improvement (discussed above) were thought equally important for monitoring. Participants referred to the role of patient feedback in providing "some very rich information about how the patient perceives the experience" (Causeway ED). But evidence from the public suggested a lack of awareness about feedback mechanisms. For example, a number of callers spoke positively about their experience, but reported no obvious way to relay this. One talked of plans to write to the hospital Manager and Health Minister to highlight the "exemplary treatment" received. Some thought they might write to the ED to thank staff, as one participant wrote: "I didn't see any feedback form and have been meaning to write to thank the A&E staff for my thorough and efficient care". And one Inquiry witness noted leaving a compliment for the NIAS on the complaints section of its website, there being no obvious method to relay positive feedback.

Monitoring through complaints was also highlighted: "any complaints that come into the Department, we look at trends and we feedback […] themes and patterns" (ED Nurse Manager, Altnagelvin). Importantly, it was acknowledged, "one couldn't equate […] the absence of a complaint with satisfaction necessarily." On why few complaints had been received by the NI Ombudsman about ED, the Ombudsman felt there might be a degree of cynicism:

I do hear from many people about their experiences many of which are very positive. But also I do think there are people who haven't had a good experience but do shrug their shoulders and say, what's the point?

Indeed, public participants often doubted the efficacy of the complaints process, with one witness stating: "I don't think the Trust should be investigating itself" and one caller questioning the independence of assisting organisations, "The [PCC's] paymaster is the Trust."

Difficulties accessing the complaints process were reported too. While some received complaints information, other callers commented that there were no forms available at the ED, they were directed to a website, or that complaints information was sought elsewhere (for example, another doctor outside of the ED; from the PCC at a town meeting). "A lot of paper work" or requests to attend meetings when the complainant was unable to "pay my own way" were also cited as barriers to complaining. The NI Ombudsman highlighted a need to work through advocacy groups to raise more awareness of the complaints process among those with learning disability, mental ill health, and older people, especially those living alone or not linked in to advocacy and support services.

Findings: Accountability - monitoring

Accountability mechanisms must have capacity to monitor conduct, performance, and health outcomes.[237] Based on what people said to the Inquiry, the NIHRC found that:

- There was evidence that both the nature and range of indicators to monitor emergency care is progressively improving.
- No indicators were cited as having been designed explicitly to monitor the right to health.

237 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 65.

- Patient feedback was recognised as an important qualitative measure, but a lack of public awareness of mechanisms was reported.
- Similarly, complaints were recognised as an important monitoring measure; but are not alone a reliable measure of performance due in part to perceived barriers and lack of information.
- Barriers to giving positive feedback were also cited, with mechanisms to do this not always apparent to participants.

Review

Public participants' evidence regarding review related to health complaints and, as noted above (under 'monitoring'), some perceived a lack of independence and accessibility in the process. Difficulties accessing independent judicial investigation into deaths of family members in ED were also reported by three callers. One said that an inquest was not ordered until the Attorney General intervened. And another indicated an inquest occurred only after concerns were highlighted via the media. It was almost three years before another caller was informed about delay having contributed to the death of their loved one in A&E: "out of the blue we got a letter saying on advice they done a retrospective report and the coroner had requested an inquest". Notably, a HSCB review of SAIs in EDs from 2009 to 2013 concludes "the statutory requirement to advise the coroner complied with" for cases where delay was a potential contributory factor to death. There is no indication, however, of the timescales in which the coroner was informed or if delay communicating this to family occurred.[238]

Accountability requires not only monitoring but internal, as well as independent external review.

Mechanisms of internal review cited included the reports and advice submitted to the HSCB by the PHA. According to the PHA: "our role is to uncover the true story seek out the factors that contribute to poor health […] we do not simply gather data we analyse it." Although the PHA was seen as "a potential champion," UNISON said it had not, in its view, challenged the HSCB's decisions. Similarly, in terms of review, the PCC said it does not have a formal monitoring role, but conducts research, publishes annual complaints reports, and gathers views on priorities for health care:

> Since our inception people have been highlighting emergency care as a priority […] we've been working quite hard through our "Care when I need it" report to make recommendations to both the commissioners and providers of services for the ways in which emergency care might be improved upon.

The RQIA was highlighted as the statutory review body, but some felt it not sufficiently independent or equipped with adequate standards on which to base its assessments. The RCN, and some callers, felt it "took [a] crisis" for RQIA to become involved in emergency care:

> It's a terrible pity that it has taken that long to do that, and its going to take great effort and resource to bring those new staff who are now being I suppose inducted at haste almost to the ED to

238 48 of the 83 SAIs identified involved a death and in 13 cases "the evidence is that there was some element of delay which may have been a contributory factor" Emergency Department Serious Adverse Incident (SAI) Lookback Exercise (2009 – 2013) Findings (http://www.dhsspsni.gov.uk/sailookback accessed 08/03/15).

bring them up to a level of competency and skill that is required.

The RQIA highlighted its routine hospital inspection programme focusing on infection prevention and hygiene, and other reviews, including of older people's care, and night-time and weekend care in acute hospitals, although these are not routine. It acknowledged the Minister ordered its recent emergency care inspections, but there would be greater focus on acute care following the call for a "rolling programme" of inspections from 2015/16. This, RQIA said, would require a "set of regionally agreed tools", although it would encompass some of the work already embedded in existing thematic reviews. But an increasing workload and disparity in investment compared to the regulatory body in England was noted:

We have taken on a number of additional functions since then [establishment in 2005] including responsibilities of the former mental health commission; we have developed our inspection footfall in a number of ways; there are an increasing number, for example, of registered Independent Care Providers, [there] are now approximately 1400 registered independent care providers all of whom require an inspection at least once a year, and some of whom require an inspection more often. Over the course of that same period we've developed our inspection programme in response to specific events so in acute hospitals the programme of hygiene and infection prevention infections was introduced in 2008 on the back of the [Clostridium difficile] outbreak and was further extended in 2011 on the back of the pseudomonas outbreak

When asked if it additional resource was required to carry out acute hospital inspections, the CE of the RQIA replied:

You will recall no doubt that in February 2013 Robert Francis published his report on the back of Mid Staffordshire and as a result of the, I think it was 290 recommendations in that report the Care Quality Commission, which is our sister organisation in England, received a significant investment in resource. Now, it's a much bigger enterprise with a much bigger span of functions. We have already signalled to [the DHSSPS] the need for additional capacity in the form of two business cases, which are currently with the Department; its quite likely that on the back of the work we'll be, as David my colleague already explained, we'll be looking at how we can deal with that [the new inspections] within our current available resource but there may also be additional capacity requirements and, if there are, we are duty bound to flag those up to the Department for consideration.

Although RQIA highlighted its signalling to DHSSPS of the need for additional capacity it was reported on 19 February 2015 its budget would be cut.[239]

There was no evidence of regular external review beyond RQIA either. The CEM said it had recently re-established active membership in Northern Ireland, and had undertaken "invited service reviews" of EDs, with key recommendations to improve service provision. As an independent charitable body, it noted it has neither resource to regularly inspect EDs, nor statutory powers, but described its recommendations as persuasive.

239 BBC News 'NI health board budget cut and public health agency to lose 2.8 million' (http://www.bbc.co.uk/news/uk-northern-ireland-31539917 accessed 08.03.15); see also NI Executive Budget 2015-16, p. 93 where DHSSPS commits to maximize savings from "non-frontline services" stating: "substantial savings must be delivered by the Department and all it's arm's length bodies in order to live within the resources available" (http://www.northernireland.gov.uk/budget-2015-16.pdf accessed 08.03.15).

Finally, three HSC Trusts highlighted the private enterprise ALAMAC as a "critical friend", but there was no evidence that its involvement in review would be long-term or routine.

Findings: Accountability – review

Internal and independent review of monitoring data is important to determine "what works, so it can be repeated and what does not, so it can be revised."[240] Moreover, there must be an effective independent mechanism to examine cause of death of an individual under the responsibility of health professionals.[241] Based on what people said to the Inquiry, the NIHRC found that:

- Some callers and witnesses reported the complaints process, and independent judicial scrutiny of deaths occurring in ED, as crucial review mechanisms.
- On deaths occurring in ED, a small number of callers to the Inquiry reported resistance to, or delay in, having an inquest established.
- Internal and external review mechanisms exist, but it was felt an effective independent challenge function was lacking.
- RQIA as the regulatory body was not viewed as sufficiently independent by some, or has having adequate standards on which to base its reviews.
- There is no statutory framework for RQIA to routinely inspect EDs, with much clearer requirements in relation to the Independent Sector (although this is likely to change with the planned acute hospital inspections).
- An increased role and investment for the health regulator in England, the Care Quality Commission, has not been matched in Northern Ireland.

Remedial action

Participants' perceptions of an effective remedy centred on what they wished to occur as a result of a complaint. Some talked about wanting to make their concerns known, for example, "to make sure staff know how to treat people with a rare illness" and "to make life better for my visually impaired friends". For those whose family members passed away in ED, they talked about wanting to "bring about change" for their loved one: "I feel I need to do this for my mother". Others wished for an explanation of what had happened, for mistakes to be acknowledged, or for an apology, as one caller said: "I'm not looking to go down the line of litigation or compensation, I just want the answers". In this respect, the investigatory process was in itself crucial, as the following contrasting case studies demonstrate:

Case study 8: "A very thorough investigation"

Witness Iris Russell explained she attended Altnagelvin ED in December 2013 when her husband, who has a history of renal colic, experienced serious illness. Iris said "our GP requested an urgent scan of the renal area because of his history" but her husband wasn't scanned for several days. The problem, according to Iris, "was a tiny stone lodged in the bottom of the ureter" but, given the delay in

240 UN Doc. A/HRC/7/11, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt' (31 January 2008), para. 99.

241 Senturk v. Turkey (no. 13423/09) 9 April 2013, para 81; see also Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 104; Oyal v. Turkey (no. 4864/05) 23 March 2010, para 54; Furdik v Slovakia, (no. 42992/05) 2 December 2008

scanning, her husband required emergency surgery and a stent for over two months.

On complaining, Iris explained that "[…] in the reply they told me the request for an urgent scan was downgraded to routine, which meant there was no urgency to do it […]."

When asked if she got what she was seeking from the complaints process: "I was looking for answers […] Now it took them four months to get a reply to me but I must say it was a very thorough investigation and […] I know radiology downgraded him to routine because that was written in the answer […]." Crucially, Iris explained, "they didn't say 'we're sorry that you *felt* [emphasis original] the nursing care was not what should be expected; they said 'we're sorry the standard of nursing care was not what *would* [emphasis original] be expected in a modern teaching hospital today in 2013.' For Iris, feeling satisfied with the complaints procedure was attributed to " a very thorough investigation" and that "[the Trust] apologised unreservedly."

Case study 9: "Doubt [for] the rest of my life"

Clare Law talked about a number of experiences attending ED with her mother, including Antrim Area ED in March 2012 when her mother was diagnosed with pneumonia. Clare's mother was placed on an "admissions ward" from the ED despite an indication from her mother's cardiologist that a specialist bed was available. Clare's mother remained on the admissions ward for four days until moved to the specialist area.

In that time, Clare said she was asked if she would consider a "no resuscitation order." She explained: "my religious beliefs tell me God makes that decision […]" and said "no."

On meeting the "health board" Clare said: I requested her notes and I discovered the doctor in the A&E had on one of the forms circled "not for CPR." Clare explained: "I have been trying to query this for two years as to why a junior doctor took it upon himself to end my mother's life and not discuss it with me […]. All [the hospital] seem to be able to do is say, 'oh, we're sorry you had a distressing time' […]. Clare said that she is not "getting at the nurses, they need all the help they can get" but, despite reassurances from two staff members that the instruction would not have been carried out: "that doubt will be with me the rest of my life." She explained: "All I wanted [the doctor] to tell me was 'I decided this because', I don't think I was asking for too much."

Indeed, reflecting similarities to Clare's experience, the most recent annual report by the NI Ombudsman states, "I am concerned that, particularly in health and social care cases, complainants are being provided with inadequate and at times evasive responses by HSC Bodies."[242]

Others perceived remedial action had occurred due to various commitments, for example, to change the recording on a 'Flimsy' form so HIV diagnosis would not be publicly visible; to admit patients with cancer directly to a specialist unit; and to issue a memo stating at least one family member could remain with patients in ED. These were generally

242 'Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints 2013-2014', p. 30.

described as positive outcomes. Moreover, the HSCB annual complains report highlights an example of one patients' experience tangibly leading to an improvement in practice:[243]

> [d]ue to a complaint being made about a patient attending an [ED] who then suffered from allergies to latex, record taking in the [ED] has been redesigned to prompt staff to ask if the patient has any allergies. A window will appear on the computer screen which staff will be required to complete before moving on with gathering information from the patient. The [ED] has developed a policy on Management of Latex and Glove Selection as well as replacing all gloves for latex free ones.

Some Inquiry participants talked about not knowing if promised changes had been implemented: "they did apologise and they said that they would put disabled training in but I don't know if they ever did that". And feelings of humiliation were described when a subsequent attendance at ED revealed the memo was not followed:

> This year my [relative] was rushed to [ED]; […] he gets confused [and] during examinations [we] were asked to leave so that memo was not implemented. We were absolutely gutted and felt humiliated […]. It wasn't adhered to so it was just shallow words on the paper that was meaningless

And for others an "effective remedy" required systemic change and they perceived little point in complaining: "nurses can't materialise beds"; "No point raising concerns in A&E as it's not the staff's fault, they didn't set up the system."

HSC representatives gave evidence about remedial action in response to individual complaints, as well as internal and external review processes. For instance, the SE Trust said: "complaints are a rich source of information for us […] and we do reflect that back out to wider organisation." Similarly, "every single formal complaint that comes into the Western Trust I see, I read, and I respond to" (Chief Executive WHSCT). The PHA reported how '10,000 Voices' is designed to facilitate immediate remedial action at a local level where warranted, and longer-term regional actions within commissioning plans. Clinicians from Causeway ED stated its ED standards were drafted in response to patient complaints, and the RBHSC said "we constantly examine our practice and follow recommendations from external review bodies," citing the opening of an eight bed short stay unit as an example. Remedial action in response to a review by ALAMAC was also outlined by the SHSCT:

> Our triage standards have come up to 90% […] and [performance against the time taken to admit patients to a ward] has increased also; the number of patients leaving the Department without being seen has decreased our complaints have decreased, our incident forms in relation to staffing has also decreased, […] the junior staff are telling us they feel very supported, [and] our senior staff.

Former Health Minister Poots cited a Regional Task Group chaired by the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) to oversee RQIA recommendations. Examples of remedial action being led by this Regional Task Group included the development of ED Values and Principles. In response to the RQIA review of the

243 HSCB, 'The Fifth Annual Complaints Report of the Health and Social Care Board: April 2013 – March 2014', p.10

Royal Victoria Hospital ED, the BHSCT highlighted a "Quality Improvement Plan" and an "IMPACT project" with dedicated work streams to improve patient experience and care. But it was reported that emergency care is "over observed and over reviewed" with the real need being "to get on with implementing recommendations" (College of Emergency Medicine).

There was no evidence, however, of routine independent assessment to examine if recommendations are achieved. The RQIA described its "follow-up" process is variable:

> The process through our inspection process, and the same would be for our hygiene inspection is that we ask the Trust to complete a quality improvement plan which sets out what the Trust is setting out to deliver against each of the recommendations, some of those recommendations were very short term, some of them would have taken a longer period but the nature if that initial set of recommendations [in relation to the RVH ED] was really I suppose in that sense immediate recommendations made on the back of an unannounced inspection; the unscheduled care report is a wider set of recommendations for a longer term process, or medium to longer term; so the process that we then engage in depends really on the circumstances but in this case we carried out one initial visit to the Trust to look to see the progress in relation to the recommendations and we will carry out a further visit and reports on those visits will actually be reported in the public domain later. But the process then would be if we've identified that perhaps there isn't progress in a particular area we will then have brought that to attention in the next report. So from that inspection we would follow up directly on the individual inspection.

But it felt follow-up to the newly planned acute hospital inspections might differ: "I think [that] may change next year as we're introducing a new programme of hospital inspections its probably more likely we would then focus on following up inspections through the process of the wider hospital inspection" (Director of Reviews and Medical Director, RQIA). And noted that follow-up to its regional review of unscheduled care entailed "a very clear structure" in the form of the regional Task Group led by the CMO and CNO.

Findings: Accountability – remedial action

Remedial action requires (1) An accessible and effective independent judicial or other appropriate remedy must be available of victims of right to health violations;[244] (2) implementation of action and learning from individual see investigations and wider system reviews.[245] Based on what people said to the Inquiry, the NIHRC found that:

- People want different outcomes as an "effective remedy", but perceiving an effective investigation and an apology or answers are crucial;
- Where commitments in response to a complaint are made, feedback on

244 UN Doc. E/CN.4/2000/4, ICESCR Committee, General Comment 14: The right to the highest attainable standard of health (11 August 2000), para 59; See also, ICESCR, General Comment No. 9 on the Domestic Application of the Covenant (1998), para 2; ECHR, Article 13.

245 ICESCR, Article 2(1); CoE, Committee of Ministers Recommendation No. R(97) 17 'on the development and implementation of quality improvement systems (QIS) in healthcare', para 1; UN Doc. A/HRC/RES/19/20, Human Rights Council Resolution 19/20 'The role of good governance in the promotion and protection of human rights' (25 April 2012), preamble; CoE, Committee of Ministers Recommendation CM/Rec(2012)8 'on the implementation of good governance principles in health systems' (12 September 2012), Tool No 1, 'Attribute 10'; see also on developing jurisprudence in relation to ECHR, Article 2 (right to life), Asiye v. Turkey (no. 24109/07) 27 January 2015, ECtHR Press release (official judgment available in French only); Byrzykowski v. Poland (no. 11562/05) 27 June 2006, para 117.

implementation is important;

- The HSC bodies gave examples of remedial action undertaken in response to reviews, including development of ED Values and Principles;
- On implementation of recommendations, Quality Improvement Plans and an Unscheduled Care Task Group was cited;
- But there were concerns about the coherence of follow-up and mechanisms of enforcement beyond carrying out further reviews

4 Developing a human rights-based approach to emergency care in Northern Ireland

In a written statement to the NI Assembly on 19 November 2014, the DHSSPS Minister, Jim Wells MLA, announced that his Department was "developing a Values and Principles Statement that will underpin the development of future policy and service delivery for Emergency and Unscheduled Care".[1] The Inquiry welcomed this initiative when the Minister appeared before it on 1 December 2014. It also took the opportunity to underscore the common ground that exists between the values driving healthcare in Northern Ireland and the principles enshrined in human rights standards.

The Minister was asked if a Values and Principles Statement from the DHSSPS might adopt some explicit human rights language, along the lines of the NHS Constitution in England, and in accordance with the NI Executive's international and domestic human rights obligations. The Minister replied that he "worried" this would become a "litigants' Charter"(Minister Wells, DHSSPS). Such fears reflect a more general view expressed during the course of the Inquiry by health professionals and public servants responsible for health care policy.

Associating human rights with litigation is understandable. For many years, a key method of seeking human rights compliance has been through the courts. This is known as the 'judicial approach'. By contrast, in the last decade or so increasing attempts have been made to ensure that human rights influence the development of policies in advance of their implementation, as well as the shaping of programmes of work, action plans and practical interventions. This is known as the 'operational approach.'

The judicial and operational approaches are mutually reinforcing. Making sure human rights are given due regard in the early stages of an initiative to help shape policies, assist with planning and identify appropriate interventions is beneficial. There is reliable evidence demonstrating that this can contribute to gains for individuals, communities and populations.[2] It may also reduce exposure to litigation because it helps to ensure conformity with human rights standards. In other words, the 'operational approach' is the opposite of "a litigants' Charter".

An exclusive associating of human rights with litigation reflects an adversarial, partial comprehension that ignores the operational approach. To portray human rights accurately, we must conceive of them as a set of principled standards that shape interventions and result in improved outcomes. This includes improving access to quality public services for all and assisting staff to achieve their professional objectives.

The Northern Ireland Ombudsman's Human Rights Manual

In his evidence, the NI Ombudsman, Dr Tom Frawley, outlined an initiative that has much in common with the operational approach to human rights. While the Ombudsman acknowledged "a huge defensiveness" towards human rights in some quarters, he was aware of "a shift of emphasis" towards understanding human rights as a practical tool. He had also concluded, "human rights could add real value to my work".

1 Written Ministerial Statement, 19 Nov 2014

2 [WHO 2013.] Human rights in a health care setting: Making it work, 2009, An evaluation of a human rights-based approach at The State Hospital, Scottish Human Rights Commission, 2009.

The Ombudsman explained how his office, working in partnership with the NIHRC, had prepared a *Human Rights Manual* to assist public bodies, "to effectively apply human rights principles." A set of values – fairness, respect, equality, dignity and autonomy – explicitly grounded in human rights informs the manual. Having decided to adopt this approach, the Ombudsman indicated that he "would commend it to all who have a leadership role in the delivery of public services." He concluded his evidence by emphasizing: "there is the real opportunity to build a different perspective, a different view, of human rights and health than the one that has held us back to date." (Dr Tom Frawley, NI Ombudsman)

The State Hospital, Scotland

It is too early to evaluate the impact of the Ombudsman's initiative, but there is evidence of beneficial impacts from an analogous health programme in Scotland. In 2000, The State Hospital decided to put the human rights of everyone – staff, patients, carers and family members – at the heart of the hospital's services. A working group, led by senior management and involving clinical and non-clinical members of staff, was established. Consultative methodologies were devised for operationalising a human rights-based approach at the hospital.

In 2009, an evaluation of the initiative found that the human rights-based approach had supported "a cultural change … towards an organization with a more positive and constructive atmosphere with mutual respect between staff and patients."[3] This led to "increased staff and patient engagement, increased work-related satisfaction amongst staff and increased satisfaction among patients over their care and treatment."[4] The new approach "coincided with staff reporting a reduction in stress and anxiety" and patients "noted significant and sustained improvements in their care and treatment and in the overall culture" at the hospital.[5]

International developments

Short, general human rights statements in domestic laws or international treaties might be enough to advance the judicial approach, but statements on their own are insufficient for the implementation of an operational human rights-based approach to public services, including emergency health care. One reason why it has taken time for the operational approach to gain currency is because the essential elements have only recently become clear.

In 2012, the UN Human Rights Council adopted guidance on a human rights-based approach to maternal mortality and morbidity.[6] In 2014, the Council also adopted guidance on a human rights-based approach to under-five mortality and morbidity.[7] In the same year, the WHO published human rights guidance on contraceptive information and services.[8] From these and other documents it is now possible to identify the essential elements of an operational approach to human rights and emergency health care.

3 Human rights in a health care setting: Making it work, 2009, An evaluation of a human rights-based approach at The State Hospital, Scottish Human Rights Commission, 2009, p.5.

4 P.6.
5 Ibid.
6 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, A/HRC/21/22, 2 July 2012.
7 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, A/HRC/27/31, 30 June 2014.
8 Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations, WHO, 2014.

Three steps towards an operational human rights-based approach to emergency health care

This report has already outlined the relevant human rights laws and standards and domestic framework that provides the foundation for a human rights-based approach to emergency health care. In addition, the NIHRC has concluded that it is beneficial to set out three steps that would translate these provisions into an operational human rights-based approach.

Step 1: Human rights principles and underpinning values

Respecting, protecting and fulfilling human rights, including meeting legal obligations, requires a process that adheres to both the principles that underpin human rights laws as well as their substantive content. Those principles are participation, accountability, non-discrimination, empowerment and legality.

The Ombudsman's *Human Rights Manual* refers to a specific set of values – fairness, respect, equality, dignity and autonomy (FREDA) – considered to be of fundamental importance to the work of the office. The manual is explicit in demonstrating how the FREDA values align with the principles of a human rights-based approach. This is notably similar to examples of The State Hospital, Scotland,[9] and the UN human rights guidance relating to maternal health and children's health.[10]

The NIHRC has concluded that the principles of a human rights-based approach - participation, accountability, non-discrimination, empowerment and legality are evident the Northern Ireland health care system. These could be given greater effect however in a set of values specifically developed for emergency health care and EDs that might include concepts such as fairness, equality, and respect for human dignity, autonomy, quality and diversity.

Step 2: Moving from abstract human rights principles towards their practical implementation

Giving abstract human rights principles operational effect requires a process of detailing their practical implementation in a specific set of circumstances. The NIHRC has identified nine points to begin relating to emergency health care:

1. *At the centre: the well-being of patients*. The human dignity and well-being of patients must be at the centre of emergency health care and EDs.
2. *Good terms and conditions of employment*. Fair, sustainable terms and conditions of employment, including an equitable work-life balance, for all emergency health care staff.
3. *Equality, non-discrimination and equity*. A human rights-based approach requires that emergency health care is accessible to all, including people with disabilities, children, the elderly, the mentally ill, minorities, those living in poverty and other disadvantaged groups. If policies do not explicitly acknowledge and address the situation of the disadvantaged there is a risk their disadvantage will inadvertently be reinforced. Given the critical importance of equitable access, indicators should be disaggregated on suitable grounds, such as socio-economic status.

9 Human rights in a health care setting: Making it work, 2009, An evaluation of a human rights-based approach at The State Hospital, Scottish Human Rights Commission, 2009, p.5.

10 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, A/HRC/27/31, 30 June 2014. Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations, WHO, 2014.

4. *Quality care and patient safety*. Emergency care must be of good quality and ensure patient safety. Staff must be polite and respectful.
5. *Respect for difference.* Emergency care must be respectful of diversity. Staff should be provided with appropriate training in this regard.
6. *Transparency and communication*. A human rights-based approach to emergency care requires that, whenever possible and appropriate, personal health information is carefully and clearly made accessible to patients and their families. Quality communication is vital. Also, a human rights-based approach requires access to all public health information, such as policies, protocols, codes of conduct and the amount of funds devoted to emergency care.
7. *Privacy*. Individuals' privacy must be respected, including confidentiality of personal health data.
8. *Participation*. All individuals (e.g. patients, carers and families) and communities are entitled to active and informed participation on issues relating to their health, including policy making and accountability. Clinical and other staff, and their associations, must also enjoy active and informed participation in relation to decisions bearing upon them and their responsibilities.
9. *Governance* (transparent, participatory and accountable). From the human rights perspective, effective governance should be transparent and participatory (above), and have other features, such as:

- Explicit recognition of the relationship between human rights and emergency care;
- Regulations, protocols, guidelines, codes of conduct etc that reflect human rights values;
- A strategy on emergency care with various features, including clear objectives, time frames, a detailed budget, outreach to the disadvantaged, patient safety and accountability arrangements (below). The strategy will have to address workforce issues and include suitable quantitative and qualitative methods for measuring progress, including appropriately disaggregated indicators.
- Situational analysis; research and development; impact assessment. The strategy on emergency care must be based on a situational analysis informed by disaggregated data, as well as research and development on emergency care, including implementation research e.g. research into the social, economic, cultural, political and policy issues that influence access to emergency services and facilities. Before finalisation, key elements of the draft strategy must be assessed for their likely impact on the human rights of all concerned.
- Accountability mechanisms i.e. monitoring, review and redress. Accountability has many forms and should not be understood as a matter of blame and punishment. Sometimes called 'constructive accountability', it is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised.[11] Where mistakes are identified, redress is required. Redress also has many forms, such as a public or private apology, an amendment to policies and practices, and compensation.

11 Lynn Freedman http://www.ijgo.org/article/S0020-7292%2803%2900147-4/abstract

These nine points are not exhaustive. Moreover, because of the complexity of health systems and emergency care, the human rights requirement is that they will be "progressively realised" over time. This is akin to the DHSSPS call for "a culture of continuous improvement". In human rights, there is a rebuttable presumption that retrogressive measures are impermissible e.g. the present level of expenditure on emergency care may not be reduced, the current level of access to emergency services may not be lowered, and so on. In addition, some human rights such as equality and non-discrimination are not subject to progressive realisation over time.

To what then should an operational human rights-based approach be applied?

The UN Human Rights Council guidance on a human rights-based approach to maternal mortality and morbidity pertains to "policymaking, implementation and review cycle."[12] This is understood to include planning, budgeting, implementation and accountability. However, an alternative is presented by the WHO, which identifies six "essential building blocks" for a functioning health system: services, workforce, information system, medical products, financing and governance.[13] It is apparent, that the question of application cannot be determined in the abstract. A human rights-based approach may be principle led, but its meaningful use is nonetheless context dependent. Any purposeful application to emergency health care would therefore need to account for the specific circumstances of EDs in Northern Ireland.

Step 3: A pilot project to develop an operational human rights-based approach to emergency health care

The NIHRC propose a pilot project to develop an operational human rights-based approach to emergency care, drawing from the key human rights principles and underpinning values set out in step 1 and the nine points identified in step 2.

With a view to being as context specific and manageable as possible, the NIHRC suggests the pilot is confined to one or two HSC Trusts that are already in a position to work on this collaborative exercise with the NIHRC and other relevant partners. The project will need the firm support of senior management in the HSC Trusts directly involved. Once completed, the NIHRC would propose an independent evaluation before deciding whether to offer an extension of the project to the other HSC Trusts. The exercise would be a learning experience for all parties. To the best of our knowledge, such a project is without precedent in the context of emergency health care. Some important features of the proposal are as follows:

A working group

The project will require a working group mandated to drive its design and implementation. To operate effectively this would need to draw upon a range of expertise, especially from the HSC Trusts directly involved.

Composition

The NIHRC envisage that the working group would be co-chaired by the NIHRC Chief Commissioner and a member of the senior management of

12 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, A/HRC/27/31, 30 June 2014.
13 WHO, Everybody's business: strengthening health systems, 2007, p.3.

the HSC Trusts directly involved. This would be time-bound to an initial period of six months. The co-chairs should ensure the effective participation of those responsible for managing, overseeing and delivery of service in EDs to include experts in health systems, information and financing, and the social determinants of health. Participation of community and voluntary sector organisations, professional bodies and trade unions in the design and implementation of the project will be important.

Outputs and working methods

The principal output of the working group will be a succinct final report, to include:

(1) a set of values for emergency health care and EDs that are explicitly grounded in the principles of a human rights-based approach - participation, accountability, non-discrimination, empowerment and legality;

(2) key recommendations for an operational human rights-based approach to emergency health care in the HSC Trusts directly involved.

The working group will aim to provide an environment where members convey information, share insights, listen, learn, and discuss openly, with a view to identifying what practical actions are required to deliver the outputs required.

The working group will not only be collaborative and participatory, but also iterative. For example, during the life of the group, the senior management of the HSC Trusts directly involved may wish to consider any provisional recommendations or propose a trial implementation. This might generate constructive feedback to the working group, leading to the strengthening of the final report and its proposed set of values and recommendations.

The NIHRC will act as secretariat to the working group. As necessary, the secretariat will distribute instructive published material (e.g. about emergency health care and human rights) and prepare background papers. Under the stewardship of the co-chairs, the secretariat will prepare the working group's final report.

5 Conclusions

The Inquiry's starting point was the human right of everyone to the highest attainable standard of physical and mental health.

The Inquiry examined the extent to which the human rights of patients were respected, protected and fulfilled when receiving care and treatment in emergency care departments. We received evidence that raised breaches of human rights including unnecessarily prolonged waits without medical reason for pain relief, food, or fluids, people placed on trolleys in circumstances that exacerbated existing conditions, patients unsupported and as a result unable to get to the toilet or have their other care needs met, and treatment and care which did not respect dignity or privacy. On the other hand the Inquiry was also told of many examples of kindness, good care and treatment which was much appreciated and of a high standard.

No evidence emerged to suggest that human rights violations were systemic in emergency departments. Where they did occur however, they left a deep and lasting impression on the individuals and families affected.

The emergency care function of our health service is heavily dependent on and influenced by policy and practice elsewhere in the health and social care system.

Emergency departments do not control who attends for treatment and rely on other parts of the hospital and social care system to allow patients to be discharged from emergency department care or cared for at home obviating their need to attend hospital. The need to look at the whole hospital and social care system, is, however, beyond the remit of the human rights Inquiry. There has been a number of such reviews in recent times; such as the Transforming Your Care review in 2011 and the review of health and social care governance arrangements by Sir Liam Donaldson in December 2014.

The Northern Ireland Executive has committed itself to implementing Transforming Your Care (TYC) by allocating funding to enable the transition from hospital to community based services to relieve pressures on emergency departments and other hospital services. During the course of our Inquiry we learned that less funding than was recommended has been provided for the transition to implement TYC. Moreover, while the monies allocated were used for many valuable purposes, much of it was not what the TYC transition funding was designed to achieve. In effect, the TYC proposals have been parked and emergency care departments have continued to struggle to meet the demands placed on them. One of our key recommendations matching that of Sir Liam Donaldson's recent review is that the DHSSPS should urgently revise and implement Transforming Your Care.

The Inquiry examined expenditure on emergency departments. Over the past five years overall expenditure on emergency care departments across Health and Social Care (HSC) Trusts has increased in real terms. In human rights terms, there has, therefore, been no apparent retrogression in funding of emergency department care. There was, however, limited evidence of long term planning. Annual budgets were constantly exceeded with in-year injections of monies being provided to deal with winter pressures and other demands.

The need for an appropriate skills mix and sufficient medical and nursing staff was a recurring theme. A particular shortage of permanent middle grade clinician posts was identified. As a result, expenditure on locum staff has increased substantially over the last couple of years. Staff in emergency departments work in pressured environments, in accommodation and facilities often not designed to deal with the demands placed on them. The President of the College of Emergency Medicine, in his evidence to the Inquiry, argued that while improved accommodation would be welcome it would not deal with the underlying problem, namely, ensuring that emergency departments treat only those people who need these services. This is key to moving forward in tackling issues impacting on emergency departments.

The Inquiry found examples of good practice across all HSC trusts, and between them and the Northern Ireland Ambulance Service Trust. Good practice when effectively applied across the system reduces the risk of human rights violations and helps protect and fulfil the right to health. The South Eastern Health and Social Care Trust's (SEHSCT) housekeepers regularly check patients to ensure that individuals are not left inappropriately without fluids, or provide support to enable patients to get to the toilet and also provide alerts to medical staff when pain relief issues arise. The Inquiry found that a number of local positive initiatives and good practice were not generally rolled out across all HSC Trusts. The implementation of positive initiatives in a systematic way is important. For example, the Card before you Leave scheme, to ensure patients with mental health issues, know they will receive a follow up appointment was rightly lauded. Nonetheless, the Belfast Mental Health Rights Group working with the Participation and the Practice of Rights project provided evidence of the difficulties in securing and sustaining a regional wide approach to implementation to ensure the initiative was consistently implemented. Given that health and social care is organised through a commissioning model with the Health and Social Care Board at its apex, with local commissioning groups working on the ground, the problem of implementation across HSC Trusts was somewhat of a surprise to the Inquiry. The need to review the commissioning process should be a priority for the Department. In the interim, ensuring many of the effective initiatives referred to in this report are considered for implementation across all HSC Trusts should be an immediate task for the Health and Social Care Board.

The right to health includes importantly the right to effective public involvement and participation in the planning and delivery of services. The Inquiry received evidence about initiatives to consult people on service developments (for example, the design of the new emergency department at Antrim Area hospital and gathering service feedback for '10,000 Voices'). Nonetheless, evidence provided to the Inquiry suggests that there was scope for significant improvement in engagement with the public. A similar message emerged in terms of feedback and redress mechanisms. It was telling that one individual told the Inquiry how she had gone online to provide a HSC Trust with positive

feedback of the service only to discover that a facility only existed to lodge a complaint. Great emphasis on the '10,000 Voices' initiative emerged from the evidence of commissioners and providers of health and social care and how some of the feedback received was beginning to be integrated into the commissioning process and utilised on the ground. The Inquiry also heard that the long term funding of the initiative was not secured. Moreover, '10,000 Voices' was not working for all groups, for example the visually impaired. There is a need to broaden and deepen feedback mechanisms.

A similar gap exists within participatory governance. There is a need to strengthen the link between those shaping services and the local communities they serve; this requires consideration of the roles of the Local Commissioning Groups, the Patient Client Council (PCC) and a more defined role for non-executive directors on HSC Trust boards to act as a conduit between the public, user and representative groups. The volume of evidence we received from user and representative groups enriched the Inquiry and illustrated the value of the feedback that is available. Issues around the need for improved communication with the carers and relatives of patients, with people with rare diseases and how to deal more effectively with patients with mental health problems and other specific groups are an important feature of the report and a number of our recommendations.

Accountability is a further essential component underpinning the right to health. Evidence emerged which commended the Serious Adverse Incident and Adverse Incident processes. The Inquiry was told about the challenge associated with marrying the twin aims of publicly getting to the bottom of what had happened in a specific case and ensuring that an effective future learning experience was created. The evidence indicated a need for improved patient and family involvement in the SAI and Adverse Incident processes. In particular, we heard evidence of the need to ensure patients and relatives receive an explanation of what has happened and where applicable how any learning from an incident is being put into practice. The publication of a guide for engagement with service users/family in the SAI process is welcome and the Department's commitment to introduce a duty of candour should be expedited.

A further key human rights element of accountability is a robust, independent regulatory and inspection framework with powers to ensure recommendations from inspections are put into practice. During the Inquiry the RQIA played a more prominent oversight role. From the evidence received and developments elsewhere we concluded that there is a need to strengthen regulatory independence and enhance statutory enforcement powers and the inspection framework. An enhanced role for the RQIA will need to be appropriately resourced.

The evidence received on measuring quality was mixed in terms particularly of the value of the four hour waiting time target. There was evidence that the nature and range of indicators to monitor the quality of the patient's experience in emergency departments is progressively improving. The Inquiry found that individual HSC Trusts were developing holistic approaches to measuring the overall quality

of care in their emergency departments. Currently, according to the Department, the way the 12-hour targets for treatment and discharge are measured in Northern Ireland does not facilitate a direct comparison with other parts of the United Kingdom. In any event, the Inquiry concludes that it is now appropriate to examine the utility of the four-hour target as part of a wider initiative to introduce more comprehensive measures of quality which should be applied consistently across all the HSC Trusts. The Inquiry found considerable data gaps, including that only the Belfast Health and Social Care Trust (BHSCT) was publishing whether the target to treat patients with mental health issues within two hours was being met. The current categories for data collection in Northern Ireland also do not meet the recommendations set by the UN Special Rapporteur on the Right to Health.

The Inquiry found that no dedicated ED minimum standards exist. As a result, human rights concepts of dignity, privacy, respect, involvement in decision-making and receiving information in a timely manner were not consolidated into one set of standards or placed within a human rights framework. This does not mean there is an absence of documentation around the quality of care in emergency departments. For example, the DHSSPS Quality Standards are applicable to various HSC settings. But the development of a single, comprehensive set of minimum standards for emergency care departments utilising human rights provides an opportunity to embed human rights values and principles in a practical way setting out the expectations that both patients and staff should have when using and delivering services. Training on human rights standards, including responding to the needs of vulnerable and marginalized groups, also needs strengthening with a focus on the specific context of providing care in emergency departments.

The Inquiry produced evidence on a number of issues that have, to date, largely escaped public attention. We learned that more than one fifth of persons reported as missing in Northern Ireland were individuals who had left an emergency department. The missing persons are often individuals experiencing mental health difficulties. There is one local initiative between the Police Service of Northern Ireland and a HSC Trust there is not, however, a regional approach to dealing with this issue. This shortcoming needs to be remedied.

The Inquiry also heard about the difficulties posed when emergency departments are left to deal with end of life care issues. We heard evidence that an emergency department is not an appropriate place for such care and the distressing impact such situations had on loved ones. In particular, we received evidence that sometimes people were transferred to emergency departments when end-of-life care could have been more appropriately provided in a nursing home or at home. This matter gives rise to a number of human rights issues. A strategy is needed to minimize the number of people being transferred to emergency departments in such circumstances including a specific focus on managing end of life care in nursing homes or at home, wherever possible. This strategy should take into account the 'what I need you to know' patient passport developed by the Royal College of General Practitioners and launched in early 2014.

When the Inquiry asked senior management and clinicians about the role human rights standards and concepts played in underpinning emergency department services, their initial response was at times questioning. Once the human rights concepts of the right to privacy and dignity, responsiveness to need, the role of participation, involvement and access to information, participatory governance and independence, transparent accountability mechanisms was explored further with them, then on several occasions we were told that these implicitly underpinned how care was developed and delivered.

The right to the enjoyment of the highest attainable standard of physical and mental health to be progressively realised was clearly a goal being pursued by the DHSSPS, the Board and each local HSC Trust. Moving human rights standards and concepts from implicit to explicit intent would be a powerful and valuable statement. The final chapter of the report set out a road map about how a human rights based approach to emergency department care could be developed. The Inquiry recommends setting up a pilot project with one or more HSC Trust to develop a human rights based approach. A successful initiative in this area would place Northern Ireland as a pioneer on the global stage.

6 Recommendations

These recommendations are based on the findings and evidence provided to the Inquiry.

1. The DHSSPS should develop dedicated ED minimum care standards, rooted in human rights and providing a benchmark for patient experience within EDs. The standards should include criterion on, *inter alia*:
   - The promotion of dignity in ED;
   - Participation by individuals, their family members and other carers in the care provided in the ED setting;
   - Measures covering staff behaviour and attitude, adequate facilities;
   - Accessible mechanisms to provide feedback of ED experiences including complaints;
   - The policies and procedures each ED should have including a hospital wide escalation policy to address overcrowding; and,
   - Ways of helping to guarantee equality of access for particular groups of patients including older people, patients with dementia, rare diseases, sensory impairments and those presenting in mental health crisis. (p26, p93, p102)
2. The DHSSPS should expedite its review of the Health and Social Care Board's commissioning process. (p93)
3. The DHSSPS should strengthen the statutory requirement for participatory governance to enhance public and staff representation on key planning and decision-making forums for ED services. A more public-facing defined role should also be developed for non-executive directors on HSC Trust boards. (p93, p108)
4. The DHSSPS should clarify the issue of confidentiality when seeking information about health conditions and the treatment process while highlighting the valuable role of family members and carers in sharing information. (p34)
5. The DHSSPS should urgently develop an implementation plan for Transforming Your Care. (p105, p106)
6. The DHSSPS should enhance the statutory framework requiring the RQIA to routinely inspect EDs, to include consideration of appropriate enforcement powers and provide the resources to facilitate the discharge of RQIA's role. (p93, p112)
7. The DHSSPS should develop a Northern Ireland single Health and Social Care accredited advice and information service. (p108)
8. The DHSSPS should develop a regional policy for the direct admission of older people and those with chronic conditions to wards. The DHSSPS should also consult with the HSC Trusts, GPs, care home providers and relevant community and voluntary organisations, to develop a policy aimed at addressing the inappropriate transfer of older people to EDs for end-of-life care. (p32, p58)
9. The RQIA should ensure through inspection of EDs and nursing homes that nursing home residents are neither inappropriately transferred nor left unaccompanied in EDs. (p93)
10. The DHSSPS should expedite the introduction of a statutory duty of candour on all HSC Trusts and independent health care providers. (p93)
11. The regional data for monitoring health care

services, including presentations at EDs should be expanded by the DHSSPS to include all of the categories regarded as a minimum by the Special Rapporteur, namely: sex, race, ethnicity, rural/urban and socio-economic status. (p46, p54, p70)

12. The DHSSPS should review and determine the utility of the four hour target alongside developing other quality measures of care within EDs for implementation across all HSC Trusts. (p39)
13. The HSCB should ensure that HSC Trusts publish waiting times for persons presenting to EDs in mental health crisis and monitor and report on compliance. (p53)
14. The HSCB and one or more Health and Social Care Trusts should pilot and evaluate a human rights based approach to care in EDs. (p121)
15. The HSCB should ensure that individual HSC Trusts identified good practice initiatives are rolled out on a regional basis. (p25, p26, p97)
16. The HCSB should provide clarity on staffing levels when commissioning services from the HSC Trusts to support long term financial planning. This should include the number and skills mix required in EDs, the need to ensure sufficient numbers at the right grade to manage staff turnover and facilitate attendance at training. (p43)
17. The HSCB should ensure that training on human rights, equality and non-discrimination, are explicitly required for ED staff. (p25, p43, p72)
18. The HSCB should develop a regional protocol to reduce the incidence of, and to deal with, persons who leave EDs untreated and subsequently become treated as missing persons. (p61, p62)
19. The HSC Trusts should review mechanisms for encouraging the reporting of Adverse Incidents and the provision made to ensure staff feedback and dissemination of learning. (p93)
20. The DHSSPS should complete its commitment to introduce a regional morbidity and mortality review system to ensure consistent, timely reporting and routine scrutiny of deaths in EDs. (p112)
21. The HSCB should broaden and deepen feedback and participation from patients and user organisations. This should include securing the long term future of programmes such as the '10,000 Voices' initiative. (p70)
22. HSC Trusts should ensure ongoing improvement in EDs of physical provision for service users with sensory impairments. The HSC Trusts should maximise the use of technology, such as screens displaying information about waiting times in EDs, and do so consistently. This should be undertaken in partnership with representative and user organisations. (p34, p58-59, p63)
23. The expected ratios of sign language interpreters available to EDs across HSC Trusts should be specified by the HSCB. Additionally the HSCB should ensure that the telephone interpreting service includes professional interpreters for the Roma language. (p63, p68)

24. The HSC Trusts should ensure that EDs raise awareness of, and provide accessible information about feedback on, the service provided and complaints procedures. Complainants should receive feedback on the outcome of their complaints. (p115, p116)

Additionally, in order to strengthen the place of international human rights within health care the NIHRC recommends

25. The DHSSPS should engage with the Office of the First Minster and Deputy First Minister to progress a legislative prohibition of discrimination in the provision of health care on grounds of birth, property, or health status. (p54)

26. The DHSSPS should incorporate to greater effect in domestic law the right to the highest attainable standard of physical and mental health. (p93, p95)

Appendix 1
Terms of Reference

1. Introduction

The Northern Ireland Human Rights Commission (the Commission) will conduct a human rights inquiry into emergency health care (the Inquiry). This inquiry is in accordance with Section 69(8) of the Northern Ireland Act 1998, under which the Commission may carry out such investigations as considered necessary or expedient in fulfilling its statutory functions.

The Inquiry will examine the right to health, providing a platform for those directly affected including patients, family members, and health care staff, representatives of professional organisations, trade unions, voluntary and community organisations.

For the purpose of the Inquiry, the Commission will access information from public authorities. The process will also involve witness testimonies, evidence gathering and participation from members of the public, experts and those responsible for service delivery and patient care.

The Inquiry will begin in June 2014 and public hearings will take place throughout Northern Ireland in September and October 2014. The Commission will consider the evidence gathered and publish a final report in April 2015. Conclusions and recommendations for action necessary for the promotion and protection of human rights will be presented to the Northern Ireland Executive and Legislative Assembly in accordance with Section 69(1) and (3) of the Northern Ireland Act 1998.

2. Background

Fulfilling each person's right to health in Northern Ireland requires the Northern Ireland Executive and other relevant public authorities to ensure that a system of health protection is in place, and that this is of good quality, acceptable and accessible to all without discrimination. Good quality care that is effective in practice treats people in a manner that respects their fundamental human rights, including their right to respect for dignity. It is also requires an assurance that there are sufficient numbers, adequate training and support for health care staff. In order to exercise their right to health, people should be provided with appropriate information and enabled to participate in health related decision-making.

Notably, in Northern Ireland, as elsewhere in the UK, there are proposals for significant change to the delivery of health care.[1] If implemented, these proposals will undoubtedly impact on how emergency care is provided. The State's obligation to fulfill the right to health includes the development and implementation of laws, policies and actions that give sufficient recognition to the right to health. In any change process, therefore, an examination of the potential impacts on the right to health is required.

Having completed a scoping exercise in March 2014, taking into account completed[2] and ongoing work[3] in this area, the Commission has concluded that a human rights examination of emergency healthcare is necessary. It is evident that the conditions within A&E departments affect patients' rights to dignity.[4] But the potential impacts on the right to health are not yet

1 HSCB (2011) Transforming Your Care: A Review of Health and Social Care in Northern Ireland, December 2011. In England, a review of urgent and emergency care is also ongoing -- see NHS England (2013) Transforming Urgent and Emergency Care Services in England: End of Phase 1 Report. England: NHS

2 For example, RQIA (2014) Final Report of the Inspection of Unscheduled Care in the Belfast Health and Social Care Trust, 31 January to 3 February 2014. Belfast: RQIA. See also the Patient Client Council (2013) 'Care When I Need It:' A Report on Urgent Care Services, March 2013. Belfast: PCC.

3 An independent review by the RQIA of unscheduled care in the Belfast Trust area and related regional matters is currently underway and due to be published in June 2014 (see Statement to the Assembly by the Minister for Health, Social Services and Public Safety: RQIA review of arrangements for management and co-ordination of unscheduled care in the Belfast HSC Trust and related regional considerations, Monday 10 February 2014 (http://www.dhsspsni.gov.uk/report-eds-statement-100214 [accessed 8 April 2014]); see also the Public Health Agency's '10,000 Voices' project that aims to gather the healthcare experiences of patients and, for its first phase, has focused on unscheduled care http://www.publichealth.hscni.net/publications/10000-voices-improving-patient-experience (accessed 24 April 2014).

4 As above n. 7

established. The extent to which the NI Executive and other relevant public authorities are fulfilling the right to health is therefore the focus of the Commission's inquiry.

3. What does the Inquiry aim to achieve?

The Inquiry aims to:

- Identify the extent to which the legal, policy and regulatory framework for emergency health care respects, protects and fulfils human rights;
- Identify the extent to which the human rights of people seeking emergency care are respected, protected and fulfilled in practice;
- Increase the public's awareness of human rights generally and in the specific context of health care;
- Identify good practice, as well as recommendations for improvements that aim to ensure human rights are respected, protected and fulfilled; and
- Enable the participation of the general public.

4. Terms of Reference

To investigate, through the method of a 'human rights inquiry,' and make recommendations on the extent to which the NI Executive and other public authorities respect, protect and fulfil the human rights of those seeking emergency care. In particular, the Inquiry will examine:

i) Quality

The quality of care, with a particular focus on:

- The right to respect for dignity;
- Responsiveness to need, including the most vulnerable and marginalised members of society;
- The provision of and support for appropriately skilled staff.

ii) Information

- The provision of appropriate information.

iii) Participation

- The participation of patients and their families.

5. How will we conduct the Inquiry?

The inquiry will be carried out by:

- A review of literature and relevant human rights standards and case law;
- A review of legislation, policy and the domestic regulatory framework;
- An analysis of available statistical and qualitative material on emergency care; and,
- A public call for evidence and analysis of data received (see below).

Public call for evidence

The Commission will use a 'human rights inquiry' methodology involving a public call for evidence. The evidence will be collected through:

- A Freephone telephone number;
- Questionnaire;
- Written submissions; and,
- Public hearings (witness testimonies).

Freephone telephone number and questionnaire

People are invited to provide their experiences of emergency care by contacting the Commission using a Freephone telephone number. People who provide evidence might include, for example, patients, family members, and health care staff, representatives of professional organisations, trade unions, voluntary and community organisations.

The telephone evidence will be gathered from 3 June 2014 to 31 July 2014. During this time people can also submit evidence by completing a questionnaire available on the Commission's website or by post. The information gathered by telephone and from the questionnaire will be analysed to:

- Assess areas of concern, as well as good practice that the Commission can potentially examine through its public hearings; and,
- Produce anonymous case studies for, and inform the findings of, the Commission's final report.

Written submissions

Submissions of written evidence will be sought from the Northern Ireland Executive departments and other relevant public authorities. Where appropriate professional organisations, trade unions, voluntary and community organisations will also be invited to submit written evidence.

Public Hearings

The public hearings will take place during September and October 2014. The Commission will hold public hearings in various locations throughout Northern Ireland. Information on how to attend or provide evidence to the public hearings will be available on the Commission's website. At the public hearings the following may be invited to provide witnesses testimonies: patients, family members and carers, elected representatives, representatives of the Northern Ireland Executive departments, representatives of other relevant public authorities, representatives of professional organisations, trade unions, voluntary and community organisations.

6. Timeline

The Inquiry will be launched on 3 June 2014 with the final report published in May 2015.

Appendix 2
Witness list

4 September 2014, Belfast

Witness	Role / Organisation
Edwin Poots MLA	Minister for Health
Dr Michael McBride	Chief Medical Officer
Charlotte McArdle	Chief Nursing Officer
	Belfast HSCT
Martin Dillon	Interim Chief Executive
Bernie Owens	Director of Unscheduled and Acute
Brenda Creaney	Director of Nursing and Patient Experience
Dr Cathy Jack	Medical Director
Maria Dunlop	Carer of patient
Tony Monaghan	Patient
Deirdre Dougal	Patient
	Health & Social Care Board
Valerie Watts	Chief Executive
Michael Bloomfield	Director of Performance & Corporate Services
Dean Sullivan	Director of Commissioning
Pat Cullen	Director of Nursing & Midwifery
Fionnuala McAndrew	Director of Social Care and Children
Claire McGariggle	Family member of patient

5 September 2014, Belfast

Witness	Role / Organisation
	Belfast HSCT
John Maxwell	ED Consultant, RVH
Dr Nick Morse	Ed Consultant, RVH
Geraldine Byers	Nurse Consultant for RVH and Mater Hospital
Dr Clifford Mann	President of the College of Emergency Medicine
Dr Richard Wilson	Chair of the College of Emergency Medicine Northern Ireland
	Belfast HSCT
Mr John Gray	ED Consultant, Mater Hospital
Ms Geraldine Byers	Nurse Consultant for RVH and Mater Hospital
Anne McGettigan	Patient
Matthew Crozier	Mental health advocate

8 September 2014, Bangor

Witness	Role / Organisation
	South Eastern HSCT
Sean McGovern	Clinical Director for Emergency Care
Ruth Watson	Clinical Manager Emergency Care
Jill Fleck	Departmental Manager Lagan Valley and Downe Emergency Departments
Helen Ferguson	Director, Carer's NI
Gail Taylor	Family member
	Ambulance Trust
Liam McIvor	Chief Executive
Brian McNeill	Director of Operations
Dr Nigel Ruddell	Assistant Medical Director
Michelle Lemon	Assistant Director of Human Resources
"Miss C"	Patient
Daryl Cupples	Patient
Barry McKnight	Patient

9 September 2014, Downpatrick

Witness	Role / Organisation
	South Eastern HSCT
Hugh McCaughey	Chief Executive
Seamus McGoran	Director of Hospital Services
Charlie Martyn	Medical Director
Nicki Patterson	Director of Primary Care, Older People and Executive Director of Nursing
Ursula Jess	Family member
Margaret Ritchie MP	Member of Parliament for South Down
Sam Kilpatrick	Patient

10 September 2014, Newry

Witness	Role / Organisation
	Southern HSCT
Mairead McAlinden	Chief Executive
Seamus O'Reilly	Associate Medical Director
Deborah Burns	Director of Acute Services
Dr John Simpson	Medical Director
Gwen Quinn	Patient
Mr S	Family member
	RQIA
Glenn Houston	Chief Executive
Dr David Stewart	Director of Reviews and Medical Director
	Public Health Agency
Pat Cullen	Assistant Director of Nursing, Safety Quality and Patient Experience
Dr Eddie Rooney	Chief Executive
	UNISON
Patricia McKeown	Regional Secretary
Jonathan Swallow	Consultant
Stephanie Greenwood	Northern Health branch
Ray Rafferty	Royal Group of Hospitals branch
Eoin Stewart	Mater Hospital branch

15 September 2014, Armagh

Witness	Role / Organisation
Mrs H	Patient
	Patient Client Council
Maeve Hully	Chief Executive
Louise Skelly	Head of Operations
Dr Paul Darragh	British Medical Association Northern Ireland Council Chair
	Royal College of Nursing Northern Ireland
Janice Smyth	Director
Garrett Martin	Deputy Director
Roisin Devlin	Board member and member of the RCN Northern Ireland Emergency Care Network
	Southern HSCT
Barry Conway	Assistant Director Emergency Department
Mary Burke	Head of Service Emergency Department
Sharon Holmes	Nurse Manager Emergency Department
David Galloway	Director, Royal National Institute of Blind People
Eamon Duffy	Victims of Medical Negligence

16 September 2014, Ballymena

Witness	Role / Organisation
	Northern HSCT
Tony Stevens	Chief Executive
Dr Greg Furness	Clinical Director
Margaret O'Hagan	Director Acute Hospital Services
Olive MacLeod	Director Nursing and User Experience
Noreen McPeak	Patient
Dr. Rosaline Rogers	Patient
Fergus Cumiskey	Managing Director, Contact NI
Clare Law	Family member
Claire Ronald	Full time Official, Chartered Society of Physiotherapy
Janet Fletcher	Society of Radiographers
Kevin McAdam	UNITE
	Northern HSCT
Dr Mark Jenkins	Clinical Lead
Linsey Sheerin	Lead Nurse Emergency Medicine Antrim Area Hospital
Linda Linford	Assistant Director Acute Hospital Services

25 September 2014, Coleraine

Witness	Role / Organisation
Richard and Janet Watson	Patient and family member
Jackie Dempsie	Patient
	Northern HSCT
Dr Aisling Diamond	Clinical Lead
Sister Patricia McKeever	Ward Manager, ED Causeway Area Hospital
Linda Linford	Assistant Director Acute Hospital Services
Elizabeth Byrne	Public Affairs & Campaigning Officer, Alzheimer's Society
Professor Derek Birrell	Professor of Social Policy, University of Ulster

26 September 2014, Derry/Londonderry

Witness	Role / Organisation
	Western HSCT
Elaine Way	Chief Executive
Geraldine McKay	Director of Acute Services
Dr Alan McKinney	Medical Director
	Western HSCT
James Steele	Lead Consultant in Emergency Medicine, Altnagelvin Area Hospital
Isobel McClintock	ED Nurse Manager, Altnagelvin Area Hospital
Gerry Sweeny	Family member
Tony O'Reilly	Patient
Bridie Sheridan PLUS Young Person	Project Manager, Youthlife

7 October 2014, Omagh

Witness	Role / Organisation
Linda Robinson Judith Cross	Chief Executive, Age NI Strategic Policy Advisor (Health & Social Care)
Iris Russell	Family member
Catherine McCrory Peter Donnely Marina Sloan	Willowbank Community Resource Centre
Iris Elliott	Head of Policy & Public Affairs, NIAMH
Dr Maura O'Neill Lynda Gordon Alison Irwin	Assistant Director Performance and Service Improvement (Acting), Western HSCT Head of Equality, Southern HSCT Head of Equality, Northern HSCT
  Joe Lusby Dr Campbell Brown Ronnie Kernaghan	*Western HSCT* Deputy Chief Executive Consultant in Emergency Medicine ED Nurse Manager, South West Acute Hospital
  Dr Ciaran Mullan Paul Cavanagh	*Western Local Commissioning Group* Chair Commissioning Lead, HSCB

8 October 2014, Belfast

Witness	Role / Organisation
Orla Barron Suzanne McCartney Susan Thompson	Health and Social Inequalities Manager, Belfast HSCT Equality Manager, South East HSCT Equality Manager, South East HSCT
Eamonn Donnelly Barbara Purcell	Bryson Charitable Trust Bryson/An Munia Tober Health Support Worker
Monica Wilson	Disability Action
Fiona McLaughlin Frances Murphy Carol McCullough	Rare Disease Partnership
Julie Magee Grace Cassidy Stephanie Green	Belfast Mental Health Rights Group Belfast Mental Health Rights Group Participation and the Practice of Rights Project
  Laurence O'Kane Bride Harkin	*Northern Local Commissioning Group* Interim Chair Assistant Director
  Dr Nigel Campbell Paul Turley	*South East Local Commissioning Group* Chair Commissioning Lead

1 December 2014, Belfast

Witness	Role / Organisation
Jim Wells MLA Jackie Johnston	Minister for Health Director of Secondary Care
Dr Tom Frawley Michaela McAleer	Northern Ireland Ombudsman Director of Health Investigations
Dr Elizabeth Dalzell Dr Karin Jackson Mandy Hawthorne	Paediatric Emergency Medicine Consultant, Royal Belfast Hospital for Sick Children Co-Director, Royal Belfast Hospital for Sick Children ED Sister, Royal Belfast Hospital for Sick Children
Valerie Watts Michael Bloomfield Pat Cullen Dean Sullivan Fionnuala McAndrew	Chief Executive, Health and Social Care Board Director of Performance & Corporate Services Director of Nursing & Midwifery Director of Commissioning Director of Social Care and Children
Chief Inspector	*PSNI*

Contact us

If you would like to know more about the work of the Commission, or any of the services we provide, please contact us.

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