Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Emergency Department Improvement Action Group

20 June 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Emergency Department Improvement Action Group

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Ms Michelle Gildernew
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Ms Margaret Rose McNaughton	Department of Health, Social Services and Public Safety
Mr John Compton	Health and Social Care Board
Ms Mary Hinds	Health and Social Care Board

The Chairperson: I welcome Margaret, Catherine, John and Mary. Catherine, I assume that you are taking the lead; you have been here three weeks in a row. Is Andrew McCormick in the bad books or are you?

Ms Catherine Daly (Department of Health, Social Services and Public Safety): I think that I am in the bad books.

The Chairperson: I will hand over to Catherine for the presentation, after which we will have questions and comments.

Ms Daly: Thanks very much, Chair. My colleagues and I are grateful to the Committee for the opportunity to brief you on the work of the emergency department improvement action group. You know John and Mary from the Health and Social Care Board (HSCB), and Margaret Rose McNaughton is from the Department of Health, Social Services and Public Safety (DHSSPS). We have provided you with a briefing paper, and if you and members are content, Chair, I will outline the background to the establishment of, and the rationale for, the improvement action group. After that, I will be happy to take questions from members.

As outlined in the briefing paper, the emergency department improvement action group was established by the Health and Social Care Board working with the Public Health Agency. It was established in response to concerns expressed by the Minister about performance in emergency

departments in hospitals across Northern Ireland. At the ward sister conference at Mossley Mill in March, he announced the development of an action plan to eliminate, as far as possible, waits of more than 12 hours in emergency departments as part of a determined effort to improve quality of care and the patient experience. At that time, the Minister made it clear that he would not accept poor or substandard services, and he wanted a significant improvement in the performance of emergency departments across Northern Ireland through a broad approach that would involve the entire health service.

In that context, the effectiveness of an emergency department cannot be considered in isolation. It needs to be considered in the context of all parts of the service, because all aspects of Health and Social Care services make essential contributions to ensuring an appropriate flow of patients through the system. This includes not only hospitals but community and primary care. We need to be reassured that all parts of the system are playing their full part, including not only nurses and doctors but social workers, GPs, district nurses and other healthcare professionals working together to deliver care where it is needed. In that context, the improvement action group has, as requested by the Department, been examining and applying the best available evidence-based good practice in whole-system management.

The Minister has set out a range of issues for the group to examine and determine whether enough is being done to improve patient pathways. They include the level of consultant decision-making in emergency departments with regard to discharges; maximising the amount of surgery that can be done on a day case rather than on an inpatient basis; increasing the proportion of patients who are discharged each day who leave a ward by lunchtime; sufficient ward rounds each day to promote early discharge, keeping only the most seriously ill waiting on wards for investigations or procedures that could be done as an outpatient; committing senior nurses to discharging patients over weekends and public holidays; actively tackling delays in discharges into the community; and developing options to deal with the 20% to 30% of patients who turn up inappropriately at emergency departments, such as triage nurses discharging individuals home and providing out-of-hours GP services and minor injuries units on the same site or on an adjacent site.

Those are just a few examples of what the group has been looking at. I am sure that Mary and John will develop on that. The group's work has focused on supporting the trusts to develop sustainable approaches to managing patient flow, including actions to improve key performance and quality measures such as the four-hour performance, the 12-hour performance, ambulance turnaround times, delivery of key process improvements, including effective discharge arrangements, and, very importantly, the patient experience.

The group has also been asked to consider the application of 18 unscheduled care key actions across the trusts. Although the improvement action group's remit extends across all the trusts, there has been a particular focus on hospitals in the Belfast, Northern and South Eastern trusts, where there were particularly high levels of excess hours against the performance targets.

Since the group was established, it has had ongoing contact with the Department to discuss progress. I meet Mary every fortnight, and there have been meetings between John, Mary and the Department. The group has been tasked to report to the Department at the end of June on the changes in performance.

That is an outline of what the group has been set up to do. We are happy to take questions.

The Chairperson: Thank you. I have a couple of questions. The Committee has visited a number of A&E departments, and we were in the Ulster Hospital this morning. I want to place on record the fact that the Committee is well aware that staff across our health service are working very hard. It is not often that we get the opportunity to say that. Whenever we get an opportunity to speak to the media, it is always about negative stories, even though those stories need to be told. However, I am using this opportunity to highlight the good work being done by our staff across the sectors, whether acute or community. People are working very hard.

That said, we cannot shy away from the fact that there are issues, whether structural, managerial or systems. As elected representatives, we have a duty to hold practitioners and people who are in charge to account to ensure that our constituents get the best service. We all have a bit of work to do. Nobody is trying to attack people or to trip them up; we want to ensure that the outcomes are the same. It is useful that we receive documentation sooner rather than later. I will make an appeal to you: if bad news is due to hit the media, let us know. It is useful for us to be aware before we are

doorstepped by journalists. I do not want to come across as criticising journalists because, recently, they have been good in highlighting certain stories.

When I read the briefing paper, it struck me that, until the crises, some of the trusts and senior personnel did not talk to one another. We could get into the nitty-gritty and say that they are meeting about this, that and the other. Also, some A&Es did not talk to one another. That has been my perception. You said that fortnightly meetings are being held between the Department and the improvement action group lead director, which is a useful way to discuss progress. What are the emerging findings? Are you looking at A&Es specifically or all hospitals? Are you looking beyond the trust boundaries? Will the trusts be able to implement the Minister's request so that they are not breaking the four-hour discharge or admission target and the12-hour waiting time target?

Ms Mary Hinds (Health and Social Care Board): I am supported by a small team. Some members of the team are sitting in the Public Gallery so that they can see democracy in action. We held a learning event this morning. It is important that the team sees that you hold us all to account.

All the trusts are making progress, and as Catherine said, we are concentrating on three trusts that have had challenges. You are right, Chair, to say that it is not about A&E only. It is about the whole system of care: the prevention of hospital admissions, how patients come into a hospital, how we move them round a hospital and how we discharge them safely. We have formal meetings with the trusts every week, and they are held to account for their progress from the previous week . My small team and I are in the trusts virtually every day, from early in the morning to late at night. We are undertaking this work in a supportive and challenging way; we are walking the floor with front-line staff to try to get under the skin of the reasons why delays are happening. As I said, there has been good progress across all the trusts.

You asked about trusts talking to one another. It is challenging, because all staff have busy days and busy jobs. There have been particular issues about the repatriation of patients from one trust area to their home or base area. One of the team's roles is to facilitate conversations among trusts. Trusts are busy, and they focus on what they have to do in their day job. It is part of the team's job to try to help them to talk to one another. A couple of team members facilitated discussions among community staff in each trust area so that we can safely discharge patients from, for example, the Belfast Health and Social Care Trust to the Northern Health and Social Care Trust area. We have also facilitated meetings among clinical staff for the transfer of patients with complex clinical needs between one trust area and another.

We are making significant progress on the 12-hour target. If we compare last year's November–June period with this year's, the Royal Victoria Hospital's 12-hour performance improved by over 40%, and the Mater Hospital's improved by over 50%. Not that long ago, the Ulster Hospital had over 150 patients breaching the 12-hour waiting time in one week, but for a number of weeks recently that number had gone down to zero. Antrim Area Hospital improved its performance by some 55% over the same time period. So because of a lot of hard work, those hospitals have made significant progress. It will be challenging to maintain progress, but one of the purposes of the group is to continue to meet the trusts weekly until that is no longer necessary. We have tried to take the work forward in a supportive and facilitatory way rather than operating in a blame culture. We are trying to make progress in a way that will result in sustainable change.

Each trust has approached the issue in a slightly different way. Each trust has unique characteristics and issues that relate to the culture of the community that it serves, which is right. One plaster will not fix all the issues, but there has been good engagement from all the organisations.

The Western Health and Social Care Trust and the Southern Health and Social Care Trust have continued to produce the goods, and they must be congratulated for that. We often talk about the trusts that have challenges, and sometimes those two trusts are forgotten. I want to acknowledge how their hard work makes a difference.

Mr John Compton (Health and Social Care Board): I will follow on with what Mary said about working together. We intend to hold a number of events at which we will bring all the trusts together, and we held a learning event this morning. Each trust had an opportunity to discuss what has happened: what is different, what they are working on, what issues are real problems and what is working successfully. They were able to share and exchange, and individuals could listen and learn. There has been a lot of engagement, for example, between the Western Trust and the Northern Trust, and between the Northern Trust and the Southern Trust, on specific pieces of work that are being undertaken in one place but not in another. That gave people an understanding about issues that

were being handled fundamentally differently in other areas or were being presented in a different way. That all bodes well for the future.

Will everything be done, dusted and fixed by 30 June? The answer is: no, it will not. The reason for that is that we are looking to see whether, other than by exception, we can eradicate 12-hour waiting times. We will then have more work to do to reach the four-hour discharge or admission target and even more work to do on system design and the required changes for looking at the people who come to A&E, what they come for, and so on. The signs are that progress is being made on the 12-hour waiting time target.

I want to reassure the Committee. As part of this morning's event, we had a patient perspective and a Patient and Client Council (PCC) perspective. The event was not simply management speak or profession speak. We had a real live example of what it feels like to be a patient in a certain set of circumstances, because that individual's circumstances often mirrored the critical comments that we heard at other events. It is important to hear the patients' side of the equation, because that adds as much weight to the debate as does a discussion on systems.

The Chairperson: That is quite useful, because we are talking about human beings and people's relatives. I do not want to come across as negative, and I appreciate that you have been in position only since April. Other hospital departments seem to be emerging as a key theme. From what I have seen, A&Es cope quite well, but other parts of hospitals are not supporting A&Es. I do not know whether you heard any of the Assembly's Research and Information Service's briefing on waiting times earlier, but I want to make some comments. A substantial amount of money is being invested to deal with waiting times and all that that entails. I could quote what the Department said in 2009 about waiting times, and I could quote what you have just said. It would be useful to know what changes have been made since April and what you hope to do now. Mary, you may not have that information to hand, but I would like to have it in writing. I do not want to be negative, but I need to be convinced that we will not be at the same place in two months' time. I want to know that we are being proactive. This project cannot be done in isolation. Other hospital areas must have a substantial change of mindset.

Mr Compton: You would have heard a message at this morning's event that the performance of an emergency department is the responsibility not only of the people working there but of the entire hospital. It is equally important for cardiology, general medicine or general surgery to enable delivery on time targets as it is for an emergency department. That is very much a feature of Mary and her team's work.

As you rightly point out, there is effort and energy in emergency departments. They are doing what they can as well as they can, but they need support to be able to discharge people sensibly in the hospital or to work with specialist teams in order to get to a better place. That is all part and parcel of what we are doing.

From a ministerial point of view, the project is time bound to the end of June, but, given the importance of the project, a decision has been taken at board level that it will continue to run. You are quite right that we cannot reach a point at which we have made improvements but then appear to take our foot off the pedal and find ourselves back to where we started in three or four months' time. So we will continue this type of work into the foreseeable future.

The Chairperson: Will you get that update paper to us?

Mr Compton: Yes.

Ms Hinds: I am happy to reassure you that I can produce a paper. If you see the changes demonstrated in a graph, I think that that will reassure you. I could not agree more with your points about the internal processes in a hospital and out of a hospital.

The Chairperson: There are more politics involved in a health service hospital setting than in politics.

Ms Hinds: You could comment; I certainly could not. Everybody's 15 minutes in a hospital counts; it does not matter whether someone is a porter, is responsible for cleaning a ward, is a pharmacist or is a consultant. A staff member's 15 minutes makes a difference to every single patient.

Mr McCarthy: Thank you very much for your presentation. Catherine, you have partly answered my concern. During our visit to Craigavon Area Hospital last week, we learned that people need to be educated about where to go for their healthcare needs other than A&Es. People need to be made aware of alternative facilities.

Your briefing paper refers to the need to reduce hospital-based outpatient appointments and inpatient admissions by increasing the number of GPs with specialist interests. Will you tell us about the line that is taken in 'Transforming Your Care' to develop specialist interests among GPs?

Ms Daly: I will give a general answer, and John may want to elaborate on specialist interests. That context aligns completely with the strategic direction of 'Transforming Your Care' of where services should be. It is about having the right place and the right service.

Mr Compton: That is at the centre of what we are planning. We have worked extensively with the GP body, individually and collectively, and I am pleased to report that they are working constructively with us. At previous Committee meetings, we discussed integrated care partnerships. The establishment of such partnerships will result in GPs working differently. We think that that has the potential to lead to, for example, a 5% reduction in inpatient use of hospitals because individuals' care or treatment will be managed more appropriately.

This morning, we heard about other important elements. Same-day reporting for plain-film chest X-rays for GPs is an issue. A GP could send a patient for a plain-film chest X-ray in the morning, have a report by the evening and be prepared to undertake the management of the case. However, if doctors cannot get that information, they say that they will have to transfer the management of a case to a hospital. Many initiatives are included in integrated care partnerships. More will be said about those in the forthcoming Transforming Your Care document. I am pleased to report that there seems to be a consensus that it is in everybody's best interests that we work differently and in this direction.

Mr McCarthy: The report focuses on the needs of older people, including those with dementia, and the prevention of emergency admissions of older people by providing the correct range of community services. That will provide a far better care setting for older people and vastly reduce the waiting times. I have asked you this question previously, but can we be assured that a full range of community service will be provided when required to keep elderly people out of hospital?

Mr Compton: That is clearly the objective. In this project, we are looking specifically at intermediate care. Sometimes, we use the language of "step-up" and "step-down" beds, "pre-hospital" and "immediately post-hospital" which is about allowing people to return home. The project has included a whole set of activities associated with the management of that arrangement. Transforming Your Care is one of the key and central drivers for that. Again, more will be said about that when the report is completed at the end of the month.

Mr McCarthy: Before I finish, I congratulate Craigavon Area Hospital and the Ulster Hospital, which, as the Chair said, we visited this morning. Everybody is working flat out and doing a good job, which is excellent. I hope that that was not because we were there. *[Laughter.]* What we saw at Craigavon last week was fantastic, and the Ulster Hospital this morning was very good, with everybody working hard and dedicated to their work. Let us hope that it continues.

Ms Daly: The Minister often makes the same point about the tremendous workforce in the health service and the tremendous job being done. When we have difficulties such as the one that we are discussing today, we need to ensure that our efforts are focused on addressing them and doing everything that we can to support the trusts and the board in moving forward. I completely agree with your comments on the workforce.

Mr McCarthy: We will congratulate you when the job is being done, but we will criticise you when it is not.

The Chairperson: That is why I would appreciate the Committee getting a written report on the work that Mary has done between then and now and the work that she will do. I could quote what was said in 2009. I am not saying that I do not believe you, Mary, but I do not believe you.

Mr Wells: I do not know whether you had a chance to hear 'The Stephen Nolan Show' this morning, but there was the most wonderful interview with a 93-year-old who had experience of the Ulster Hospital in Dundonald. If you get a chance, you should listen to it on iPlayer.

The Chairperson: It was really Jim. *[Laughter.]*

Mr Wells: He was 93 years old — I might feel as though I am 93, but I am not quite there yet. It was the most extraordinary interview that I have ever heard, and the health service came out of it very well.

We recently visited Craigavon Area Hospital, and we were at the Ulster Hospital this morning. Last Thursday, I visited the wonderful new facility in Enniskillen, which is where A&E meets 'Star Trek'. It is an extraordinary building, and all the other trusts will be desperately envious when they see it. It has been very interesting to visit the various hospitals.

I see that, once again, the Southern Trust is top of the league in the tables provided by the Department. When I asked each trust why there is a disparity in the figures, the primary reason given for the Southern Trust and Western Trust coming out well is that they can attract and retain consultants and senior health professionals, which other trusts have difficulties doing. Interestingly, Craigavon recently advertised three posts and filled them almost immediately, whereas other trusts are struggling.

Secondly, and I think that this is a valid argument, the Southern Trust, in particular, has large units such as Lurgan Hospital and the South Tyrone Hospital, to which it can decant patients from the acute hospitals into the second level of care. There are, for instance, 120 beds available in the old hospital in Lurgan. Other trusts do not have that option, which means that there is a bit of bed blocking, because there are folks whom they simply cannot get on to the next stage of care. Historically, the Southern Trust closed a lot of A&Es but retained the bed capacity, so it has that option. Therefore, its figures, say the trusts, are bound to be better, whereas the South Eastern Trust would say that it has less than half of that capacity available.

Finally, there is a belief that some trusts fared better in the funding packages than others. Although the trusts may all be the same size, some receive higher per capita funding, so they are bound to perform better. I am saying only what the other trusts are saying to me, but could there be some validity in the claims that we are not comparing like with like with some of the statistics and that some trusts are, therefore, much better off in terms of resources?

Mr Compton: It can never be said that there is no validity in the perception of staff of why things do or do not work. It would be entirely false to dismiss that perception. You raised the capitation argument — the fair shares in money argument — but the Southern Trust is, in fact, the one furthest adrift from receiving what is meant to be its fair share, and even that is only by one or two percentage points. Funding is very nearly equitable across the area, so I do not think that that argument holds particularly true.

To facilitate the recent changes and temporary arrangements at the City Hospital, we made substantial investments in the Belfast Trust and the South Eastern Trust to ensure that they were put in place in a sensible and orderly way, so there is no issue there.

Recruitment is always a slight problem. Northern Ireland is a small place, and sometimes people choose to apply for jobs so that they can, for example, work with certain colleagues, although that can work both ways. At certain times, some organisations find it more difficult than others to recruit, but there is no historical pattern of any organisation simply being unable to recruit. One issue with recruitment is that those living in the greater Belfast area can work in four of the five trust areas. They cannot work in the Western Trust area because it is too far away and too difficult. So the apparent recruitment issues in the Western Trust may arise because of the requirement to relocate. However, the Western Trust's accident and emergency performance is excellent, so any link to the disparity in figures is not borne out.

I am sure that some components of what you said, Jim, play a part, but the explanation for the disparity is much more straightforward. It is more to do with how the organisations approach the task of managing emergency departments. At today's learning event, we asked everybody who attended to listen to what works well elsewhere. We asked them to think about that, take it on board and tell us what works really well for them so that everybody could benefit from the sharing of views.

Intermediate care beds are available to all the organisations, and, in fact, the Southern Trust does not have access to the largest number in the Province. It is more a matter of the system of using them and the processes by which that has happened. Simply put, the Southern Trust may have organised its beds slightly better than other trusts. That is another area about which we will talk to the other trusts. Honestly, it would be lovely if only one or two issues were involved because I am sure that we could fix those, but it is more complicated than that.

Mr Wells: Am I right in thinking that the Southern Trust has more intermediate care beds than any other trust?

Mr Compton: No, it does not.

Mr Wells: So its having the best performance cannot be explained by that.

Mr Compton: No.

Ms Hinds: The Western Trust is unique in how hospital and community staff work together. For over two years, leadership walk arounds have started at 8.30 every morning. Senior staff from the hospital and community, and social care doctors, go round the wards to assess whether any patients no longer need to be in hospital and to ensure that any so assessed are placed appropriately. Their uniquely integrated way of working is quite exceptional.

Mr Wells: Last week, when we visited Craigavon Area Hospital, it was a case of before and after. A few years ago, its position was similar to the Northern Trust's today. Staff outlined the changes that had been introduced, and the hospital is now run with military precision. Twice a day, notes showing exactly where they stand appear on staff's BlackBerries. I am pleased to hear that you had a sharing experience this morning, but that begs the question of why, if various trusts were getting it right earlier, more sharing did not happen sooner.

Mr Compton: We have always worked with the trusts on their performance, and there is now a renewed vigour to that. It is not that we ignored issues. As discussed with the Committee previously, we were closely involved in dealing with all the complications that occurred in the Northern Trust area. Over time, there has been a lot of ongoing contact with the organisations. The approach that we have commenced is very much one that involves our being on the ground all the time, often from 7.00 am until 10.00 pm and at weekends. That is a different approach. Although the programme of work continues until 30 June, we have already taken the decision to continue to work in this way. It will be slightly different, and we will tweak it, but the principles will be the same. We will not return to what did not work as well as it should have.

Mr Wells: Finally, as you know, there has been a freeze on posts for over two years now. Therefore, when a member of staff leaves, a business case must be submitted for his or her replacement, and if that does not happen, the post is frozen. That is one of the ways in which you have stayed within your budgets. Is it the case that some trusts have fared less favourably because of that? Is there an evenness in the number of posts frozen?

Mr Compton: Again, the situation is not quite as you describe it. Sometimes, workforce control simply happens, as opposed to being planned, so, in some areas, people may leave jobs that we might not want them to leave. We have been quite clear about that. When we instructed the Northern Trust, for example, to regularise its nursing position, it recruited 40 nurses to sort out the workforce control issues that were causing it untold difficulties. The trust had to deal with the very complicated situation of moving a group of staff from one place to another, which required it to manage all sorts of compelling and difficult issues.

Another issue that we have addressed, which is sometimes referred to, is that workforce control falls unfairly on the allied health professions, whose workforce is largely younger females. From our demand/capacity analysis, we know how many staff are in post and, therefore, how many patients can be seen. We do the maths, which gives us a capacity and, therefore, an expectation of what is being done.

All of that changes what might be described as the potential for haphazard workforce control, although I am not saying that that happened. We are very sensitive to and mindful of that. So workforce

control will not happen in a way that creates unreasonable difficulties for staff. In the end, we must make their task doable.

Mr Wells: So the differing numbers of posts frozen does not explain the variation in the figures?

Mr Compton: No. There are many other linkages to consider before it could be said that there is a straight line between one and the other.

Mr McDevitt: Thank you very much. I have a couple of questions, the first of which is about the composition of the action group. Who speaks for GPs and primary carers?

Ms Hinds: A colleague from integrated care, who is a general practitioner, joins us. We have also had regular meetings with local GPs where appropriate, particularly in the Northern Trust area, where we are trying to help to facilitate some ambulatory care pathways.

Mr McDevitt: So the group is bigger than the team members?

Ms Hinds: Yes. We have input from a senior nurse, allied health professions, social care, public health medicine and general practice. We also get support from our colleagues in information and some business administrative support. We call on other colleagues as we need them.

Mr McDevitt: Mary, who in the group speaks for the Ambulance Service?

Ms Hinds: At this stage, no one. However, the Ambulance Service is part of our engagement, and we meet to talk about specific issues. The Ambulance Service is unique in being the oil that makes much of the rest of the system work. As we move towards what is potentially a slightly more complex pattern of services, with hospitals taking on unique and individual roles, patients will move between them. The issue of how to transfer patients safely between institutions and to and from home is quite significant.

Mr McDevitt: In Craigavon last week, staff said that the next stage for ambulance/paramedic teams will be to take, let us say, a geriatric patient to an ambulance for treatment and then take him or her back home. So ambulance staff are more than just the oil; they are a critical part of the reform.

Ms Hinds: Absolutely. They are important in how we manage potential falls: how people are seen, treated and left in their home. I think that it was Mr McCarthy who mentioned the care of older people. Also, how we see and treat the frail and the elderly at night becomes significant.

To be fair to the group, our concentration has been on trying to deal with the most stark problem: the 12-hour breaches and how we manage the system of care. We have been engaging with the Ambulance Service, which, earlier today, gave a presentation to the trusts on areas beyond those normally associated with traditional ambulance practice in which it thought that it could make a more positive contribution.

Mr McDevitt: Will you provide us with the names of the other individuals in supporting roles?

Ms Hinds: Surely. I will do that as part of the report, if you are happy with that.

Mr McDevitt: There has been a debate on the whole question of emergency care policy and whether it is a good idea to have one. What is your view?

Ms Hinds: What do you mean by "emergency care policy"?

Mr McDevitt: As I understand it, two trusts have an emergency care policy. The Department told us that two trusts have a written policy on emergency care; the rest do not. I am curious about whether having an emergency care policy is important. If it is, why are the worst-performing trusts the two that have a policy? If it is not important, why did the Department raise the issue with us?

Ms Hinds: I am patient-focused: I focus on areas in which things do not work for patients, policy or not.

Mr McDevitt: Maybe I will illustrate —

The Chairperson: Sorry, but on that point, so that we do not lose sight of it, did you know, Mary, that there was —

Ms Hinds: I do not understand what you are getting at. I may know what it is when —

The Chairperson: I take it that you did not know.

Mr McDevitt: We are told:

> *"The Belfast HSC Trust has a number of policies and plans which cover their emergency department. Similarly the Northern Trust has an emergency department handbook for each of their two hospital Type 1 emergency departments. The other three Trusts do not have a specific emergency care policy. It is important to note that the work being carried out by the Improvement Action Group will ensure all Trusts adhere to best practice guidelines flowing from the work of that Group."*

We are being told, Mary, that this will be a major output of your work. Maybe it is a question of semantics.

Ms Hinds: It may be. My group's focus is on improving patient care, whether through reducing 12-hour breaches, meeting four-hour targets or anything else that contributes to the efficient delivery of emergency care services in a patient's home or in an A&E department. Perhaps we are alluding to the 18 key actions that tend to turn up in discussions. Those are evidence-based actions that will make the whole service better. If you add all that up, together with a range of other factors, you end up with a procedure, a policy, a description or a thing. As long as whatever it is makes care better for patients, I do not particularly care what you call it.

Mr McDevitt: A description, a thing — OK. Will one of the outputs of your work be a policy, which has a certain standing in various places, including the Assembly? Will it be a framework, an operational plan or a series of standards? Will it be of a regulatory standard? Will the Department monitor it? What role will the Chief Medical Officer play? We need clarity on all that.

Ms Daly: Absolutely. I will backtrack a wee bit to give some clarity on the issue raised in response to correspondence from the Committee. We looked at which trusts had explicit documents that detailed their emergency care policies. Some trusts did; others did not. That does not mean that they do not have a policy in place.

The Chairperson: Mary Hinds was appointed in April to deal with this. As she sits here now, she did not know about it. There is a breakdown at that level. It goes back to what I said at the start: it is a systems issue and a managerial issue. We can get into a play on words. I want the information in writing from you, Mary, because I can quote what was said in 2009. The issue is the difference between what the Department is telling us and what Mary, as the lead person, knows, regardless of how it is described or its title. We need an update on what has happened between April and now.

Mr Compton: It is important that we clear that up. If there is a real issue, we say that there is a real issue, and it is as straightforward as that. In answer to your particular question, the board has commissioner specifications. When we produce our commissioning plan, we tell each organisation what we want from its emergency department. The plan may specify that senior doctors should be on the floor from 8.00 am to 10.00 pm, and it may contain a series of quality standards, and so on. That is uniform, and that is understood. The plan is clear and applies across, if you like, the Northern Ireland situation. It builds on and extrapolates from the evidence of what in a specification makes an emergency department a successfully functioning department. We then have a debate and discussion with the organisation through the local commissioning groups or the Health and Social Care Board, depending on the nature of the debate, about whether the cash allowance that we propose for the running of the service is reasonable, fair and equitable. As you might imagine, those debates are sparky enough at times, but we tend to get to a position of accommodation, and we work out a way to handle it. The commissioner specification is a very important document that sets a standard of expectation: what a member of the public might expect to see and experience when he or she uses the emergency departments.

Mr McDevitt: Chair, could I just —

The Chairperson: Sorry to do this, Conall.

Mr McDevitt: No, that is OK.

The Chairperson: Mary, the response from the Department states:

> *"the Northern Trust has an emergency department handbook for each of their two hospital Type 1 emergency departments."*

On the day that you arrived at Antrim Area Hospital's emergency department, did anyone say to you, "We have a handbook"?

Ms Hinds: No, but I probably did not ask for one. On the day that I arrived, I walked around and stayed in the department to see how it worked. A handbook is a handbook, and a handbook that describes what each unit does is slightly different from a policy.

The Chairperson: Maybe you should ask the Department what it meant. I am concerned that this is the response that we received from the Department, yet you are dealing with the issue at the coalface, and you do not know about it.

Ms Hinds: We will clear it up and get back to you.

The Chairperson: It is alarming. Sorry, Conall.

Mr McDevitt: That is OK. I was curious about that as well. I saw that the language used was different, which is why I asked the question.

I have questions on a couple of other areas. It seems to me that everyone is settled on the estimate of 20% to 30% of attendances being inappropriate. Is that the case?

Ms Hinds: There is a range of evidence. The word "inappropriate" is not always helpful. Sometimes, people attend A&E because they have no alternative. Some patients might take offence at being termed "inappropriate" attenders. Are there alternatives to which a patient can go? Yes, of course there are. If you look at the evidence, you will see that the that figure probably shifts between 5% and 20%, depending on whom you talk to. There is potentially scope for more patients to go to primary care; there is perhaps scope for a greater role for our minor injuries service. That is the whole system of emergency care services. However, you are right: 30% appears in some evidence; it is not consistently in all evidence. Some trusts are testing having general practitioners in the emergency department or co-located with it to see whether that steers some patients away from the A&E department. However, I would not like to use the term "inappropriate" patients.

Mr McDevitt: This morning, I had a private conversation with someone about that very example this morning. I will not go into it in detail, as it would not be fair to do so in public session.

May I try to nail you down on the figure, Mary — or Catherine, John or Margaret? I am looking at a departmental response, which states:

> *"However estimates are that around 20-30% of attendances are inappropriate."*

That is the paper's language, not mine. You have said that it is more like 5% to 20%. Where does the figure of 30% come from?

Ms Margaret Rose McNaughton (Department of Health, Social Services and Public Safety): Perhaps I can answer that. The figure came from a Southern Trust survey a while back, because there were no hard and fast figures. I think that the figure was given in response to a question from an Assembly researcher, and, at the time, we had absolutely no figures.

Mr McDevitt: I am concerned about data. The Committee asked a series of questions of the Department. Most of the answers were to the effect that the Department could not provide the requested information because it would be disproportionately costly. We asked, for example, which months tended to be the busiest for A&E and whether weekends were generally busier than weekdays. We were told:

> *"Information on emergency care attendances by day of the week is not collected by the Department and could only be provided at disproportionate cost. Information on number of new and unplanned attendances is available on a monthly basis and information for the past 15 months is published quarterly."*

Obviously, all this data is available; it is just not being collated. To say that it is unavailable is not true; it is available and collected somewhere. As a group, do you think that there is an issue with how we collect data and what we know? Are there, to quote Donald Rumsfeld, "known knowns" and "known unknowns"? Does this issue hinder your ability to conduct the review properly at a regional level?

Ms Hinds: I will start, and John may wish to add something. We collect a lot of data routinely, and the team and I use that data daily. The detail of that data goes down to attendances by time of day, never mind by day, because each trust is different. You will see, for example, a peak in attendances at the Ulster Hospital on a Friday but that the opposite applies in other trust areas. There is a pattern of attendance to some degree. Often, people look at A&E and see chaos and unpredictability, but there is a certain predictability to some of the figures.

Mr McDevitt: So you can tell me which days of the week are busiest.

Ms Hinds: In some trusts, yes, because there is a pattern, and we look at the minutiae of that every day.

Mr McDevitt: This is quite important, because the reply from the Department is that it cannot tell me what days and/or months are busiest.

Ms Hinds: Perhaps we can do so because of this project, which means that we look at the data every single day.

The Chairperson: Maybe we should give you a copy of what the Department sent to us, Mary, and maybe you should talk to the Department. When we were at the Ulster Hospital this morning, hospital representatives were able to give us their figures; we were in Craigavon last week, and that hospital's representatives were able to give us their figures. Every hospital that we visited knew its figures.

Mr McDevitt: Yes.

Mr Compton: Again, it is all about context, questions and answers, and so on. Without cutting across, we have information. We are aware of daily attendances across Northern Ireland, which is, as you might expect, materially very important for us. When we plan for change, for example, it is very important that we have that information, because we have to make judgements and assumptions about what way that information is likely to affect other facilities.

Having a routine collection point and having information are two different things. We have a set of standardised routine information documents that the board exchanges, on request, with the Department. I suspect that the departmental response is stating that there is no routine request for information on the busiest days for A&Es. If the Department were to ask us what we could reasonably supply routinely, I am sure that we could provide proportionate and sensible information. You are right that we could spend a lot of time getting a lot of information, but you want information that is meaningful, sensible and appropriate. You are right that every single A&E department knows exactly what its daily take is and the time of day at which it is most likely to be at its busiest.

Mr McDevitt: Chair, I think that your suggestion is absolutely right. I do not wish to pursue the matter in public, because I think that it would only get worse, and I do not want that to be the case, because that is not what I set out to achieve. However, I want to make an observation: this is supposed to be a regional review, and it is supposed to be so because there was a problem. It strikes me that it is very difficult to scrutinise a regional review if we are being told that regional data does not exist, even though, clearly, it does. I do not know whether that is a systems breakdown that is indicative of other

system breakdowns that the review is looking at or whether it is just bad luck on someone's behalf. I will leave it at that.

The Chairperson: We will give Mary a copy of the departmental response. Conall is right in saying that we are very conscious that a decision made in one A&E will have an impact on another. If you are not looking beyond trust boundaries, whether that applies to the Department, the board or the Public Health Agency, questions need to be asked. We will leave that for now and come back to it.

Ms Gildernew: You are very welcome, and thank you for your presentation. Mary, I was glad to hear you recognise that the Western Trust and Southern Trust have performed very well in the past number of years.

Mr Wells: That is because it is your area.

Ms Gildernew: It is my area, and I am very proud that it is my area.

Mr Wells: I never boast about the Southern Trust.

Ms Gildernew: You have the Southern Trust to boast about, and I have the Western Trust. It is no coincidence that both are under the excellent leadership of two very capable women. *[Laughter.]* I do not think that that should go unsaid.

In the past, the Western Trust has had its difficulties with attracting and retaining staff. I do not think that those difficulties are necessarily over, and we have to be pragmatic enough to realise that. Recently, I heard, anecdotally, about a number of people who had applied to work in Altnagelvin and were interested in training there. However, they were sent to Newcastle in England for training. There are issues about where we send people. If people train in a certain place and are based there for a period, the chances are that they will meet somebody, settle and not come back. Three people who wanted to work in Altnagelvin in the Western Trust area were sent across the water. That is not good enough. I know that we planned to invite the medical and dental training agency (NIMDTA) to the Committee to discuss this issue. I accept that it is not your fault, but I also know that the Erne Hospital had to close obstetrics and gynaecology some years ago because of this very issue. It is not an issue to which any area is immune, but we are probably more vulnerable to it in the west than other areas would be. However, that can be a strength as well as a weakness. People who decide to live and raise their families there are part of that community. That came across strongly when we went to Daisy Hill Hospital to talk to some of the emergency department staff. They knew that they were part of the fabric of that community and were very committed to the people whom they served. The chief executive gave a great commendation of Daisy Hill A&E in particular. She praised how people gel together and work as a team and said that Daisy Hill's success was down to the people who lived and worked there and were part of that community. We can look at it as a weakness, but if we get the right people into those positions, it can also be a strength .

I was also at the new hospital in Enniskillen last week, and it is amazing — a fantastic facility. I was proud that, when we went to see the MRI scanner, we met two people who had been attracted to the new hospital from the private sector. That is a really good omen and bodes so well for the opening of the new hospital and its future. Staff said that the MRI scanner would run at full tilt, which means, I suppose, from 9.00 am to 5.00 pm on Monday to Friday, but that they were willing to move to additional working hours if they get the staff and the throughput of patients to do so. The diagnostic facilities include X-rays being viewable anywhere. The technology in that hospital will, I hope, enable staff to work even better in the future.

At Craigavon Area Hospital, we heard that GPs in the out-of-hours service sent people to the emergency department, and an interesting element of Enniskillen's emergency department is that the pathway goes both ways. So somebody arriving at the emergency department in Enniskillen who would be more appropriately cared for by the co-located out-of-hours service would be referred there, and vice versa. We need to consider applying that across the board.

The minor injuries units in the Southern Trust are one of its strengths. The fact that people can be seen there takes pressure off A&E and changes the culture of, if you like, appropriate self-referral. A patient who knows that he or she has a minor injury faces an average treatment time of only 24 minutes — in and out — in the South Tyrone minor injuries unit. Craigavon Area Hospital has done very well with its four-hour target, but there is an awful lot to be said for patients arriving, being seen and getting out in 24 minutes. Therefore, the culture is changing as well.

The Chairperson: I am giving Michelle a lot of time because it is her last Committee meeting. I am sure that she will come to a question.

Ms Gildernew: The culture is such that fewer people land at the emergency department because a ring is stuck on their finger and for other stupid reasons that we hear about on the 'The Stephen Nolan Show'.

The Chairperson: She has now covered every local paper. *[Laughter.]*

Ms Gildernew: My question is about ambulances —

Mr Dunne: A question — what a relief.

Ms Gildernew: Gordon, I can still reach you. *[Laughter.]* At present, ambulances cannot decant patients at a minor injuries unit. That needs to be looked at. If somebody calls for an ambulance, and the crew of that ambulance can carry out the triage, surely the ambulance can take any appropriate cases to a minor injuries unit. I would like to hear your thoughts on that.

Part of my constituency is on the border. I know that we asked for information about out-of-hours services, but I would also like to hear formally from the Department about ambulatory services on the border. At present, for people who have an accidental fall in Emyvale, which is four miles from Aughnacloy, the nearest hospital is Craigavon, but they are taken to Cavan General Hospital. That does not make sense. We need more pragmatic working along the border to ensure that people get the right level of care and are seen as quickly and efficiently as possible. So —

Mr Dunne: That was some speech.

Ms Gildernew: Are you impressed, Gordon?

Mr Dunne: Very. *[Laughter.]*

Ms Gildernew: You should have been here in 1998, when I made my first speech — it was terrible. *[Laughter.]*

The Chairperson: She has improved since then.

Mr Dunne: We will miss you.

Ms Gildernew: I am sure you will. We have said that it has been done really well elsewhere, and it is being done right. Ambulances are a big factor in that.

Mr McCallister: You do know that you are leaving in July?

Ms Gildernew: Yes. That will do me.

The Chairperson: I would appreciate short answers.

Ms Hinds: I will build on what I said to Mr McDevitt. You are absolutely right about the Ambulance Service. The ability to pick up, see, treat and leave, or to bring a patient to somewhere other than an A&E department, would be a new departure, and the Ambulance Service is keen to look at that. We are keen to look at it with the Ambulance Service, and we will keep those discussions going.

Ms Gildernew: What about the cross-border issue? Will you come back to me on that?

Mr Compton: When you receive the population plans, you should not be surprised if they include something along those lines and refer to a different way to handle ambulances. That will clearly be a matter of fact. We have been in discussion with colleagues in Dublin, who have strongly signalled that they want a different relationship not only with the south-west but throughout the border region. We continue to meet them to understand specifically what they want us to do, and we are open to a

collaborative response. This is about people and the most sensible options for them. Clearly, certain issues to do with timing are sensible. With the opening of the new hospital in Enniskillen, it is sensible to have an understanding of what we should do in that arena for residents on the other side of the border. We want to appreciate and understand that. The development of the cancer facility in Derry is similar. Some weeks ago, I spoke to the new secretary general at a Cooperation and Working Together (CAWT) event, and he signalled that it was interested in particular issues on the south-eastern side of the border. From the point of view of the Department and the board, it is an open door, and we are keen to work sensibly and proportionately with colleagues to reach the best possible solution. It is just common sense. We will keep you advised of what specifically is likely to emerge from all of that.

The Chairperson: You will be glad to know that Gordon is next.

Ms Gildernew: I would never do to Gordon what he did to me.

Mr Dunne: I take it, Chair, that there is very little time left. Thank you very much, panel, for your information. The action group has been going for about two or three months, the intention being to produce a report. I take it that the report is well under way and that it will include recommendations. Conall went into great depth about what you were trying to achieve. I take it that those recommendations will apply across the Department.

Mr Compton: Yes.

Mr Dunne: How will those fit in with the famous Compton report?

Mr Compton: I do not think that you will find that they are inconsistent. At its core, it is about a proper and proportionate response for emergency departments, making sure that people get to the right place for the right support and treatment. I share Mary's view that the word "inappropriate" is not very helpful. It is, however, a signpost. People need to be signposted to a minor injuries facility. If they are older and frailer and can be maintained in their home or in a step-up facility, that is where they should go. In some instances, of course, people should go to hospital. The report will cover all that. I would be very surprised if there were any inconsistency in what emerges from the report.

Mr Dunne: Is the intention that there will be a consistent approach across the trusts as a result of the work that you have carried out?

Mr Compton: It starts not so much with the trusts but with the population. It is about a consistent response to a population, irrespective of where that population lives. There are ways to organise support under the language that we use: trauma, emergency care, urgent care, minor injuries, out-of-hours services and general practitioner care. That will be consistent across the region. Obviously, it will always express itself slightly differently. The way in which a minor injuries unit in Belfast is expressed might be very different from the way in which such a facility is expressed in the Southern Trust. We have to take account of geographical issues and a local expression that reflects a local community and its issues, but the principles will be the same.

Mr Dunne: Our visit to the Ulster Hospital this morning was very useful. We were impressed by the staff's professional approach and their commitment and dedication, but we were concerned about a number of issues. We were concerned about the number of people who go through that hospital, not only in A&E but in the maternity unit, which is a separate issue. The 12-hour breaches at the Ulster Hospital is a big issue that must be addressed. In April, 271 people waited for more than 12 hours in A&E. We are aware of various measures being taken to address the problems. Consultants' job descriptions, for example, have been restructured. Can that be done consistently throughout the trusts?

Mr Compton: The short answer is yes. Substantial negotiations are ongoing on what were referred to this morning as team job descriptions, so that instead of having individual roles, staff will work as members of a team in the delivery of an emergency service. The job description is designed to enable the team to operate in that way.

Mr Dunne: It is all about teamwork.

Another big issue is the flow of people through A&Es and in and out of hospitals. I am sure that you have come across the bottlenecks, which must be highlighted and addressed. Jim made a good point about the alternative outlets that available to some hospitals. We are under the impression that other hospitals in other trusts are not addressing the bottlenecks. How are they being addressed?

The GP out-of-hours service is another issue. It needs to be extended and awareness of it increased. We were impressed with the Southern Trust and Craigavon Area Hospital. I understand that its out-of-hours service is on the same site, so people can be referred from the hospital to the GP service, which is only yards away. That seems to work well and, obviously, has an effect on figures. However, it is not practical for the Ulster Hospital to send people to Ards in the middle of the night. That issue must also be addressed.

You said that 20% to 30% of patients who turn up at hospital do so inappropriately. There is a big concern about how we educate the public. They get a good service, and I have said previously in the Assembly that the health service provided is of a good standard and quality. The problem is getting people into the healthcare system, on the ladder and receiving treatment, because there are delays. When people receive a service, the satisfaction levels are generally high. People are quick to complain, but they also recognise professional standards and what is achieved, which is also noteworthy. Those issues need to be addressed.

Mr Compton: You touch on something fundamental: the entry and exit points, how people get into the system, how they move through it and how they exit it. Much of the discussion at this morning's event focused on the management of entry points, from the front door of a hospital to the centre to the exit point, and finally to the correct place for a patient. The management of the entry and exit points is fundamental. Much of Mary and her team's work has concentrated on streamlining that process and asking why it could not be done in a certain way or whether what works well in one hospital might work equally well in another. The group's work concentrates on specific areas. In one or two hospitals, we tell staff that, working with them, we will concentrate on four wards over a two-week period, during which we want them to work in a certain way. The idea is that we want to enable staff to work in a particular way to find out whether any benefit is derived and whether it changes the arrangements for the entry and exit points. There is a lot of granular, detailed work on that issue.

Mr Dunne: Finally, do you agree that the Ulster Hospital needs a new A&E facility? *[Laughter.]*

Mr Compton: Yes. As you know, the Ulster Hospital is being substantially redeveloped in a phased way, and at some point that will mean a new A&E facility. It is in —

The Chairperson: Gordon, do not be parochial and sexist. We also visited the maternity unit, and you should raise that issue.

Ms Gildernew: Yes, absolutely.

Mr McDevitt: Remember the bid for the maternity unit?

Mr Dunne: Yes. Ironically, the maternity unit is only five years old and, for whatever reasons, is 40% oversubscribed.

Mr McCallister: You must be hoping that —

The Chairperson: For whatever reasons? *[Laughter.]*

Mr Compton: There is only one reason. *[Laughter.]*

Mr Dunne: I do not know.

The Chairperson: We will not go down that road.

Mr Dunne: Thanks very much, Chair.

The Chairperson: We will bring in our chief midwife, John.

Mr Wells: He is the real expert.

Mr McCallister: I was not going to focus on me. *[Laughter.]* Gordon will probably want the hospital named after him. *[Laughter.]*

The Chairperson: Been there, done that.

Mr Dunne: Not after the publicity that you got, John.

Mr McCallister: It was a very interesting visit this morning.

Mr Dunne: Have you been there before, John?

Mr McCallister: Hugh and the team at the South Eastern Trust talked about some issues not being solely time-focused. They said that we should consider other factors, such as what had kicked in and what can be done. Would you like that to be rolled out across the system? It may even be a better way of benchmarking.

Conall asked about monitoring. The message from your presentation is certainly that different elements work well in each trust, so it is a question of how to get all those elements working in all the trusts. Mary said that the interaction between the community and social workers in the Western Trust provided an exemplar for the other trusts. How do we transpose that?

John talked about signposting and pathways through the system, which is better terminology than "inappropriate". It is a question of how that signposting is used to give the public confidence. The system would evolve, but the public do not need to know about that. Patients are simply sent to alternative treatment centres, with the Ambulance Service knowing that those patients do not need to attend a particular A&E, as Michelle pointed out. The practice seems to exist across the service but not in all the right places at all the right times. The challenge for the report is to establish all those best practices in the right places.

Ms Hinds: Part of our job is to get out and make sure that good practices are shared. Indeed, this morning's event was an example of our doing just that. Your comment about other indicators that would more wholesomely describe the quality of care in A&E was well made. Our clinicians are keen to take that forward. We are determined to do that, but we are just as determined to deal with those patients who inappropriately wait for longer than 12 hours. We have to keep our foot on that pedal and improve on the four-hour target. You are absolutely right to say that when we get everybody to a better place, we can then open a discussion on having a broader set of measurable and meaningful metrics, including some on patient experience, which is central to what we are doing. Even now, our focus is on the 12-hour breaches, the four-hour targets, ambulance handover times and many numerical indicators. The way in which we treat every patient entering our A&E departments, whether he or she is there for 30 minutes, four hours or 10 hours, matters significantly. It is central to what we are looking at.

Mr McCallister: However, we do not want the system to become too bureaucratic.

Ms Hinds: Absolutely.

Mr McCallister: We collect all this great data, but that prevents people from doing their jobs.

Ms Hinds: At the centre of all that we do, the target is the target, but we are also trying to improve the safety, quality and patient experience of everybody who interfaces with our A&E departments, because that is what we are about. It is not appropriate, except in very exceptional circumstances, that patients face long delays in A&E. You are right to say that we should not make ourselves so rule bound that we take away professional judgement, which should, however, be open to challenge. We will know the detail of every patient, without an individual indicator, who waits for more than 12 hours in our A&E departments, and everybody will be held to account for that because it is not right.

Mr Compton: There are other measurements to capture the outcomes on how many people leave A&E before being seen and treated, how many reattend within set times and how head injuries are managed. Those are all good things. At this morning's event, we made the important point that, when we reach a position whereby the timeliness of someone being seen is better controlled, we will

definitely proceed to consider those professional matters. That will not be done in a bureaucratic manner, because this is about clinicians — I use that term generically to apply to nurses, allied health professions, doctors and social workers — being skilled and good at designing solutions to situations and then monitoring them. Clinicians should be enabled to do that and not be hidebound by a sense, or even a perception, of bureaucracy. However, first, we need to put things in order and move the timing issue into a different place.

The Chairperson: That wraps up this part of the meeting. Mary, we will send you the departmental response. You can talk to the Department to deal with some outstanding matters and provide us with a written report on the progress since April and what future plans are in place to tackle the issue. Thank you for attending, delivering your presentation and providing the information, whether or not it is right. The Committee will return to the issue, so we will stay in touch.