Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Accident and Emergency Improvement Action Group: DHSSPS/HSCB Briefing

6 February 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	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 Deputy Chairperson [Mr Wells] in the Chair)

The Deputy Chairperson: Ladies and gentlemen, you have all been here many, many times before, and I am sure that members need no introduction from me, particularly to Andrew and John. I welcome you to the hearing. We will try to get through this session in about half an hour, all being well. We have been concerned about A&E performance, and we are grateful that you have come to update us on the current situation. Andrew, you are leading off, and Kieran has already put his name down for a question.

Mr McCarthy: I want to be away by 5.00 pm.

The Deputy Chairperson: We will try to let you in as soon as we can, Kieran.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): I will keep my introduction as brief as I can. We are here to give the Committee an update. The other members of this team were here with you in June and November. I wanted to come along this afternoon simply because we want to underline the fact that the Minister continues to take the issue extremely seriously. In fact, his replies to our updates are continually demanding. As you would expect, he continually looks for improved performance. The Minister has also taken a different tack on the work of the turnaround and support team in the Northern Trust. So we take different approaches to different contexts, and that is the intervention that we have made there. I have just come from a lunchtime meeting with the team. They have been working over the past number of weeks, and I think that their

work is progressing. Our request is that you give that work some time and space to mature, and I am sure that we will see significant improvements as a result because it is going in a good direction.

We have a major task in hand in dealing with this issue, which has built up into a significant problem. John and Mary have done very significant work through the improvement action group over the past year, but we need to see that through and take it on even further. It was a particular concern of the Minister, who focused on 12-hour breaches at the start of last year, and there has been progress there. There are still significant issues, and we are also turning our attention increasingly to the associated target of 95% of patients being seen within four hours, which is another very important aspect of emergency department performance.

I stress that we do not look only at performance targets. The first obligation and requirement on us all, as leaders in health and social care, is the quality and safety of what we provide to patients. High-quality services, safe services and good patient experience are the three most important elements, especially safety. We need to secure good financial management and good performance, but, in managing those together, we do not allow one to be traded off against another. We put the patient at the centre — that is fundamental.

Members have our briefing paper, which details the numbers for November and December. We do not yet have validated information for January, but the emerging information is that January is still showing a significant problem, particularly in two hospitals. There is, however, a significant improvement compared with this time last year. So winter 2012-13 has been markedly better than winter 2011-12, and the clear position is one of very few, if any, 12-hour breaches in the Belfast, Southern and Western Trusts.

There are two generic types of issue: the longstanding issues, which we are tackling through the turnaround team in Antrim and looking particularly at the Northern Trust position. The idea behind the team is to get right to the heart of the issues, work to support the trust to secure sustainable corrective action and make sure that good practice is applied. There is a long way to go, but very good progress is being made. More recently, starting from mid-autumn onwards, there has been a difficult issue in the South Eastern Trust, predominantly in the Ulster Hospital. The key focus of work — I am sure that John and Mary will say more about this — is to assess to what extent it is to do with capacity. We will get to the root causes. We think that the root causes are different in the two situations that we face, and, therefore, we need different kinds of interventions. We need to make sure that our interventions are informed and wise.

That is all work in progress. There has been a strong signal from the Minister, as from the Committee, that we should continue to give this issue priority and make a difference. There are some areas of strong performance and certainly no question at all about the commitment and dedication of the staff who deliver the service, day in, day out, 24/7 across the sites. The issue is how the service is led and managed, how the different aspects of the service work together and how we secure the commitment and engagement of the leadership teams across all the different professional and managerial groupings.

A major issue is looking at the trends in demand. We know that there are predictable times when demand increases, so we need to make sure that the capacity is managed and deployed in line with that information. Of course, there is also the need to cope with what emerges by way of flu and vomiting bugs, some of which emerged earlier than usual in this winter cycle.

That requires continuous oversight and management and some capacity to be flexible with staffing levels and bed numbers as appropriate. It is a matter of keeping on top of it all of the time. In securing the best possible outcomes, we must look, in particular, at the way in which the service is delivered and whether there is an effective and real process of clinical prioritisation. We do not just look at the headline numbers but at the total quality of the service being delivered, and we seek to manage that in the best possible way.

Ms Mary Hinds (Health and Social Care Board): Chair, I will give you a high-level summary. Briefly, I will talk through the activity from November to January. Although the information has not yet been validated by departmental colleagues, I think that it is reasonably up to date and accurate. It will, at least, give you a theme of what is going on in the system of care. I will look a little bit at activity and at four- and 12-hour performances. I will provide some commentary on December given that it was the holiday period. I will also talk a little about the Northern Ireland Ambulance Service because Committee members asked specifically about that when I was last here.

First, I advise Committee members that there was an increase of about 3·8% in attendances from November to January compared with the same period last year. Specific increases of note occurred at the Ulster Hospital, where the increase was 6·6%; Antrim Area Hospital, where it was 2·8%; and Craigavon Area Hospital, where it was 4·3%. So the increases were not just in the trusts that are challenged.

From November to January, compared with the same time last year, regionally, there was a 45% reduction in the number of patients who breached 12 hours. In the Northern Trust, the rate was reduced in Antrim Area Hospital by 37%. In the South Eastern Trust, the rate was reduced by 32%. Indeed, as the permanent secretary said, 12-hour breaches are now a rare event in Belfast, which is welcome.

The four-hour performance has not been good. Indeed, as noted at previous Committee meetings, it has slipped in many areas. In the November to January figures, the only marginal improvement is by Craigavon Area Hospital. We will continue to work with the trusts to try to improve performance. It is worth bearing in mind that experience teaches me that the 12-hour target is primarily, but not exclusively, a feature of the entire system of care; the four-hour performance tends to be primarily, but not exclusively, a feature of how the emergency department itself works.

Of note, particularly in December, given that it was during the holiday period, is that the increase in attendances was similar to that for the three-month period. A&E attendances on Christmas Eve and New Year's Eve were, as you would imagine, higher — 17% and 16% respectively — across the piece. Again, the number of breaches stayed in the area that they had been in — in other words, regionally about a 41% reduction.

As Andrew mentioned, there have been issues with norovirus. If norovirus occurs in the community and affects nursing-home beds, that can delay discharges from hospital because a discharge must be safe.

Ambulance diverts have caused some attention in the press. It is worth knowing that, at times of particular pressure, trusts work together to try to manage the flow of GP urgent ambulance calls. Operationally, that means that, at times, we have time-limited diversions of GP urgent calls, particularly across Belfast, the South Eastern Trust and the Northern Trust areas. All trusts have worked in co-operation and partnership to try to manage that process. We are working with all three trusts to see whether we can refine that process a little more so that we can anticipate demand and, therefore, respond to it. We had some diverts in place over the Christmas period and moved patients from the general area of the Ulster Hospital to the Royal Victoria Hospital; from Antrim to the Causeway Hospital, and from Antrim to the Mater Hospital. The movement tends to be small. However, even though small in number, diverts can make a material impact on how A&E departments work.

We continue to work with the Ambulance Service. We have provided it with a live feed of information into the control room to help it to inform decisions about ambulance flows. We are reviewing the process of diverts and considering the zoning of emergency care admissions. We are running learning events, as the Committee knows, and we held one in October. Colleagues from the Pennine Acute Hospitals NHS Trust and the Heart of England NHS Foundation Trust have come across to help colleagues in trusts to improve their performance. We have another learning event scheduled for 17 April, which members may be interested in. Following that, there will be what amounts to an end-of-year report from the improvement action group.

In summary, demand increased over the three-month period, with spikes on Christmas Eve and New Year's Eve. The Ulster Hospital and Craigavon Area Hospital were under particular pressure from increased attendances. The 12-hour wait performance has improved regionally, with a 45% reduction compared with this time last year, with the Southern and Western Trusts continuing their excellent performance. The Belfast Trust showed the best improvement, but the other trusts are working hard with us. The four-hour performance has not been good across the trusts. The Ambulance Service and all trusts have worked in partnership, there have been improvements and we have invested in addressing winter pressures.

Finally, I want to note that each number or percentage is a patient or relative. Every number is somebody's mother, son or a member of our families. We all care about them and are working very hard to make the situation better. I express my thanks to trust staff, who continue to co-operate in this work, particularly those on the front line of care.

The Deputy Chairperson: Thank you, Mary. It is worth recording that Belfast has performed particularly well, considering that it dealt with 13,000 admissions in December and had no waits of over 12 hours at the Royal or the City, with the Mater having only one. That is quite significant. We tend to be negative at times, but that is to be applauded. Of course, the Western and Southern Trusts are having no real difficulties with 12-hour waits.

Still, we have the same two hospitals — Antrim and the Ulster — where this is a problem. As a minor issue but worth noting, Lagan Valley Hospital, of all places, has recorded a high level of 12-hour breaches as a proportion of the patients whom it treats. Out-of-hours A&E has closed at Lagan Valley, so where is the problem there? Does anybody know why it has suddenly appeared on the scene?

Ms Hinds: We are working closely with the trust because we have not got to the root cause. You are quite right that it is unusual to have 12-hour breaches at Lagan Valley. There has been the occasional 12-hour breach at Downe Hospital. I am due to meet the clinicians at Downe Hospital on Friday to discuss what they feel are the issues. We are working closely with the South Eastern Health and Social Care Trust.

The Deputy Chairperson: At Downe, for instance, there were 18 breaches and 1,586 patients. Not a huge number of people go through Downe Hospital, so you would not expect such a large number of 12-hour breaches.

I hate to keep labouring on the Northern Trust, but I have a practical question that John may be able to answer. An extension is being built at the Northern Trust. I had a look around it in August. Will that come online in May?

Mr John Compton (Health and Social Care Board): June.

The Deputy Chairperson: Will that offer extra capacity to help Antrim's situation?

Mr Compton: The short answer is yes. It will do two things. First, the environment in which the emergency department operates will be much improved, which is important for the individuals who attend. An additional 24 beds are coming on site in the hospital. So we think that the overall position will improve. We are talking to the organisation about how best to manage the introduction of the extension and how that will affect the speed of treatment and other areas when it comes online in June.

The Deputy Chairperson: You have spent a lot of time in the Northern Trust. Has the turnaround and support team come up with any initial ideas as to what is causing Antrim in particular to have so many 12-hour waits and so much difficulty with its four-hour turnaround? Is there any inherent reason? Other hospitals handle roughly the same number of patients, yet the performance seems to be considerably lower in Antrim Area Hospital. Are there any thoughts about what is going on?

Mr Compton: The issue, as I understand it from the turnaround team, is that there is no one, simple explanation. If there was, I am sure that we would all have got to it and responded appropriately. It is fair to say that we are waiting for the turnaround team to come back with its diagnostic appraisal. Andrew may have more information on that, but I would rather wait until the team reports before making any observation.

Dr McCormick: As I mentioned, I was at a meeting with the team at lunchtime. It is still gathering information and engaging in discussion. In the process of that, the team is starting to make suggestions for change and development, so there is a lot going on. I would like to hold back until we have a more considered formal view from the team. At the heart of this is the set of relationships in the organisation. Much had already been drawn out in the work that Mary and Ian Rutter did last year, and a lot of that is emerging as confirmed.

The question is how to ensure that the trust has the support of the leadership to implement good action. We have an abundance of good ideas about what to do but a deficit in implementing and delivering what is known to be right. So the focus needs to move on soon. As the diagnostic phase of work is ongoing, I agree with John about reserving final comment until we have a more formal report from the team.

The key thing is that good, up-to-date, modern practice is applied to the total management of the trust. As I said earlier, emergency department performance is the tip of an iceberg of issues — it works only if the total system is working. Getting the right relationships and leadership, and engaging and empowering clinicians in leading change, are cultural and behavioural issues that are quite complex in practice, but many of them are people issues. It is about getting people who are confident and empowered to do the right thing: to focus on the patient and to ensure that services are delivered around the needs of those requiring immediate care and those who will need to be cared for tomorrow, next month and next year. All of that requires complex management working, especially the empowered leadership of doctors and nurses across the trusts.

So good work is happening, and the emerging findings are good, but I am not in a position to give you details at this point.

The Deputy Chairperson: The figures that you have given and Mary's update indicate that, again, we have an issue with mid-winter pressures. There is, however, no obvious pressure this year: there is no swine flu, and we are, thankfully, on top of hospital-acquired infections. There have been some indications of an increase in demand, such as the increase of 4·3% in Craigavon. Yet, Craigavon has taken that on the chin and seems to have worked round it. Mid-winter pressures suggest to me things that are unexpected. However, I cannot see anything in this year's figures that is unexpected and could not have been planned for. What happened, particularly at the Ulster, to catch it on the hop?

Mr Compton: The issue in the Ulster Hospital is not just about the winter. There has been a sustained growth in activity coming through the facility. We are in very close negotiations with the Ulster and expect to finalise additional investment for it this week. It is a fairly well-established fact that total activity through the hospital is showing real growth. There has been a very significant rise in the number of admissions. Numbers coming through the front door have increased by, from memory, 6% or 7%, and the acuity of that group's conditions has been greater, which has led to more admissions. We are in the process of finalising the negotiations, after which the hospital will have extra capacity in the facility to deal with that. That reflects Andrew's point: there are different issues in the two arenas where problems currently exist. Our expectation is that, when we confirm the extra capacity, the hospital will be on a different platform three to four months down the line because it will be recruiting additional staff and opening extra beds as a consequence of the negotiations.

The Deputy Chairperson: The Minister has just confirmed that the City A&E is closing permanently. Was that not a temporary arrangement?

Mr Compton: No. A consultation with a series of options on the best way forward for emergency departments west of the Lagan has just gone out to the public arena. The consultation has just commenced and will complete in about 12 weeks from now.

The Deputy Chairperson: Yes, but a major proposal in the consultation is permanent closure.

Mr Compton: Yes, the recommendation, or preferred option, is that it remains shut. It is important to be clear that the Ulster Hospital's problems are not directly attributable to that. Planning was undertaken and £6·6 million was given to the hospital to facilitate the transition, and the numbers turned out to be not too far away from those predicted.

The Ulster Hospital has had, from its own population, an increase in demand for services. That is what we are concentrating on in the current debate. You have to go through a period of demand to confirm that the demand is permanent and not just a temporary and transient arrangement. So we now accept that there is an increase in demand there, and we expect later this week to confirm with the organisation another substantial investment to accommodate that. That should make things much easier at the front door. The Ulster Hospital will say to you, quite reasonably, that its difficulty has not been with the absolute number of people coming through the front door. Instead, the problem has been the acuity and extent of individuals' illnesses and the fact that the conversion rate — the number converted from attendants to inpatients — has jumped markedly.

The Deputy Chairperson: Some of the extra demand at the Ulster Hospital must have arisen from the closure of the A&E at the City Hospital.

Mr Compton: To be honest, only a relatively small amount. At least as big a problem is the demography of the Ulster Hospital's area and the age structure of the people coming to that hospital.

Mr McCarthy: The Deputy Chairperson has explained my concerns about the Ulster Hospital. Ambulance diversion has not been mentioned. I understand that there has been a severe increase in the number of ambulances being diverted from all over the place to the Ulster Hospital, which is contributing to the current crisis. I am glad to hear you say, John, that there will be investment. I am not even sure that there is space there for further capacity. Will you confirm that there is?

Mr Compton: Yes, we are in discussions with the organisation, and I am sure that we will come to an understanding about how to deal with that investment.

In answer to your question about ambulances, we have been very mindful of the Ulster and Belfast interface area. That is a very interesting interface area, particularly when it comes to where ambulances go: sometimes they go to the Royal; sometimes they come to the Ulster. There is no doubt that, for a period around Christmas, the Ulster Hospital was receiving, as a proportion of the total ambulance delivery across Northern Ireland, an abnormal number of ambulances. That is what led us to reflect, as Mary said, on whether we should zone populations. That would determine to which zone someone picked up in an emergency would go, and it is a better way of controlling that.

We have an interim position on what are referred to as "doctor urgents" with the Ambulance Trust, the hospitals in Belfast and the Ulster. So, in all other circumstances, we have asked for an equal flow in both directions of "doctor urgents" in interface areas between the Ulster and the Royal so that they are not all going in the one direction. In the commissioning arrangements for next year, we want to explore whether we should take that a little further through the zoning of populations so that people know what hospital they will go to in an emergency. Undoubtedly, we will talk to you about all of that at a later stage. It is a matter of fact that more ambulances came to the Ulster, and we are working with the Ambulance Trust to ensure a more even spread.

(The Chairperson [Ms S Ramsey] in the Chair)

Mr McCarthy: That created the chaos that there was, and maybe still exists, at the Ulster.

Mr Compton: The hospital was very busy. If you talk to everyone in the Ulster Hospital — Mary and her team were there, so she may be able to make better observations — there was never a sense that the place was in chaos. It felt very busy on occasions, but it was always very controlled in its busyness. Going back to Andrew's point, I reiterate that this is a balancing act between the quality and experience of patients and their outcome. We have no evidence to suggest that, despite the busyness, the efforts and the extra stress on staff, individuals who went to the Ulster had a poorer experience when it came to their clinical presentation. They had very busy days, but we never had the sense — nor did the organisation ever lift the phone to say — that they were in a position where they did not think that they could deal with it. They would certainly have kept us advised that they were very busy and under a lot of pressure, but at no point did anybody raise that sort of issue. It is credit to the clinical staff that that was the case.

Mr McCarthy: Finally, I have to voice my disappointment at the outcome at the City. We were in this room when it was announced that the City A&E was to close temporarily, and we knew that "temporary" meant closure. Despite your answer to Jim Wells, I am convinced that it is going to close. We heard this morning that some of the furniture has been taken away from it already. All I am saying is that I think that it is unfair for whoever is responsible to string people along. They would have been better coming clean at the start and saying that the place was going to close because of staff shortage or whatever. We are going to be strung along for another 13 weeks, before we finally hear that it is closing.

Mr Compton: I think that they have a process. The issue —

Mr McCarthy: No.

Mr Compton: — was that there was an urgent and pressing need to make a change at the City Hospital that we could not avoid. Those circumstances triggered a set of events. That does not remove, in any shape or form, our obligation to do the thing correctly through a public consultation.

Dr McCormick: Clear and well-established consultation procedures are set out that we are obliged to follow. Consultation has to be honest and genuine and about what are realistic and possible future

options. We have to act quickly, as John said, because patient safety trumps the obligation to consult. So, in an immediate crisis, a change must happen immediately. However, such a change, by its nature, is always established as temporary, subject to confirmation of what is realistic and feasible, going forward. That is what the document is now setting out. It draws out very clearly what the realistic options for the future are.

Mr McCarthy: But you know as well as I do that, at the end of that consultation, the doors will shut.

Dr McCormick: That is the nature of the process that we have to go through.

Mr McCarthy: OK.

Ms Brown: Thank you for your presentation, and I apologise for missing the beginning. You will not be surprised that I am going to raise the issue of Antrim hospital. The figures are very disappointing, which is, of course, really nothing new for Antrim and its continued and unfortunate bad press. I am really looking forward to the opening of the new A&E unit and the extra 24 beds. I really hope that that will have an impact on the waiting times in Antrim, because they are a big problem. I know that, recently, there was a communication from the trust to the local GPs, asking them not to — I am not sure what the wording was — unnecessarily refer patients to A&E. Given that and the fact that there is such a bad press in regard to the A&E and waiting times in Antrim, do we have figures? Are the majority of people still presenting themselves to A&E? How could we combat that? You would think that, given the bad press, people would rather head down the road of going to their GP than unnecessarily present themselves. Do we simply not have enough capacity to deal with the queue?

Mr Compton: I will answer one part and let Mary deal with the other. I think that it is important that we are clear about the letter that you referred to. The letter that went out to general practitioners was not saying, "Don't send anybody to Antrim Hospital". When we escalate, and places are under pressure, we ask everybody in the system — first, we tell them what the problem is — to lend assistance in making the system work a little bit more effectively. So, for a 24-hour period or thereabouts, we told general practitioners to be alert to the fact that the place is very busy at this point, and they should reflect on what they wish to do in respect of referring people to the hospital. At no point were we transferring the responsibility; it was simply a request to ask the system to understand the nature of the pressure, just as we would when we talk, in a similar context, to the Ambulance Trust about potential diverts. I know that it got a bit of publicity that seemed to suggest other than that, which is unfortunate, but it is important to put that on record.

Ms Hinds: My little update was around November, December and January, and there has been an increase in the number of attendances both at Antrim and at Causeway Hospital. I hope that that shows that the public have confidence in the services. On that particular day, when they were particularly busy and particularly stretched, I have to say that the trust's response was very good. Senior staff were on the floor from early in the morning. They kept in contact with us and colleagues throughout that whole day. Their entire focus was on what was the right thing to do for the patients who were with them, and that is reassuring. That evening, I joined colleagues, and, although I did not speak to every member of staff, I spoke to staff, and there was a sense of a team pulling together to do the right thing in a very, very difficult situation. That does give you more confidence.

Ms Brown: That is comforting. As you said, the fact that the number of attendances has stayed up is a good sign. News tends to be the bad news and never the good news. You do not get headlines about the confidence that people have in Antrim Area Hospital where people are still arriving by the bucketload. Of the people presenting at A&E, what percentage are self-presenting?

Ms Hinds: I cannot give you a split between those presenting by ambulance and self-attendances, but I do not think that it is anything unusual. I can get that for you.

Ms Brown: Is there a possible proposal to introduce a new 111 phone number as part of Transforming Your Care (TYC)? That kind of system would be very effective in weeding out a lot of people who should be elsewhere and not in A&E.

Mr Compton: I have a couple of observations on that. First, the zoning system that we are talking about, and end-to-end commissioning from level 1 Antrim A&E, right through to GP out of hours is being done as one thing. It is important that they are seen as part of one emergency response service and that the information from the 111 number is able to direct people more appropriately so that they

will be able to ring, have a conversation and go to a more appropriate and better location. It is not about stopping people going anywhere. Sometimes, people will tell you that they arrived in emergency departments because they believed that that was the only place where they could go to have their particular difficulty attended to. In many instances, that is correct, but, in other instances, it is not.

One of the important things for us to understand and appreciate in the middle of all of this is that small numbers make a big difference. We talked about ambulance diverts. For example, if you can divert four or five doctor-urgent ambulances, you will materially change the pattern of behaviour in a hospital. Over a period, it will probably account for the equivalent of 12 to 15 beds in that hospital. Small numbers are really important here, so the ability to properly signpost people to the area where they can receive a responsive and quality service is really important. That is what is behind the 111 number, but that will not happen immediately. It is something for the next couple of years.

Mr Beggs: Thanks for coming along. The latest figures on the 12-hour breaches during this period show that the Ulster Hospital was the worst performing, with major concern at Antrim and a number of others, including Causeway, Downe and Lagan Valley. You mentioned the conversion rate, and I will come back to that later. You also said that you did not think that A&E closure at the City Hospital had a bearing on it, because there is an equal increase in demand from the normal catchment area of the Ulster. When you are operating at capacity, do you not accept that any increase, no matter where it comes from, tips you over and causes the problem and that, therefore, the closure of A&E at Belfast City Hospital has a significant impact on this?

Mr Compton: I understand what you are saying, but, in the preparation and planning, the £6·6 million and the opening of 40 extra beds in the hospital, and all of that, was very direct and, broadly speaking, given the numbers that came, in the right direction of travel. What has been different for probably 12 months or maybe a little longer in the Ulster Hospital is that there has been an inexorable growth from its indigenous population. The Ulster Hospital is located at the outer edge of east Belfast, which is part of the Belfast Trust area. There has been a move from some people in east Belfast to the Ulster Hospital. Although it is not in their trust area, it has always been seen as their core catchment area because history and tradition takes people there. A reflection of that has led us to work to agree with the trust how best to handle that additional activity. Clearly, we will finalise that. Hopefully, that will mean a better platform for the Ulster Hospital to deal with its difficulties. I am confident that that is the right approach. As Andrew indicated, we have a different approach for the Antrim Area Hospital. I am confident that that will give us a better platform, along with the reopening of the capital work that we expect in the early part of the summer.

In case anybody is of the view that the changes in performance in Belfast are simply attributable to the fact that the City Hospital A&E unit closed and, with that, a whole lot of activity moved out of Belfast, that could not be further from the truth. A large amount of change that has happened in the organisation in how the emergency department and admissions operate. The whole-system approach that has been applied is very important. We have moved from a position of having two good performing trusts to three, and there is a clear strategy for trusts four and five. We are optimistic that we are on the right direction of travel.

We are not at all complacent about where we are as a consequence of the winter. It definitely shows that we are in a better place than we were last winter. That is not an excuse or complacency; it is confirmation that the approach is the right one and that we are on the correct journey.

Mr Beggs: Antrim Area Hospital has the worst four-hour figure — 61·7% — for December. I heard a story about a 101-year-old who waited for six hours on a trolley in A&E. That is horrendous. Clearly, improvement is vital. Virtually every consultant-led A&E in Northern Ireland is in the 60s or 70s. The English figures show that virtually every one is over 90%. I think that there were two exceptions. The vast majority are above the 95% target. What is wrong with Northern Ireland? We are struggling at 60% or 70%, but England and Wales are way up. The average for Scotland in the latest published figures is 95%. What is wrong here?

Ms Hinds: We have struggled with the four-hour performance. We talked about that the last time I was here. As I said, the four-hour performance is primarily but not exclusively about how we run our A&E departments. The focus of our work has been on 12-hour breaches because they are the longer waiters and the patients who require admission to hospital, and we need to focus on them. Although an A&E department gets overcrowded often with patients who wait 12 hours, that has an impact on

the rest of the system, so the two are connected. Addressing the 12-hour target will help to manage down the four-hour performance.

We have also put in other milestones. When I was here before, I was asked whether we monitor other time bands. We do. We are looking at those who were not discharged within six hours to try to improve that performance. We are also looking at other clinical indicators, such as time to triage and the time to medical assessment. The important thing is the quality of care. We should not lose sight of that. Absolutely no one should be delayed. Four hours is long enough to wait if you are in pain. However, if you are triaged effectively, you will be provided with the right pain relief and ongoing care while you wait to see a doctor. Although none of us accepts that delays are acceptable, patients and families can cope with them a little bit better if they know where they are on the journey of care. I accept entirely that we have not made enough progress on the four-hour target. However, I would like the Committee to know that we are committed to working with trusts to try to improve that performance. However, we must address the areas in which patients are waiting for 12 hours and more.

Mr Compton: We understand only too well the performance in other parts of the UK, and that has led to the learning event and to our involvement with Heart of England and other organisations because, quite straightforwardly, if there are things that we are not attending to and could easily attend to, why would we not do that? That is why we have had learning events across Northern Ireland and have involved the rest of the UK. As part of the focus on the turnaround arrangement in the Northern Trust, we are using colleagues from Heart of England to give us an opinion on that perspective. It is not about putting our head in the sand and not looking outside for support and assistance.

Dr McCormick: There was a period when we lost focus on that, and we are having to make up some ground. That is a matter of fact. The system lost some belief and confidence that that was possible. We have done a lot in the past year, and much credit goes to John and Mary for what they have done. The intervention with Sue Page and her colleagues in the Northern Trust will add to that further. We deal with this formally at my level twice a year with each organisation, and John and his team are in the face of the trusts, dealing with performance management issues on a monthly or fortnightly basis. The question is: are the right things being applied? The question that I keep coming back to is: are we applying evidence-based good practice? England has achieved what it has achieved by consistent application of technique. We know what works, but we must apply it consistently and secure the levels of engagement and commitment. That is by no means only about telling people what to do; it is about helping people understand what works and drawing on their confidence and motivation to do the right thing. As Mike Farrar said on television this morning, people come into health and social care because they want to make a positive difference. If consistent information is available about what works, and that is handled well by clinicians and managers, this can be done, and we believe that substantial improvement is possible. I harp on about it all the time, but we are looking for the application of evidence-based good practice.

Mr Beggs: Will the review team look at other areas where there are major problems?

Dr McCormick: The turnaround team is focused on the Northern Trust. Undoubtedly, if lessons and evidence of success come through in that context, we will want to spread those across. Absolutely.

Mr Beggs: You said that relationship difficulties or problems are being addressed. Are you saying that consultants are reluctant to evolve and change practice?

Dr McCormick: I would not characterise it in those terms at all; no. Many clinical consultants of all sorts are very progressive in wanting to make progress. It is variable, and the question is how to secure consistent application of the right things and secure confident working together of the different parts of the team. It depends on integrated care. The most central facet of TYC is the fact that we have major progress to make, and better integration can make a very big difference to how the system works. That means mutual esteem for different professional groupings and different contributions. It means people working together as teams, seeing how they can help each other and drawing on the skill and leadership of the different groupings. There is undoubtedly a massively important role for the A&E consultants, who are incredibly committed individuals.

Mr Beggs: You mentioned the conversion rate in the Ulster; that was the terminology that you used. I keep hearing that the Northern Trust has an older population proportion than other areas. The elderly population tends to require more medical interventions. Is the conversion rate in the Northern Trust a factor?

Mr Compton: Yes, it is partly a factor, but the real issue, as Dr McCormick pointed out earlier, is that when you look at the solution to this, it is not simply about bringing more people into a hospital, but about alternatives and better management, for example, for individuals who are in a nursing home. The evidence suggests that better management of medical care in nursing homes will prevent a number of people coming to hospital. That is a good thing for them, principally, and for the system. We would want to see that being handled differently.

Conversion rates vary from time to time and we track them every day, but we do not use them as a rate on a daily basis. We track them over a slightly longer period.

Mr Beggs: When should we expect to hear about the outcomes of the review and improvements happening on the ground?

Mr Compton: I can say that, looking at the Ulster Hospital position, we expect to close the negotiations —

Mr Beggs: I am talking about Antrim Area Hospital at this stage.

Dr McCormick: The terms of reference for phase 1 are on their way to you, but phase 1 is primarily to give us a diagnostic; in other words, it is for the team to tell us what is the root cause of the issue. They are already well advanced with that piece of work. The question then is for us to consider what further work we need them to do.

There is an outline for phase 2, which will extend into March and April. As I said earlier, we will get a more formal summary of their assessment of the situation very soon. They are making very good progress on that work. They are having further meetings tonight and tomorrow, and there will be a further update at the end of this month. We will then go back to the Minister with the emerging findings and ask him what he wants to happen next to make sure that this is achieving what it says on the tin in terms of turnaround and support.

It is about getting to the root cause of what has been a long-standing problem. Undoubtedly, the new facility will work, but, much more important than the building, it depends absolutely on the people working together across the whole spectrum from demand management and prevention, engagement, the technicalities of how the hospital works, through to discharge. All those issues have to be handled, and there is a major leadership challenge which includes the responsibilities that we have as regional leaders working on these things.

Interim findings will be presented in February or March, after which we will look at what more needs to be done to make this work.

The Chairperson: I apologise for missing your presentation. I just want to make a couple of quick points. If you have already covered what I am about to ask you, please tell me.

I am aware that you might not have the information here, Mary, but I want to ask you about staff ratios, which I have mentioned a few times. What is the staff ratio breakdown in A&E?

Ms Hinds: For nursing staff?

The Chairperson: For all staff.

Ms Hinds: There is no ratio per attendance. We are testing, and have used, what is called a "best tool" for nursing staff, which has been developed UK-wide by the Royal College of Nursing. We have been part of the development of that tool in two areas, and we are going to roll it out to all A&E departments. That will give us a measure for A&E nursing.

On the medicine side, there is a College of Emergency Medicine standard or suggested level of medical staff, depending on the size of the unit.

The Chairperson: Are we meeting it?

Ms Hinds: No, not everywhere, but nowhere in England meets it either.

The Chairperson: Roy mentioned that some of the hospitals in England and Scotland reach a high percentage. Are we comparing the staff ratio with those places?

Ms Hinds: I am not quite sure what you mean. If you look even in Northern Ireland there are —

The Chairperson: Do our A&E departments have the right staff complements?

Ms Hinds: We have a mixed complement of staff across our A&E departments. Whether they have the right complement depends on what you mean by "right".

The Chairperson: The paper that was provided shows that additional funding was given to support a temporary staffing increase to improve seven-day working. We are in a crisis, and that, to me, shows that the staffing is an issue.

Ms Hinds: Seven-day working is an issue. That is part of what Transforming Your Care is about. It is about having the right number of staff to provide care in a modern and new way.

The Chairperson: So we are talking about making changes in the way that it works?

Ms Hinds: That is across the board, and not just in A&E, because seven-day working is in every ward and department.

The Chairperson: Can you give me a breakdown of which A&Es the money referred to in paragraphs 16 and 17 is going to? You may not have it with you now, but —

Mr Compton: I am sure that we can.

Ms Hinds: I certainly have the £1·85 million —

The Chairperson: There is the £7 million non-recurrent and the £1·85 million.

Mr Compton: Yes, we can give you the information about the £1·85 million; we will send you that.

The Chairperson: I do know if you are aware of this, and it is, at this stage, just a rumour — I am conscious of saying that it is only a rumour, because we are in public session — but is there a possibility that, over the next couple of weeks, the Royal will have no emergency medicine consultants?

Ms Hinds: We are aware that there are issues with vacancies and the ability to fill them at this point. It is an issue that the trust is engaged with. Certainly, there will be arrangements to fill the vacancies, although not on a permanent basis. Some of them may have to be filled through locum appointments. We are aware of the issue. Vacancies have arisen and we are still having difficulty recruiting permanent staff to A&E areas.

The Chairperson: Is there no clinical director either, at the minute, in the regional hospital?

Mr Compton: I think that they have made an alternative arrangement for that, and a senior physician — Dr Jack, I understand — now overviews the department. I think that you are raising the issue of Northern Ireland Medical and Dental Training Agency and the allocation of training grade staff. That emerges as an issue every February and August, right across our entire system, and it sometimes differentially applies to various organisations. We are aware that there is an issue that might potentially affect the period just ending, but any issues will obviously be handled in the normal contingent way.

The Chairperson: And are we looking at additional discharges there, today? The South West Hospital do four a day, I think.

Ms Hinds: We monitor the number of discharges every day and the also the number of discharges before 1.00 pm because, if discharges are appropriately managed and people get home good and

early and have day arrangements sorted, we can get more admissions in. That is because admissions tend to stack up around 2.00 pm.

Mr Compton: That is the point that Andrew made earlier about using what we know to be good practice that delivers better. It is a known fact that discharging people from hospital before or at lunchtime on a given day, if you can organise it, will improve that hospital's throughput. That requires a lot of re-engineering of things such as pharmacy, social care and the whole gambit of issues, not just one simple thing.

The Chairperson: OK. Thank you, and my apologies, again, for missing your presentation, but I am sure that you are now glad that I did. Thanks very much for your presentation. We will definitely stay in touch about this.