Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

A&E Improvement Action Group: DHSSPS/HSCB Briefing

22 May 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 Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Ms Maeve McLaughlin

Witnesses:

Mr Jackie Johnston	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

The Chairperson: I take the opportunity to welcome John Compton, Andrew McCormick and Jackie Johnston. You are old hands at this Committee now. I assume that Andrew will take the lead on this. I will hand straight over to you for your presentation. Afterwards, we will open it up for questions and comments.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): I am happy to take your steer as to how much you want to focus on the general position on A&E. If you want particular information about turnaround in the Northern Health and Social Care Trust, I can adjust a bit if you want me to.

The Chairperson: I think that we will go for the general position on A&E. Some people might get into specifics on the Northern Trust. I am sure that there will be questions about other A&E departments.

Dr McCormick: That is fine. It is no problem at all.

We sent you some information. Some further information came very late. Apologies for that. You had asked for the breakdown by two-hour time bands. That took a bit longer to put together. It is not something that we would collect routinely. That was sent only at lunchtime today. If you need to come back to us about that at another stage, that is not a problem. We would be happy to take that further. We do not yet have a report on the turnaround. It will come through in due course as further discussions issue today.

On the general position on A&E, the Minister was actually at a learning event on accident and emergency work this morning. I will say much of what he said, in a sense, because he acknowledged

that, although a lot of good work has been done by the improvement action group (IAG), there is significant disappointment with the way things are. The important thing for us all is to get beneath the figures and understand what is going on.

There is definitely a real problem and significant disappointment that the number of 12-hour breaches in March and April has been high. There is ongoing difficulty with the four-hour target. We are not in the place where we want to be. It is important to draw attention to the fact that the number of unplanned admissions through emergency departments has been rising. That is an indicator that there is a problem of acuity. There is the problem of a lot of ill people turning up. That is a symptom of the wider context of what is going on in the health of the population. We need to understand properly that a real increase in illness has a lot to do with the way in which risk is being managed and how much of that is due to the relationship between hospital care, nursing-home care, GP out-of-hours services, and we have to look at those different aspects of service. The job for us, with regard to our role and John's role, is to look at the totality of the issues and try to find the best overall way forward to ensure that what we know about good practice in managing the flow of patients through hospitals is managed very well while always holding to the point that every patient is an individual and needs to be treated with respect and care. So, it is about holding to the aspirations of providing a good patient experience, high-quality and safety of service and good performance on time. Every one of us, I am sure, has had experience of a family member needing attention in A&E. It is very important to get that right. A lot of further work needs to be done.

We have reached an important stage with the work of the IAG. It was originally set up in March 2012. The remit was extended and needs to be refreshed. Mary Hinds, who would otherwise have been here today, has been redeployed to other duties in the Northern Trust, so, as the Minister said, we need to look again at the membership remit mandate for the work. It is intended as a way of securing improvement, and some significant improvements were achieved in the past year. Indeed, the winter was generally better than the previous winter. There were still a lot of difficulties, but there was some measurable and demonstrable improvement. It has been all the more frustrating for all of us that there is a significant problem with 12-hour breaches at present.

We are looking at all those factors and seeking to understand that more fully. The response that we make has to be tailored to the detail. There is no single solution or single package of solutions. It is a matter of making sure that we understand the culture and leadership in each of the organisations and the way in which the system is functioning. There are aspects of workforce and physical environment that need to be understood. Then we will try to make the best possible decisions to try to secure improvement.

There is a lot of good work being done across the organisations. Almost all trusts presented this morning at the learning event, and they had indicators of initiatives and valid and helpful things that they are doing. For us, the issue is to make sure that good practice is known and shared and that there is sharing and learning among the organisations. Hence, we do all that is possible to secure improvement, but there are significant issues there.

The board has worked in particular with the South Eastern Health and Social Care Trust to secure additional resources looking at the issues that have been difficult at the Ulster Hospital. They are making sure that the capacity is flexed to look at demands. That is known and understood. There were additional amounts. Most recently, there was an additional £2·8 million to ensure that the capacity is the best that it can be to monitor demand. That is never static. We need to be sensitive to that evolving and changing and respond to that.

As you know, we have taken a specific approach to the Northern Trust. A turnaround team was established in December. We have had ongoing discussions with the team and made the intervention that happened earlier this month in respect of a change of leadership at the trust. That is a very important intervention, with the clear objective of securing a significant change in the organisation in time for next winter. That is the Minister's remit. It involves all of us here — the board, the Department and the Public Health Agency (PHA) — working with the Northern Trust with ongoing intensive support. That is a very important piece of work.

This issue remains very challenging and, as the Minister said this morning, it remains unacceptable. There are things that are not where they should be. It is about making improvement as far as understanding why and tailoring interventions and changes according to a real understanding of what is happening across the system as a whole and in each individual hospital and then the relationship between each hospital and its community services. All those things matter. It is a complex and

challenging problem, and we remain committed to securing positive change. I am not sure whether John wants to add anything in particular.

Mr John Compton (Health and Social Care Board): Not really. Other than maybe having a conversation with you, I just want to say that we are working very energetically to get to a better place. Although there has been some evidence of improvement in some areas, we accept that the improvement is not where it should be. At the event this morning, we had each of the organisations, and it was quite clear that at a professional, clinical level, as well as at a nursing, allied health professional (AHP) and managerial level, there was resounding commitment to get to a better place. There is no lack of industry or lack of importance perceived by health and social care as to the priority of this issue.

The Chairperson: OK. Thank you, and I thank you for the information that you sent us. Some of us have arrived late at the meeting.

Andrew, you said that the Minister says it is not good enough, and I agree with him totally. John, you said that we are working to get a better place, and I agree with you totally. However, the reality is that we are not in a better place. Look at the figures from August last year to March this year. If I read them correctly, over 59,000 attended last August and just over 57,500 attended in March. Fewer people attended in March. However, the number of patients waiting more than 12 hours in August last year was 97, and that is without discussing the figure for people who had to wait for four hours and more, which, itself, is not good. The number of patients who waited over 12 hours in March, when there was a lower attendance, was 1,021.

I do not mean to take away from the work that the turnaround team has done under Mary Hinds. A bit of effort was put in there, and we saw some improvements. With all this focus on it, everything that the Minister has told us in the Assembly and the focus from the board and trusts, why is it that we are now back to this stage? You cannot tell me that it is all because people are getting ill. So that is my general point, but I have specific questions.

We were told in one of the Minister's previous statements that nurses were going either to be rebranded or looked at to allow them to discharge patients. I asked the Minister about this at Question Time the other day, and he said that he did not have the information to hand, so I assume that we will get it shortly. I have always said that the problem is not just an A&E problem. The problem is the hospital, and the concept of what a hospital is, but other parts of the hospital do not change to allow and support what happens in A&E.

I made an unannounced visit to a hospital in my constituency the other day. Granted, I did not stay too long, because there was an ambulance accident, and I did not want to add to the problems of the staff. However, I was there for 10 or 15 minutes. It is a regional hospital and there are four trauma rooms. If the trauma rooms are being used because it is a regional hospital and there is a serious road traffic accident, that adds more pressure to A&E. I do not like this term, but it is a "constituency A&E", though it is a regional hospital.

I am also led to believe that the pharmacy issue is still a problem in some of our A&Es. We are told that, in some hospitals, the pharmacy works 24/7 but, technically, it does not because orders have to be in. I am aware that people who were due to be admitted are being admitted medically in A&E, and because there are no beds in other parts of the hospital, for whatever reason, they are still in and around A&E. You might come back and say that they are under the care of the staff in that ward, but you cannot expect staff to run up and down stairs to deal with it, so that adds to the problem. So, whatever the focus we have had over the past year, we seem to have peaked at getting a handle on this, and now we are back to it — and we are not even in a winter crisis.

Are all our A&Es up to full staff capacity, with doctors, consultants and nursing staff, as we stand? For how many of them are we still dependent on locums? What work has been done with GPs and other health professionals to ensure that they are supporting A&E? I am still convinced that A&E can cope. The reality is — as I have said — that other parts of the hospital cannot. So what has changed since last year? Are there more ward rounds in the hospitals? Are consultants being told to do more than one or two? I was very impressed with the South West Hospital, where the consultant told us that they did four ward rounds daily. Has that changed in some of the other hospitals that are under pressure? Convince us. When the Minister says that it is not good enough and you say, John, that we are working to get to a better place, convince me that we are getting to that better place. If it is not good enough, what is done to ensure that we are doing it?

Dr McCormick: All the points you made are absolutely relevant. Everything that you mentioned needs to be dealt with in the totality of managing the system, and it is up to each organisation and trust to align those things and to make sure that they are working, be it — *[Inaudible.]* — or be it the roles in relation to discharge. There are ongoing issues in relation to staffing. There are some limits on that, and Jackie has details on that and the character — *[Inaudible.]* It is always difficult to attract staff to work in that speciality. There is always an issue there, but that is the responsibility — *[Inaudible.]* — to recruit and retain.

Absolutely, the relationship with primary care is critical. All those things need to be pursued. Going back to where you started, as to why there is a difference between August last year and now, there is some increase in the degree of illness in the community. That should not be all that surprising in that, with an ageing population, there will be more people with long-term conditions and more risk of them having acute episodes that require hospital attendance. The task for the whole system is to manage that, anticipate that and get prevention and early intervention as the strategic means of dealing with that. The big strategy in Transforming Your Care is to try to do exactly that. We are trying to change the system radically while also keeping the existing system working, as it is, in a steady state. That is proving very difficult. No one at Department, board, PHA or regional level is satisfied, but we do not have all the answers as to exactly why those issues are going the wrong way in some respects at the moment. There has been some improvement, but some deterioration as well. We need to tackle that by looking at all the issues that you have mentioned there.

Mr Compton: You raised some very important issues. It is important to outline some matters of fact. For the 12-hour breaches over a three-year period, we had 7,379 in 2010-11, 10,211 in 2011-12 and 5,577 in 2012-13, the year just closed. Although there is nothing to be particularly celebratory about, there is movement in the right direction.

March and April were particularly difficult. March affected those figures. We had anticipated them to be lower. The reason for that was that there were outbreaks of norovirus and chest disorder-type conditions, particularly among older people. That was Province-wide, so we had pressures on the A&E system where we normally would not have them. For example, we had some 12-hour breaches in Altnagelvin and some in Craigavon. Those are very unusual over a period of time, but it is a reflection of a particular level of illness that occurred over a six- to eight-week period, which was of a different volume. Happily it is quieter. If you look at this month, you can see that those numbers are much more settled. I simply say that to set the context, not by way of excuse. It is important to have that sort of context.

As Andrew said, staffing remains a problem. It depends where you go. If you are in Belfast, in the hospital that I think you are referring to, the staffing issues are among middle-grade medical staff. They have tried exhaustively to recruit. It is not a problem that is particular to Northern Ireland. If you look across the whole of the UK and the Republic of Ireland, you will find that middle-grade doctors are difficult to recruit because it is a difficult specialty. We have had difficulty in recruiting consultants —

The Chairperson: Sorry, John, but some of them are locums. I was asking about the recruitment of full-time staff.

Mr Compton: This is the recruitment of full-time staff. As the trust told us this morning, it has been trying extensively and exhaustively to recruit and has been unable to recruit individuals to substantive posts. If the right people turned up, they would be employed tomorrow morning — be under no illusion about that. We have had difficulty recruiting at consultant grade, particularly in the west. When an attempt to recruit for extra consultant posts was made in the west, there were no suitable applicants. Staffing remains an issue, and we will grapple with it. There is no quick fix because there is a UK-wide shortage of doctors working in this area. It will be a persistent difficulty and problem for us.

You raised issues about the totality of the hospital: pharmacy, nurse discharge, medicines, and so on. Sometimes, we refer to that as the 18 core actions, or evidence of things that we know work quite well. In the past year, through Mary and her team, we have piloted different pieces of work on various sites. We now know and have examples of what works really well. In Antrim, for example, we have changed pharmacy activity to the morning, and so on. Once we get that established, we will roll it out. Part of today's learning event was about sharing all such experiences so that we can roll them out across Northern Ireland. Doing so will mean that we no longer have difficulties with discharge being delayed

because the hospital pharmacy does not come to see patients until 2.00 pm or 3.00 pm when that could have happened at 10.00 am. We know that, if 50% of the patients who are ready to be discharged on any given day leave around lunchtime, that makes the functioning of the hospital much more successful. We are moving on the idea of nurse discharging. All that work is ongoing.

We have undertaken quite a piece of work on primary care. We now put on extra general practices on bank holidays and are planning extra practices for the coming winter. We have done an extensive workload analysis on primary care, so we know the busy times. We have asked primary care, and are supporting it in this, to put on extra reception staff at the busiest time of the day — that may be between 9.00 am and 10.00 am or 4.00 pm and 6.00 pm — so that people do not get frustrated and turn away from that side of the house.

We have also gone through last year's Transforming Your Care arrangements. We have identified the top 20% of patients most likely to go to A&E. As part of the integrated care partnership work in the coming year, we will target all our focus on that 20% of patients in primary care to try to do what is appropriate. Some people will need to go to hospital — no one will say that they should not — but there is a lot of activity going on behind the scenes to try to improve the management and control of all that.

Issues with ward rounds are very common. The expectation is now that there will be at least double ward rounds each day in most hospitals. This morning, we heard evidence of moves towards the seven-day working of emergency department (ED) consultant staff, allied health professionals and social work staff. We heard from the Ulster Hospital some very promising evidence about seven-day working, and we want to consolidate that.

We recognise that discharge is really important. The extra £9·5 million coming into the system in 2013-14 through the local commissioning groups, again with regional commissioning support, will focus on areas such as reablement and elderly services. It will be commissioned on a capitation basis across Northern Ireland and focus on enabling the better and quicker movement of patients, particularly older patients, so that they have a more appropriate and speedy opportunity for discharge. At this morning's event, one or two very powerful personal accounts were given of examples of work that had been very successful.

Do I think that we can fix it? I think that we can. When we talked to everybody this morning, I felt that there was a sense in the room that we could fix it. Is it a difficult task? It is absolutely a difficult task. Nothing is straightforward. I hope that what I am saying to you persuades you and gives you confidence that this is being taken very seriously. We anticipate improvement on these matters.

The Chairperson: I come from the school of thought that if, for example, the changes to pharmacy are working in Antrim, they should be implemented in all hospitals. Will that happen?

Mr Compton: That is the point. The learning approach has been to look at a whole of range of measures that have been working. On the AHP side, for example, it was the Ulster —

The Chairperson: So I take it that all the changes talked about this morning will be made tomorrow.

Mr Compton: All of that will be put to everyone. We will talk to people about the implications of introducing any change universally across Northern Ireland.

The Chairperson: It will not take months, will it? Changes can be —

Mr Compton: It will happen as quickly as is practical. There will be some practical things to do. It may mean changes to rotas and rotations, extra staff or whatever. Some of this will be determined by the speed at which we can introduce the changes.

The Chairperson: I appreciate that. What I am saying is that I hope that we are not going to talk about this for another six months.

Dr McCormick: We have been talking about this for quite some time. We have known a lot about evidence-based good practice for quite some time. All the trusts know that, every time that we have a meeting — we have twice-yearly accountability meetings — I ask this question: is this trust applying evidence-based good practice? I am looking to John to give me assurance on that. We need to

pursue that. In my brief contribution to this morning's learning event, I said that the phrase that I have adopted is "Comply or explain" — either you do it through what we know is good practice or you say, "Here is a better way of doing it." There is a variety of practice. All the clinical teams have their own ways of doing things. We need to respect the fact that clinicians are highly trained, intelligent people who know their own context. I would not argue for uniformity. What I want is for people to know that they are doing things that work and to be able to demonstrate that they work. That is what matters, and we need to take that forward as part of holding people to account.

The Chairperson: The experts in this are the nursing and clinical staff at the coalface. That is not to take away from senior management because an overview role is also needed. As I said, the Minister told us that a change would be made to allow nursing staff to discharge patients from parts of the hospital. Where does that sit?

Have you talked to nursing staff when management are not present? Some of their ideas and suggestions could make a big difference. There is the whistle-blowing process whereby staff go through their line manager, but staff are not whistle-blowing. They just want to be listened to because they work there and think that their suggestions could make a difference. If I worked in a chippy and someone suggested a better way to cook fish, I am sure that the owner of the chippy would be glad to hear it, but the person told to make the change might not like it. It is about finding a way of creating ownership, especially among the nursing staff because they get the tail end of what goes wrong. The majority of interviews or comments that I have heard have been to the effect that the staff could not have done enough. However, the staff seem to think that they are working against the tide. Outside of what you did this morning and other work, I ask you to take a dander and talk to the nursing staff.

Mr Compton: I could not agree more with you. In the past year, Mary and the IAG have spent a lot of time in units talking to all sorts of individuals. They did so in an environment outside the traditional context in which conversations take place. Key among those individuals are nursing staff. When Mary talked to staff, there was a straightforwardness to it. There was a straightforward reception of sensible commentary about what would be helpful, what would work, what is difficult and what would make it a bit easier. We have no desire to do anything other than that. Mary has done that in her role as the IAG co-ordinator, as a senior nursing representative in the PHA and as someone who sits on the board.

We have taken account of all that and responded to requests. There has been a fair degree of investment. Much of what we talked about in respect of the Ulster Hospital and Antrim Area Hospital emerged from those discussions. We will continue to do that. We will continue to see this not as an academic exercise with numbers on a page but as a real exercise that deals with the people who work on the ground. It is also important to listen to the people who receive the service because they have some very sensible comments. Often, their comments are not about money or resources but about communication.

The Chairperson: So where does nursing staff being able to discharge patients sit?

Mr Compton: We are working on the discharging arrangements and beginning to introduce nurse discharge across Northern Ireland. We are moving towards that.

The Chairperson: What do you mean by "beginning"? When will that start?

Mr Compton: It has already started. Do you mean when will it be universal?

The Chairperson: Yes.

Mr Compton: I would need to confirm that with Mary, but it has commenced.

The Chairperson: I think that I have a duty to ask this question, and it does not necessarily mean that I believe it, but on the basis of some of the media coverage here and in England in the past weeks, is the system in meltdown and can our A&Es cope? My reason for asking is to give you the opportunity to reassure people.

Mr Compton: No.

The Chairperson: No, it cannot cope, or no, the system is not in meltdown?

Mr Compton: No, the system is not in meltdown.

The Chairperson: Where does the City Hospital A&E department sit?

Mr Compton: The consultation has just closed. The expectation is that the results will be analysed, and, as I understand it, that analysis will go through the trust board before coming to the Health and Social Care Board in August or September 2013.

The Chairperson: Is work taking place on the City Hospital?

Mr Compton: On the City A&E? No. What has happened in the City Hospital is that the admission unit for direct admissions from general practice has turned out to be very successful. This morning, I heard about the several hundred people coming straight to the hospital through GPs. We think that that is the way forward and are looking at how we might develop it across the Province. That is what is on the City Hospital site. There is no ED, as people would commonly understand it, on the site.

The Chairperson: So the consultation results —

Mr Compton: The consultation has just closed.

The Chairperson: If the outcome of the consultation were that there should be an ED on the City Hospital site, would any work being done there mean that it could not reopen as an ED?

Mr Compton: The consultation will say what it says, but —

The Chairperson: I am asking whether you are aware of any building work being done in the emergency department.

Dr McCormick: On the physical environment? Not particularly, no.

Mr McCarthy: I hear what you have been saying, John and Andrew, but I remain unconvinced. There is never anything really positive when you come here. You are always trying to get the figures down but they do not seem to be coming down. That is particularly true of last month's figures: the April 2013 figures for those waiting for over 12 hours at Antrim Area Hospital and the Ulster Hospital are very disappointing. The figures for waits of between 10 and 12 hours are also disappointing: 375 people had to wait for that long at the Royal Victoria Hospital, yet your answer to the Chair was that the system is not in meltdown. I am not convinced that we will crack this in the immediate future. I hope that I am wrong, but I remain to be convinced.

Before I forget, Andrew, you mentioned accountability meetings. Your meeting this morning was not on accountability, was it?

Dr McCormick: No.

Mr McCarthy: When do those meetings take place? Did you say twice a year?

Dr McCormick: Yes, we had the first of the end-year cycle of meetings with the Southern Trust last Monday, and we have to do the rest of those. We need a bit of time after the end of April, so the meetings tend to take place from around now to the early summer. Once it is possible to take stock and be clear on what has happened in performance activity and finance, we have a discussion with each trust in May/June. As I said, the first of those has happened. Meetings with a further 16 arm's-length bodies will take place very soon, and then we have mid-year meetings, which should happen from October onwards. Most tend to be in November/December. That is the routine.

Those meetings are the formal tip of the iceberg; there are ongoing working relationships with all arm's-length bodies. That is what holding to account is all about. We make sure that those in the Department are aware of what is going on, so they are able to report to the Minister and provide assurance. If issues arise, it is for the accounting officer of an arm's-length body to let me or my team know. It is for us to be in a position to act and resolve an issue. We are trying to stay on top of the issues. I recognise what you say about waiting times, and I share your concern because the numbers

are very difficult. We need to be very clear about and act on these issues. That is one reason why we have taken specific action at the Northern Trust. It was a very unusual and significant intervention. We have also acted to provide resources to deal with the capacity issue at the Ulster Hospital. We are trying to tailor the response to the underlying reason for the difficulty in order to get some solutions there.

Mr McCarthy: For clarification, was your most recent accountability meeting in November of last year?

Dr McCormick: The mid-year meetings probably finished in January; some did not happen until then. They are roughly six months apart.

Mr McCarthy: I must insist. I want to know when your most recent accountability meeting was. That is not such a hard question.

Dr McCormick: I do not know off the top of my head, but I can get the schedule for you.

Mr McCarthy: You can get us that.

Dr McCormick: No problem.

Mr McCarthy: For now, we presume that it was in January, so you have not had an accountability meeting this year.

Dr McCormick: We have had one, which was the first meeting of the new cycle. The Southern Trust end-year accountability meeting was on Monday of this week. The rest of those meetings, including one with the Health and Social Care Board, which is happening next Tuesday —

Mr McCarthy: I want to know when you had the most recent one. You cannot tell us that now, but you can furnish us with that information.

Dr McCormick: Yes, we will get you the full information on that. That is no problem.

Mr McCarthy: OK, thanks. My other question goes back to the Chair's concerns about staffing levels. Are you happy that the staffing of emergency departments is at the recommended and appropriate level? Correct me if I am wrong, but the Minister, in a response to someone on the Floor this week, said that there was no shortage of nurses anywhere.

Dr McCormick: Each unit has to operate at certain levels. When units cannot fill permanent positions, as John explained, locum appointments or agency staff will be used so that the right cadre of staff is in place at every stage. So there will always be an appropriate level of staffing. There are times when it is strained and times when people need to be called upon at short notice from the bank or agency, for example. That is part of what happens, day to day, but every chief executive knows that having a safe level of staffing in place is essential and that there is no compromise on that.

Mr McCarthy: Does that include consultants?

Dr McCormick: Again, locums will be in place, where necessary, but, as John explained, there are shortages in these specialties, particularly on the medical side. It is a UK-wide and Europe-wide problem.

Mr McCarthy: Finally, Chair, we know about the extreme pressure that everyone is under, particularly in A&E. Do you have any knowledge of A&E nursing staff being harassed or bullied by superiors to get work done? I hear that there are such instances of harassment, and nurses cannot perform to the best of their ability if they are under that kind of pressure.

Dr McCormick: Harassment and bullying are very serious and must not be tolerated. You have to recognise that there is a gradation from things being tense and difficult — when human nature is such that people may be a little short, which must be recognised as part of what can happen — to something more serious. We are all sensitive to that.

There has to be good behaviour and respect because people are trying to do very difficult jobs under great stress, and it is important that no one's inappropriate behaviour adds to that stress. There are times when it is not possible calmly to provide a long explanation of why something has to be done, so I would not be surprised if there were some sharp exchanges. However, we need to distinguish between a sharp exchange and inappropriate harassment or bullying, which is not acceptable.

Mr McCarthy: In conclusion, do the trusts have a list or note of any such nurse experiences? If nurses are being harassed, is a list kept somewhere?

Dr McCormick: When someone raises a case, that will be dealt with. There is good HR practice in all the trusts. They are sensitive and aware of the issue.

Mr Compton: I want to make it clear that there is a very strict process for dealing with that. If there is any evidence, or the elected member has evidence and furnishes us with that, we will certainly follow it up. Andrew's point is that an occasional sharp word between colleagues is different from bullying and harassment. There is no place for bullying and harassment. It is as straightforward as that. To be honest, I do not believe that there is any real evidence of that culture — I really do not.

Mr McCarthy: If the trusts have a record of that, could the Committee be furnished with the details so that we can see what is going on in relation to any harassment or bullying of nurses?

The Chairperson: We can get an overview, Kieran, but we need to be very careful that we do not go down the line of looking at individual cases. What we need to do is ensure that the policy is right and is applied throughout the trusts. There is data protection to consider, but we can get an overview.

Mr Compton: We can certainly get you copies of the policies and let you know the aggregated numbers. As you say, Chair, individual cases are subject to —

Ms P Bradley: For all disciplines.

The Chairperson: We are all in touch with the trusts, the board and the Department about individual cases. We need to ensure that the policy and the procedure are right.

Mr McCarthy: All I am saying is that if there is any of that activity, which affects the quality of nursing care, something is not right with the system, and we should investigate that.

Mr Compton: I accept that.

Mr Beggs: First, I want to pick up on the Chair's question about staff vacancies. You referred to a problem attracting key consultants and mid-grade critical doctors throughout the UK. That has been ongoing for a number of years, so what is happening at a national level to ensure an adequate number of professionals to fill these essential roles?

Dr McCormick: Efforts are being made to attract people to train in that speciality. This is a matter for the deaneries across the UK, including the Northern Ireland Medical and Dental Training Agency (NIMDTA).

Mr Beggs: Their efforts are not working.

Dr McCormick: They continue to try to find solutions. Across the water, the Department of Health established a task force led by David Sowden. Work is being done to try to address the issue, but it has not yet been fully resolved. There is also a need to look again at immigration rules, and so on, to ensure that recruitment from outside the UK is handled properly and effectively. It is difficult because the truth remains that, at present, emergency medicine is not the most attractive area, especially for doctors, so we need to look at that strategically across the UK.

Mr Beggs: Do you accept that, until you have a full complement of staff, EDs will continue to be very stressful and so it will be difficult to attract new staff?

Dr McCormick: Yes, it is a vicious circle.

Mr Beggs: So what will we do to ensure a full complement of staff?

Dr McCormick: We will seek to ensure that there is a full complement, whether of full-time or locum staff, so that the rotas are manageable. However, that is difficult to manage when we have rising demand. We need to continue to look at this with colleagues in other jurisdictions.

Mr Beggs: I want to move on to another issue. When representatives from the improvement group were here last November, they also spoke about the improvement. You said that there had been improvement since last year but that you were disappointed. What evidence can you show me to prove that there has been improvement since last year?

Mr Compton: Very straightforwardly, if you look at the number of 12-hour breaches for the year just past, you will see that there were 5,577 as opposed to 10,211 —

Mr Beggs: May I give you another figure? Why are you not talking about the four-hour targets?

Mr Compton: I was going to come on to that when you asked for evidence. There were significant problems with 12-hour breaches, particularly in the Belfast Trust area, throughout the 2011-12 year, but those have all but disappeared, and there are now only a very, very small number.

The first drive of the IAG work was to try to get the 12-hour position under control. It is a fact that, on the four-hour position, there is a deterioration of some 2% to 3% when the numbers are aggregated across Northern Ireland. I realise that that will express itself differentially in individual units: some will be a little above the average and some will be a little below it.

One of the other benchmarks that we looked at across Northern Ireland was how long it took for patients to be seen, and we now know that precisely 90·2% of people are seen within six hours. So the direction is not perfect by any stretch of the imagination, but we think that it is in the right shape. It is not perfect, and I do not want to leave anyone with the view that we think that it is acceptable, that we have cracked it or that it will simply disappear. It requires a lot of work, and there are issues. There will be months, or perhaps one month in the year, when, because of exceptional illnesses in the community, it will be difficult to hold that rate. We think that it is better to look at the matter over a period of time rather than on a given month. However, I accept that, on a given month, if you are the individual involved, you are in that situation.

Mr Beggs: I am looking at your quarterly report, 'Emergency Care Waiting Time Statistics, January-March 2013'. It contains a summary of the situation across all accident and emergency services. I do not want to point the finger and pick out one bad figure. I am looking at the average throughout the A&Es for each month. In the summer, there are better performances, and there are greater difficulties in winter because of winter pressures. However, I read from those statistics that we have been on a downward trend. The last two months are the worst two months in the past five years. Is that factually correct?

Mr Compton: The trend has dropped on the four-hour position; there is no disputing that. With four-hour and 12-hour targets, the past two months were particularly difficult with regard to the absolute number of individuals.

Mr Beggs: Even during the summer period, those best performances have been declining in recent years.

Mr Compton: I am not sure what you mean specifically.

Mr Beggs: I refer you to figure 12 of the report. It shows that there has been a pronounced decline in the proportion of patients seen within a four-hour period, whether you look at the best performance of any month in any year or at the worst performance of any month in any year. Both have been declining. There has been a downward trend, and I do not understand how you can say that there has been an improvement when there is a clear downward trend that has yet to show improvement.

Mr Compton: We have no issue with the four-hour target. The 12-hour issue is a matter of fact. The total numbers are a matter of fact, and they are about 46% less in the year that has just closed than in the previous year.

Mr Beggs: You say that the situation is not in meltdown. However, a constituent recently told me that, at Antrim Area Hospital, all the cubicles were full, there were trolleys everywhere, and three ambulance crews were inside the hospital and had to stay there because they could not hand patients over to A&E. Does that not sound like a crisis?

UNISON advised us of a change in the rapid response vehicle (RRV) and A&E ambulance response times. Is it correct that a rapid response vehicle will no longer be dispatched in addition to an ambulance to 999 calls?

Mr Compton: With respect to the Ambulance Service, I need a better understanding of what you are asking. I can certainly find out the information directly. I understand, from the Ambulance Service, that it responds, as it sees it, quite appropriately. The service is changing the response. There is no question of a diminution in response to a serious event or situation.

Mr Beggs: We have been provided with the following information:

> *"An RRV and A&E ambulance must not be sent to the same 999 call. The only exception is to purple calls."*

Previously, an RRV and an ambulance might have been dispatched to a 999 call in the hope that one vehicle would have got there first and commenced treatment. Obviously, that is no longer the case. Is that because ambulances are being caught up at our A&Es?

Mr Compton: No, it is not to do with that. It is a decision by the Ambulance Service as to the most appropriate way to respond to an emergency. As I understand it, and from what you say to me, it is confident that whatever emergency vehicle it dispatches will arrive in a sensible and reasonable time to deal with the emergency, as opposed to dispatching two vehicles to the one emergency.

Mr Beggs: Perhaps you can come back to us about whether there has been a change in the policy in directing RRVs.

Dr McCormick: As John said, the clear point is that the Ambulance Service is seeking to use its resources as effectively as possible. There is an issue about turnaround in hospitals, but everyone is aware of that and is seeking to manage it. That is part of the challenge. When an A&E department is under pressure, it is harder to turn ambulances around. It is a practical aspect of management. However, everyone is well aware of that, and there is good co-operation between the Ambulance Service and the hospitals in dealing with the situation. All that we can seek to do is to adopt good practice. The four-hour issue has been intractable. Your point about the long-term trend is very concerning, but it shows that the issue goes back a number of years. There was a mandate to improve A&E and to reform the practice. I was first involved in 2006, and some of that has not been seen through. As a result, we had a long-term problem that we are now seeking to address. We will commit to taking the right action in each context, and the contexts will vary. Therefore, there will be a different response from the Northern Trust and the South Eastern Trust. The Belfast Trust has made the most sustained improvement on the 12-hour target, so our highest level of anxiety does not lie there. As John said, none of us is here to defend the performance on the four-hour target. It is very worrying that that is the trend that you describe, and we need to redouble our efforts, clarity and purpose, look at all the issues, understand them and get right to the heart of the issue.

The Chairperson: I go back to the staffing issue, which you said was Europe-wide. Have you looked at the possibility of seconding doctors from countries outside Europe — namely, Cuba? It is an idea.

Dr McCormick: Immigration rules are significant in how that works out. We need to source only where we can.

The Chairperson: Have you done any work on that?

Dr McCormick: I am afraid that we have not followed your example yet about searching —

The Chairperson: If we are under pressure —

Mr Compton: We and NIMDTA went to India, for example, where we have had a traditional relationship, on a number of occasions, and that did not prove to be very successful. Staff have gone

out on several occasions, and we have worked with the Foreign and Commonwealth Office and the immigration department about the immigration rules. Even with all that energy and effort — it is neither easy nor straightforward, and immigration arrangements are extremely difficult and fraught — we have not been successful in recruiting outside of a European context. If there are opportunities for us to recruit outside a European context, there is no restriction on us doing so, and we will be more than content to reflect on the best way to handle that.

The Chairperson: I suggest that you have another look at that. If there is an issue across Europe, we need to look —

Mr Compton: We have gone beyond Europe, which has not proved to be successful.

The Chairperson: In our conversations with the Cubans, they are interested in trying to do what they can.

Is there any suggestion or proposal about opening up more beds in other parts of a hospital? People believe, rightly or wrongly, that there is a lack of beds in hospitals.

Mr Compton: Generically in hospitals?

The Chairperson: Yes.

Mr Compton: As you are probably aware, 24 additional beds opened on 24 April in Antrim Area Hospital. From our point of view as a commissioner, the bed complement is always about what we need to do a task. There is also a balance. We expect bed occupancy to be efficient. Therefore, the average length of stay, for instance, determines, to some extent, the total bed complement that should be in the system. The expectation is that beds should be there to enable a task to be done, not for beds to be open just for the sake of additional beds. It is to enable the task to be done. I think that the effort is not so much about beds but about working between the front, middle and exit of a hospital. In particular, the exit from hospital is the issue, because people do not want to be in hospital any longer than they should be, whatever their condition may be. If there are issues about beds, we will certainly look at them. The Ulster Hospital, for example, has given the trust permission to increase the bed complement. There is no issue about that. That is a direct reflection of the demand and the ability to do a task. As much effort needs to be applied to pulling people through the hospital sensibly and correctly to a proper discharge.

The Chairperson: Unfortunately, in April this year, even with the extra beds in Antrim, the number of people waiting over 12 hours was higher than it was previously.

Mr Compton: To be fair, the beds opened on 24 April, so the month was essentially over.

The Chairperson: Even with the turnaround team focused on Antrim.

Mr Compton: Pardon?

The Chairperson: The number of people waiting for over 12 hours in April this year was higher than the previous months.

Dr McCormick: For clarification: the task set for the turnaround team was, first, to give us a deeper understanding of what was happening. The phase 1 report has not yet been published. The team has been moving into a phase of working with the clinical teams —

The Chairperson: I am not disputing that, Andrew. What I am saying is —

Dr McCormick: That will take time.

The Chairperson: The black-and-white issue is that there seems to be an increase in the number of people waiting longer than 12 hours in Antrim, so you can understand why people are cynical about the service.

Mr Compton: Yes, I do understand that.

Mr Dunne: Thanks very much, gentlemen, for coming in again today. There seems to be evidence that the Ulster Hospital is in overload. The figures for April this year were almost up to the same level as the figures for the Royal. Some 7,112 people were admitted to A&E at the Ulster Hospital, and 7,749 were admitted to the Royal. There seems to be clear evidence that many people from south Belfast who formerly would have gone to the City Hospital are now going to the Ulster Hospital for various reasons. The Ulster Hospital is in overload, which is a concern. In many constituencies — just think about the neighbouring areas of Castlereagh, north Down, Ards, and so on — hospitals have virtually disappeared, so we depend on the Ulster Hospital for a service.

In April, I calculate that about 2,750 people were waiting for more than four hours. That is unacceptable and equates to roughly 30% of those who came through the door. Some 280 people waited for more than 12 hours, which is totally unacceptable, and 272 people waited for eight to 10 hours. Those issues need to be addressed. I understand that additional funding has gone to the Ulster Hospital, but how has that funding been targeted? How will it address those issues?

Are GPs getting to grips with the issue of dealing with people at the first line? Are people going to their GPs, or are they going to A&Es when they should be going to their GPs? Are they getting access to GPs? Some of our GP practices are closed at lunchtime. Evening surgery seems to be a thing of the past. Those issues need to be addressed to try to reduce the load on our A&Es.

Mr Compton: I will respond to your questions about the Ulster Hospital and the beds issue. Since the changes at the City Hospital, the total amount of investment to the Ulster Hospital is just short of £10 million. That sizeable amount of money has allowed a substantial number of extra beds to be opened. The final tranche of those beds will open in June when the £2·8 million that Andrew referred to is finally in situ. We agreed those numbers with them. Extensive work has been done between the board and the trust. We signed and agreed that on the basis of the way in which numbers can flow, and it should give the hospital a reasonable capacity to deal with the numbers of people coming through the door. We now have to resolve some issues about ambulance flow into the hospital. With that proviso, in the summertime, we should be in a much better position to equip the Ulster Hospital to deal with the pressures that it will face over the summer and towards the winter. So there has been a straightforward arrangement. It has not been imposed and is a consequence of negotiations between the commissioning organisation and the Ulster Hospital.

On the general practitioner side of the house, we mentioned that we had completed some work on increased general practitioner availability over the winter; planning; increased general practitioner availability on public holidays; increased support at general practitioner level at busy times and at certain points of the day, which includes how GPs deal with emergencies and what happens when somebody rings up and says that he or she is feeling very unwell — what actually occurs in that arrangement — and also in identifying the 20% of people on the patient list across Northern Ireland who are most likely, because of their clinical condition, to end up going to hospital. The integrated care partnerships will be established later, before the summer, and the first 12 will be up and running. They are concentrating on particular patients — frail or older people, people with diabetes, people who have recently suffered a stroke, people with respiratory conditions, and the end-of-life-care portfolio with that group of patients. All of that is there. That is the point about not seeing it as a single dimension or issue. There is the issue of primary care.

On the other side of that, for example, around one third of the £9 million that is being invested this year is going into re-enablement services, which are designed to enable people to leave hospital situations much more quickly and be placed either back at home with proper support or in proper and appropriate nursing care. Evidence from the re-enablement work over the past 18 months is really quite exciting. It shows that it is much better for people to do that.

We are approaching the issue from all those fronts, because you cannot solve the problem simply by looking at one area. No matter how big you might make the Ulster Hospital's emergency department, if you do not do something with primary care, with the discharge arrangement, with understanding how the middle of the hospital works with the front door of the hospital, the problem will not solve itself. There is a concerted effort to approach it in that way not only at the Ulster Hospital but across the Province.

Mr Dunne: Do you think that, come this time next year — God willing, if we are all spared — those figures will have been reduced as a result of the actions of Transforming Your Care?

Mr Compton: I would be very disappointed if the figures were not reduced. We have set ourselves an enormous challenge. I do not for one minute minimise the challenge. However, I do not know anybody in the health and social care system who feels content with where this place is at. They want improvements. That was quite palpable this morning when we spoke to a lot of professional staff — the people who do the job. This is not about managers but the people who do the job on the ground. There is a real sense from them that they want the situation to be better. They understand that they are at the front door. They understand the pressures, and they want things to be better for patients. We would be really disappointed if we were not at a better place.

Ms Maeve McLaughlin: A high number of admissions to A&Es, and to hospitals generally, are from the elderly population because of their being prescribed the wrong medication. With the commitment to health innovation and Connected Health, what is being done to look at them as a specific target area?

Mr Compton: For clarification: they are the identified 20% of people who are most likely to end up going into hospital. In that core of people are some who are on multiple medications. We know that poor compliance — either over-compliance or under-compliance — with medication is one of the biggest drivers for older people arriving at hospital. The integrated care partnerships will focus clearly on that to ensure that there is better compliance. There is a particularly skilful role for pharmacy. We will use pharmacy to assist in that arrangement. That will not mean that we will not have medication problems with admissions, but again, it is an evidence issue. We know that if you have poor compliance with medication and you are on complicated medication, that may mean that you come into hospital. We also know that that can be managed differently, and that is our direction.

Ms Maeve McLaughlin: So those people are included in that 20%?

Mr Compton: Yes.

Ms Maeve McLaughlin: I will come at Gordon's point from a different angle. Has there been an analysis of self-referral, particular for physiotherapy, and its potential to reduce waiting lists?

Mr Compton: This year's commissioning plan makes it clear that we want to try to introduce a much greater involvement in self-referral for physiotherapy, podiatry and the allied health professional arrangement and to maximise their skills and expertise. Again this morning, we had a powerful presentation from staff at the Ulster Hospital about allied health professionals and their ability to work seven days a week and how that changes patterns and people's length of stay in hospital. It can decide whether people come into hospital and the treatments that are offered. So that is all changing.

Ms Maeve McLaughlin: I am told that there are 350-plus GP surgeries in the North. Has there been an analysis of the potential effect of that on waiting lists as well as cost savings? Is there a figure?

Dr McCormick: There is not a figure as such, but as John said, it is about exploring the way in which different roles can evolve. We do not always have to hold to the traditional way of doing things, so piloting some of the — *[Inaudible.]* — which is where AHPs can make a distinctive contribution is mandated; that has to happen. As you said, we need to maximise the use of information in all its forms: electronic care records as a means of providing better information for clinicians; better security of information; confidence that people can get the right treatment and the right medication; and help with the work on adherence. There is a range of initiatives and many good actions, all of which will underpin long-term condition management. That should be part of what we are doing to prevent the need for A&E attendances. The better we can take care of people, the better GPs and primary care and integrated care partnerships can anticipate people's needs, help to look after them in their own homes or in out-of-hospital settings, monitor them, be aware of what is going on and intervene early. That is the strategy. As I said, we are trying to put that strategy in place, which will require new ways of working. It will require different training, different protocols and everything that needs to be set up, built and put into place while we deal with a genuine difficulty of demand in the community because of the present position. It is a big challenge.

Ms Maeve McLaughlin: If we are saying that we see the benefits of self-referral, particularly in physio, and it is on the commissioning plan —

Dr McCormick: It is to be piloted.

Ms Maeve McLaughlin: When will it be rolled out, and why would we pilot it? Why would we not just roll it out?

Mr Compton: You end up in a situation in which you need to work with people and professional groups. This is about changing professional practice and how people do their jobs — physios, doctors, nurses — and if you simply impose something on professional groups without listening to and placating their concerns and being quite clear about how you introduce it, there will be failure. It takes a bit of time to have that debate and discussion but, in the end, it produces a more robust introduction for a change management programme. There will always be an enthusiastic allied health professional in a particular discipline who will do a fantastic job in a pilot arrangement dealing with 40, 50 or 100 people, but that will not change the pattern. To change the pattern, you have to get that professional group as it works with other professions. People have to understand and handle the change. That is what makes this both exciting and difficult; it is exciting because of the opportunity, and it is difficult because you are handling change and sometimes asking people to work in a very different way with a different pattern of behaviour in different work. That is why it is done on a pilot arrangement. We have to be able to show that it is working very successfully. We have to at least listen to some of the genuine concerns that other professional groups might have about whether it is the right or wrong thing to do, and understand the issues.

Ms Maeve McLaughlin: So is there time for the pilot study?

Mr Compton: It will be coming through this year, 2013-14.

Mr Wells: I was up in the Antrim Area Hospital in August, and Sean Donaghy showed me around the new extension. I got the impression from him that it was not extra capacity, but that it would make life a lot easier and more efficient for the staff. It would make it easier for the staff to deal with their present workload. It would not necessarily lead to an improvement in waiting times. Is that correct?

Dr McCormick: There is some genuine additionality in total capacity. It is much better because there are more single rooms. The space standards of present-day build are higher than at the time when the original Antrim Area Hospital was built. It is, however, very important that the focus is on the way in which the system works, patient flow is organized, and so on. That is what will make a real difference to Antrim. Yes, it is important to complete the building. The ward is open, the 24 beds are open and the new ED is coming on very soon. The key thing is to ensure that there is a fresh approach to the total management of the system within that hospital, and also in Causeway. So that is part of what we are mandating through the team that are now in place there. It is not sufficient to have a building; it is the way of working. All those things John said earlier about ways of working within a site matter very much and need to be applied systematically and faithfully, and that is what will turn this around.

Mr Wells: The only other point I want to make, on top of what members have said, is that, looking at these figures, it is clear that the system is under a lot of stress and that folk are working really hard to address it, but if we got a particularly difficult midwinter peak problem, like the swine flu that we had three or four years ago, planted on top of what we have at the moment, we could have an extremely difficult situation. Is anyone giving any thought to the eventuality that we could have a really cold winter?

Mr Compton: Yes. Clearly, we have contingency and emergency planning. The one thing that health and social care does well is emergency planning. If we were faced with a major flu outbreak — swine flu, or whatever — we would do different things in how we handle our elective work. All hospitals have contingency plans to deal with major events and major situations that would lead to decisions that change where priority and focus lie. The clear priority here is that those who are the sickest are treated first, and those who are most in need will be treated. I believe that our contingency planning would come into place, in such an eventuality, if we had an outbreak of something or other that we had to deal with.

Mr Wells: The other issue, over this past year, is the major changes with the opening of the new South West Acute Hospital. I have been down there a couple of times, and it seemed to be at undercapacity. It seemed to be very quiet, truth be known, compared to what I am used to at, say, Craigavon, Daisy Hill or Antrim. It is a bit worrying, given that fantastic new facility, that in April 2013, there were 72 six-to-eight hour waits, 15 eight-to-10 hour waits and four 10-to-12 hour waits. That surprises me, because you have the most wonderful technology, brand-new spacious premises,

everything going for you and yet, even there, there seems to be stress. Surely that hospital cannot be at capacity at the moment, given that you have 240 or 250 beds?

Mr Compton: There are a couple of things to talk about there. Does it have difficulty in its beds and bed management? In the round, it does not have difficulty with those aspects because it is the most recently planned and, therefore, the best-sized hospital, as far as that is concerned. That does not turn down the fact that, at various times, you might get an abnormal number of people who arrive at the ED, the majority of whom will not necessarily be admitted. So, from time to time, they will be very busy and will have to deal with that. It is, in the scheme of things, a relatively small ED with the overall staffing capacity that it has. It is scoped to do with a certain number. If it gets a turn-up of 10% more than that number, that is the same as being very busy at, say, the Ulster Hospital.

Mr Wells: I said, maybe facetiously, that it is 'Star Trek' meets A&E. It is the most wonderfully advanced and scientific hospital. It is a dream. Most hospitals in Northern Ireland would love a scaled-up version of what it has.

Mr Compton: Yes, they would, of course.

Mr Wells: You have had huge opportunities to plan that, and it really is disappointing. For instance, in April 2013, there were only 2,600 cases, compared with 7,000 at the Ulster Hospital. It worries me that even when you provide the absolute ultimate in facilities, and presumably you have a lot of staff enthused by working in wonderful, new conditions, it still seems to be drifting in the wrong direction.

Mr Compton: We have said all the way through that the four-hour position remains disappointing and unacceptable. The South West Acute Hospital is no more excused from that position than anywhere else. Our objective is to get to a position where the four-hour position is in a much better place, and that means as much in the South West Acute Hospital as in the Ulster Hospital, the Royal or anywhere else.

Ms P Bradley: Thank you, gentlemen. I get a little annoyed sometimes when we totally fixate on medical and nursing. They are probably the most protected of them all because of the obligations surrounding patient safety. I know that there has to be a certain number of staff and that we are meeting the obligations for nursing and medical to meet the nurse:patient ratio.

What about the allied health professionals and social workers? When we look at extra beds and the extra pressures in A&E, it not just medical and nursing that run A&E departments or the wards. It is that vast array of allied health professionals as well, and patients cannot be discharged without them. No one ever jumps up and down or bangs on about whether we have the correct number of occupational therapists, physios or social workers to carry out that job.

Coming from that background, and still speaking to people in that background, I know that they tend to get left behind because everything is put on medical and nursing, which it should be — and that should be the health and safety aspect around that. However, a ward or A&E department does not run purely on medical and nursing. Do the costings that have been put in for extra beds or extra turnover in A&E include the allied health professionals? Can you assure us that the money is going directly to those departments to employ more staff if they are expected to facilitate more wards?

Mr Compton: The short answer is yes. If we are commissioning a new service, it is supposed to be a complete service and take account of a full range of staff. What I think —

Ms P Bradley: They are probably the least protected of all the disciplines.

Mr Compton: I understand the point. The interesting thing this morning was the way in which the pilot arrangements in the Ulster Hospital accepted the seven-day-week working arrangement —

Ms P Bradley: Antrim Area Hospital has been doing that for many years.

Mr Compton: — and how that had changed, and the difficulty. We are planning to look at that because we are moving towards a seven-day-week position right across. You cannot do that, as you say, exclusively on the basis of nurses and doctors. You also have to have allied health professionals and the social work profession involved. There are issues for ambulances and stuff like that as well.

To answer your question specifically: if we have a new service or project coming in, we expect and look at whether proper arrangements are being made for AHPs and social workers, and those are costed.

Ms P Bradley: It just annoys me a little bit, Chair, because the nursing and medical are protected under, I suppose, legislation or an obligation that there must be a certain number of nursing and medical staff to meet the needs of that ward for patient safety. However, they do not seem to bang on quite so much about all those other disciplines that are vital to a patient's progress.

The Chairperson: In fairness, when we talk about staff, it covers them all, including porters, catering and all that stuff. However, you are right that they are an important part.

Ms P Bradley: They are unprotected.

The Chairperson: Yes. Can I just get into some detail, which members will be glad to hear, about the figures from April. In total, 8,465 people waited between four and six hours. Jackie, I appreciate that you might not have these details with you. Can you give us a breakdown, of the patients who waited in the four to six hours, the six to eight hours, the eight to 10 hours, the 10 to 12 hours and the over 12 hours, how many were admitted, how many were sent home and how many rolled over into the next stage? What was the hold-up for those who were admitted? If someone was waiting for four to six hours and was admitted, what was the hold-up to prevent them from being admitted within an hour? If someone was waiting for eight to 10 hours and was admitted, what was the hold-up? That would allow us to dig deeper on what the shortage is and what the concern is. I know that you might not have those figures with you, but I would like them sooner rather than later.

To finish this session, I also ask that we as a Committee get a monthly report on what concrete proposals or changes or suggestions are being put in place to deal with the whole issue of A&E so that we are not back in the next six months. If there is a change in the pharmacy, we need that in a monthly report, and, if there is a change in that you are looking beyond Europe to try to second doctors in, we need that on a monthly basis. To dig deeper on this, we need the percentage of the number admitted, why they were not admitted in those scales and what rolled over.

Dr McCormick: As I understand it, there will not be a rollover, because this will refer to the time before a patient is either discharged home or admitted. Therefore, there should be one or other. We can probably secure that information from the trusts, but getting the reason for delay retrospectively on large numbers is, I suspect, an impossible task. I doubt whether that information is available.

The Chairperson: If you go to the figures for the Royal, you will find that nearly 2,500 people were seen within nought to two hours. I assume that all the people in total, nearly 8,000, were triaged. So, in the triage system, it was worked out who was serious and who was life-threatening or whatever. I do not know the medical terms. There is an issue about how they were triaged, so the difficulty is that, if someone has minor injuries, a focus needs to be put on minor injuries.

Dr McCormick: I see where you are going.

The Chairperson: Roy made this point the other day in the media, so I can say it. He had to get two stitches out, and how long had you to wait? So, if we see that the focus is not on the bigger medical terms but on someone having to wait for six to eight hours or eight to 10 hours to get two stitches out, we need to know that. Out of the people who waited for six to eight hours, how many were admitted to the hospital and what was the blockage in getting them admitted?

Dr McCormick: The detail of what the blockage was would be difficult to get to. I doubt that there is a systematic recording of a particular reason against that batch of statistics. I am reasonably confident that I can say whether they were discharged or whether they were admitted. That is more a matter of fact.

The Chairperson: In fairness, Andrew, we have all talked to people who say that they are waiting to be admitted but that there is no bed, so there must be a record of that somewhere.

Dr McCormick: There will have been a reason, but, to be honest, I doubt whether that is recorded in a systematic way that allows data capture.

The Chairperson: I also know of patients who have waited for 11 hours, and I can quote this. At 11 hours and 15 minutes, they were admitted, just because they were about to go over the 12 hours.

Mr Compton: We will try to find the information as best we can, but, just to reinforce, one thing I would say is that there are some conditions where it would be not surprising to wait a little longer because people may have had a test and it is on the basis of that test that they had whether a decision to admit was made.

The Chairperson: I am not disputing that, and if that is the medical reason, that is fair enough. I am looking at these figures, and if you come back to me and say that 1,000 of those people were waiting for three hours extra because there was a test, so be it. We need to tell people that.

Ms P Bradley: I do not know. They may not, or maybe they do, but I know when I worked all evening on the wards that, if a patient breached their discharge, there were breach codes. If they are breaching their four hours, their eight hours or whatever it is, there are breach codes for that as well. Those will tell you exactly. It could be the case that they are just waiting on blood results, but it could be other things, like waiting on whatever. A lot of the time they are not even waiting on a bed but something else.

Mr Compton: We will look at what we can do and make it as inclusive as possible.

The Chairperson: Can we have that monthly report on the changes, because I do not want to come back on this and say, well, what you told us now is what we were told last year; we need to move on it.

Mr Compton: OK. I understand.

Mr McCarthy: The new accident and emergency department at the Royal has not been mentioned. Is there any opening date for that? That would have a bearing on what we are talking about.

Dr McCormick: That was delayed because of the difficulty we had with the construction project. As I understand it, that is coming later in the year.

The Chairperson: A question on that has been put to the Minister.

Mr Compton: As we understand it at this point, it will open later this year. There are construction issues that need to be sorted out.

The Chairperson: OK. Once again, thanks very much. Jackie, you had an easy time today.

Mr Jackie Johnston (Department of Health, Social Services and Public Safety): I did.

The Chairperson: We will get you the next time. If you can just get us that information, thank you very much.