Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Accident and Emergency Services and Budgetary Pressures: Minister of Health, Social Services and Public Safety

12 February 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Poots	Minister of Health, Social Services and Public Safety
Dr Michael McBride	Department of Health, Social Services and Public Safety
Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Dr David Stewart	Regulation and Quality Improvement Authority

The Deputy Chairperson: Minister, you are very welcome. Your entourage needs absolutely no introduction; you are well known to us all. Michael, Andrew and David, you have been here many times before and know the routine. Obviously, this is an issue that is extremely relevant to everybody around the table and to the community generally. We welcome the fact that you have been able to come here to give us your view on the current situation. There will, of course, be questions. There will be questions on various themes, and we have tried to make the best use of the time that you have given us. Minister, are there any limitations at your end?

Mr Poots (The Minister of Health, Social Services and Public Safety): None.

The Deputy Chairperson: Right. That helps us. Members have dedicated themselves to being here for as long as possible.

Mr Poots: We are here for as long as you wish.

The Deputy Chairperson: Thank you very much,. The Chair is stranded in Londonderry and cannot make it. That is why I am here. Minister, as usual, if you could make your opening statement, we would be very interested to hear what you have to say.

Mr Poots: OK. Thank you, I will just make a brief statement. I am grateful for the opportunity to speak to Committee members about some important issues. I am accompanied by my permanent secretary, Andrew McCormick; the Chief Medical Officer, Michael McBride; and the medical director of the Regulation and Quality Improvement Authority (RQIA), David Stewart. Chair, you indicated that most of you know David. You will have an opportunity to ask him, and the rest of the team, questions later.

When I was invited to this session, it was to talk about finance and A&E issues. Accordingly, a briefing paper was provided to you to cover those issues. Since the briefing was submitted, there have, of course, been some significant events in relation to our emergency departments. Of particular note is my statement to the Assembly on Monday and the announcement of an independent review by RQIA into the major incident at the Royal Victoria Hospital (RVH) last month. There has also been significant media coverage of five deaths at the Royal Victoria Hospital emergency department that resulted in serious adverse incidents (SAIs) being reported. I want to take some time this afternoon to say a little bit about those issues, and we will then, of course, get into the questions.

I hope that you have all had a chance to consider and reflect on the statement that I made to the House on Monday. If so, you will know that I have asked David, with expert assistance from outside Northern Ireland, to lead an independent RQIA review of unscheduled care in the Belfast Trust. David was also involved in the inspection of the emergency department at the Royal over the weekend of 31 January, and I asked him to come along today as he is well placed to respond on the detail of any questions that you might have in that specific context.

I would caution the committee that RQIA has not yet completed its inspection report, and it would be wrong to attempt to prejudge that in this meeting. Members will know that the RQIA inspection identified a range of issues that caused me to have serious concerns about whether the Belfast Trust is performing to the high standards that I and, more importantly, patients expect. The inspectors spoke to more than 100 staff across a range of roles and functions, and the inspection confirmed concerns about staffing levels in key areas, allegations of bullying, staff under intolerable pressure and a system of care that does not function fully as it was set up to do. Although those findings will rightly cause us serious concerns, I believe that it is important that all of us, as public representatives, act together to reassure the public that the Belfast Trust will continue to provide services in the RVH's emergency department to meet the needs of its population as a result of the commitment of all staff and will act to manage the risks to safety that have been highlighted.

Members should know that the trust's management team has responded with an open and fully transparent approach to the RQIA's inspection and is working constructively with the board, the Public Health Agency (PHA) and my Department to implement solutions to those issues. I recognise fully the very difficult job that staff in our emergency departments do on a daily basis and I again want to express my fullest appreciation to them for their dedication and commitment to patients.

As I said in my statement, the results of RQIA's wider review will be reported to me by June. Although its focus will be on the RVH as the Province's major trauma centre, there will undoubtedly be learning that can be of general benefit across the system. The review will, therefore, identify and recommend opportunities for all parts of the healthcare system to contribute to improving emergency care in Northern Ireland. It will look at how the whole system could remove some of the burden on emergency departments and offer a much improved patient experience.

Members will be aware that much attention has been given to the issue that five people died in circumstances where a delay in the emergency department might have been a contributing factor. Although it would be premature at this stage to conclude that the outcome in those cases was related to waiting times, I think that it is important to respond to those five deaths with deep concern and sympathy for those affected and a clear and thoughtful perspective that recognises the reality that it is impossible to eliminate the risk of avoidable errors and failures. The Health and Social Care Board (HSCB) has told me that five is the correct number of relevant cases that the RVH reported as SAIs during 2013. I have asked my officials to obtain comparable data for other hospitals across Northern Ireland and any available comparable data for other jurisdictions. That will be confirmed and provided to the Committee in due course. Those issues are within the scope of the RQIA review.

Members will know that I have made it clear from my first day as Minister that the overriding objective for the entire health system is to protect and improve the quality of services that we deliver. The health service must be safe, effective and totally focused on the patient. They are at the heart of everything that we do. I want to emphasise to the Committee that, although we have to grapple with those issues, we cannot let ourselves be distracted from an overall health system that is improving.

For example, it is improving in the care that is provided to people with strokes, in cardiac services and in waiting times.

I hope that members will join me in talking up and not talking down the amazing National Health Service that we have. Although we absolutely have to be resolute in our recognition and response to addressing issues, including those that have been identified by inspections such as carried out by RQIA, we cannot let those take away from that. I am sure that you will appreciate the context and focus of my opening remarks on our emergency departments and issues of concern, but I am happy to take questions on all the issues that we are here to talk about today.

The Deputy Chairperson: Thank you, Minister. I take it that your colleagues are quite happy for us to go straight to questions. The first set of questions will be led by David and Fearghal. I will allow Fearghal to lead off and David will come in on the issue of the deaths.

Mr McKinney: Minister, I am sure that, like us, you have been saddened at the latest news. What we have heard is sad for the families, staff and those who find themselves in the front line of medical provision. I am sure that, like us, you must be very concerned about what we have heard about families not being told about the circumstances of their relatives' deaths and some further information that, potentially, the coroner was not involved. Will you reflect on that?

Mr Poots: My understanding is that the trust has reporting procedures with the coroner. We can certainly seek to ascertain whether those procedures have been fully followed.

Mr McKinney: Do you not know whether the coroner has been told?

Mr Poots: I can check and perhaps Michael can —

Dr Michael McBride (Department of Health, Social Services and Public Safety): I am happy to provide some further details. The knowledge and information that I have is that, in four of the five cases, contact has been made with the coroner and details of those cases have been discussed with the coroner. It is a matter for the coroner to determine whether a coroner's inquest is required or a death certificate can be issued at that time.

Mr McKinney: When was the coroner told?

Dr McBride: I do not have that level of detail, Fearghal. However, I am certainly very happy to ensure that we provide that.

Mr McKinney: Was the coroner told recently or at the time of the death?

Dr McBride: The coroner would have been told at the time. The case would have been discussed with the coroner at the time of death because, if there were reasons for discussing a case with a coroner, a medical certificate detailing the cause of death could not be issued until such time as the coroner confirmed that he was content to issue it. So, that would have been at the time.

It is also important to bear in mind that there are ongoing investigations into three of the five cases that have been discussed. We do not know whether there were delays that were material to the outcome for the individual patients. The in-depth root-cause analysis has not been completed in three of the five cases, and one of the three cases is subject to independent review. Therefore, it would be premature at this stage to prejudge the outcome. It may well be that, in due course, if other material issues are identified, there may be rationale or reason to refer further or additional information to the coroner.

Mr McKinney: We understand that the cases are serious adverse incidents. We also understand that some of the families have not been involved. How is that consistent with the coroner being told or not told?

Dr McBride: First, let me clear about serious adverse incidents. The serious adverse incident system is largely there as a system of learning. If a case is reported as a serious adverse incident, it does not mean that something materially went wrong with the individual's care, but there may be case for question as to whether the care has been provided to a satisfactory level and it may require further investigation. Primarily, the system is there to ensure that, if there are any circumstances that require

investigation, those are investigated, that there is an appropriate degree of rigour in the investigation at an appropriate level and that those cases are reported by the trust to the Health and Social Care Board. The board then directs the level of the incident and the level of external input to the investigation and receives the report within a 12-week period.

The Department's guidance is quite clear and unequivocal on this. Families and relatives should be informed of two things —

Mr McKinney: Do you agree that, at this point, two families have not been told.

Dr McBride: The details that I have are that three families, at this point, have not been informed fully of all the details. I do not have full and comprehensive —

Mr McKinney: How can we get a learning process when families do not understand the circumstances of their relative's death?

Dr McBride: As I said, we have taken up those matters with the trust already and they will be fully considered during the RQIA review.

Mr McKinney: Do you accept that the —

Mr Poots: In all of this, Chairman, we need to be quite cautious. We are talking about five people and five families here. We have not been given authority by the families to talk about their cases in a public forum. Due to the small number of cases, there is the potential for them to be identified in the public domain. We have to be very cautious in our discussion to ensure that we do not infringe on people's privacy. They may not wish for the cases to be discussed in a public forum. We should exercise caution.

Mr McKinney: I understand and respect that, Minister. However, in two cases, the families do not know.

Dr McBride: Can I answer the question again —

Mr McKinney: Can I ask the Minister to respond to that, please? In two cases, the families do not know.

Mr Poots: The Chief Medical Officer has already responded to you on that issue.

Mr McKinney: No, he has not.

Mr Poots: He indicated that the circumstances —

Mr McKinney: Sorry, Minister. You said to the Committee that you felt that we could not discuss the issues in this regard because there were issues of privacy. We do not know; the families do not know.

Mr Poots: I said that we needed to be cautious. We have the potential of discussing in a public forum issues that families may not wish to have discussed in a public forum. That is something that we need to be cautious about. However, we can indicate that five serious adverse incidents have been reported that may have been a contributory factor to a death or may not. That is a matter for Dr Stewart to investigate. He will report on that in due course, and he will liaise with the families if that is the case. That is the role of an independent report; we asked for independent work to be carried, and that work will be carried out. However, you are asking questions that may infringe on people's privacy and you should always be cautious about that.

Mr McKinney: Yes, I understand that. Can I turn your analysis round the other way and say that there are families out there who are questioning whether or not they know something about the circumstances of a family member's death because far more people presented to accident and emergency and some of those people died. Therefore, there are people out there who do not know whether the waiting time contributed to the death. My understanding is that some of those cases were particular conditions that needed treated urgently, so the waiting time was crucial.

Mr Poots: I think that Dr Stewart will be the person best placed to indicate what his intentions are with regard to getting to the nub of the issue and having appropriate engagement with the families to inform them of whether there were issues surrounding the death of their loved one that may have been a contributory factor.

Mr McKinney: I understand that, but to be honest, I think that we are following a pattern on this with regard to information: the information around whether the coroner has been told has come late in the day; the information about the deaths themselves has come very late in the day; and the information came three weeks after a statement that you made on 13 January, which was that there was nothing basically to see here. I am misquoting, but you know the point that I am making. There was only a —

Mr Poots: I ask you to make your point with some more clarity than that and not to put words into my mouth that I did not say.

Mr McKinney: You said that there were no emergency issues in emergency departments —

Mr Poots: I did not say that —

Mr McKinney: No crisis issues in emergency departments.

Mr Poots: OK, I said that there was not a crisis. That is a different matter.

Mr McKinney: Do you accept now that there is a crisis?

Mr Poots: No, I do not accept that there is a crisis. I accept that five people died out of 80,000 who attended. Others died as well. I accept that the treatment and care that those five people had may well have fallen short, and, therefore, we will have an appropriate investigation of that matter. Five people dying in hospital of 80,000 being treated is not a crisis, and, if it is a crisis, the entire UK hospital system is in crisis.

Let us stop talking up problems here and trying to indicate that there is a crisis. We have issues, we have problems and we have pressures. I do not know whether you have ever been in an emergency department, Mr McKinney —

Mr McKinney: I have.

Mr Poots: — and I do not know whether you have been behind the scenes in an emergency department.

Mr McKinney: I have.

Mr Poots: Someone could come in who has been badly beaten up. They have been jumped in the street. They might have had a few drinks in them. That individual might have broken bones and concussion and need care. You might have a series of elderly people who have urinary tract infections, are dehydrated, have respiratory illnesses and all need care. On top of that, you might have cardiac incidents, strokes and major trauma. You might get all of that in the space of an hour.

On some occasions, you will have to give priority to people. To do that, others who require care may not be seen as often as you would like. That is the nature of an emergency department. You can get it all in a short space of time. We should stop damning our emergency departments because they respond very well to people and provide excellent care to people. If you would like to look at the mortality rates, you will see that Northern Ireland hospitals fare better than other hospitals across the United Kingdom. So let us stop talking down our emergency departments.

Mr McKinney: I need to make a number of points here; it is important. One is that, in every statement that the SDLP and I have made on this, we have praised the staff. In fact, we made it very clear even to the training agency people who were in just before you that we admire the enormous professionalism and endeavour that they show against the enormous stresses that they face.

However, Minister, the issue for us is around how we learn about some of these things. At the outset, you were clearly playing down the incident itself. We have now learned about these things only

through information that the professionals themselves have given to the media. How does this service learn anything about improving if the details were not going to come out and have only come out through the media?

Dr McBride: There is a material point here. I have to take issue with this. The five incidents were reported as serious adverse incidents by the very trust that was providing the care. To re-emphasise the point that I made earlier: three of those five cases are still undergoing thorough, rigorous investigation —

Mr McKinney: By the coroner?

Dr McBride: Sorry; I said they were reported as serious adverse incidents. The degree of scrutiny and rigour is ensured by the Health and Social Care Board. Our Public Health Agency is advised of those within 72 hours. The appropriate degree of scrutiny and independence is assured by the board and the agency requiring the trust's concern — in this case, it was the Belfast Trust — to ensure that degree of independent scrutiny and rigorous examination. There is a requirement that those reports are made available to the board and the agency within a requisite timescale. The board and the agency then look at those reports and identify learning.

This is an important point. The investigations into three of those five cases are ongoing. As the Minister said, we do not yet know the full details of whether delays had a material impact here. What we do know is that two learning letters were issued in relation to two of those cases and disseminated in the system. That is how the system learns. It learns by reporting incidents like this. It learns by investigating them thoroughly and rigorously. It learns by ensuring that that is rigorous and thorough. It learns by disseminating that information. Our Health and Social Care Board regularly issues learning letters. It issues a newsletter. It provides regular updates on events to the Department. It seeks to identify themes and emerging themes.

Now, it may be that, at a particular point in time, you do not see a particular theme or problem with one case that is undergoing investigation. In the case of two of these investigations, where there was a learning incident, a letter issued. It was only when there was a second case in similar circumstances that the Health and Social Care Board, working with colleagues in the board and agency, issued a learning letter to the system that said, "A&E departments, be very aware of circumstances. Where patients present in this situation, be sure to do the following and make sure that the following does not happen." That is how the system learns. That is why the situation that the Minister has outlined does not occur.

Individuals do not come in with a stamp on their forehead saying, "I am seriously ill. I am confused. I have taken too much alcohol. I may have a subdural haematoma." They do not come in selected like that. That is why we have a triage system. That is why we need to make sure that we get to those patients and identify those most at risk. We have to bear in mind that people coming into our A&E departments are the sickest people who present to our healthcare system.

Mr McKinney: No, they are not. No, they are not. No, they are not.

The Deputy Chairperson: Fearghal. Order.

Mr McKinney: Up to 30% of the people who come to A&E, Chair, do not need to be at A&E.

Dr McBride: I said "some of". With due respect, I have been working in health and social care for a long number of years. I have significant experience of working in an A&E department and of being responsible for an A&E department. I have significant experience of working in the Department of Health, so, with due respect —

The Deputy Chairperson: Fearghal, I will let you back in. You have made some valid points, but I think that we need to move on. David is to come in next, and, if you want to raise anything, I guarantee that you will get back in.

Mr McKinney: He said "all".

Mr Poots: I do not think that he said "all". He said that they are the sickest people who come in, and they are the sickest people who come in.

Mr McKinney: He did say "all". He did say "all".

The Deputy Chairperson: Can all answers come through the Chair, please?

Mr D McIlveen: We are possibly witnessing some of the confusion that has resulted from this information coming out, and some of it has maybe been as a result of the way in which the information came out. Obviously, we had a few sound bites on a very dramatic trailer for a television programme that has now been aired, and there have been other issues, with other people speaking publicly. To bring some clarity on that particular issue, when did you receive the information from the Belfast Trust about these five adverse incidents?

Mr Poots: Is that question for me?

Mr D McIlveen: Perhaps you, Minister, or —

Mr Poots: I did not receive the information, and I understand that 400 serious adverse incidents are reported in Northern Ireland each year. It is not a practice to send those to the Minister.

Mr D McIlveen: In the Department, when did the information come forward about those five fatalities, potentially as a result of the delays, or how was that put out?

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): We learned of that at the same time, just recently, but, as the Minister has explained, we do not receive information on the SAIs as such. They are reported and then dealt with in the way that Michael described by the Health and Social Care Board and PHA. In parallel, there is an obligation on the organisations, including the trusts to send us early alerts where particular criteria are met. Sometimes there is a question to judge whether these cases do or do not meet that set of criteria. In the five cases that we are dealing with now, that is not straightforward and clear cut, partly because, as Michael explained earlier, some of them are under investigation and we do not know the circumstances.

Part of what has happened here is that a very specific question was asked that was not and is not part of the routine collection of information. The question asked was, "Tell me about deaths that result from delay in emergency departments". That was not a trend identified by the Health and Social Care Board in its scrutiny and analysis of all the SAIs throughout the year. That was not there. A number were related to the departments being busy, but the trust, conscientiously, in response to the questions that arose, started to look harder at the number of cases and found these and then, openly and clearly, when it was asked again, told about them. During Monday, that information was clarified by the trust. It has responded to public scrutiny in a very open and genuine way and in a way that was not inherently part of the ongoing system.

With hindsight, maybe we could have been told something sooner. In real time and in the real world that people work in, people have behaved conscientiously and fairly in fulfilling their responsibilities. We will need to look at this to see what other changes in procedure we need to adopt. Again, there are lessons that David and his team can pick up in the review, but that is the fact. We heard about these very recently, and we are now just looking to understand what lessons to draw out of that.

Dr David Stewart (Regulation and Quality Improvement Authority): To put this in context, the inspection that we carried out was an inspection of the unit at a specific point in time, so we were going in there to look at that unit to see what the circumstances on the ground were over that weekend period. We were advised that there had been a serious adverse incident but not of the detail or even when it had occurred. That is an area for, if you like, looking at after the inspection as to what the details were. We were in there to get as clear a picture as possible about what was actually happening at that point.

At this point, I have no information about the detail of any of these incidents, and I think that the issues are emerging. I would like to bring in a couple of factors that I am aware of that may or may not be relevant in this situation. The first is that the Belfast Trust has done a very significant piece of work on previous studies and pieces of work to establish a new system for monitoring all deaths in the hospital. That really is a landmark piece of work, and I am not aware of anyone in any UK setting developing similar. Lots of people are interested.

Every single patient death that occurs in the Belfast Trust is now subject to an additional period of consultant scrutiny. You quite rightly raised the issue of deaths being reported to the coroner. During that additional scrutiny, a team of people will look at the death, consider the circumstances that led to the death and look at the evidence. Before the system was in place, a death certificate could be issued by a junior doctor, and that may be still the case, but the death will now be reviewed afterwards. If there is a concern that the death should have been reported to the coroner, a subsequent report will go to the coroner. As I understand it, the coroner has been in close liaison with the trust about the process. So I think —

Mr McKinney: Can I just, Chair —

The Deputy Chairperson: Fearghal, Roy has indicated that he wants in on this specific point, and then I will come back to David.

Mr McKinney: Sorry.

Mr Beggs: On the issue of the five deaths at the Royal, there have been ongoing delays within the four-hour measurement at the Royal's accident and emergency department over a number of years. Equally, there have been excessive waits, particularly at Antrim and the Ulster, and that is also reflected in 12-hour waits and even 24-hour waits. So, my question is this: have serious adverse incidents at other hospitals throughout Northern Ireland identified other deaths that could be attributed to delays?

Dr McCormick: We do not have the information now on that scenario. The Minister has asked us to look at it. The information needs to be handled very carefully and thoughtfully. The numbers are very small, so there is a material issue in relation to breaching confidentiality. We are engaged in that ongoing piece of work, and, as the Minister said, the results will be brought forward as soon as they are ready. It needs to be done very thoughtfully. The numbers will be small, and the issue is to make sure that we look at them in a systematic and proper way. These are highly complex cases. It is usually very difficult to establish whether delay was a factor and, if there was a delay, what effect it had. Those details are often very uncertain.

We are well aware of the general issue. It is one reason for time-based targets; they are intended to be, I suppose, a baseline. Many, many cases are and must be dealt with much more rapidly than within four hours, and the clinicians judge that. We trust the clinicians to make the right judgements quickly about what to do. As the Minister said, sometimes that is very, very pressurised, because there are a whole lot of very urgent cases to deal with at once. Those things are all part of the day-to-day management. We need to look at this with great thought and care before coming forward with any numbers.

The Deputy Chairperson: I will let Fearghal in on this specific point, and for one question only, and then I will come back to David.

Mr McKinney: Just to be clear: your understanding is that there are more than the five that were revealed; that there are additional numbers?

Dr McCormick: Yes.

Mr Poots: In Northern Ireland.

Dr McCormick: There were five at the Royal.

Mr McKinney: As a result of waiting time?

Dr McCormick: Possibly. Again, to be clear: we are looking only at where waiting time may be a contributory factor.

Dr McBride: If I may, Chair, I will just speak on Andrew's comment. I think that it is about putting it into the context that the Minister outlined. If we look at the Royal Victoria Hospital, we see that there are about 80,000 attendees a year. If you look at the hospitals across Northern Ireland, we see that there are 700,000 attendances at our A&E departments. I think that it is within that context —

Mr McKinney: I am very frustrated at this point. I need to come in here, Chair. I understand that people present themselves in substantial numbers to A&Es, but it is my father, my sister, my brother and —

Dr McBride: I accept that, and I understand that very valid point. I hear what you are saying and I hear the passion in your voice, and, obviously, you heard the passion in my voice when giving my response. Some of the patients who come to our A&E departments are among the sickest patients who enter our healthcare system. That is the front door for some of the sickest patients whom we see. You are absolutely correct. Within that, there are many other people who are less sick, and there is a question about whether that is the most appropriate use of our A&E service and all of the work that we do in relation to that. I am sure we will come on to that.

The point is that it is not straightforward to separate those individuals who need immediate care and attention from those who are less acutely unwell, and in some circumstances, it is not readily apparent. These are often very complex situations and, as Andrew was saying, it is often difficult to determine what material impact the delay in the length of time that someone is waiting to be triaged, waiting for diagnostic tests, waiting to get appropriate treatment and care or, indeed, waiting to get transferred to a ward, and moving from one aspect of the care into another part of the system, will have on the individual. It is not straightforward, Fearghal. I am not seeking to create smoke and mirrors; it is complex. That is why it is a piece of detailed and thoughtful work to ascertain whether —

The Deputy Chairperson: To follow on from Mr McKinney, why, out of thin air, did this figure of five suddenly emerge in the media? It seems very odd. It did not seem to be planned; it just appeared, I think through Tony Stevens.

Dr McCormick: As I said, my understanding is that the Belfast Trust was asked the question and —

The Deputy Chairperson: By whom?

Dr McCormick: It was asked directly by 'Spotlight'. The specific question was on deaths where delay may have been a contributory factor. That question was put, and it is not part of our routine data collection.

Mr McKinney: That point was put to John Compton.

Dr McCormick: Yes.

Mr McKinney: Not the trust.

Dr McCormick: It was first put to John; it was put to the trust later.

The Deputy Chairperson: I will let members back in on specific points, but I want to get back to David.

Mr D McIlveen: That is the point that I was trying to get to in my initial question, Andrew. This has turned into trial by media. We are sitting here a week after the information came out, doing things the way that they should be done, through the Committee and the mechanisms that are available to us.

How did we get to a point where a very senior clinician in the Belfast Trust announced the possibility of five deaths on a morning radio show, before the Department knew? How did we get to that position? I think that has been a major contributing factor to a lot of the confusion that seems to exist around the issue.

Dr McCormick: I would say that that was because the trust was genuinely responding to questions that it was being asked, and being open and responsive to enquiries, as we would expect it to be.

As was said earlier, the question was asked of John Compton when he was interviewed by 'Spotlight' on Friday. The interviewer was aware of two cases, and those are the cases that Michael mentioned earlier. There is a learning letter, which shows the way in which those SAIs were handled, and there is a response to that process on a website. That is a totally open process. Those were two deaths that happened during 2013, and there was a similarity of context. Learning was, therefore, undertaken by the PHA and the HSCB, and a learning letter was issued. That is all in the public domain and

known, so it was quite reasonable for the interviewer to ask John Compton about those in the interview on Friday.

Then, on Monday, Colm Donaghy was asked about the same two cases, and the supplementary question was exactly what your question to me is many times, "What else have you not told me?". The interviewer asked Colm Donaghy, "Are there more cases?", and Colm said what he said; you saw it last night.

The Deputy Chairperson: Did they not advise you as permanent secretary before they made that statement?

Dr McCormick: How can they advise me when they are in the middle of a media interview?

The Deputy Chairperson: I would have thought that they would have, since it was so significant.

Dr McCormick: Are they going to say to the interviewer, "Stop, interviewer. I need to phone the Department before I answer that?".

The Deputy Chairperson: This is the last time, Fearghal.

Mr McKinney: On that point, John Compton knew on Friday that this information was going to be broadcast.

Dr McCormick: Yes, we knew that on Friday.

Mr McKinney: You knew that?

Dr McCormick: Yes.

Mr McKinney: Were there any other communications between you and the trust?

Dr McCormick: I had a conversation with Colm Donaghy on Tuesday morning.

Mr McKinney: What was the nature of that conversation?

Dr McCormick: He described to me what had happened in the interview he had given to 'Spotlight'. We talked about it. Simultaneously, Tony had been asked to go on 'The Nolan Show', and he was asked the question. How could he not answer it?

Mr McKinney: Was he asked by 'The Nolan Show' to go on or did anybody ask him to go on in terms of the media preparation for the event?

Dr McCormick: My understanding is that he was asked to go on. Again, we are an open, responsive system, so Tony went on and did his very best to answer the questions. They had clearly thought through and looked more carefully at a number of cases, they had reviewed the recent SAIs during the course of 2013 and identified five cases.

Dr McBride: If I could come in specifically on David's point, because I think that this is at the nub of this. The risk is that we create a crisis of confidence. I absolutely respect, Fearghal, the legitimate questions that you are posing in that context, and it is in seeking to understand the issue that we maintain confidence in the system or not through the responses that are given. I think that we need to have a system and trust is maintained through behaviours and actions and following through on those in terms of what we say and do.

One of the important things that we need to ensure is that we have absolute openness and transparency in all our dealings with the public. Certainly, as public servants, all of us, whether it is working in a Department or working in the health service, are absolutely committed to that and should follow that completely and absolutely. When you are then asked a very direct question, then you have to answer in an open and honest way, including where you do not know all of the circumstances. If you are asked a question, as we were asked today in relation to these deaths, the information that I have is that, at this point, three of those deaths are still undergoing active investigation. In two of

them, the root cause analysis (RCA) is outstanding, it is incomplete and, as I said, one is now subject to an independent review.

So, what the trust did in the spirit of openness and transparency was to get that information out there. The corollary of that is that we need to respond and deal with and manage that information in a mature and appropriate manner.

Mr D McIlveen: I agree entirely with you, Michael. From memory, Dr Stevens's interview took place on Monday morning. It is not the first issue that I have noticed recently, whereby there almost appears to be a, I suppose, an internal battle, particularly within the BBC, as to who breaks the story. It was well known that this programme was going to be broadcast on Tuesday night. Is there any suspicion that, for whatever reason, a senior clinician may have been drawn in to what was actually an internal battle within the BBC?

Dr McBride: I am not in a position to comment on that, David. I think that it is a legitimate question for you to ask, but I am really not competent to answer that.

Mr D McIlveen: When a clinician gets drawn in to it, would that concern you if that was the case?

Mr Poots: We cannot really speculate, but what is evident is that 'Spotlight' had two SAIs and it should not have had them. That was people's confidential information that it had hold of, so somebody gave it that information that led to the questions and so forth.

Now, if someone wished to and had particular concerns about the SAIs in that they felt that they were not being dealt with appropriately, they could have brought them to this Committee, they could have brought them to me, they could have brought them to the permanent secretary, the Chief Medical Officer or others outside of the Royal Victoria Hospital and the Belfast Trust, but for whatever reason, someone decided to give them to the media and that was inappropriate.

The Deputy Chairperson: Have you finished, David?

Mr D McIlveen: I have just one final question, and perhaps I can direct it to the Minister. Obviously, some people may argue that the closure of Belfast City Hospital's accident and emergency department did not particularly help the pressures that we see at the minute. Would it be a fair challenge that a third emergency department in the Belfast city area would help alleviate the pressures that we are currently suffering?

Mr Poots: All the professional advice, and I have not been picking anything up from the consultants or senior doctors and clinicians, is that the Belfast City Hospital would have been something that would have helped us in these circumstances. The problem that we had with having three hospitals within the space of two or two and a half miles of each other was that we had clinicians spread over three sites.

Now, if you want to get people dealt with efficiently and you want to get them the best possible treatment, you want your junior doctors working on the same site as the senior consultants so that whenever they need assistance, whenever they need advice and whenever they need help, or whenever they need a consultant to see a person, that is available to them. If you do not have the requisite number of doctors and clinicians on a site, you will only compound the problem that you have.

I want to mention the safety issue again. This is what this is all about: safety. The mortality rate in the Belfast Trust is 99% of the UK average; that is less. The mortality rate in some of our other trusts is down into the low 80s. The Belfast Trust has a major trauma unit and obviously, therefore, will have the most serious illnesses and you would expect it to have the highest in Northern Ireland.

People are very good at comparing figures when it comes to four-hour and 12-hour breaches. It may well be the case that our staff in our emergency departments in our hospitals are carrying out their work more thoroughly. That may deliver poorer waiting times but also deliver better outcomes. We have better outcomes in our hospitals in Northern Ireland than the average across all the English hospitals. That is the important message. I challenge the media to put that message out that we actually have lower mortality rates than the English hospitals. That is a very, very important message that the public need to hear. Hospitals in Northern Ireland are performing safely.

The Deputy Chairperson: Thank you, Minister. We are going to move on to the theme of the RQIA's inspection over the weekend of 31 January. Mr Stewart will probably want to come in on this, and particularly on issues such as the allegations of bullying. I will ask Gordon Dunne to lead off on that.

Mr Dunne: Thank you very much, Minister, for bringing your senior management here today. We appreciate you coming here to address the Committee. We all appreciate that you have a most difficult job in trying to manage the health service at this time.

The RQIA carried out an inspection over the weekend of 31 January; perhaps you will elaborate on that, David. How did you carry out that inspection or audit? I assume that you had a team that went in there and looked at the various processes. From my experience, I understand that you would go and look, probably, at how they manage quality on the site and in the organisation. Perhaps you could give us some information on that. I would be expecting you to look for trends that were, perhaps, identified previously. Was that the case? Perhaps you could add to that, please.

Dr Stewart: It may be helpful to the Committee if I describe the process of this inspection. This inspection was not a review of all the processes in the organisation; we will look at that area in the longer term. This inspection was the type of inspection that we would carry out in relation, say, to going into a nursing home or an independent hospital. We send a team in to look at the circumstances in the units at a point in time. We want to engage with staff and with patients or clients who are in the unit, but we also want to observe what is happening. It is not a process whereby we ask for lots of information; it is not an audit. It is an actual inspection.

Maybe I should explain the background to this inspection. The Minister asked us on the Wednesday of that week to carry out an inspection of two areas of the hospital. A lot of the focus of the debate has been on one of those areas and perhaps less on the other. The two areas that we were asked to inspect have similar names, which I think causes confusion in the system and maybe the names of the consultants may also have caused confusion.

The first area is the accident and emergency department, the front door of the hospital. All the members of the Committee will be aware of that. The second area is a unit called the acute medicine unit, which is staffed by consultants in acute medicine, whereas the staff in the accident and emergency department are consultants in emergency medicine. Consultants in emergency medicine are trained in dealing with trauma and immediate care of urgent conditions. Consultants in acute medicine — it is a new specialty — are looking at the urgent care of patients with medical conditions after they leave the A&E department. So they do not look at patients with surgical conditions — they go off to the surgical teams — they look at the medical conditions.

The concerns that have been raised with the Minister and RQIA related to both of those units, so the Minister asked us to do the inspection. The reason we were able to carry out the inspection so quickly was that we have a team of inspectors who are currently carrying out inspections of all acute hospitals in Northern Ireland, looking at the experience of older people in acute wards. That team is made up of experienced inspectors from two parts of RQIA. One part relates to that team that carries out hygiene inspections and looks at the environment. The other members of the team come from our nursing home inspectors, so they have long experience. Although the team was put together very quickly, it was an extremely experienced team of people who have a long history of carrying out a whole range of different types of inspection.

So we looked at the two units. The intention was to use the tools, broadly, that we were using in the older people's review, but to rapidly expand the focus of those on the A&E department. There are a number of processes in the inspection. One is standing back and observing what happens — actually watching the processes, watching patients arrive and seeing what happens. The second one is to talk to staff and get their views as to what the circumstances are within the unit. The next area is to look at some of the policies and procedures, and sometimes look at care records to see what is happening, and also, importantly, to talk to people who are in the department at that time.

To put it in context, the Minister, in his statement to the Assembly on Monday, very clearly set it out, although he has not yet had the preliminary report from us, and then there will be a final report. Everything in the Minister's statement is a very fair assessment of what we have told him, but I think I should let the Committee know the experience that our inspectors had when they arrived in the department.

We had planned that the inspection would last one full day —

Mr Dunne: How many were in the team?

Dr Stewart: We had a team of, I think, eight to nine.

Mr Dunne: Between the two departments?

Dr Stewart: Yes, they were spread between the two departments.

Mr Dunne: So you had about four in each.

Dr Stewart: I cannot remember exactly, but it was in the order of eight staff who went in. I joined the team later in the process and went in and spoke to staff as well.

The original focus was to look at the service over that one day. With accident and emergency departments in particular, you can go into an accident and emergency department at 10.00 am and it could look perfectly calm, with very little patients, and you could go in four hours later and it could be a completely different environment. We therefore needed to be in for long enough to see what the situation was, so our plan was to also go in on Saturday afternoon and stay into Saturday evening.

In the experience of our inspectors, who have long experience, what happened when they arrived has never been the situation. Large numbers of staff wished to engage with our inspection team to describe their experiences and bring ideas in relation to how they felt the service could be improved. So, in effect, we then expanded the inspection over four days. We were in the unit to 2.00 am on Saturday, we were in on Sunday, and I was also in with the whole team on Monday. Large numbers of staff wished to speak to us. We are extremely grateful that they were open and transparent, but they exactly described their experiences.

Although a lot of the focus is, quite reasonably, on the emergency department, I think — I am conscious that I do not want to take up too much time — you need to be aware of the situation in the three departments. I am not going to go into the detail, but they all relate to the situation that we need to look at in the context of the second phase of the work. In the emergency department, I observed — I can give my personal observation because I was there and saw the situation — an extremely competent team of professionals at work who were managing the ongoing admission of patients. They have very good processes in place for hourly review and they get together. I observed the process as they were going through it, and it was clear to me that they were aware of the situation. Delegation to individual staff was excellent. However, there were two major issues. One issue relates to the staffing levels, and we brought that to the attention of the trust and, subsequently, the Department. Another very significant issue that it was easy to observe in the department was that patients were being assessed and cared for as you would expect by the emergency department team, and when the ED team had effectively finished its role and the patient was due to be transferred out of the Department, those patients were not getting out of the department. So, the people who we are talking about who were on trolleys —

Mr Dunne: It is a patient flow issue.

Dr Stewart: It is a patient flow issue. The patients on the trolleys are patients who have already been assessed and managed by the emergency department team.

We then went in to look at the situation, and we had split the team. So, while one part of the team was looking at the emergency department, another group was looking at the situation in the acute medical unit, and it was very clear that staff in that unit were also under significant pressure with the staffing that was available at that point in time. Again, I had the privilege of observing how that process was operating, and it became clear that a large number of patients who should have been in that department being cared for by the acute medical physicians were now at points all over the hospital. Therefore, we decided to expand the inspection and visited quite a number of other locations in the hospital where, in fact, patients who really should have been in the acute medical unit were being looked after. That brought immediate concerns to us because, in effect, if the acute medical physicians are going around the hospital, they will not have the time that you would normally expect to manage the patients. It was taking longer, and patients were being treated in units when that was not the original intention of the unit.

We will report on the detail of the individual units, but your point, Mr Dunne, is exactly what I saw there. There was a major issue of patient flow through the system, and the whole system needs to be looked at. We were told about patients who could have been discharged but were still waiting and about patients who could have been transferred but were waiting. So, the front end is where the symptoms are seen most acutely in this situation, because they have the patients on the trolleys, and one part of the solution has to be to get that flow moving throughout the hospital.

Mr Dunne: You touched on a point about staffing. In the report and in the evidence that the Minister gave to us, there was mention of accusations of bullying. Do you have evidence of that and could you maybe summarise briefly where it came from or where the potential for it was?

Dr Stewart: The evidence that was brought to our attention was from staff speaking directly to our inspectors. That was through a large process of engagement. We spoke to over 100 staff and they raised concerns. The word "bullying" was used to our staff on a number of occasions.

Mr Dunne: Bullying by whom though?

Dr Stewart: They perceived the culture as bullying and said that the pressure was on to move patients through the system. It was not about victimisation of an individual but about the fact that enormous pressure was being pressed on the system and the staff to move patients through the system.

Mr Dunne: To meet targets perhaps.

Dr Stewart: Targets were driving processes and a number of staff brought that to our attention.

Mr Dunne: You obviously have considerable experience in the management of quality systems and managing quality processes. Are you not somewhat alarmed that these issues are coming up? Would RQIA not have been aware of this, through its ongoing surveillance and audits in the Royal? You should have regular sight of those. I take it that you meet management about quality of patient care and quality matters generally. Have these issues in relation to the A&E been flagged up to RQIA by the management in the Royal?

Dr Stewart: The specific issues that relate to this flow of emergency patients, at this point in time, have not been brought to our attention, but we have been in. We have done hygiene inspections. We have seen improvements in hygiene. We have had staff on the ground. I think that our staff who had been in that hospital before were really taken aback by the situation that they saw. They would not have described to us, in our previous work, and noted that so many patients were not in the appropriate area of the hospital. Therefore, we have to put this in context: why was such a situation found on the day of this inspection? It is a critical point that we understand what happened to the flow of patients in the hospital. This is not in all aspects of the hospital. It relates to specific areas of the hospital and clearly is extremely acute. It is not something that has happened solely over the past month. An excellent presentation was shared with us as we went round — we were not given the presentation; we were just given the slides — which shows that, in November, there were already indications of issues. We need to understand what has led to the situation, but I have to say that we were not aware of the issues. We have had information in relation to mortality. We have had information in relation to our hygiene —

The Deputy Chairperson: The obvious question would be that surely you should have done audits such as this before and should have been aware —

Mr Dunne: Sorry, Deputy Chair, the other thing is that internal audits would have been going on. I have talked to staff at the Royal who are sick, sore and tired of doing audits — audits, audits, audits. What happens to those audits? Are they not fed through to management? Is there not a management review? Is there not a structure looking at them? Are corrective actions not taken as a result of the audits? Clearly, they have not been. You are going in there, and you have not even carried out an audit yet. All that you have done is some surveillance and visited, but you have not done an audit, as such. When you go in and carry out an audit and look at these reports, it could well be the case that the evidence is already there and has been flagged up by staff to management and corrective action has not been taken. If that is the case, it is serious. How long have we been hearing about bed-blocking in hospitals? How long has that been going on? It was a cliché long before I was on the Health Committee, and you health professions are aware of it. Are we back to that? Are we back to bed-blocking in our hospitals and the knock-on is that the bottleneck is back in A&E? Is that

part of it? If it is, these issues need to be addressed. We look forward to your report, by the way, David. When is it likely to come forward?

Dr Stewart: The report will be in June, but I advise the Committee —

The Deputy Chairperson: The short one, not the full report.

Dr Stewart: No, the short one will come through to the Minister by the end of this week, but it will be describing the situation.

Your question absolutely hits on what, I think, is the critical area that we need to look —

Mr Dunne: You need to look at the processes.

Dr Stewart: Exactly. My experience was gained much more from my previous roles in relation to jobs in public health and, originally, as a junior doctor a long time ago. Over a long period, we have seen that there are times of intense pressure in the system. In my experience, they come with a frequency of around 10 years. You described the symptoms exactly: people on trolleys, delays in processes —

Mr Dunne: Yes — bottlenecks.

Dr Stewart: Bottlenecks. To be honest, I have wrestled with this problem for some 25 years. At times, we have got to the point of effectively controlling the situation. It will never be fully controlled, but it is under a state of control. The situation is specifically difficult in the Belfast area — that is not to undermine problems in individual hospitals outside the Belfast area — because it is a balance of the flows of patients who come into Belfast from other parts of Northern Ireland, particularly when other hospitals are in difficulty. So, more patients tend to come into the system. At the same time, it has to be balanced by the flow of patients through the hospitals. It is a really complex issue. There will not be —

The Deputy Chairperson: Mr Stewart, you should be a politician, because, for a third time, you have avoided answering the specific question. Should the RQIA not have been on top of this? You have explained a lot of the background, but you were carrying out inspections and reports, so should you not have been aware and on top of the situation before the latest issue?

Dr Stewart: In the context of the immediate situation in the past month, we were not aware of the situation in the hospital. We have a small team of inspectors who do hygiene inspections across Northern Ireland. We do not have continuous inspection processes. We carry out reviews, including reviews of hospitals at night: about 18 months ago, we were in every hospital. We do not have people in the units, so we are relying on getting information.

The specific area of concern is that this has been an issue that has been growing in this hospital, but the hospital has had very specific problems in the past four to six weeks.

Dr McBride: Gordon, you are absolutely right: the fundamental responsibility is within the system of accountability in an organisation. It is the organisation that is responsible for ensuring that it has systems and processes to carry out the very audits that you described, to identify areas that may be problematic and to take action. Two important points are critical to that: information from patients about their experience of our services must be used, as must what staff tell us about service. That is why we have staff surveys. It is crucial that we listen to those who use our services and those who work in our services. Primarily, that is the responsibility of organisations that are providing the care. We get the added assurance from RQIA, which carries out its series of thematic inspections and reviews or, in cases like this, is directed by the Minister to carry out a specific piece of work.

Mr Dunne: In my experience, you are really just doing inspections. You need to be looking at system audits: you need to be going in and auditing systems, processes and procedures and following up on that through the management structures. There is limited value in carrying out an inspection to see if someone has washed their hands and if there is soap where it should be.

Mr Poots: Mr Dunne asked about bed-blocking, which is still a problem. I will look to this report to be very aggressive in ensuring that we minimise that activity. That is critical, because the staff from the emergency department who directly spoke to me indicated that one of their biggest issues was getting

a ward to accept someone who they needed to get out of the emergency department and felt should go to a particular ward. The consultants and specialists on the wards were saying, "No, that is not my specialism" and then explaining why. So, they were getting lots of people who were capable of telling them why something was not their specialism, when they needed to have the person attributed to a specialist for further care and treatment. That is something that will be critical in the work that is done. When the emergency department, which is the most generalist department in the hospital, identifies that someone should be moved to a particular part of the hospital, it needs support in having that person attributed to that part of the hospital.

Mr Beggs: What took RQIA in, in the first place?

Dr Stewart: The request to go into the department was a direct request from the Minister. We had received a letter from a group of consultants, not from the ED but from the acute medical unit, two days, I think, before that request, which we had immediately forwarded to the Department, the Health and Social Care Board and the trust. That letter related not to the emergency department, but to the acute medical unit. It related to concerns about staffing and the tracking of patients. When we saw the situation in which patients were at a range of locations across the hospital, we could understand where that particular concern was.

Mr Beggs: You mentioned that staff were very open and willing to talk to you and wanted to talk to you. It is quite unusual in any organisation that you would talk to outsiders. Do you get the sense that they felt that their own management was not listening to them?

Dr Stewart: Some staff said that they had raised concerns and that issues were not being — but it is not possible to give you an absolute situation. However, I think that some of it was about the intensity of the pressures that they felt and were observed to be experiencing at that point in time. They felt that RQIA would be a vehicle to allow them to actually bring those concerns to a group of staff. The lead for this inspection was a nurse who has a long experience in inspection. Previously, she was a sister in an A&E department. So, they were discussing their concerns with people who actually understood the nature of the concerns.

Mr Beggs: Finally, in the Minister's statement, when he was reflecting on information that he had received from you, he said that:

> *"It appears that concern about the 12-hour and four-hour targets for emergency care may have led to some unacceptable behaviour by some staff on some occasions."*

Can you tell me what you found?

Dr Stewart: We found that staff perceived and told us that they felt that they were being put under pressure at times to move patients out of the department at a period that was quite close to the 12-hour breach time. Because they perceived the need that the target must be achieved, that effectively forced decisions to be taken that patients could be moved out of the department, and they were telling us that they had a strong sense of pressure that those patients had to go. At the same time, they had concerns about other patients who had been in the department for less than 12 hours.

Mr Beggs: Did you come across any reports of misreporting of times?

Dr Stewart: The words "stop the clock" were used, yes. We did not go into detailed analysis, but people said that there were times when they had been asked to stop the clock. Those types of terms were used.

The Deputy Chairperson: We might be following that up at some stage. Fearghal, one supplementary.

Mr McKinney: Can you reflect for me and compare what you found with what was being reflected publicly at the time?

Dr Stewart: I will do my best to give you my current analysis.

Mr McKinney: When I say "publicly", I mean by the trust and the Minister.

Dr Stewart: I think that what was being reflected after the event of the night when the hospital declared a major incident to bring staff into the unit — I think the perception that was being presented publicly, and I think I am not giving any view as to whether I think this was a reasonable perception, because at the point in time, actually very quickly, with the additional staff, patients had been moved into beds in the hospital. I think that what I am seeing here is a lack of understanding in the whole system about the consequences of that night.

Those consequences are very significant. This goes back to my previous experience when I was establishing the emergency-admissions coordination centre for Belfast. We were working to put systems in place to coordinate flows to deal with pressures in the system that we set up — I think that we started in 1999 — to build a system that would actually allow the whole system to, as Mr Dunne said, if you like, smooth the flows in the system and understand the pressures. But, from the perspective of getting patients into beds and out of the A&E department on that night, that was a very major success in terms of opening up capacity.

From our experience, I do not want to give the impression that the situation in Belfast has changed dramatically since then. This will need some significant thinking to work out a solution, but I will describe my experience over a period of about five years when there was a phenomenon in healthcare at that time which, I think, is clearly re-emerging where there is a major impact on the system due to the Christmas and New Year period.

That period, in effect, is one when the whole system operates in a different way and we became clearly aware that, over that two-week period, a lot of patients leave hospital. If you visit a relative in hospital during that period, you will find that there are very few beds occupied in some wards. A lot of beds are empty and only major, urgent cases are brought into the hospital. Lots of systems in the hospital are not operating at their normal capacity, such as X-ray departments. People are operating at that level.

The situation then happens that, once the first Monday in the new year occurs, a lot of patients are brought into the hospital — not just the patients that we see moving in through the accident and emergency department, but into all the other departments, such as surgery and elective medicine. Every department brings patients in over a very short period of time. So, on that Monday, there are generally a lot of beds available in the hospital but, as more patients come into the hospital by Tuesday and Wednesday or so, effectively, the hospital fills up with patients very quickly. It is back to, I think, Mr Dunne's comment of knowing about the flows of the situation. Very few patients are being discharged and so the pressure builds up. This leads to situations across different hospitals. What happens is that situation is very clearly then seen to be resolved because patients are got into beds.

The Deputy Chairperson: The record for a Committee meeting is 8.10 pm. I endured it two weeks ago and I do not wish to breach that record. We have only two sections done and we have a lot to go. The next set of questions are from Mickey Brady. There may be opportunities in that to finish off. It is the RQIA external review of emergency care in the Belfast Trust and in the wider regional context.

Mr Brady: You said initially, Minister, that you did not accept that there was a crisis. However, I think you accept that there are current problems. Those have been dealt with by the system and, obviously, need to be addressed urgently.

With respect to the RQIA review of emergency care in the Belfast Trust, let us look at the regional context. How will that involve A&Es in other areas outside Belfast? Will it involve the A&E at the Mater Hospital in Belfast? Another question is: what is the difference between this and the A&E improvement action group? We have taken evidence from Mary Hinds on a couple of occasions. She was specifically tasked to deal with some of the problems in the Antrim Area Hospital at that time. It seems to me that these problems recur again and again, and maybe that leads to crisis. As far as I am aware, 8 January was a Wednesday; it was midweek rather than at a weekend and for that reason you would expect it to be less busy.

The reason I ask about the regional aspect is that there are busy A&Es. For instance, Daisy Hill was a busy A&E: two years ago, it had something like 35,000 to 36,000 people through in a year. That is busy. If you are looking specifically at the Royal because of recurring problems, will other A&Es be involved in that? What is the difference between Mary Hinds's group and what the RQIA will be doing in the instance?

Mr Poots: The course of work will be specific to the Royal in the first instance. I recognise that this is a highly pressured situation. EDs are inevitably highly pressured, and that is something which occurs over and over again. I think that probably where we are at this moment in time is that the constancy of the pressure that they are feeling is taking its toll and putting probably greater degrees pressure on staff than ever before.
I have a concern about the welfare of our staff, because if our staff are not performing to their best, then that has an impact on the quality of care. The first instance that was raised with me was that staff were feeling under so much pressure that it was having an impact on them. So, in the first instance, I want the RQIA to look at the Royal, to look at the practices that are being adopted, to look at how we can get people into the ward setting more quickly, and how we can ensure that the discharges that are taking place are taking place appropriately.

We are in the privileged position of having health and social care trusts and, therefore, I do not accept that bed-blocking should be common place. On occasions, it may be difficult to find alternatives for individuals, but we should be in a much better position to ensure that people are transferred elsewhere when they are no longer appropriate patients for hospital.

So, in all of that, we will look at best practice in the Royal and, where that best practice is not being instituted elsewhere, we will want to assist other trusts or other hospitals in the Belfast Trust to achieve that as well.

Mr Brady: I want to expedite matters, because I was going to ask a couple of other questions later. You brought up the point about dealing aggressively with the bed-blocking and the social care aspect of that. There is an opportunity under TYC to put in place an infrastructure where people will not have to stay in hospital. The previous Chair, Sue Ramsey, quoted an example last year of a women being in the Royal for almost a year because adaptations had not been done to her house. There are overarching issues that need to be addressed there.

My other question was about Mary Hinds and the A&E improvement action group. What is the difference? Will there be a substantial difference? I am not necessarily saying an improvement.

I do not think that anybody is putting down the staff. I think that the staff do a very difficult job in difficult circumstances and are often faced with life and death issues, and we have that issue in front of us. It is the systems that seem to be failing the staff; the staff are not failing the systems, and that is the important point. In talking to staff, certainly in my local hospital, the systems do not always come up to the same standards as the staff. Maybe management needs to take some responsibility, because the staff are doing a very difficult job and are doing it very well in the vast majority of cases.

Mr Poots: With regard to your last point, it is important to understand that whatever criticism is levelled at a particular service, very often the individuals who provide that service feel demotivated as a result. From my experience of talking to staff long before I was Health Minister, I know that a lot of the stuff, a lot of the criticism, ends up in the media. A lot of the very often unwarranted and ill-informed criticism was demoralising for staff. There is that aspect, and we need to be careful.

On Tuesday night, I talked to an emergency clinician who said that all this publicity has been bad for emergency care; that was from an emergency department consultant. We are trying to attract young people and young doctors to come into this, and he said that all of this is hugely damaging to us achieving that. So, it is OK for the media to grab a headline, and health will always be an easy touch for that because we have 70,000 people dealing with millions of cases each year, and there will always be failings. So it is always an easy touch for the media, but very often there is a worse impact as a result. However, I think that the staff wanted attention to be brought to what they were doing. They felt that management were not listening to them as well as they should have been, and, consequently, we asked David and the team to preside over this.

Mr Brady: I will just finish on one point. Transforming Your Care is a huge issue. Do you see possible alternatives to A&E being available? I am thinking about integrated care centres. In some hospitals, such as my local hospital in Daisy Hill, the out-of-hours service is in the hospital. So, it takes the pressure off. People go to the hospital because, in their heads, they have to go to the hospital, but if the out-of-hours service is in the hospital, they are dealt with in a different context. They are not in A&E as such. There seems to be an opportunity, but, again, there is a time factor because I am sure that the staff in the Royal are not sitting thinking that TYC is going to change all this. That is the reality, but it may be an opportunity to provide viable alternatives where people will have somewhere else to go where they can be seen to properly.

Dr McBride: We are really at the nub of the issue. As David said, at the moment and for the last little while, we have been looking at the symptoms rather than the causes. It is absolutely correct to say that, right across the United Kingdom and the Republic of Ireland, we have a system of care that is not currently aligned to meet the needs of the population.

The truth of the matter is that there have been huge advances in medicine. There have been advances in surgery and advances in anaesthetics, and we do more day-case surgery. If you look at hip surgery, for instance, people used to spend 12 days in hospital recovering from hip surgery, but it is now eight days. There is more community rehabilitation, and we have enablement programmes. There are a range of issues. So, our length of stay right across the system is much shorter. Therefore, activity is much more intense. We have a third fewer beds in the system than we had a number of years ago right across the UK. We have one third more admissions to our A&E departments, and two thirds of those are over 65 years of age.

The whole thrust of the vision under TYC is realigning how we provide healthcare to meet the needs of the population today and into the future. That will need us to redefine what is provided in A&E. It is almost seen as a victim of its own success. Emergency departments are a victim of their own success. A&E does not mean "always and everything." Unfortunately, too often, it is used as a gateway. We need to have alternatives in terms of unscheduled care, as you have described, whether that is enhancing GP services, enhancing community care packages, alternatives, better diagnostics to support GPs to manage people with long-term conditions in their home, rather than individuals arriving at our A&E departments. So, I think that you are absolutely correct. Hand in hand with that, we will need to equip the workforce with the new skills and competences that they will require for working in a range of different environments. That is the vision in TYC.

We are on a journey. We have started on that journey, and it will take some time to complete that journey. It is a very fundamental and radical change. That is why we have 17 integrated care partnerships, it is why they are looking at pathways for the frail elderly, for those with respiratory disease and those with diabetes. That is the direction that we are taking and steering the system, and that will take time.

Dr McCormick: Just to be clear on the point about the IAG and previous work, we have been on a journey for a long time to try to improve emergency care. This review will build on some good work done by the IAG, which you heard about in previous sessions with Mary and others. Last May, it was necessary to focus that small team on the issues in the Northern Trust area. That is where Mary and her team have been, and there has been significant progress there. It is by no means a total solution to the issues there, but there has been significant progress.

This is a similar theme. The Minister made it very clear that the review will be informed by external support. So, the issue in previous performance management, in the IAG and in this review involves establishing good practice and checking that it is being applied in a practical, straightforward way. So, there are a range of known areas of good practice, and many of them relate to what we have just been talking about, which is integrated care working, discharge and different flows. The difficulty is not identifying what is good practice; the really difficult thing and the complex business of a culture of an organisation is applying that good practice. So, in conjunction with RQIA, we are looking to appoint a number of external experts who will contribute to that process and who will help to build on what has gone before. In the meantime, the process of monitoring and managing unscheduled care remains, with the objective of ensuring high quality.

The Deputy Chairperson: The only member who is down to ask a supplementary question is Sam. We will then move on to the next issue, which Fearghal will ask about.

Mr Gardiner: I have a couple of issues to ask about that relate to emergency department staff recruitment. Why do we not recruit new super-paramedics, as has happened in Wales and now in London? Surely that would help to lessen the pressures on the A&E departments.

Dr McBride: That is an excellent question. Yes, we are looking at how we can enhance that role, for instance. I will give you one example, which, I think, was covered recently. In the South Eastern Trust, emergency nurse practitioners are trained to work alongside GP out-of-hours services to provide services in the interim in Downe and Lagan Valley hospitals. So, that is an initiative from the South Eastern Trust. Similarly, we have emergency nurse practitioners in training in the Royal Victoria Hospital, so we are looking to enhance and to expand the range of excellent expertise and experience of our cadre of nurses working in emergency medicine while expanding that yet further.

Obviously, we also need to consider whether there is a role for physician assistants. Many such models have been applied in the States and elsewhere. So, those are all models that we are actively considering, and, indeed, there are examples of their being piloted in Northern Ireland at the moment.

Mr Gardiner: I welcome your comments. However, how soon are you moving? What is your timeline? Take Craigavon, for instance, which is in my constituency.

Dr McBride: I outlined what is happening in the here and now, but I am certainly happy to provide further details of timescales for that work or of other trusts that are actively looking at that. However, I think that we certainly need to make absolutely certain of some elements. Mickey mentioned workforce development in the context of TYC, and I mentioned realigning the workforce in how we provide care. There is a piece of work on that, and part of that is also about looking to see how we best ensure that we have the right people with the right skills providing care and that they are qualified and competent to do so. That will mean enhanced roles for specialist nurses and for others in A&E departments who are trained to fulfil other functions. They will be working as part of a team alongside doctors in training and alongside other individuals who are at the consultant level in our emergency departments. So, again, I am happy to provide further detail on that.

Mr Gardiner: I welcome that. How soon are you going to let me know that that is all in place and working?

Dr McBride: I think that they are being piloted —

The Deputy Chairperson: No pressure.

Mr Gardiner: Yes, I am putting pressure on.

Dr McBride: No pressure, Sam.

Mr Gardiner: Yes, it is pressure.

Dr McBride: I think that there is always the risk that we rush to a solution or to a particular model without piloting it to see whether we can attract people to the roles or whether the roles will actually assist in providing the sort of team-based care that is required. We also have to ask whether we will be able to retain those people in those roles, because retention in some new roles has always been a problem. I experienced it in the past as a medical director in a trust. Sometimes it is very easy to invent new roles, and you can recruit and train people to them, but it is also sometimes very difficult to retain individuals. So, I think that we need to look at what is being taken forward in Wales and in other parts of the United Kingdom and —

Mr Gardiner: In London.

Dr McBride: Yes, absolutely. So, I cannot give you a specific timescale, Sam, but I am happy to get back to you with examples.

Mr Gardiner: Could it be within six months?

Dr McBride: Certainly, those pilots are under way at the moment. I do not have the details with me today, Sam; otherwise, I would give them to you.

Mr Poots: The pilot in the Downe is to start in March, all being well.

The Deputy Chairperson: Could we move on to the impact of other decisions? Fearghal is playing the lead in this one. However, I have a personal interest in this. The issue has come up in many parts of Northern Ireland, such as Lagan Valley, Downe and the City Hospital. When the decisions on those are made, the accusation is that they will place enormous strain on the Royal's services. Usually, you, Michael, or Andrew will say, "Oh no, we have it all sorted out; we have it all monitored and have built in excess capacity". There will be people out there who will say, "We told you so, and you are reaping the harvest of decisions that were made elsewhere in Northern Ireland."

So, that was me just setting the scene. Fearghal wants to lead on this issue.

Mr McKinney: Just before we get there, I will say that part of our concern has been about decision-making and sometimes the public representation of it. So, Minister, on 28 January, when talking about the Downe and Lagan Valley, you said that:

> *"it came as news to you that there was not an adequate number of middle-grade doctors to provide a safe service." — [Official Report, Vol91, No4, p63, col 2].*

On 14 January, you said that the South Eastern Trust had advised that:

> *"the situation had worsened over the previous six weeks, due to the departure of two specialist doctors". — Official Report, Vol 90, No 6, p87, col 2].*

It knew, so why did you not know earlier? Why did the trust make a decision without informing you?

Mr Poots: It informed me. I think that I picked up the information the week before Christmas. I had a meeting with the trust chief, John Compton, with Andrew and with my special adviser on the Saturday morning before Christmas. I think that it was that week that we learned of it. That was the time frame for me being informed of it.

I think that, in that instance, the South Eastern Trust attempted to keep the hospitals going until it got to the point where it was clearly unsustainable. So, for the previous number of weekends, it had consultants in the hospitals. There were some middle-grade doctors, but they were being supported by consultants, which ensured that the continuity existed. The Lagan Valley has junior doctors, which the Downe does not. In those instances, the consultants were working, I think, four weekends out of five. It was indicated that that would not be sustainable into the future. So, the trust agreed to maintain it until early January to get us over that difficult period. That is what happened.

I contacted the chief executive of Belfast Trust, as did others, to indicate what the South Eastern Trust's intentions were. Knowing the geography of the area, I anticipated that much of the work would end up with the Belfast Trust. It took additional actions over its normal winter pressures to absorb additional people. In the Assembly, a number of Mr Brady's colleagues, for example, referred to the 40-odd per cent of people who turn up at the Ulster Hospital who are actually from the Belfast Trust area. A considerable number of people who are from the South Eastern Trust area use the Belfast Trust area, because the South Eastern Trust area takes in Colin, Poleglass and so forth. Lisburn people, if they were not using the Lagan Valley, would look to the Royal before they would look to the Ulster.

Today, I was speaking to paramedics who wanted to inform me of certain things. They indicated that they take all the blue light calls to the Royal Victoria Hospital, because, when they get a 999 call and it is a blue light situation, they have to take the person to the nearest hospital. So, there is absolutely no doubt that the closure of Downe and Lagan Valley emergency departments would have an impact on the other facilities. However, the other facilities had been in discussion prior to that and had indicated that they had taken actions to absorb the additional numbers. I am not sure whether you have the details of the numbers of people and so forth who were redeployed to do that.

Mr McKinney: Had you found out earlier, would you have made any other interventions to provide a different outcome?

Mr Poots: A politician should never make an intervention that goes against safety advice. So, what I might desire and what I might want to do will always be tinged by my asking whether I am actually putting people in danger as a result. If that is the case, I cannot do the second thing.

Mr McKinney: Yes, I understand and appreciate that point, but you said that the trust was clearly able to manage it within a certain time frame and within a certain, if you like, safety spectrum. Was there anything that you could have done in that safety spectrum that could have provided a different outcome for Downe and Lagan Valley?

Mr Poots: In the case of Downe and Lagan Valley, this has been largely down to the recruitment of, in the main, middle-grade doctors. The fact that the trust lost two doctors in the autumn was part of the problem. I do not think that it anticipated that. It also had another locum doctor who had worked very hard all year and had indicated that he wished to go back to his home country for a month in January. It led them to a point at which it was very clear to them that there were 70 unfilled shifts in January. That would have caused a real danger to the people in both Lagan Valley Hospital and Downe

Hospital had they tried to proceed. It would almost certainly have led to an unplanned closure, which would have been a worse situation than what was proposed. However, I remain profoundly unhappy that it happened in the first instance.

Mr McKinney: Should they have told you earlier?

Mr Poots: My view on all these things is that the more information is shared, the more assistance can be given. Yes, they should have told me earlier. They were attempting to avert a situation. It might have been better had they informed us earlier. I do not know whether we could have offered assistance but we could have at least made some effort to help.

Mr McKinney: That decision impacted elsewhere.

Mr Poots: It will have an impact. The evidence and data, particularly relating to 8 January, does not indicate that it was additional numbers from Downe and Lisburn that caused the problem. I have previously quoted the fact that there were 380 admissions to the hospital. On the same three days the previous year, there were 300 admissions to the hospital. They would normally admit around 80 people per day to the hospital. Things had been ramped up to deal with the winter pressures, but they had 300 admissions the previous year and 380 admissions in the same period this year. No matter what preparations you make, there are occasions when you are just overwhelmed with the amount of illness and sickness that comes your way. They made the response that they made on 8 January, which dealt with the issue at that time. It was an unprecedented pressure without doubt.

Mr McKinney: It was not a strategically positive decision. They pulled the plug, if you like, as a result of finding themselves in that scenario. The Department, the Public Health Agency and the Minister were told at the end.

Mr Poots: It was neither strategic nor positive.

Mr Wells: Are there any other supplementaries on the specific issue of outside hospitals?

Gentlemen, you will be glad to hear that we are a long way from finishing. I want to move on to the issue of recruitment of staff. We had a useful session with the Northern Ireland Medical and Dental Training Agency (NIMDTA) just before you came in. We went at this issue for quite a long time, so we do not want to repeat some of the points that were raised.

Mr McCarthy: Staffing has already been spoken about this afternoon. In the Minister's statement to the Assembly on Monday, which has been referred to, he said:

> *"The inspectors spoke to more than 100 staff across a range of roles and functions. The inspection has confirmed concerns about staffing levels in key areas, allegations of bullying, staff under intolerable pressure and a system of care that does not function fully as it was set up to do." — [Official Report, Vol 91, No 7, p2, col 2].*

That is shocking in anybody's book. The Minister and the officials must be very concerned if that is the case. Let me put on record once again my admiration for the work that the front line staff have done and will no doubt continue to do. That has now become rhetoric and a rhyme. We must ensure that what is happening is ended and that something new is put in its place to support those dedicated staff 100%.

I have a number of questions, but, when it is in my mind, I will ask this one. At the end of last night's programme, Declan Lawn referred to a number of emails that had been prepared by concerned consultants, staff and doctors. Did you receive any emails, Minister? Who received them and did nothing about them? Surely that is damning, not of the Minister but of his office, as the emails should have got to you.

Mr Poots: I understand that the emails that were referred to in the programme were internal Belfast Trust emails. A consultant saw a problem and emailed management to identify that problem and to ask that something be done about it. That was the nature of the emails. I do not believe that even Michael received those emails.

Dr McBride: No.

Mr Poots: They were probably not sent — *[Inaudible.]* I imagine that they stayed within the Belfast Trust.

The Deputy Chairperson: Kieran, remember that we are dealing with recruitment of staff and, OK, it is tangential —

Mr McCarthy: It comes back to making sure that the staff that we have are treated properly. In an earlier programme, I heard of staff actually crying. Have you seen staff crying? You are nodding your head, but to have staff cry is wrong and shameful.

Dr Stewart: Our team found staff — *[Inaudible.]*

Mr McCarthy: Can you explain that? Why is there crying? That should not be allowed to happen.

Dr McBride: I can perhaps comment on that. The Minister has referred to it, and David in his feedback referred to the severe stress that staff have felt. As I said earlier, we should not for a moment underestimate the passion and commitment of staff. None of us does, and we have all said that during the course of our discussions this afternoon. They have absolute commitment. Indeed, I think that David communicated the sense of frustration among staff who feel that something can be done and want to be part of the fix. However, it can be extremely distressing for an experienced member of staff who is feeling that pressure and seeing the consequences of, perhaps, not being able to deliver care as best they wish. That is why we need to ensure that immediate steps are taken — as the trust is doing in the feedback that David has already provided, through the detail of the substantive report and, indeed, the further steps that will be required when, in due course, we get the detail of the review and its recommendations.

Mr McCarthy: Were doctors' concerns any different from those of nurses whom you spoke to at the A&E in the Royal?

Dr Stewart: I think that we saw a team response. We felt that this was not a doctors versus nurses response: it was a combined response, the issues commonly came from both. The doctors were clearly aware that pressures in the department were causing difficulties for nurses. Nurses were clearly aware that the issues were causing problems for doctors. Equally, we found that the teams in AMU recognised their close relationship with the teams in A&E, and vice versa, so there was no divide between doctors and nurses.

Mr McCarthy: What are the key obstacles preventing hospitals outside Belfast being able to recruit enough emergency doctors? What consideration have you given to changing doctors' contracts to require them to work on more than one hospital site, including in rural areas? Are you working on anything that would improve the situation along those lines?

Dr McBride: There are a number of levels to that. In the wider context, we must recognise that, right across the United Kingdom, there are workforce issues in relation to emergency medicine. It is estimated that, across the UK, in the region of 50% of posts in emergency medicine are vacant, and we have to understand why. I think that you have gained some sense of that this afternoon, from the Minister's statement and the pressure that staff are working under in our accident and emergency departments.

I think that trainees experiencing that and working in that environment under supervision are not inspired with confidence about pursuing a career in emergency medicine, even though such a career is rewarding. That is because they see the pressure that their consultant colleagues are working under. We have also just discussed the external scrutiny and the pressures that staff feel from that.

I can think of no other area where the rapidity of decision-making is as intensive as it is as intensive as it is in our emergency departments. Doctors and nurses working in that environment have to have to make very rapid decisions and assessments that are sometimes based on fairly limited information, and they must continually review those decisions. David has given a flavour of that process. So we need to look at how we make careers in emergency medicine more attractive, and I can certainly speak for doctors. We need to look at how we make the training programmes more attractive. Keith may have explained that to you earlier, and I will not rehearse it again. It involves giving them greater job security and making sure that they stay in emergency medicine and do not find working in other specialities more attractive.

Mr McCarthy: Finally, did I hear someone say that eight consultants had recently been recruited? You were looking for 11 but eight have been recruited. Is that right? If it is right, why is coming only now? When we closed the City Hospital's emergency department, we could not get sufficient people to staff it.

Dr Stewart: After the inspection, the chief executive of the trust invited RQIA, two days later, to describe the actions that were planned and taken to deal with the issues that we raised. There was a very immediate response. We learned in conversations that significant actions were already being taken before this process to tackle the issues. It is important not to think that the actions were all in response to the inspection. The trust had already advertised for a number of accident and emergency consultants and for nurses for acute medical units and, I understand, the A&E department. I do not know the outcome, but my understanding, from what I was advised, is that it hoped that six consultants could now be appointed. Our immediate feedback was that there were major pressures on staff and certain things that needed to be done immediately. It was very positive for us to see on the Friday, two days later, that a number of actions had already been taken to address those immediate issues, but those will not necessarily address the longer-term flow systems issues that we now have to tackle.

Mr McCarthy: Thanks for your information, but, again, that is contrary to what I am led to believe, which was that 11 positions were required and eight people have been recruited. You are saying that it is only six.

Dr McBride: Can I provide some clarity? It is important to put in context the figures that we are quoting. The College of Emergency Medicine has made recommendations on securing optimal staffing levels in ED departments and major trauma centres. That report was published some time ago. In England, the average number of consultants working in an A&E department is four and a half whole-time equivalents. Our numbers of consultants working in emergency medicine compare favourably to those in Scotland and England. However, there is absolutely no doubt that we need to increase the number of consultants and nursing staff, particularly in the Belfast Trust. The aim should be, as the College of Emergency Medicine indicated, to have 16 hours of consultant presence seven days a week to ensure that we are providing those senior decision-makers for patients presenting. The recommendation for a major trauma centre is that we should aim for an additional 11 posts to be appointed.

The difficulty is that the Centre for Workforce Intelligence in England estimates that, even to get to 10 whole-time equivalents, which will give you 16 hours seven days a week, it will take, in England, until 2020 and will take until 2030 to get to 24/7 cover in major A&E departments and trauma centres. So the issue is particularly pressing right across the United Kingdom. The Belfast Trust will clearly seek to recruit the best calibre of people that it can, but there is an ongoing recruitment process, and it cannot appoint people who are not appointable and that it does not feel are suitable to fill the role. It can only appoint how many apply and how many it feels it is able to appoint. Obviously, it will appoint as many as possible. I know that it has had discussions with the Health and Social Care Board about that aspect of workforce, and the important point, as David indicated, is about the trust management team. We have heard a lot about the trust management team. It was in that space and identified and recognised that there were staffing issues with nursing and consultant medical staff, and we are actively seeking to resolve that through the process that it has sought to accelerate to increase the number of staff that it will recruit.

Mr Poots: I am sure you will agree that optimal numbers of staff by 2020 and 2030 is not particularly acceptable. I raised the issue with the Secretary of State, Theresa Villiers, who has written to Theresa May about our inability, at this time, to recruit staff from countries outside the European Union. We traditionally had a good supply of doctors, particularly from the Indian subcontinent, including Singapore, Malaysia and places such that. They were excellent doctors. We also need to look at why, for example, 25% of emergency consultants in Australia come from the UK and Ireland. The information is that they have better working conditions, and so forth. So we need to address those issues, and that is part of the work that David will be doing. Those doctors who have gone to Australia have to go through all sorts of convoluted hoops if they want to come back and practice in the UK. We need to look at how we can ensure that people, who are very skilled and have been practising in other countries but wish to come back to work once again in their home country, can be facilitated in doing that, as opposed to us putting obstacles in their way.

The Deputy Chairperson: A couple of members have indicated that they want to ask questions. We need to keep moving on, but I must ask the question: why can we not give doctors a contract that tells

them where we want them and what we want them to do? We are spending £0·5 million to train them and paying them a very good salary. I use the analogy of the police. You do not get police stations closing because there are not enough sergeants. Sergeants are moved to where the need is. Can we get to a situation where doctors are forced, by their contract and their generous pay, to go where they are needed? Your starter for 10.

Mr Poots: I think you will find that there have been more police station closures than ED closures in your constituency, Mr Chairman.

The Deputy Chairperson: Not closures because of a lack of staff.

Mr Poots: It is much easier to recruit police officers — others talked about teachers — than it is to recruit doctors. That is the reality. Workforce changes have taken place. European working time directives are now applied. A whole complexity of things have led us to the situation that we are in, and there are no simple answers. However, there has to be a series of steps that we can take that will mitigate against it.

The Deputy Chairperson: I am letting Fearghal in last because he has had a very fair crack of the whip. Roy, do you want in on this very briefly? There is just yourself and Gordon left to ask questions.

Mr Beggs: Three years ago, there was this problem of a shortage of specialist staff in accident and emergency units. Just before you came in, in the session that we had with the training unit, we were told that there is this new 2014 pilot. However, we are advised that, unfortunately, this will not make much difference this year. So what are Government, or rather Governments, doing to engage with the various Royal Colleges to ensure that changes happen to meet the needs of this community. It is not enough for everyone to say: "We cannot do anything." One thing that came up during the earlier conversation was that we should perhaps require and give greater recognition to time spent by any doctor who does training in accident and emergency units. It is very worthwhile training, and it is essential that we have such doctors. I understand that, at present, GPs spend at least six months there. Can we not do other things to get middle-grade capable doctors to provide assistance to the community?

Mr Poots: In response to that, I think that, first of all, while "the buck stops here", finding solutions to those issues and ensuring that our emergency departments are more attractive places to work in, is not purely the responsibility of government. It is the responsibility of hospital management and society. It is for hospital management to ensure that the working conditions are improved. If people need to have more flexible working hours, time off for training and all those things, they should be treated appropriately. We need to work very closely with our clinicians to ensure that we can do that, and that is one of the reasons why I believe Australia is proving more attractive to emergency practitioners than the UK or, indeed, Ireland.

However, society has also to stand up. We have to make it very clear that it is unacceptable for people to abuse staff in emergency departments. We all say that it is unacceptable but what do we do about it? What are we doing about the fact that, in our emergency departments at the weekend, eight out of 10 people are there as a consequence of consuming alcohol? Very many of them turn out to be aggressive.

If you are a young doctor and you have been in an ED for a while, you might get the opportunity to do orthopaedics, cardiac or something else where you would be on call one weekend in the month, rather than be an ED doctor who is on call at least two or three times a month. The people whom the other doctors are treating are saying, "Thank you very much, doctor. You have done so much for me. I really appreciate what you have sorted out", as opposed to someone who is effing and blinding at them, being aggressive or potentially hitting them. You understand where I am coming from. As a society, we need to ensure that our emergency departments are attractive places and we should not tolerate a lot of the things that take place. We should support initiatives to discourage and dissuade such things from happening. There is an element of that.

There is an element of people who will turn up to emergency departments when staff are already under pressure. I have spoken to emergency practitioners who have said that, on a Saturday night, a guy will turn up and say, "I have had a sore back for three weeks now". He then makes a complaint because he is not seen within four hours. There are lots of opportunities and other avenues for individuals like that. It goes back to always and everything and the pressure that is piled on individuals. People are coming in and are cheeky with it.

Societal change is needed, but the responsibility will still come back to us as to what we do, and that is to make the working conditions and governance as positive as possible for emergency practitioners. Emergency practitioners, unlike a lot of other parts of the profession, will not benefit much from private work. That is another issue, and I suppose we cannot do much about that. At the same time, many people who work in emergency medicine find that they get great enjoyment and satisfaction from the work that they do. It is something with a buzz and excitement about it. It is a place that you will go into and something different will happen almost every day, so it is not monotonous. So there are attractions as well. That is why people are signing up to it.

I should say that we have a very young cadre of emergency doctors now, and we have quite a number in training as well, so that element of it is not that bad, if we can keep them. It is incumbent on us to ensure that we keep them in Northern Ireland, because those people have decided to do emergency practice.

Mr Beggs: The point of my question is that we have very valiant staff working in very difficult positions. How can you assure me that the health service, the entire system, the management, consultants and the rest of the hospitals are all putting their shoulders to the wheel to help those in that front line who are under-resourced in people with the necessary skills? That is my question. How do we really value them, show that they are valued and make sure that we work with them to help them so that more will remain there and assist their community?

Mr Poots: You have indicated a very clear problem with the entire hospital helping them and ensuring that they can get on with the work that they need to do in dealing with the emergencies that come in. Once they have done their course of work, other elements of the hospital receive the patients. That is going to be critical part of the work that RQIA has to do. Michael, do you want to say something?

Dr McBride: There are so many aspects to it. Jim quite rightly mentioned the working time directive, the New Deal and some of the pressures. Mickey mentioned that as well in driving some of the hours that doctors can work. One of the problems that we had in the 1990s when the New Deal came in, with the European working time directive, was that we had doctors in training who were working excessive hours, putting patients at risk and putting themselves at risk because they were working to a state of exhaustion.

We have that issue, which is that doctors are working shorter hours, and that is a good thing, because it is ultimately good for patients and means better quality care. Similarly, we have the demographic drivers, which we cannot change, such as an aging population, sicker patients, more people living longer, thank goodness, but more people living longer with more long-term conditions, and all the pressures that that creates. We have indicated the need to move from the current model of how we provide care, whether that is primary care, care in the community or acute care. The Minister outlined his vision in TYC for how we take that forward. I mentioned earlier that we need to align the model of training with the skills that health professionals — doctors, nurses, social workers and other allied health professionals — will need to provide that future model of care.

In medicine, we now have a very fundamental review of the future training of doctors, namely the Greenaway review, the Shape of Training. The Minister met the lead on that, and it is with all the Administrations across the UK. It is about the future model of care. You are absolutely right: that is the future, but what about the here and now? How do we bridge this gap and transform our services to a model that is fit for the needs of the population now and into the future? How do we bridge the gap between the current training model and the future training model and the skills set that will need to be aligned with that? The truth is that there are things that we can do. We need to look at the systems and processes and the flows through the system. Can more be carried out in primary care through enhanced roles for GPs? Can we give more resource and support to GPs in the community sector? Are there pathways that we can look at? I mentioned the integrated care partnership before. It is about looking at those who most frequently need our health and social care services and how we can better coordinate those pathways and flows so that we get timely care to patients and keep them out of hospital. If you are a frail elderly person, the last place that you want to end up is in hospital. The whole direction of Transforming Your Care is about addressing that. The Minister previously outlined to the Committee — John Compton has also been here to discuss this — the pilots in those areas that we are working on.

Then, it is back to Sam's point. We can look at all the systems and processes, at community care packages, at how we manage long-term conditions and at how we provide care differently, but let us also look at enhanced roles. Let us look at whether there is a model whereby individuals other than

trained, experienced nurses and doctors can get enhanced training and the appropriate qualifications so that they can provide and support that role.

It is back to the line that the Minister used in his speech: if this were straightforward and easy, we would have done it. It is highly complex, and every time you make a change in one part of the system, you create a series of other issues and challenges further down the system. The Belfast Trust is one example. As David alluded to, it has been reviewing and improving its services across a wide range of areas, including acute surgical admissions and moving from a general medical take-in to a specialist medical take-in for the primary purpose of getting better, more timely care to patients. It is on a journey that it has not yet completed. We are on a major journey of reform in looking at how we provide health services right across the UK and how we make sure that we provide and train future staff to work in the health service.

The Deputy Chairperson: Folks, I think that we have given this a fair airing. Three members want to ask very brief questions. We will try to bounce through this because we want to move on, with questions from Pam, to the important issue of waiting times.

Mr Gardiner: Very briefly, when I was a wee boy — I am still a wee boy — doctors came into the surgery in the evening, from, say, 6.00 pm to 7.30 pm or something like that for so many nights during the week. Can that be introduced again or can doctors be spoken to about it? That would reduce the number of people who just need strapped up or need something seen to running over to, say, Craigavon Hospital or any of the emergency hospitals. It would be encouraging. Although doctors would be working in the evening, they would be entitled to time off during the day. That was the old system. It was good, and it should be considered again.

Dr McBride: Many aspects of the previous system worked well, but other aspects did not work well. I worked in the previous system — I am getting old now — and I remember that it was not a good place to work.

Mr Gardiner: Is that the one that I am speaking of?

Dr McBride: I do not know, Sam, whether I was providing treatment and care to you or not. When I trained as a junior doctor, I worked weekends that started at 7.00 am and ended at 6.00 pm on a Monday. That was not a good way to provide healthcare. It was not a safe way —

Mr Gardiner: Was that hospital care that you provided?

Dr McBride: That was hospital care. It was not a good way —

Mr Gardiner: I am speaking about GPs.

Dr McBride: You are absolutely right. We are in that space in that we are engaging with general practitioners, the BMA and other organisations about models of care. That is an active area that we are looking to, and it certainly is a very core component of TYC.

Mr Gardiner: It will reduce visits to hospitals, too, which take up time.

Mr Dunne: We had a very useful session with representatives from the Medical and Dental Training Agency. One issue that they raised was the out-of-hours service. As I understand it, there are no consultants available in that service. Would it be cost-effective to reintroduce consultants into that service to try to deal with some of those who end up in A&Es?

Dr McBride: It is the right question, but I am not sure that I have the answer to it. What you absolutely need are senior decision-makers with all the necessary expertise to make the right decision for an individual patient. That comes with years of experience. We also need to bear in mind that we need to maximise the use of consultants' time, and this goes back to David's point. If a consultant is resident in a hospital overnight and the flows through the A&E department are such that it does not require the presence of a full-time consultant, that would not be a very effective use of their time. That time could be better utilised during very busy periods.

I go back to the College of Emergency Medicine's report, which recommended at least 16 hours of consultant presence 24/7. We, and hospitals right across the UK, will struggle to deliver that

comprehensively. There are consultants available. I picked up on one of the quotes from one of our media outlets, which was that there was not a consultant about the place after hours. There are consultants about the place after hours. We have consultants in the Belfast Trust until 12.00 midnight and at weekends. They can also be contacted and come into the department when there is a need for them to do so. During the major incident on 8 January, we saw the commitment and dedication of staff who come in from home when required. In that respect, the escalation plans in place in the trust worked well and ensured that key staff were available to meet the pressure and need at that time.

There is a question of how to make the most effective use of consultant time. I suppose that it goes back to Sam's point about whether there is a way of ensuring that you get that level of expertise through the right mix of staff with the right skill set. I do not think that there is an easy answer to that.

Mr McKinney: Reflecting back on what the Minister said, I do not think that you would get any argument here that society needs to take a look at all of this and at how we behave, interact with staff and value people who are highly trained and want to do the best for us and provide the best outcome.

We have been talking here about what the answer to this might be. Representatives from the training organisation told us earlier that we would be looking at a different answer if we understood the demand separately. So, for example, they said that, because of the significant proportion of people who present to A&E but should not be there in the first place, they might not need to train as many accident and emergency doctors and may have to put their focus on training elsewhere.

I appreciate what you said about the future vision and how it all might work well. However, what can you point at that is happening now that satisfies what your training organisation feels would make a significant difference to the problem?

Dr McBride: I have been involved in that, at a UK-level, for more years than I care to remember: how we reform medical training to ensure that we can absolutely —

Mr McKinney: No.

Dr McBride: That is the point, Fearghal.

Mr McKinney: No, this is the demand —

Dr McBride: That is the demand here and now. Many of us have been involved in this for a long number of years. We could have had this conversation 10 years ago — indeed, as Sam reminded us, we did. We also had the conversation five years ago about modernising medical careers. We had it in 2006 with the medical training application service (MTAS) recruitment exercise. We have been trying to reform, ensure greater flexibility and ensure that staff have the right skills on an ongoing basis.

Mr McKinney: I understand that, but we need more accident and emergency doctors —

Dr McBride: Yes.

Mr McKinney: — because more people are going to accident and emergency, and many of them do not have to.

Dr McBride: Indeed.

Dr McCormick: Therefore, we are looking again, as Mickey said earlier, at co-location —

Dr McBride: That is what we are doing

Dr McCormick: — of different kinds of front door. Different models are emerging in different locations because that can be site-specific. However, generally, we have been and are looking at that as an option.

Mr Poots: Ideally, we would get to this point: when a blue-light vehicle comes into an emergency department, a triage nurse says, "This person is for ED; this person is for minor injuries; or this

person's condition is more chronic and requires GP care." Essentially, that is what needs to happen at the front door of our hospitals, and it is happening at some of our facilities. Craigavon hospital, for example, has an out-of-hours doctor on the same site.

Mr McKinney: How much analysis has been done of those who present to A&E but should not? Does that not stem from, for example, three-week and four-week waiting lists for GPs? Does it not also stem, potentially, from consultant-led cancellations, an issue on which we have taken evidence? What analysis has been done on the length of GP waiting lists and how that impacts on A&E?

Dr McBride: I think that all of that has been looked at. Earlier, you quoted, correctly, a figure: there have been estimates that one third of individuals who attend A&E do not need to be there. It is difficult to say how much of that is related to an inability to access service through other routes, such as getting a timely appointment with their general practitioner or their general practitioner being unable to access a diagnostic test, be that a chest X-ray, ultrasound scan or whatever. It will vary in individual circumstances. The real problem here is what I said before: A&E is too accessible.

Mr McKinney: May I stop you there? I did not ask you about whether it was accessible; I asked whether any analysis has been done. If 30% —

Mr Poots: The Southern Trust has done that.

Mr McKinney: What did it say?

Dr McBride: I do not have the specific figures in front of me, but we can provide that to you.

Mr McKinney: I do not think that it is a figures argument; surely there is a strategic answer.

Dr McBride: The strategic answer is yes, there are alternative pathways, which are not currently in place but need to be in place as effective alternatives to individuals attending their A&E department.

Dr McCormick: One of the tasks for the integrated care partnerships is to identify new pathways to take on board exactly the kind of analysis that you are talking about. Yes, that is a major piece of work. We cannot take all of it on at once, so the ICPs have been given a remit in a number of specific areas. It is in the realm of improving integration and, therefore, of ensuring that it is "right place, right time". You cannot say that people should not go to A&E, if that is where they choose to go. They have chosen to go for a certain reason. We need to develop the alternatives, and that is what the ICPs are there to do.

Mr McKinney: With respect, they choose to go because the EDs at the Downe Hospital and Lagan Valley Hospital are closed at weekends; because they cannot get a GP appointment; or because they cannot access an alternative front door. The front door to the service is now the accident and emergency unit.

Mr Poots: There is fair enough reason in that argument. I said that we could probably man the minor injuries side with advanced emergency nurse practitioners as opposed to doctors, which would ease the pressure and increase the optimal use of EDs.

We also need to recognise the reality of EDs now. Michael was in an ED in the 1980s, when it was a completely different place. People with gunshot wounds and injuries from bombs were coming in. Now, an awful lot of elderly people come into our EDs. What more work can be done to avoid the situation in which those elderly people are coming into an ED? If they need to be admitted to hospital, how much more can we do in respect of direct admissions as well? The South Eastern Trust is particularly focused on that now, given the situation at the Downe and Lagan Valley. So there are elements of work to be carried out there as well.

Mr McKinney: I have a final comment.

The Deputy Chairperson: There are three or four big issues, Fearghal.

Mr McKinney: I know, Chair, but it is important to try to extract as much as possible from the Minister when he is here and giving his time.

The Deputy Chairperson: A lot of his time.

Mr McKinney: We will not go over the four hours.

The Deputy Chairperson: We will, the way we are going.

Mr McKinney: The problem is that things have not been done to this point. Now, the South Eastern Trust is putting in a plan against the backdrop of a non-strategic and non-positive decision. It cannot get the emergency nurses, because they are not trained, and the Lagan Valley Hospital will not get them for at least 10 months.

Mr Poots: The issue in Lagan Valley is the co-location of doctors. In Downe, the co-location of doctors happened some time ago, and the out-of-hours GPs are willingly serving that community and keeping the front door of the hospital open. Unfortunately, Lagan Valley has not got to that position, and the out-of-hours doctors have not expressed a willingness to do that. So the South Eastern Trust has work to do with the doctors and the local commissioning group to make that happen. Were that to happen, we could get the emergency nurse practitioners— that is less of a problem.

We need to be training more advanced emergency nurse practitioners who can take this a step further. What nurses did when Michael was a doctor is dramatically different from what nurses do now. We have not reached the end of that process: there is still much more that nurses can do, and we need to extract that skill base and use it even more.

The Deputy Chairperson: We need to move on to the issue of waiting times and the four- and 12-hour targets. We are about to set the record for the longest inquisition of a Minister, so we need to keep moving.

Mrs Cameron: Thank you for your presentation. Apologies for putting my coat on, but it is an attempt to make sure that I do not present at the Ulster Hospital A&E: Gordon would be very displeased if I did not stick to Antrim.

I did not see the programme last night because I had a happier event to attend. I was privileged to be present when the healthcare workers of the Antrim borough were conferred with the freedom of the borough. That event is testimony to what we think of the entire medical profession, right down to pharmacists and community nurses. The event was testimony to the appreciation that we have for them in our area.

How was the policy of four- and 12-hour targets arrived at?

Dr McCormick: I was around when the targets were introduced in Northern Ireland in 2006. They were broadly read across from the practice adopted across the rest of the UK. One important difference at the time was that the four-hour target in England was set at 98%; in Northern Ireland, it was set, following discussions with the clinicians, at 95%, recognising that, in practice, a small proportion of cases involves a need to await decisions and monitor patients.

The targets have to be clinically informed. They are a response to public expectation that conditions in A&E departments should be managed well. So they were adopted broadly by reading across from England but with some adaptations for the local context. They were introduced in Northern Ireland in the summer of 2006.

Mrs Cameron: What are the strengths and weaknesses of those targets?

Dr McCormick: They are a clear signal that access time matters. When it comes to quality of care, that is very genuine because, as we have seen, there can be additional risks associated with time. However, time is only one element that needs to be managed in an emergency department. The clinicians know very well that there is a significant range of outcome measures that are much more important clinically in individual cases and are specific to the presenting conditions. So, in practice, there is a range of other indicators and measures that clinicians use.

Time is one thing, but it has to be seen as a very basic, and in some senses crude, measure. There has to be a much more sophisticated form of clinical management, which is what is happening. I go

back to what the Minister said at the very beginning of the session: you are dealing with a range of different things happening all at once and judging very quickly how to intervene and how to triage. That is day-to-day practice.

So the targets have a role to play, but they have significant limits. A point that has come up with me a lot on this issue is that the targets are intended to be dealt with and handled at corporate level: they are targets for an organisation. I do not think that front line clinical staff should be all that bothered about them. Their job is to look after their patients. Yes, they need to do that in a timely way because that is part of normal good practice. The actual achievement of the targets is an organisational matter, and the issues reflect differently. The delivery of both targets depends on the whole system. It is impossible for an emergency department to deliver properly if the flow is not right. I will come back to the earlier discussion on flow. It is very important that that is looked at from a system level. We need to make sure that there is no bad reflection on front line staff in relation to targets. That should not be an issue at all.

Furthermore — this links into the earlier discussion about bullying and the signals — it is of grave concern that anybody should be under undue pressure because of the significance of waiting times. They have a significance and are not unimportant, but no one should ever be asked to do the wrong thing to meet a target. That is absolutely wrong and not to be tolerated.

The care of a patient has to come first. There should be no question about that. Sometimes, the message gets lost in translation. The Minister explained in the Chamber that this is an attempt to fulfil an expectation. The targets have a validity in that sense, but if the message gets mixed up, and if we are not focusing on quality of care, safety of care and patient experience and those get lost in the process, that is totally wrong. We need to ensure a balanced message.

The Deputy Chairperson: We accept that they can be a rather crude measurement, but there was a reference earlier that, during the RQIA investigation in the Royal, there was mention of stop the clock. Crude and all as they are, it is absolutely essential that there is no manipulation, deliberately or otherwise. If the staff are making those allegations and there is any truth in that, that would be a very serious issue. Although we can say that they have their imperfections, I do not think that the books should ever be cooked.

Dr McCormick: Absolutely. The objective is to deliver a good system. That includes good flow management. The issue is not only to achieve the numbers but to make the system work properly. If false information is in there, how can you tell? Therefore, it is important to give the right signals and to promote a culture in which the focus is on doing the right thing.

Dr Stewart: It is also important that a target is not seen as something that is OK. The clinicians to whom we talk want those patients out of the emergency department, not at four hours; once they have made their decision that a person needs to be admitted, the best system is that the patient will be admitted immediately on to the next stage. What we have seen in the hospital is that, if patients spend too long in the emergency department, they may not be moved up to a bed, even though they were admitted into the hospital at 2.00 pm and do not get up to a bed until 6.00 pm or 8.00 pm, vital tests and investigations that could have been done that afternoon for those patients may wait until the next day. Four hours is better than 12 hours, but four hours is not really what you want. You want is a system in which movement is immediate if at all possible.

Dr McBride: The longer individuals spend in A&E without being moved into the appropriate ward area, the harder it is to provide quality care and good experience of care.

The Deputy Chairperson: We will move on to Roy. We are going to look at resources, money and staffing levels. Pam, do you have a question? Sorry, I should have checked to see if you had finished.

Mrs Cameron: After all my patience —

The Deputy Chairperson: I am getting tired.

Mrs Cameron: Yes, indeed; we all are. In the past number of months, I have had a very recent positive experience from A&E with a family member. I was in the new A&E in Antrim, and I can honestly say that the best care was given, and every precaution was taken. We were there for well

over four hours. I am sure that it was five or five and a half hours, but it was absolutely for the right reason. The doctors were being very cautious, very thorough and left us and themselves absolutely positive that it was safe to go home, that everything was all right and that they had taken the right precautions and done all the tests. They were ultra-thorough, and there was no feeling of being rushed. Maybe I was there on a very good day, but it was excellent. Has any consideration been given to altering the targets, and, if so, how would you alter them?

Dr McCormick: The sense is that it remains an important measure. The disappointment is the difficulty of achieving better performance against those standards, which is a long-term difficulty. The large number of 12-hour breaches and the fact that our performance is materially poorer compared with the rest of the UK is disappointing. However, we have to look at it in perspective and try to secure systematic improvements. There is no particular revision of the targets under way at the moment. They are seen as an element of a package of standards.

Mr Poots: They should never be an exclusive means of measuring how an ED is performing. Considerable work has been done in the South Eastern Trust to have a series of other measurements, which put it in a very favourable position vis-à-vis other parts of the UK. You talked about the potential of changing those standards. The Republic of Ireland has six-hour and nine-hour standards. Around 60% of people were seen within its six-hour standard, and we have 80% of people being seen within four hours. Therefore, a considerably better standard is being set here.

Dr McBride: As Andrew and the Minister said, there are other things that matter, and we are measuring them. They are in trust quality reports, and the first of those — the Belfast Trust — will be published, and you will see the remainder of the trusts reporting those quality reports on a range of other measures that matter to patients and clinicians. It is about how we respond to that. Andrew made a point about it not getting lost in translation. The response of us all cannot be to work harder, work faster and do more of what you are doing. It goes back to Fearghal's point. If you have process measures, which is all they are, what are those process measures telling us about the system of care and what are they telling us about how we can provide that care better? Are they telling us that there is an alternative way to improve flows, which impacts on Gordon's point? Are they telling us that there are issues outside the hospital that we need to address? It is about how we use those process measures, how we analyse that and what it tells us about how we should be doing things differently, either inside or outside the hospital, either before people get to a hospital or when we want to get them back into the community.

The Deputy Chairperson: Are there any other questions? I think that Roy has a question.

Mr Beggs: I said at the start that I wanted to ask this question. With the four-hour target, my perception is that there is a risk that there might be a change in someone's condition four hours after they had been seen initially by a triage nurse, and that that is why the target is there. Therefore, they should be seen by a medical expert within four hours. Four hours is a long time in any accident and emergency unit. However, I am struck by some statistics in a graph for October to December. My perception of that graph is that it shows a downward performance on the numbers being seen within four hours. If you look at the lowest level of performance in any year, you will see that, in February 2011, 73·2% were seen within four hours; in February 2012, it was down to 68·7%; and in 2013, the lowest performance was 66·5%. Those figures are the average for every hospital for any month in Northern Ireland. I am not zooming in on the worst or the best performance. Those are the average figures on lowest percentages.

If you were to look at the highest percentage of patients who were seen in any month, you would see that in April 2011 it was 80·7%; in 2012, it was down to 79%; and in June 2013, it was down to 77·8%. Again, the highest percentage of people seen within four hours has also declined.If we are to solve a problem, it is important that we acknowledge that there is a problem. I do not understand how people can say that we are having better performances, because that is not what the statistics say. Can someone explain what is happening?

Dr McCormick: Yes. When the Minister committed to a fresh piece of work — the initiation of the improvement action group in early 2012 — the first objective was to work towards reducing 12-hour breaches. I think that the statistics that you have will show significant improvement on that metric. The intention was to reduce or, ideally, eliminate 12-hour breaches and then focus more on the four-hour issue. Both require intervention across the totality of the system, as I said earlier, from prevention to discharge. It is a big, challenging issue for the total system, given the many other issues there are to manage and, again, to keep the focus on quality. The direct answer to the your question

is that the reference to improvement relates to 12 hours. We are all very conscious and concerned about the fact that we are not getting traction on the four-hour target.

Dr McBride: It is very valid point. The figures that I have show that in December 2012, 579 patients waited more than 12 hours. That is in the context of the 60,000-plus patients who were seen. In December 2013, it was 168 patients. I accept —

Mr Beggs: If you look at the detailed figures —

Dr McBride: No, you are absolutely right.

Mr Beggs: Look at the detailed figures for four- to six-hour waits. They have also bulged. What has happened? You may be dealing with 12-hour breaches, but it has bulged at an earlier stage in the process.

Dr McBride: If you look at the figures for 12-hour breaches in the Belfast Trust, you see that, in December 2012, there were none. Things certainly did affect the system. We have talked about the pressure in December 2013. The trust had 79 breaches of more than 12 hours. You are correct: if you look at the figures for four hours over time —

Mr Beggs: I have heard that there has been undue pressure on staff not to record 12-hour waits. That is why I asked the question.

Dr McBride: I was not aware of that. If that is the case, it is reprehensible. That should never be the case. Roy, you know our views on that.

Dr McCormick: There is no point whatsoever in doing that either by pressure or by any kind of manipulation. Artificial solutions serve nobody. There has to be an integral process because the real issue is to provide quality care to patients. That has to be our focus.

Mr Beggs: My point in raising the figure is that there is still huge stress on the system. I have acknowledged to the Minister previously that I have seen improvement in Antrim Hospital. That is because of the new facility, better flow of patients, additional staff and the whole hospital starting to work together.

Mr Poots: Your point is absolutely valid with regard to the four hours. It has not been a dramatic fall; however, it is falling incrementally year by year. An element of that has to do with the complexity of the patients whom we receive, a complexity that continues to grow as people age. On average, people will develop a chronic illness at the age of 40, and, on average, they will develop a further chronic illness every 10 years thereafter. Therefore people are presenting who may have three chronic illnesses, as well as having something else wrong with them. Sometimes, it is very difficult to have those people seen and admitted or discharged within four hours. Earlier, I referred to the issue of an emergency consultant having discussions with consultants in other parts of a hospital and saying, "Well, actually, that is not really ours". Those discussions go on. That holds things back as well. I honestly think that we can do better on that. We need to do better on it. There is no other way round it.

The Deputy Chairperson: Folks, I have just been told that the Building is closing at 8.00 pm. Hopefully, that will focus people's minds. It is also quite an unpleasant night —

Mr Gardiner: You could always close the meeting now.

The Deputy Chairperson: No. Unfortunately, we have a few more to go. Some folk, like Mickey here, have long journeys ahead of them.

Mr McKinney: In fairness, some of the issues that we want to raise in various categories have been touched on. Chair, if it is helpful, it might be worth —

The Deputy Chairperson: Yes. If that has happened, folks, just skip over the issue. We will go back now to Roy's substantive questions on resources. Have you anything to ask, Roy?

Mr Beggs: I must ask about resources in particular. In the in-year monitoring bid in December we were told that there were £43 million of inescapables. Thirty million was actually handed. Inescapables not covered by in-year monitoring include elective surgery and Transforming Your Care, which is about doing things differently and potentially stopping people coming to accident and emergency departments. It strikes me that additional pressures have emerged from in-year monitoring and that pressures at A&E have not been receiving support. Not only that, we were told before Christmas that the trusts are in deficit and that, to meet the inescapables, savings will have to be made between the original bid and the end of this year. How on earth is that all going to add up?

Mr Poots: It is still a very challenging situation. I can give you a breakdown of how the money has been allocated: to safety and quality of service, £7 million; domiciliary care, £5 million; children's services, £5 million; unscheduled admissions and winter pressures, £7 million; and elective care, £6 million. That still leaves pressure on the trusts. I hope that that gap will be filled as time passes. Hopefully, there will be a bit more money in February as well, since, given the nature of things, some Departments may have difficulties spending. We still have an issue with clinical negligence. That was genuinely unanticipated, as the courts have speeded things up significantly. What will the figure be this year?

Dr McCormick: It will be £57 million in total.

Mr Poots: We had originally set aside £30 million for it, but we are being hit with a bill for £57 million. That is where we are. At all times, I have put my accounting officer under immense pressure with respect to elective surgery. My view on it is that, if we do not do elective surgery, we build ourselves problems further down the line and into next year. We will, as a consequence, have more unscheduled admissions to hospital. Therefore, we have tried to retain elective surgery as far as possible, in order to eat into some of the waiting lists that have been quite historic.

Mr Beggs: I have one final point. The past few weeks have highlighted huge pressures, which have not been fully reflected in the in-year monetary settlement. That is it.

The Deputy Chairperson: The next section was Mickey's, but we have covered so many issues that we really have —

Mr Brady: Sorry, Deputy Chair. I think that the next section was the alternative ideas under Transforming Your Care, alternatives to A&E, and perhaps co-location of A&E and out-of-hours services. I think that we dealt with some of that earlier.

Mr Poots: Yes. One of the bids that I indicated was £5 million for domiciliary care. That has always been a big issue. Usually, at this time of year when people need money they take it from domiciliary care. However, we are allocating money to it, as we think that it is very important. If we are to be genuine about Transforming Your Care and keeping people out of hospitals, we should invest in domiciliary care.

Mr Brady: We are taking people out of hospital, but we should prevent them from going into hospital. Going into hospital has almost become an alternative. If the infrastructure of domiciliary care is not there, people go to hospital. You mentioned earlier the number of older people who present at A&E departments, and that is often because of isolation. There are many reasons, and they are not necessarily related to the condition that an older person may have at that particular moment.

Mr Wells: My tummy has been rumbling for the past hour: my body clock is telling me that we have been going for far too long.

Let us take five minutes to wash up. I have a couple of quick questions emerging from what you have said. We have mentioned situations in the rest of the UK, but how does our delivery compare with that in the Irish Republic where the demographics are similar?

Mr Poots: I referred to it earlier. In the Republic, they have a six-hour wait, as opposed to the four-hour wait that we have. We are delivering 80% within the four hours, whereas they are delivering something like 62% or 63% in the six. I cannot be absolutely precise about that.

Mr Wells: Can we not drill down to find out whether we are comparing like with like between ourselves and the Republic? Is there no way of doing that?

Mr Poots: Well, it is like for like —

The Deputy Chairperson: They have six hours and we have four, so it is a different target.

Mr Poots: Yes, but we have 80% of people seen within four hours. In their six hours, they are not even seeing 65%, I think, at this point. So, they are quite badly behind us.

Mr Gardiner: This is Northern Ireland, you know.

The Deputy Chairperson: Are "serious adverse incidents" unique to Northern Ireland, or do other health trusts elsewhere in the UK and Ireland have this mechanism?

Mr Poots: Over 10,000 of them were reported in England last year.

Dr McBride: There are similar systems across the other jurisdictions.

The Deputy Chairperson: I seem to remember, when Michael McGimpsey was before us, an undertaking that at least a list of them would be given to the permanent secretary or the Minister. Given that it is 400, would it helpful to have those arrive on people's desks, just to keep an eye on any trends?

Dr McCormick: The role of the HSCB is to monitor trends, report and produce learning letters. That is in place, and it certainly includes an obligation to alert the department, through the early alert system, when particular criteria are met. I assure you that things have not changed that much since you asked me that question some time ago. Chief executives ring me when they are worried about something. If they are aware of something that is going wrong, I get a regular flow of phone calls. So, there is an information flow that is formal and systematic. It is well structured and organised, and that is where learning comes out, because anecdote is dangerous, but where people have a concern there is good contact. I am sure that Michael would say similarly.

Dr McBride: We do. Just to reiterate what I said earlier, there is a range of levels. There are learning letters, and I gave two examples of SAIs where a learning letter was issued following the second and similar set of circumstances. There is a formal process jointly between the board and the agency, where they look at all of the SAIs that have been reported to seek to identify themes, patterns and connections. There is also a biannual report in which all of those are published. It is a regular theme in engaging with trusts. Workshops will be run. There are examples where a particular issue emerges and there is an identified training need on work that was taken forward on a regional level. The board and the agency will facilitate a workshop with front line staff to ensure that improvements are made and learning is disseminated. I can provide you with a number of examples. Also, the important thing is that, as part of our accountability arrangements with individual trusts, the board and the agency, we get regular updates of serious adverse incidents or early alerts that have been reported to the Department and what actions have been taken by the system.

Dr McCormick: I am glad you raised that, Michael. One thing I have noticed in the most recent cycle of meetings that we have had with the trusts — as Michael said, we have them twice a year, and I used to worry that they were dominated by finance or the performance metrics — is that we have had a series of meetings in which the largest proportion of time has been in the realm of quality and safety, which emphasises where the conversation has been.

Dr McBride: We lead off all the meetings with all of our organisations with the subject of disease prevention and the public health agenda. That presentation on a range of issues is there up front. Predominantly, the issues are around the quality of care, the patients' experiences of care and how we take forward Quality 2020, our vision for how we improve the quality of health and social care in Northern Ireland. I can certainly provide you with real-life examples. I can talk to them now or provide them later, if that would be helpful, or come back and talk to you about what we are doing under Quality 2020 to improve the quality of our care — not only about what we are doing differently or better but also how we are getting that information into the public domain to provide assurance to the public.

The Deputy Chairperson: I thank everyone. I hate to suggest it, but are there any other questions? We have covered a huge mass of information here today. It has been extremely helpful. At this late stage, are there any outstanding questions that members have and feel they must ask? *[Laughter.]* Surprise, surprise.

Mr McKinney: I am at risk of ripping the whole thing up, but I am concerned around decision-making. I have to be concerned about what the South Eastern Trust did on residential care and about what the Northern Trust did before that. We have to be concerned that we are only finding out some of this information through the media. That is an important point to make. I do know whether the Minister wants to reflect back on it. The decisions are made through pressures elsewhere, but the Minister, the Department and the board are informed late. Or does it fit into some strategic direction that we are not aware of — does it, in a kind of serendipitously negative way, fall into a plan? So, in other words, things are happening and decisions are sometimes made and we can point to fractures in that decision-making process. Certainly, as the Minister said, it is strategic and not positive, and I am sure that that is a mild way of describing it.

Mr Poots: No, I suggested neither strategic or positive. As has been established, the Department bids for money and then allocates the money, largely through the Health and Social Care Board but also through the BSO and the Public Health Agency, and then that is distributed to the trusts. The Department's role is, very clearly, to set policy, to ensure that that policy is applied, to set the standards and to ensure that those are applied. The CMO has a particular role on that with safety and quality. However, the trusts have full authority to carry out day-to-day operational matters, and that is probably right. I think that the best people to actually deliver on operational matters are those who are dealing with it on a daily basis, as opposed to someone from outside of an organisation who thinks that they know better. They might know better on occasions, but, very often, they will get it wrong. However, we also have the HSCB in between, and it is its role to commission. That is how it has been established. Were we to take over that role in the Department, we would know a lot more information about what is going on in the trusts. However, as has been established, the HSCB is the commissioner. In some senses, the Department could take on that role, but that would be a very big decision for us to take.

Mr McKinney: It would, but are you hinting that the process of decision-making and the structures are flawed?

Mr Poots: Are the structures as they are set up perfect? No. Are they flawed? They are probably flawed. Are they fundamentally flawed? Probably not. Nothing is perfect in life. Particularly when you get to something like health, you really will have problems, on occasions, that are unanticipated. You certainly will have issues arising from that.

Dr McCormick: Part of the context and approach of Transforming Your Care was to set a clear strategic framework and to minimise the risk of non-strategic, non-positive decisions. It was to set a broad direction in which everyone knows what they are then seeking to do. So, commissioners have a remit to work within the broad approach that is set out in Transforming Your Care, and trusts are required to continue to work in that direction. That is partly to ensure that, where future decisions are required that might involve, for example, aspects of service reconfiguration, they are in a strategic context rather than being responses to workforce crisis. We learned the lessons of previous workforce crises, which led to abrupt and unplanned decisions. It is manifestly not perfect yet, but the idea was to set a framework to look at some of the big issues, such as the approach to the fact that we have a concentration of acute functions in fewer sites, and more diverse functions aligned in a community context. All of those things are set out very clearly in TYC and the work in response to it, and that provides a framework. It is not perfect, but that is the way to do it, and I think that that is a fulfilment of a ministerial role in setting direction.

Mr McKinney: If the Chair will grant me one last question, given that we are experiencing the pressures and have seen some of the fragmented decision-making and the flaws and the outputs or negatives that have emerged from that, is it now time to rigorously interrogate the strategy with a view to seeing whether it is actually working? Or, could it produce further potential pressure? In other words, should we be testing the very decision-making and strategy?

Mr Poots: Do you mean the —

Mr McKinney: The overall TYC strategy.

Mr Poots: I certainly think that the TYC policy is being implemented, and I think that support for that policy is almost universal among the professionals and that it is the right direction. My only issue with it is that we are probably not going fast enough at it. I want to see it implemented more quickly. I find

it frustrating, and there are always problems and issues and so forth. I will keep chivying at my officials and, indeed, at the trusts and so forth to ensure that that is the case.

The Deputy Chairperson: Thank you, Minister. We will call it a day. There is a tweet going around that there is only one more job that is more difficult and that that is the job of David Moyes, the manager of Manchester United.

Mr Poots: I hope to have greater success than he is having at the minute.

The Deputy Chairperson: We thank you for giving us three hours of your time. That is much appreciated. You have addressed a huge range of issues, and you brought a strong team with you. We will need to reflect on all of what has been said. I see that you are making the news already, so, clearly, it has caught the public imagination. Once again, I thank your team and the members who have stayed behind.