Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Accident and Emergency Services: Belfast Health and Social Care Trust

26 March 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
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

Witnesses:

Ms Brenda Creaney	Belfast Health and Social Care Trust
Mr Colm Donaghy	Belfast Health and Social Care Trust
Ms Bernie Owens	Belfast Health and Social Care Trust
Dr Tony Stevens	Belfast Health and Social Care Trust

The Chairperson: OK, folks, you are very welcome. We have with us Colm Donaghy, the chief executive; Tony Stevens, director of medicine; Brenda Creaney, director of nursing and user experience; and Bernie Owens, director of unscheduled and acute care. You are familiar with the process. Please give a 10-minute presentation, and then we will open the meeting to members' questions.

Mr Colm Donaghy (Belfast Health and Social Care Trust): Thank you very much, Chairman. If you do not mind, I will take up the 10 minutes for the presentation. I welcome the opportunity to have a discussion with the Health Committee. Thank you very much for inviting us here this afternoon.

I want to cover several areas very quickly. I want to look at the context of the trust to give you some idea of its scale and size; highlight some of the quality indicators, as it is important to assure the Committee about the trust's performance; talk a wee bit about the reform programme because it is relevant in the context of the changes that are happening; and, finally, I will outline for you, very quickly, the emergency department (ED) journey that we have had over the past couple of years.

Let me first set the trust in context. As you probably know, we employ more than 20,000 people. We are the largest employer in Northern Ireland, bar none, in both the public and private sector. We have a turnover of about £1·3 billion. We see about 130,000 inpatients every year. We have more than 800,000 outpatient attendances every year. We have almost 154,000 emergency department attenders. We have almost 111,000 day-case patients. We look after 669 children in care; we are the

corporate parent for those children. We have 424 children on the child protection register, and we provide almost 6,000 domiciliary care packages to provide care in the local community.

I am not sure whether this document was tabled for today's meeting: our 'Annual Quality Report for 2013'. I want to highlight, very quickly, some of the indicators in it. A number of measures are used in hospitals across the world, and in the UK and Europe, to gauge the quality of care provided in the hospital system.

One of those is the emergency readmission rates; in other words, the number of people who are readmitted to the system because the treatment might not have been optimum when they arrived. Belfast Trust readmission rates are lower than peer hospitals in GB. We have roughly a 4·5% readmission rate, compared to more than 6% in other hospitals in the UK.

I want to mention infection control, because it is not so long ago that we were before the Committee as a group of trusts in relation to the level of infections in our hospital system. Again, infection control is an indicator of the quality of care provided across our hospital system. Over the past three to four years, we have dramatically reduced the extent of infections, including clostridium difficile and MRSA. This year, we are the only trust of the five in Northern Ireland that will meet our infection control targets. With respect to MRSA infection, we were 100 days free during this year across all our sites. That was a big achievement for the staff and the organisation, with regard to the ownership and commitment that they have shown to provide such high-quality care.

With respect to mortality rates, people are familiar with the case of the Mid Staffordshire NHS Foundation Trust. Mortality rates are an indication of whether good-quality care is provided. In Belfast, mortality rates are lower than would be expected for a hospital of our size and profile of services. In fact, they are lower than many of our peer hospitals in the UK and other hospitals in Europe. So we perform very well with respect to mortality rates.

Our critical care is world-leading, in relation to the mortality rates that we have in that system. That is something that all of us in Northern Ireland should be very proud of.

Cardiac arrest rates are important in the context that, if you continue to provide proper care for people, they should not suffer a heart attack in your hospital because of the attention that they receive. Our cardiac arrest rates have reduced significantly over the past two to three years as well. That is another, very positive, quality indicator.

Finally, I want to mention the national hip fracture database, which indicates that our death rate for people who have had a hip replacement is the lowest in the UK. It compares very favourably in the context of those quality indicators overall.

I beg your indulgence, Chairman. I want to turn to the reform programme that we have put in place in Belfast over the past two or three years. Some of you will be familiar with the changes that we have made. For example, we have a vision that we will have, as far as we can, one hospital on four sites and will provide services that are local, where possible, but centralised where we believe that it is necessary. People will be familiar with the changes that we recently made in obstetrics. We centralised our obstetrics in the Royal Victoria Hospital site, which meant that the obstetrics that were in the Mater site were moved to the Royal Victoria Hospital site. We ensured that a midwifery-led unit was retained on the Mater site to provide local accessible services.

In relation to a range of other services, we have ensured, as far as possible, that we have complementarity and one hospital on four sites. We have centralised our vascular services, our ENT services and our gynae surgical services. We have also centralised our emergency surgery services on the Royal Victoria Hospital site. I will talk later about the emergency surgical unit that we have introduced there, which will help with how we move patients through our emergency department.

I want to turn very quickly to the journey of our emergency departments over the past two to three years. I will start with the changes in Belfast City Hospital because it is important to give a context to that. Members will recall that the driver for the change at Belfast City Hospital was staffing issues. It had nothing to do with costs or with downturning the number of staff; it was that we were not able to recruit middle-grade and senior decision-making staff to cover the emergency department at Belfast City Hospital. We were spread over three emergency department sites, and we just did not have enough staff, nor were we able to recruit staff to cover Belfast City Hospital. When we made the changes, we transferred staff from Belfast City Hospital to the Royal and the Mater. We went from a complement of six consultants on the Royal site to a complement of 10. It meant that we could put our

consultants on a rota. So instead of 9.00 am to 5.00 pm Monday to Friday and Saturday and Sunday, we put them on a rota during the week from 9.00 am to midnight. If you had gone into the Royal previously, you could have been seen by a junior doctor, but now our senior trainees and middle-grade staff cover from midnight to 8.00 am. So we have senior decision-makers to see you; whereas, in the past, junior staff would have done that.

Part of the impact has been that, over that time, when the City was open, we would have had about 1,700 people waiting 12 hours or longer for admission to our hospital system. We are now down to — I am not saying that it is acceptable — just over 300 people waiting longer than 12 hours this year for access to our hospital system. We want to reduce that further, as we do not believe that it is acceptable.

We have also put in place changes that we believe, as part of the journey, will help patient flow in our hospital. We have introduced an acute medical unit in the Royal Victoria Hospital site; we increased the number of beds from 28 to 61 a couple of years ago; we have direct access for GPs on the Royal Victoria and Belfast City Hospital sites; we have a programmed treatment unit in our emergency department to ensure that people who come in with certain conditions are turned around quickly without requiring admission directly into our emergency department.

We also have given pathways. We have pathways into our specialties in the Royal Victoria and Belfast City hospitals, which do not require patients, in some cases, to go through an emergency department. That is all designed to reduce pressure. We also have rapid access for neurology now. So if people come into our emergency department suffering from headaches, etc, they will now have rapid access, and our neurologists have agreed that those people will now bypass our AMU and go directly from our emergency department into neurology. We have also introduced a primary percutaneous cardiology intervention service.

Mr Wells: What does that mean?

Mr Donaghy: It means cardiological intervention. If someone has a heart attack and requires a stent or a physical intervention, that has now centralised on the Royal Victoria Hospital site. Seventy-five per cent of people in Northern Ireland who have a heart attack go directly to the Royal Victoria Hospital site. That is working well for the numbers using, and getting a very positive outcome from, that service.

We have also introduced an emergency surgical unit with an assessment and inpatient unit. People who come in with abdominal pain or potential surgical problems are seen quickly and turned around quickly rather than having to wait in our emergency department or go as an inpatient into our hospital system when they can be turned around by our surgeons very quickly.

I realise that I am probably using more than my 10 minutes, but, to finish off, we recognise that there are still challenges for us. We recognise that there are other elements of the system that we need to improve, particularly patient flow. What I have tried to outline is the level of reform and change taking place and the fact that we are working hard to ensure that the change and reform improve the patient journey exponentially. We are focusing on discharge. We recognise that the patient journey is not just about people coming through the front door of our emergency department; it is about ensuring that we create capacity in our hospital system and that we have timely discharge.

We have a strong focus on that, and we have a project that is running. We are working with our integrated care partnership in Belfast to put in place various schemes and proposals to manage the demand coming into our hospital system. We have an acute care at home pilot, which is led by one of our geriatricians, together with general practitioners in our local community, looking at maintaining the frail elderly at home. People who might otherwise have required admission to our hospital system are being maintained at home through our acute care at home project. We are looking at other projects such as that with our integrated care partnership that we believe will also help to manage some of the demand coming into our emergency department, as well as looking at how we manage capacity in the hospital.

Finally, we have shared with you the action plan from the College of Emergency Medicine. One of the key planks in the college's plan is seven-day working, which is not just for our emergency department; it is right across our hospital system. It is not new just to Belfast; right across Europe, hospitals are struggling with how to introduce seven-day working. We recently offered additional posts to emergency department consultants, and we are looking at how we can equalise, over a seven-day week, the pressures that exhibit.

The Committee will know that we face most pressure on Mondays and Tuesdays because it builds up over the weekend, and we do not have the same level of senior decision-makers on over the weekend, nor do we run our elective care over the weekend. Therefore it tends to build up at the beginning of the week. We are working with our commissioner, and, in the commissioning plan, which our commissioner has just approved, seven-day working has been highlighted as a priority. At present, we do not have the resources to do that, since it would require additional consultant resource across a whole range of specialties to make that happen in a short time. However, our commissioner has shown willing that it is a priority for them as well as the trust. I will leave it there, Chair.

The Chairperson: OK. Thank you, Colm. The Royal College of Nursing witnesses were very frank in saying that the system is too focused on targets and that targets have become more important than people. How would you address that concern?

Mr Donaghy: We would not find that tolerable in our system. Let me start by saying that, where systems or organisations are judged by performance against targets, that can sometimes skew behaviour. Judging how many 12-hour breaches you have can sometimes skew behaviour in your hospital system. We are very keen in Belfast that it should not skew behaviour. For us, the care and clinical priority given to patients is of primary concern. I can give you an example. We have a system called Symphony, which highlights all the people waiting in our hospital system. I was in the hospital's emergency department recently when one of our ED consultants told me that she had given clinical priority to a patient to be admitted above another patient who had just breached 12 hours. That was absolutely the right thing to do. The 12-hour breach was not given priority over the clinical condition of the patient whom the doctor had made the decision to admit. Admissions decisions are made by our doctors and nurses, as is the priority given to people for admission. They would not put the 12-hour target in front of a clinical priority.

The Chairperson: Are we saying that there are no circumstances in which a patient would be moved from an emergency department in order not to breach a 12-hour target? Are we saying that that simply does not happen?

Mr Donaghy: No. I suppose that we need to be clear. The 12-hour target is a target because the evidence shows us that the longer someone waits on a trolley in an ED, potentially the poorer the outcome is for them. That is the reason for and objective behind the target: that people wait only as long as they need to so that they have a better outcome. That is what drives us.

In dealing with the care of patients, when we identify a solution for patients waiting in our ED, we are keen that we move them to that solution as quickly as possible, and certainly before they are waiting for 12 hours. The 12-hour target does play a part, but it does not take precedence over clinical priority. Clinical priority will trump the 12-hour target all the time.

The Chairperson: There is no suggestion that a patient would be moved into a situation that was not safe or not sustainable.

Mr Donaghy: No, we would not move patients into an unsafe environment. I will give you another example. In the context of some of the recent instances, — for example, on the evening on which the major incident was called — part of the reason that we did not have sufficient capacity in the hospital was because we could not open sufficient beds with the proper nursing skills to nurse the patients in the hospital system. The only way in which we could get properly skilled nurses on to the site was by triggering the major incident.

We had exhausted all the agency nurses and bank nurses to get ones available with the required skills. Although nurses were available, they were not of the skill level that we required to look after patients when they were admitted. Therefore, it is not the case that we would admit patients into an unsafe environment.

The Chairperson: OK. It was indicated in the previous evidence session that there are nurses working above their competency levels in emergency departments.

Mr Donaghy: I will ask Brenda to address that, but it would not be our understanding that nurses are working above their competency levels.

Ms Brenda Creaney (Belfast Health and Social Care Trust): The Regulation and Quality Improvement Authority (RQIA) also raised that matter with us. We have over 90 nurses at the moment working in the Royal ED. Some qualified recently, while others are experienced. Part of our process for bringing in nurses is that they have a period of induction. They will work alongside a more experienced nurse in areas such as triage or resuscitation to gain those skills.

We have had issues with, for example, sickness levels, but the nurse in charge will allocate nurses on a shift-by-shift basis, and they will be supported depending on their skills. On occasions, if we have vacancies — for example, if staff are ill — we will bring in bank and agency nurses, but they are always supervised by the nurses in the department.

What you have suggested would be of great concern to me, and we have done an awful lot of work with the emergency department to look at the skills of the staff in each area.

The Chairperson: But you are saying that it is happening, because the RQIA raised the matter with you.

Ms Creaney: The RQIA raised it as a concern with us.

The Chairperson: So it is obviously a matter of concern.

Ms Creaney: It would be a huge concern, because nurses need to be trained in the area of expertise. When they graduate, nurses have a degree of expertise. They have half their clinical time with us when they are at university, but in a specialist area, such as the emergency department, they need to have more on-the-job support, which we provide for them.

The Chairperson: Ultimately, if there is a concern about anyone in any walk of life who is working above his or her competency levels, is there not a risk to safety?

Ms Creaney: Yes, there would be a risk, and that is why we have in place the processes that we do. It is my expectation that the nurse in charge of the department will allocate nurses dependent on their level of skill.

The Chairperson: I may not be framing this properly, but the issue has been flagged and is of concern. Do we wait for the outcome of the RQIA report? It is still happening.

Ms Creaney: No, we do not wait for the outcome. In fact, we have done a number of pieces of work on emergency department staffing levels. That work started several years ago when we made the move to the Royal and the Mater sites. We reviewed the skill mix then, and we reviewed the skill mix again in October of last year. We were in a period of recruitment to bring more nursing staff into the emergency departments.

Where it becomes an issue is if we have vacancies or higher levels of bank and agency nurses than we would like. Certainly, staff need to be supervised in areas. You have seen the way in which the emergency department is laid out. There are areas of higher risk, and the two key areas of higher risk for us are triage and resuscitation. In the normal course of events, nurses will expect to have a certain lead-in time before they work in those areas. That is what happens in the emergency department.

The Chairperson: Yes, but, ultimately, as we sit here, a risk is still in the system. We have not removed the issue.

Mr Donaghy: Chairman, the question that you are asking is this: do we have nurses currently working above their competency levels in our emergency departments?

The Chairperson: Yes, and we do. Therefore, there is a risk.

Ms Creaney: The nurses who have less experience than others are being supervised. We allocate nurses dependent on their experience, and it is the role of the nurse in charge to mitigate risk. We do have a lot of new staff, who have been starting with us since the beginning of the year, and they are working in a supervised capacity. When the risk was raised with us by the RQIA, we initially had a two-week off-the-job induction followed by a two-week on-the-job induction. We have now increased that to six weeks on the basis of the preliminary recommendations.

The Chairperson: I turn to whether or not the recent deaths were potentially linked to undue delays as a result of serious adverse incidents (SAIs). Why did the trust not inform the Minister, if the information is indeed accurate that it did not?

Mr Donaghy: I will ask Dr Stevens to fill in some of the detail, Chairman, but, first, I will give you some background and context to serious adverse incidents. In any hospital system, every serious adverse incident is a human tragedy. It is something that we do not take lightly and that we do not want to see happening. We are very keen that, when we do have a serious adverse incident, it is first highlighted, because we need to learn the lessons from a serious adverse incident. That is the case in hospitals throughout the world. In America quite recently, led by the Institute for Healthcare Improvement (IHI) in Boston, the campaign to save 100,000 lives was predicated on the basis that around a million people in the American hospital system were either having serious harm or were dying because of mistakes and errors in the hospital system. Therefore, the IHI set out to save 100,000 lives by introducing safety bundles, which we have introduced in Belfast as well.

I am telling you that to emphasise that each one of those SAIs is a tragedy. What is important for us is that we learn from them. We want to encourage our staff to continue to highlight them. Serious adverse incidents are raised by us and investigated in our hospital system, so it is important that we continue to encourage staff to do that. Last year, we had 93 serious adverse incidents in our hospital system. We have a governance arrangement in our organisation where we learn from those serious adverse incidents as we take the learning from them, and that learning is shared throughout the wider health and social care system so that we learn regionally.

On why the Minister was not told, a governance assurance framework was in place, and there was appropriate escalation for the SAI process in our system. Therefore, it is not the case that there is an obligational requirement to indicate on every SAI, or on every individual SAI, to the Minister what happened or the circumstances behind each. I am not sure whether that answers your question —

The Chairperson: Accountability and governance bring up their own questions. Ultimately, it is the Minister and the Department responsible. Why the Minister of any Department would find out about serious adverse incidents through the media leaves as all asking that question. Therefore, what you say does not really answer my question. The follow-on question is this: why were the families of the individuals affected not informed?

Mr Donaghy: I will answer that, and then I will ask Dr Stevens to give you some more background on the SAI process.

It is entirely unacceptable to me and the trust that families were not informed. It is an integral part of our policy that families should be involved and engaged with. In the vast majority of SAIs, they have been involved, but in those particular instances they were not. Our organisation is looking into that and investigating very thoroughly why families were not informed in those cases, because it is a part of our policy that they should have been involved and engaged with.

The Chairperson: Finally, why call a review now? Why is there a review into serious adverse incidents now, if learning has been shared from the 93 cases?

Mr Donaghy: I will ask Dr Stevens to answer that. There is constant learning from SAIs, and it is an ongoing process. Every SAI is taken forward in the context of the learning that we can get from it. We have an SAI review board that is chaired by Brenda, our director of nursing, to assist learning right across the trust. Therefore, if an SAI happens in one area of the trust, we want to find out what we can learn from that across the trust. More importantly, because the SAI is also monitored by the Health and Social Care Board (HSCB), learning can be proffered across the entire system. It is not that we keep SAIs secret; rather, we share that learning right across the health and social care system. We are very transparent across the system about SAIs. The families should have been involved in those particular SAIs, and they were not, so we are looking at why that was the case.

The Chairperson: I know that a number of members want to come in at this point, but I have a question on a separate issue. The Minister's recent statement referred to the recent recruitment drive for emergency departments and the fact that there were no applicants at the middle grade. Why is that?

Mr Donaghy: I will ask Dr Stevens, who is more conversant with the detail, to answer that. However, the availability of middle-grade doctors is a problem right across the UK and Ireland. It was the primary reason for the changes that happened at Belfast City Hospital. Right across hospital systems

in the UK and Ireland, people are not choosing middle grade as a career grade in emergency departments. There is not the availability of people. It is not the case that we have not attempted to recruit, because we have; rather, people are not choosing it as a career option. Dr Stevens will elaborate for you.

Dr Tony Stevens (Belfast Health and Social Care Trust): We need to define the middle grade. In the health service, we talk of consultants as being our senior doctors and our junior doctors as being, in this context, the younger doctors who are at houseman level, which is what we used to call senior house officer (SHO) level. We then have a group of people who are in specialty training. They are training to become specialists and then consultants. We also have people who choose a career in a certain area. They may not go on to become a consultant, but they do become very experienced, and we normally call them specialty doctors or associate specialists.

Therefore, the middle grade is made up of the more senior trainees and people who have made a decision to have a career in a specific area but below consultant level. It is a very important group. The reality is that it is very difficult to recruit senior trainees and those who have chosen a career just below consultant grade. The people who are looking for that career position are not looking to work in emergency departments. There are more attractive specialties for those people to work in, particularly given the hours and demands involved. Among senior trainees, there are just not enough people in the United Kingdom or other parts of Europe, including Ireland, who want to train to become a specialist in emergency medicine. We are fishing in the same pond as every other trust in the UK.

In many ways, Belfast does quite well but not well enough. For example, the senior trainees are allocated to us. We do not recruit them. We are allocated seven registrars to work in the Royal, and that is barely enough for us. We really need more of them, but they really do not exist, partly because senior trainees are a scarce resource that has to be shared out with the other trusts. However, the Belfast Health and Social Care Trust has a particular challenge, in that the General Medical Council (GMC) and, indeed, the Northern Ireland Deanery require us to have somebody at senior trainee level — middle-grade level — or consultant level in the department 24 hours a day. We are the only department that is obliged to do that, and it reflects the regional nature of the Belfast Trust, in particular the Royal and its role as the trauma centre.

We are handed a manpower situation that we cannot change. We cannot increase the number of senior trainees that we have, because they do not really exist. Those that there are are allocated. The other middle-grade group — those people seeking a career in an emergency department below consultant level — does not exist either.

The Chairperson: Is it not sufficient to say that it is not an attractive career because the system is so under pressure, particularly emergency care? People are voting with their feet and not applying.

Dr Stevens: That is absolutely true. You have to understand that there are lots of issues across the UK. The emergency department is a very demanding area to work in. We are also dealing with a reality that medicine is now predominantly a profession of women. Some 60% to 70% of people who come out of university are women, and they are making choices that take them into other specialties. I can list the specialties that are very popular and the ones that are less popular. That is a national and international problem.

The Chairperson: That we know that and have identified it leads me on to issues like contracts. When we visited the Royal on Monday, we were told that the trust could be more creative with contracts as far as workforce planning and all the associated issues are concerned. If we have identified that it is an issue and that the trusts have control of it, what have they done to deal with it?

Dr Stevens: There are two things there. The first creative thing that we are doing is to look at alternatives to doctors. We are the first trust that has started to train nurses as advanced nurse practitioners. That is a genuinely creative move. It will take us another year or two before those people are fully functioning, but that is part of the solution.

We have also been creative in arranging for general practitioners to work in our emergency department in the evenings. Again, they are a very scarce resource, but they are helpful to us. They come in and see more of the patients who are more suited to general practice than to an emergency department.

We have also advertised very heavily for middle grades and have accepted that, if we cannot recruit middle grades and it is a truly international problem, we should not expend all our energy on it. We have accepted that we may have to recruit more consultants. We have done that and will continue to do that. We are in discussions with the HSCB, and I think that there is a positive recognition that we will have to expand the number of consultants who are working in our emergency departments. We also accept that, for emergency departments really to thrive, they will have to be services that are not only led by consultants but, in large measure, delivered by them rather than by doctors in training and middle-grade doctors.

Mr Donaghy: Chair, you will be aware that the consultant contract is a national contract, and there are ongoing negotiations on what the GP and consultant contracts might look like in future. In the nationally agreed contract, there is flexibility in how we can negotiate with our consultants. I will ask Bernie to outline some of what we are doing. For example, each consultant has an individual job plan, but in the contract there is also a means of annualising those job plans in order to make the best use of our consultant workforce.

The Chairperson: Ultimately, the trust has control of terms and conditions of contracts.

Mr Donaghy: No, it is —

The Chairperson: You have just said that there is flexibility.

Mr Donaghy: Yes, there is flexibility in how we can, for example, apply job planning and team or annualised job planning. However, the national contract is quite strict.

The Chairperson: I do not want to get into the detail. Work in the emergency care department is seen as being pressurised and stressful. That has been flagged as an issue and as an obstacle to recruitment, and, as such, people are not applying. We have seen the recruitment drive, and no middle-grade doctors applied.

What I am trying to say, without getting into the details of negotiating contracts, is that trusts have a degree of flexibility. Why has what you are doing not happened before now if we knew that this was an issue?

Dr Stevens: I will make a very quick point, Maeve. We have national terms and conditions, so our flexibility is not as great as you might think. Moreover, if we as one trust were to waive the terms and conditions very substantially and make a very generous offer, all that we would be doing would be stealing the competent and able doctors from other trusts. That might please the people of Belfast, but it would seriously inconvenience those served by Craigavon Area Hospital, Altnagelvin Area Hospital and elsewhere. We have to be fair, and we expect the other trusts in Northern Ireland to be fair, and try not to go too far outside the terms and conditions.

There are not enough trained and competent people for us to recruit. We do not determine the number of people who come into training; that is not the trust's responsibility. We cannot make the specialty more attractive to young doctors who want to train in it rather than go into anaesthetics, general practice or surgery. That is not our role or function. All that we can do is make our jobs as attractive as possible. If we were to break the terms and conditions substantially, there would be howls of protest from the other trusts in Northern Ireland.

The Chairperson: The recommendation about being creative and innovative with contracts came from your doctors.

Mr Donaghy: Bernie is in discussions with our ED consultants at the moment on an annualised job plan. That is very positive with both —

The Chairperson: Sorry to cut across you, Colm. It is not about money. It is about sustainable workforce planning and the other opportunities that go alongside it, particularly in stressful scenarios such as those experienced emergency departments.

Ms Bernie Owens (Belfast Health and Social Care Trust): We make sure that there is a balance for every consultant in their individual job plan. The contracts set out consultants' periods of work and the periods when they have protected time away from the workplace. Our consultant workforce are

seeking to have their jobs annualised so that they can have some flexibility and weeks that are more or less onerous. We have agreed a way forward with them. Subject to their agreement and to them signing it, we will put it in place from the beginning of April.

Mr McKinney: Did you hear the submission from the RCN this afternoon?

Mr Donaghy: No.

Mr McKinney: It might be fair to repeat some of the remarks that were made. They said that the plan that you are basing this on, Transforming Your Care (TYC), is a vision without action. They also said that the change agenda is neither open nor transparent and that enough is enough. They asked where the patient is in all of this and said that the system is neither effective nor efficient. They also described things as being not fit for purpose. They are seriously concerned about targets being prioritised over people and that the system supports bureaucracy, not the patient. Can you contrast those remarks with your opening remarks, in which you referred simply to challenges ahead around patient flows?

Mr Donaghy: I am disappointed to hear that that formed part of the submission that you received earlier. We work very closely with the RCN, our trade union side and staff-side colleagues in a partnership arrangement, which, I think, is a very positive arrangement. We have had many discussions and engagements with the RCN, and it raised issues with us that we addressed with it at the time. What you have just outlined to me is in complete contrast to what I said. It is in pretty stark contrast, Fearghal. Therefore, there is a judgement to be made. When the RCN says that the system is not open and transparent, I have to say that I accept that we still have a journey to go to be as open and transparent as we possibly can be. However, I believe that we are as open and transparent as many other healthcare organisations across these islands.

Mr McKinney: Yes, but, in fairness to the RCN representatives, I think that they were talking about outcomes. Yes, I agree that there is a judgement to be made, but, in this case, it is not a fine judgement. There is a yawning gap between front line nurses' perspective of the service that is being provided for patients and your perspective. What do you put that down to?

Mr Donaghy: You will be familiar with the RQIA's preliminary feedback that we received recently on the emergency department and the acute medical unit (AMU). I was very disappointed, as was the trust board, with the feedback that we received. On the back of that, we immediately put a support group into the ED and the AMU to see whether there was that chasm that you identify between the views of people on the ground and what we as senior management believe is happening. The support group comprised occupational health, psychology, a senior nurse and a HR practitioner to help staff by running clinics in our ED and AMU. Over 50 to 60 staff availed themselves of the opportunity to speak in those clinics. They did so anonymously, so it is not as if they were identified. The feedback from staff was that they felt under tremendous pressure at times; that they were working in a very pressurised system; and that they were not necessarily being given the support that they should be given. We then immediately moved to put in place the supports that were identified to us by staff at the time to ensure that they were provided with the necessary support. We have introduced such things as daily team briefs. That might sound very simple, but some of what happens in the midst of the change is quite radical and transformational, so communication needs to happen to keep staff informed and up to date with the direction of travel and the overall objective of the change. Otherwise, that sometimes gets lost. We believe that that was the case in this instance. In fact, we are now putting in place, and have moved very rapidly to do so, the changes that we hope will bridge that gap of understanding between what I have outlined to you about the direction of travel and how we ensure that staff are properly supported to deliver that change.

Mr McKinney: Notwithstanding what you are saying about the systems that you are putting in place two and a half years after the introduction of a major change platform, there are still huge gaps between those who are on the front line and those who are implementing the change, at least on the basis of the evidence that we have heard today.

I wish to deal with policy around A&Es' departmental perspective and how it applies to you. Is Transforming Your Care clear on the policy direction for A&Es?

Mr Donaghy: It is pretty clear on the direction for the five acute hospital networks identified. It means that we have one hospital network in Belfast. What TYC was not specific about — I think that it is right

that it was not — is how we manage that network. How many EDs should you have in Belfast? How many should you have elsewhere? Transforming Your Care is not specific about the number of EDs there should be as part of the hospital network. It is for the hospital network, along with our stakeholders — our local communities, politicians and others — to determine what the future of our acute services looks like. As you will understand, changes at Belfast City Hospital have still not been finally decided on in the context of the final configuration. However, our view is that we should have two EDs in Belfast: one in the Mater and one in the Royal Victoria Hospital.

Mr McKinney: So the current situation is not satisfactory, either structurally or as regards policy.

Mr Donaghy: No, I would not say that. I would say that, at the moment, there is a clear direction of policy, but how we get there is entirely up to the system and the optimum delivery of care for patients in the system. I will explain that in another way. In my view, the most important part of the commissioning providing system is that you have a commissioner who is very clear about the outcomes that it wants as part of the system, the standards that it wants to deliver to and the funding that is available. As an organisation, we are then responsible for how that is done. We engage with our stakeholders — our staff, our GP colleagues and other community providers in the voluntary and community sector — about what we can do and how we can design a model of care that will deliver the outcomes from within the available money and standards.

Mr McKinney: Right now, we are seeing it as pressure. Our party has always been of the view that this is a symptom and not a cause and therefore we need to influence the demand, however that can be done — in the community and so on. At the start, you articulated that there are 159,000 ED attenders. It is accepted that some 30% of attenders — that figure is disputed, upwards and downwards — do not need to be in the emergency department. If you were to remove approximately 60,000 of the current 160,000, how much would that influence your need for middle grade doctors or emergency nurses?

Mr Donaghy: It would have an impact, which is why, in Transforming Your Care, the drive is to reduce the reliance on hospital systems. The purpose behind the acute care of the elderly pilot, for example, which is led by one of our geriatricians, is to ensure that frail elderly people who would otherwise have had to come into our ED for admission are prevented from having to do so. It reduces the numbers, which is the demand management part.

Mr McKinney: When did you introduce the pilot?

Mr Donaghy: It was perhaps six or seven months ago.

Mr McKinney: Why was the pilot not foreseen at the start of TYC?

Mr Donaghy: I am not sure what you mean.

Mr McKinney: We talked in very simple mathematical terms about care being transferred. I assume that, at the start of this process, somebody somewhere must have done a calculation on the back of an envelope and said, "If we are going to move to community care, we will want to take out roughly 30% of ED attenders". Why have we been waiting two and a half years for a pilot to deal with something that should have been foreseen at the start?

Mr Donaghy: I will ask Dr Stevens to come in, because he is more familiar with the detail of the pilot and its gestation.

Mr McKinney: I am not so much interested in the pilot and its specifics. I am talking about the thinking behind —

Mr Donaghy: A lot of the concepts and principles in Transforming Your Care are not new. Care in the community is not new. Some people might remember the People First policy that was introduced in the mid-1990s. It was about a drive to put in place sufficient community infrastructure to ensure that we had the opportunity to deliver care closer to people's own homes and in their own homes. Transforming Your Care takes that one stage further and looks at it vis-à-vis the hospital system and a reduction in the demand and need for admissions to the hospital system by ensuring that people are more appropriately treated closer to their own home.

I think that your question is this: given that Transforming Your Care was introduced two and a half years ago, why did it take two and a half years for a pilot to be in place?

Mr McKinney: Yes.

Mr Donaghy: I will ask Tony to come in on this. You may say that it has been too slow, but a process has been put in place, and we have gone through it. As part of Transforming Your Care, for example, it was identified that integrated care partnerships are an integral vehicle in helping to deliver things such as acute care at home. It took time to set up the integrated care partnerships, which were driven from a Health and Social Care Board perspective, and it has taken time for their work to bed down. Proposals are now coming forward from us and from the integrated care partnerships, which are a virtual provider, so it is in the providing arena as opposed to the commissioning arena. We are working very closely with the integrated care partnerships to redesign services that will have an impact and potentially reduce the need for hospital admission. Acute care at home is one of the redesigned models.

Dr Stevens: Colm has covered the matter very well. We were running issues in parallel. In the pilot, we were very lucky to recruit a community geriatrician who came from England with huge experience of developing the hospital-at-home model. We did the pilot to try to demonstrate how that would work. We are now in the business of moving more of our care of the elderly resource out of hospital and into the community.

At the same time, through TYC and the Health and Social Care Board, we are working regionally on the integrated care partnerships. The key issue with integrated care partnerships is that it is a partnership of providers, of which the trust is only one provider. Community pharmacy and general practice are the other key partners. The exciting thing that is now emerging are the frail elderly integrated care partnerships, which truly are a partnership between primary care, community pharmacy and others. Although the trust might have been running pilots to shift things from within our resources, the partnerships are the key because they get us and the GPs together. One challenge in Northern Ireland has always been that, although we have had integrated health and social care, we have never had integrated primary and secondary care. Just as the rest of the UK does not have it, we do not have it. That is the key piece for us.

It is exciting that we are now starting to have conversations with primary care about how, between our resource and primary care's resource, we can better look after people in nursing homes and residential homes. Those people represent about 2% of our total intake. That may not sound like a lot, but it is 2% of roughly 100 people whom we admit a day. If we can keep two frail elderly people out of hospital every day, that is 700 people a year, which is a huge level of resource. The work with primary care is one of our focuses. It is taking a bit of time to get that off the ground, partly because we are bringing together this completely new invention: the integration of primary and secondary care, plus the other partners.

Mr McKinney: Have you done any assessment of the impact that Transforming Your Care is having on the service overall? What systems or measurements are you putting in place?

Mr Donaghy: We are not putting in place a system or overall measurement for Transforming Your Care. Our organisation has a close focus on the things that we are putting in place that will have an impact that are consistent with Transforming Your Care. Those will be evaluated individually. The acute care at home pilot that I mentioned, for example, will be thoroughly evaluated. We are in discussions with our commissioner about rolling that out right across the trust. At the minute, it exists only in Meadowlands in south Belfast. We want to roll it out across the trust for the benefit of frail elderly people. However, that will be done only on the basis of a thorough evaluation of the benefits of the pilot.

The Chairperson: I am not cutting you off, but if you do not mind, Fearghal, I want to move on because quite a number of members have indicated that they want to speak, and there is a lot to get through. I am not stifling debate, but we need to give everybody an opportunity to ask questions.

Mr D McIlveen: Thank you for your presentation, folks. Chair, you will be glad to hear that I have couple of reasonably short questions. If we were to jump forward to the full implementation of Transforming Your Care, to what extent would the problems in our emergency departments be alleviated?

Mr Donaghy: It would not fully alleviate them, David, but it would take pressure off attendances in our emergency departments, particularly of frail elderly patients, diabetes patients, stroke patients, and so on. It would reduce the need for some admissions. However, it does not negate the need for further work on the patient flow system in the hospital itself and how we make that even more effective, particularly in ensuring that our discharge systems work well in relation to capacity in the hospital system. It is a factor, and it would have an impact, but it would not fully alleviate the pressures in the hospital system.

Mr D McIlveen: My next point is on a completely unrelated matter, and I questioned the Minister about it when he attended the Committee after the major incidents. It relates to the distribution of information about such incidents. The perverse nature of intellectually redundant journalism — we have quite a lot of it in Northern Ireland — is that it can make very intelligent people look quite inept. Therefore, a disciplined approach to how the media is dealt with is probably necessary. The morning after the night before, there was clearly a lot of confusion about many people potentially had lost their life as a result of delays, and so on. That sent out a very worrying message. I am not laying the blame for that solely on the trust — of course I am not. We all know how irresponsible the media can be. However, what lessons have been learned from that? Will there be a change in the trust as to how disciplined it is with the distribution of information?

Mr Donaghy: Lessons have been learned, David. It is ironic that, as we received the information, the trust tried to be open and transparent. That openness and transparency was translated into a big stick to beat us with. I am not blaming the media for that, because news is news when they receive that sort of information. The issue you referred to was when, the morning after the 'Spotlight' programme, it was identified that there were five SAIs and not four. The mistake that I probably made on 'Spotlight' was that, although I knew that there were four SAIs, I was not sure of the timescale. I did say that I did not have the information in front of me, but I should not have given a timescale when I was not sure of it. That lead to miscommunication and, as you said, allowed me, potentially, and the organisation —

Mr D McIlveen: It is not personal, by the way.

Mr Donaghy: I know that it is not.

It allowed me and the organisation to be portrayed in a light of not knowing the information or not being fully conversant with it. That was unfortunate. In Dr Stevens's interview the next day, he identified five SAIs. We had a conversation and decided that, if that is the case and we have identified five SAIs, we cannot say that there were not five. We needed to be open and honest about that information. However, we learned from that, not to be less transparent but to manage the information flow much more effectively.

Mr Dunne: Thank you for coming in today. To start with, I have just one question. We are moving towards an independent review of the ED in the Royal. How do you see that review? Do you see it as an opportunity or just another review?

Mr Donaghy: I see it very much as an opportunity. It is an improvement process. Although the terms of reference have identified that there will be a focus on the Royal, the review will look at the emergency care system across Northern Ireland and recommend changes and improvements that can be applied across the system. I see it very much as a learning process. If the review team can come up with any improvements that we have not thought of, we would be very keen to take that support.

Mr Dunne: I want to go back to our visit on Monday. We should extend our thanks to all the staff and everyone who took the time to show us around. The emergency department is certainly a very busy place. We came away assured that there are competent staff there who know what they are doing. They gave us a good feeling of their strong commitment to what they were doing. That certainly came across.

The building is spread out into various units. We moved from one unit to the next, where various treatments were being administered. It does not seem to be a great building, but I understand that a new building is under way, which is very positive. We were somewhat shocked that the waiting room and its facilities are very poor. There are about 50 seats. For an emergency department of a major regional centre — it is the regional centre for Northern Ireland — that is substandard, and it needs to be addressed even in the short term. No information about waiting times is provided on the screens, and I know that there are pros and cons about that. It also shocked me that there are only two booths

for triage, and 50 people sit outside them, making it a bottleneck. I understand that there is another triage facility where the ambulances arrive, so there are probably three booths, but it still seems limited. I accept that consultants and doctors were available.

When I spoke to the consultants, it struck me that they feel that the workload in A&Es is usually predictable. I did not feel that that was the case, but I came away understanding that it is so. The workload is predictable, even at weekends. Points were well made by Brendan and others that the rest of us slow down at weekends. Other MLAs do not agree, but A&E consultants move up a gear on Fridays, Saturdays, Sundays and Mondays. With 24-hour working, that needs to be thought about.

We then went to wards 7B and 7C, which I think is where the bottleneck is. Those two 30-bed wards are very busy, and I think that they need attention. The new consultant there is Mark.

Mr Donaghy: Mark Roberts.

Mr Dunne: Mark said that 32 patients have to move out of those wards every day to make the system work. That is a really difficult challenge. Half the patients in those two wards have to move out. Many people come through A&E, and, as I understand it, most are admitted to those admission wards. Major work goes on there, but there is a bottleneck that needs to be addressed.

Without ranting on, let me give you the bottom line. What is senior management doing? I know that a review is under way, but the senior managers are there. It is a huge organisation with 20,000 staff. We talked to Brenda about communication in the organisation. Communication worries me. The trust is accredited under Investors in People (IIP), and the criteria include:

> *"engaging and empowering the workforce [and] recognising and continuously improving performance".*

Those are key factors. You have met those requirements and standards. You are blowing about it in this report, which is not a bad thing to do. However, there are weaknesses. The public are aware of them, and the media latches on to them. How can senior management move those issues forward, without having to wait for someone from across the water —

Mr Donaghy: Let me say that we are not waiting and are moving on those issues. I want to touch on what you said about blowing about IIP accreditation and give you a wee bit more information about it.

You may know that the Investor in People award is made across the organisation and is not confined only to ED or the acute medical unit that you visited. We were reaccredited with the award in November. Eight inspectors came into our organisation over two to three weeks. They picked 800 staff members at random; we do not identify the staff to them. They interviewed the staff in detail about the organisation. Our organisation got a very positive report from that inspection about staff engagement. That is why it is even more disappointing to get feedback on our ED and AMU, which is why we moved quickly to put in place the engagement processes that I outlined to Fearghal.

We are moving. You mentioned wards 7B and 7C, which are the acute medical unit, and we are concentrating on that area. Part of the principle of an acute medical unit is that it is just that: people should be there for no longer than two midnights. They should be there for 48 hours, assessed and, if necessary, moved on to the specialty where they will receive treatment or discharged, having received treatment in the AMU. So it is always going to be a very dynamic environment in terms of people moving through quickly. That is the way that we want it, but in doing that we need to ensure that we support staff properly. I will ask all three who are here to outline some of the changes that we are making to the acute medical unit, including the recruitment of additional staff and, not only that, the process changes in relation to rapid access to other specialties etc that bypass AMU to ensure that people are supported properly.

The Chairperson: I do not want you to think I am stopping you, but we are getting into operational issues as well, and a lot of that is reflected in the briefing paper that you supplied for us. I am just conscious of giving everybody the opportunity to have their direct questions, so if I can move it on at this point, we are quite willing to re-engage on these issues.

Mr Dunne: For clarity, just give me some answers briefly on those issues, please.

Mr Donaghy: OK, I will do it very quickly. In terms of the acute medical unit, we have recruited 25 additional nurses. That recruitment process did not start in just the past month or so. It has been ongoing for a period of time. We constantly carry out a review on our staffing levels within each of our areas. It is fair to say that as a result of the RQIA inspection, we increased that again, but we were already recruiting additional nurses.

Mr Dunne: Is that referring to the admissions wards?

Mr Donaghy: Yes, that is the acute medical unit: 25 additional staff there. We are also ensuring that only those who need to go to the acute medical unit, go there. We are in discussion with specialties in other parts of the hospital, like neurology and cardiology, so that people get access to those specialist areas directly from ED rather than having to go through the acute medical unit, so that it is really the people who require to go to the acute medical unit who go there. Those patient flows have been worked on very closely.

The emergency surgical unit that we have in place is designed to ensure that people who have surgical issues get direct access to our emergency surgical unit rather than going through our acute medical unit, again so that they are dealt with in a high-quality way and quickly, so that they are turned around much more quickly than they would have been had they gone through the medical system.

Ms Owens: Going back to why the acute medical unit is there in the first place, we have not always had it. That has been a development that we have had, going back to 2012. It was one of the areas that, shortly after Belfast City Hospital's emergency department closed, was an issue for us in that we still had a sizeable number of beds that we needed to access on the City Hospital site for patient care. Patients were being transferred to Belfast City Hospital for specialist intervention. However, rather than having patients waiting in the emergency department to be transferred to the City, we had to have acute physicians assess them and start their treatment plan of care before they transferred to the specialist, thereby having a safer journey for patients.

We then resourced the acute medical unit from the point of view of making sure that senior medical staff were available and seeing patients on a timely basis and assessing and starting that care. That is why, from a medical point of view, we still have patients going through the acute medical unit. However, as Colm said, one of our focuses now is having an assessment area. We have the acute medical team coming more into the emergency department and assessing patients earlier in the journey, so they do not all have to go to the acute medical unit if they have been seen by the acute physician in the emergency department and get to the right specialist team first time.

Mr Dunne: OK. Thanks very much, folks.

Mr Beggs: Thank you for your presentation. I want to go back to the issue of the shortage of middle-grade A&E doctors. That was given as the main reason for the closure of Belfast City Hospital and a number of other units. Why was it only recently that you announced this issue of training for advanced nurse practitioners? Why did something not happen two or three years ago?

Ms Creaney: The advanced nurse practitioner is a new role, and we have two people in training, one of whom you may actually have met on Monday. It actually takes four years in total to train them.

Mr Beggs: When did you start to train those new nursing practitioners?

Ms Creaney: One of them two years ago, and the other one year ago.

Mr Donaghy: We have emergency nurse practitioners as well.

Ms Creaney: We also have emergency nurse practitioners. You will recall that when you were in the department, there was the minor stream and the major stream. The emergency nurse practitioners are those who work with the more minor injuries. That has a very rapid turnaround. We have almost six emergency nurse practitioners who run that area and manage minor injuries.

Mr Donaghy: Maybe I should also say that that training is not available in Northern Ireland. We have to send those nurses elsewhere to be trained.

Mr Beggs: Can I compliment that emergency nursing? I was actually in and out of Whiteabbey Hospital within 25 minutes, having had my shoulder X-rayed and been given a sling appropriately. That service can work very well for a minor injury.

With regard to the Royal, the RCN has indicated to us that it thinks that only 50% or 60% of accident and emergency nurses are permanent staff who are there regularly as a team. What do you say to that? Explain.

Ms Creaney: That is not the case. We have had some vacancies in the emergency department, but in the past year, since April 2013, we have recruited 18 new staff nurses into the emergency department as part of our ongoing recruitment. We have also recruited six deputy sisters into the department. At present, our total number of core staff, not including the emergency nurse practitioners, is actually 87·5. We are in the process of increasing that to 100. As it stands at present, we had 10 vacancies. We have now appointed staff into those positions.

One of the greater issues for us in nursing generally, similar to the medical profession, is due to its being a largely female-oriented profession. It is good news; we have a number of people who take maternity leave. It is roughly about 5% of our workforce at any given time. This year, we have had between three and five people on maternity leave. We do replace those staff.

Mr Beggs: What percentage of the staff are bank staff? They may be your employees, but what percentage of them are bank staff who are not normally on the rota in there like permanent staff?

Ms Creaney: It is variable. It depends on the amount of absence.

Mr Beggs: Can you give me a figure?

Ms Creaney: Yes. I can give you the actual numbers precisely. I can provided those to you, but it is between 11 and 12 bank staff, which would be approximately —

Mr Beggs: Fifteen per cent, maybe?

Ms Creaney: Yes.

Mr Donaghy: About 15%.

Mr Beggs: Why is it that high?

Ms Creaney: At the moment, because of issues that we have in the emergency department whereby we have difficulty placing patients in a timely fashion, we bring in additional bank staff to care for those patients. I would prefer that they were not being cared for on trolleys in the department. However, those who are there waiting for a bed need to be cared for, so we bring in additional staff over and above our complement.

As I said, for example, our staffing in January was 87·5. However, we had the equivalent backfill of 103 staff to cover absences and treat people who are waiting.

Mr Beggs: Can you clarify the numbers? You said that you have 87·5, moving to 100. However, there has been an announcement of 40 new staff. How do the numbers work?

Ms Creaney: Twenty-five of those staff are for the AMU.

Mr Donaghy: The acute medical unit.

Mr Beggs: It is already in existence, though.

Ms Creaney: I am sorry; I do not understand.

Mr Beggs: It is already there. I thought that this was something new that was happening.

Ms Creaney: No. As I said, we had 87 staff originally. We are going to have more than that. So the 15 staff are new, but we also had recruitment to replace vacancies as well. When the department is busy, we bring in staff over and above our funded staffing level.

Mr Beggs: So the 40 new posts are actually 15 new posts. Is that correct?

Ms Creaney: No. It is 15 new posts for the emergency department.

Mr Donaghy: It is 15 in the emergency department and 25 in the acute medical unit.

Ms Creaney: Yes.

Mr Beggs: How many are currently in the acute medical unit?

Ms Creaney: In the acute medical unit? At the moment — well, prior to our investment, we had —

Mr Beggs: How many have you today?

Ms Creaney: Today, we have 88. However, we have recruited new staff. The original staffing level was 75.

Mr Beggs: I do not understand. You have an acute medical unit at present and you have announced 25. There is a total of 87 staff in this overall area.

Ms Creaney: No. Because we have had recruitment —

Mr Donaghy: Sorry; I think that there is confusion here.

Mr Beggs: There is.

Mr Donaghy: The emergency department and the acute medical unit are two completely separate areas. We have recruited an additional 15 staff into our emergency department area, and we have recruited an additional —

Mr Beggs: Already?

Ms Creaney: Well, we are in the process.

Ms Owens: On top of the 87 that you have cited there.

Mr Beggs: OK. The announcement was made last week, was it not?

Ms Creaney: Yes, but —

Mr Donaghy: Sorry; it might be useful, Brenda, to say that we were already in a recruitment process to recruit additional staff. Some of them are already in post. Some of them are in training. When the recruitment is completely finished, we will have recruited an additional 15 staff for the emergency department. I think that what you are asking, Roy, is how many are there now. How many of the additional 15 —

Mr Beggs: Above and beyond your original plan to recruit, how many additional staff will be in post as a result of the ministerial announcement recently?

Ms Creaney: There will be an additional 25 staff in the acute medical unit and an additional 15 staff in the emergency department.

Mr Beggs: OK. I will let it go at that.

On Monday, I was concerned when I was approached by a member of nursing staff. I spoke to trust staff when that happened. I would describe that member of staff as being distressed in terms of the

pressures that they were under. I was led to believe that there was one nurse and one auxiliary nurse looking after a ward in the acute medical unit.

Ms Creaney: That is not correct.

Mr Beggs: Well, I can say that it was a highly stressed nurse who took the time, very briefly, to make a point of speaking to me and expressing concern about the conditions under which she was working. I wish to pass that on to you directly. I have already done so, but I wish to do so formally.

Ms Creaney: I am aware of that. Our team has been supporting that nurse. For clarity, did you mean a bay or a ward, because a ward is the entire —

Mr Beggs: It was described as being eight plus 15. That is what I have noted down here. I assume that that means 23 beds.

Ms Creaney: That would not be correct.

Mr Beggs: When I spoke to one of your staff members — I am not sure whether it was Brenda or Bernie — the indication was that there was a shortage of bank staff because they had not turned up or you were unable to get them. Was it you I was talking to?

Ms Creaney: No, it was not. I will say that the purpose of using the bank or agency is to fill short-term vacancies. People who work from a bank or agency do so at their own volition.

Mr Beggs: What do you do when there is a shortage and the recommended rota number of staff posts cannot be filled? This is acute medicine, and there is a shortage. What do you do in that situation?

Mr Donaghy: There is a protocol.

Ms Creaney: Yes. There is a protocol. We obviously try to fill those vacancies from within. Certainly, the work that we have done with the opening of wards 7B and 7C last year has increased the nurse-to-bed ratio, as we call it. We increased it again in October, which was what the recruitment was based on. We had a process to increase it further. In its preliminary feedback, the RQIA made recommendations and other suggestions. So, we have taken further action, hence the additional staff I have spoken to you about.

On a day-to-day basis, you have a roster number of staff and support staff for an area. When people call in ill at very short notice, we have a team in place in all of our sites called patient flow that will try to allocate additional nurses. We ask our staff to work additional hours. If we have more notice, we will ask that staff change their rotas. That is the day-to-day way in which we manage that.

Mr Beggs: What happens in an acute medicine area? These are patients who have just come out of accident and emergency. It was expressed to me that there was a shortage on Monday. Was that the case?

Ms Creaney: We had two staff phone in ill at very short notice. The ward sister, whom you met, was managing that within the resource that was available.

Mr Donaghy: I do not want to diminish any feedback that you have had from staff; I am keen to take that feedback on and recognise it. In any ward environment, on any day — and the point that you make about this being the acute medical unit is important — there are operational issues regarding staff who phone in sick at short notice. There is a protocol that we go through to ensure that we fill those posts or provide mitigation in relation to providing the care in those areas. That is an ongoing operational issue in quite a number of our —

Mr Beggs: I hope you take the time to look at the Hansard transcript of the RCN, who were here before you. They indicated concern about burnout in acute medicine. They also indicated that they had recruitment issues and issues regarding how you redeploy staff to other areas. There are a number of issues that I hope you will take a look at so that there is not staff burnout, and you minimise the number of agency workers so that there are effective teams working together.

Ms Creaney: We work very closely with the Royal College of Nursing around staff support, at a local level within the trust and at a regional level. I had a staff meeting with AMU staff last night. It is very important that we keep those discussions at operational level within the Department, but also that we have a mechanism to escalate concerns. Certainly that is what we are very keen to do in all of our departments and in relation to the issues that you have raised around the emergency department and AMU. We work very closely with the Royal College of Nursing and our other trade unions to provide staff support.

Mr Donaghy: I give you an assurance that we will look at the transcript of the evidence that was provided earlier today.

Mr Beggs: The consultants were saying that the pressures were largely predictable. When we were there on Monday, we saw that the nine trolleys in the outcomes area were already full. I do not know where the next person who went through A&E was going to be placed — no doubt in a corridor somewhere. That was normal for a Monday. It has got to the stage where that is normal. My question is this: what are you doing so that this is not normal? In particular, why are there not beds to receive patients who are going through your accident and emergency unit? That stops the flow in the hospital and stops it functioning.

Mr Donaghy: I will deal with that on a general basis, Roy, and I will ask Tony and Bernie to provide some of the more detailed aspects of what we are doing. As part of my presentation, I mentioned seven-day working, and I said that part of what hospital systems want to do is even out the work and the flow across the seven-day week. Currently, that is not the case. So, on a Saturday and Sunday, we do not have our senior decision-makers on the floor making decisions in the same way that we have on Monday to Friday. That does not apply just in ED; it applies in other parts of our system. That is not to say that people are not working seven days a week. They are just not working over the same period of time seven days a week. You are quite right, and ED consultants are quite right: that means that we find that it is more likely that we will be under pressure on a Monday and a Tuesday, because we have not had the discharges over the weekend that we would normally have on Monday to Friday. The decision-making that is being taken is being taken by more junior staff, and sometimes it takes longer. So, it begins to build up over the weekend and manifests on a Monday and Tuesday.

We have started to recruit additional ED consultants, with the intention of deploying those additional consultants on a Saturday and Sunday for a longer period so that we have our senior decision-makers over the weekend for a longer period. That will only work as long as we also have the discharge at the back door working in a way that ensures that we optimise discharges over seven days a week. Our commissioner has identified seven-day working, and, right across these islands, it has been identified as an important aspect of delivering hospital care in the future to relieve pressures. We are working to do that with our commissioner, and we will be putting in additional medical staff to do that at weekends, particularly in our ED.

Mr Beggs: Are you operating at above the recommended optimum level of bed occupancy rates?

Mr Donaghy: At times, our bed occupancy is above 80%, which is described, in some cases, as the optimum level. We are working above an 80% bed occupancy, particularly in the early part of the week on Mondays and Tuesdays.

Mr Beggs: Another issues the consultants highlighted was the need for diagnostics at weekends, and also that their views and concerns should be better reflected at a leadership level. Why is there no emergency department clinical director in the hospital?

Mr Donaghy: We would like there to be. We would like one of our emergency consultants to come forward to be a clinical director. There was a clinical director for a period of time, but there is not now, and we are very keen to encourage one of our emergency consultants to be a clinical director. It is no lack of willing in relation to management to have a clinical director and a clinical leader in an emergency department, believe me.

You mentioned diagnostics at the weekend. I will ask Bernie to outline some of what we are putting in place in respect of diagnostics, particularly access at the weekends.

Ms Owens: I will address the issue about the clinical director in the emergency department. We have two emergency departments — one in the Mater and one on the Royal site — and we have a clinical

lead. He is an emergency department consultant who is taking the clinical lead roles on both sites. Up until the end of March, we had a clinical director in the emergency department, but his background was not in emergency department medicine. However, he was a very experienced clinical director from another discipline — anaesthetics — within the trust.

In relation to diagnostics, we have a diagnostic service as an emergency service across the weekend. It is a very busy service undertaking CT scans, plain film radiology and ultrasound. However, that deals with the emergency department solely. We need to put in place additional resources at the weekend over and above that emergency. The staff are there providing that solely for the emergency department. We need to put another team of radiology and radiographic staff in to be able to undertake the diagnostic tests of patients who have been admitted over the weekend, so that their diagnostic test is not waiting until Monday or Tuesday and, therefore, further decisions or discharge decisions are being delayed until Monday or Tuesday because of the lack of additional capacity for those imaging tests.

Mr Beggs: Finally, in respect of your wider role, the GP out-of-hours service provides relatively limited support. The last resort is to go to A&E. I have experienced that myself, where the GP out-of-hours service could not actually remove two stitches that needed to be removed from a wound to relieve pressure or give antibiotics. Are you looking at the GP out-of-hours service to extend what it does so that fewer people have no choice but to turn up at accident and emergency?

Mr Donaghy: This year, we have a pilot running in our RVH ED where we have our GP out-of-hours service collocated in our RVH ED. The intention is that people are appropriate triaged through our GP out-of-hours service, as opposed to coming in to our emergency department. We have found that that has not worked as effectively as we would have liked it to, in that the triage has not resulted in as many people going to our GP out-of-hours as we might have thought. In fact, our GPs were a bit disappointed about that as well, and they came into the emergency department to case-find to see if there were people that they could treat, and they found that there were not. So the level or illness, or the acuity as we call it, is quite high in terms of those people who are requiring to come in to our emergency department.

In respect of our GP out-of-hours service, I am in discussions with a number of GPs looking at how we could fundamentally change the system. That is not to say that this will happen, but one of the models that we are looking at is that the only way that you would get in to the Royal Victoria Hospital ED in future is in a blue-light ambulance. The only other way that you get into the ED — you do not walk in off the street; you do not drive in — is through a primary care/secondary care triage system. Therefore, people who walk in, walk in to a primary care triage system and, through that system, they are filtered to attend the ED. You cannot just walk in off the street. We have looked at how that system works in Norway as a possible model for Belfast. It would not happen overnight; it would take time to plan and to get in place. We would also want our community stakeholders to sign up for the changes that it might mean. In Belfast, it could mean that we would not continue to provide our GP out-of-hours services in the same places where they are now.

The Chairperson: Three more members wish to speak.

Mr Wells: Colm, you must be a soothsayer, because the Norwegian situation was exactly what I was about to bring up. I was going to suggest it as a solution and claim it as an original thought; unfortunately, you got your retaliation in first.

The Norwegian system seems to be a very good idea, because various estimates show that between 30% and 40% of the people who present as walk-ins at A&E should not be there at all. You need some way of getting them out of the system so that the genuinely ill people who come in an ambulance can be treated. However, is there not a danger that, if the public learned that, you would have far more call-outs for ambulances?

Mr Donaghy: There is that possibility. Initially in their system, the Norwegians found that their primary care practitioners used ambulances more than they had done before. However, it is about learning from that in the context of how we manage and put in place controls and levers in the system to ensure that that does not happen. Nevertheless, you are right: it could lead to an abuse of the Ambulance Service to get people into an ED, although that would require sending people in a Blue Light ambulance who did not necessarily need to go in one.

Mr Wells: Have you any idea what proportion of the walk-ins in the Royal at the minute should not be there? Have you any recent figures on that?

Mr Donaghy: I look to Bernie and Brenda. I know that our figures were slightly lower than the 30% figure because of the regional trauma centre and because of the acuity of the people who tend to come to the Royal. However, we still had a fairly high proportion; it would have been more than 20%.

Ms Creaney: Yes, more than 20%. It is important to differentiate the emergency nurse practitioner minor stream. As we said, they are minor injuries, but those people may need diagnosis or treatment and are turned around very swiftly. However, with regard to the other people attending, the percentage would be in the mid-20s.

Mr Wells: If you could take those numbers out of A&E, would that be it solved?

Mr Donaghy: It may not. Some of those who do not require admission do not necessarily put the pressure on the system. Those who put pressure on the system are, quite rightly those whom the doctor has decided to admit. When a doctor decides to admit, it is those people who need to get into the system. In Belfast, our admissions have gone up over the past couple of years by 8%. There is a phenomenon around fractures, and we are still trying to discover why that is, but admissions for fractures have gone up by 9% in the past year. Those people would come into the hospital system and be admitted anyway.

If we could take out the primary care attendances and those who do not require to be in ED, it would allow us to put more resources into the areas where people require treatment or admission in our hospital system.

Mr Wells: I have looked up some worrying stats . There are 69 more middle-grade doctors now than there were in 2011, despite all the problems. That is 20% up on May 2011. Even though you have been running fast, you are actually slipping backwards. It is not because we do not have more middle-grade doctors; we do not have enough middle-grade doctors.

Mr Donaghy: That is it; we do not.

Mr Wells: There are 400 vacancies for middle-grade doctors in the UK. The situation is worse than you portray it.

Mr Donaghy: It is across the hospital system. It is well known that, in England for example, some trusts have paid £3,000 for doctors to cover shifts because of the vacancies in their rotas at middle- and consultant grade. We have not done that, and that is the point about contracts. If we were to pay £3,000 a shift, I am sure that people might come to work for us. However, we do not believe that that is the right way to deal with the issue, because paying such rates is not a good use of public funds. That is happening in different parts at the moment, and they are, quite rightly, being criticised by their public accounts people.

Mr Wells: Although not directly relevant, we have had to face the wrath of people in south Down over the Downe and Lagan Valley hospitals issue. One of the points that was made there was that the solution to this problem would be to engage the services of doctors from Europe, particularly eastern Europe, who have language proficiency. Is any attempt being made to fill that very large hole with European doctors?

Dr Stevens: We have, for a number of specialties, including ED, attempted to recruit in Europe, and it has not been successful. We have never really recovered from the loss of people coming from India or Pakistan, the traditional countries that supplied us very effectively with doctors. Europe does not seem to be offering us a solution. We have used recruitment agencies to go to jobs fairs in Europe, but it has not proved successful. Moreover, not all doctors working in other parts of Europe have trained in a system similar to the British or Irish system. British and Irish systems are remarkably similar and quite interchangeable, but when you go to Europe, you find that people's training is different, and it can be very difficult to be sure that you are getting exactly what you require.

Mr Wells: Can we recruit in the Irish Republic?

Dr Stevens: Yes, but we are fishing in a very small pond there, and we are competing with their system. That has not been a rich source for us.

Mr Donaghy: It may be because the remuneration has changed in the Republic of Ireland. It would not have been financially attractive for doctors in the Republic of Ireland to take jobs in the North.

Mr Wells: Perhaps you could recruit from Sussex. Is that a good place to get doctors? *[Laughter.]*

Dr Stevens: Jim, can I make one more point? Our consultants tell us that it is more difficult to recruit work at middle grade in the Royal because of the acuity of the patients. We have sicker patients, and it often tends to be busier. I am being advised that, because of workload, the level of skill, and potentially the demands on individuals, it is not the easiest place for us to keep people.

Mr Wells: The other very worrying stat that I have been given is that there has been a 60% increase in the number of doctors emigrating to Australia in the past four years. What is the Belfast Trust doing or what can you do to stop that haemorrhaging of staff to the sunny climes of Sydney or Bondi Beach?

Dr Stevens: Many of our junior doctors, and, indeed, some of our consultants, are going there and to other parts of the world. We have, by and large, always encouraged that, because if it is part of their training or development, we want them back. There has always been a strong tradition of going to the States. Australia has been a more recent phenomenon. We are keen on that because you do not want doctors working in Belfast or Northern Ireland who have never been outside Northern Ireland. That becomes incestuous and ultimately patients and the rest of us suffer. Let us encourage it. The issue for us is getting them back, and we are reasonably assured that those doctors from ED who have recently been to Australia are coming back. Indeed, our clinical lead in the Royal, Sinead Campbell-Gray, has benefited from spending time in England and Australia, and now we are benefiting from it. The secret is not to stop them going; it is to ensure that we offer jobs attractive enough to get them back.

Mr Donaghy: Recently, people have gone from the Royal to Australia on career break; had we not agreed to a career break, we might have lost them permanently. On the basis of being allowed a career break, they have given a commitment to come back.

Mr McCarthy: I am glad to hear your response to Jim about putting extra pressure on the ambulance service, Colm, as ambulance staff are under immense pressure. Your trust has operational control over both health and social services, but a major issue seems to be timely discharge to the community in order to free up hospital beds. Colm spoke about that earlier. Why is the trust not better coordinating with social care, given that it comes under your control?

Mr Donaghy: You are quite right. If anybody can make integration work, it should be us. We have health and social care under our control. There is a lot of close working in health and social care. In fact — again, this goes back to seven-day working — we now provide social work services in our hospitals at weekends so that we can facilitate weekend discharge as well. We can do that because we employ social workers. We also have reach-in from our community care; we will case-find for people who have particularly complex discharges. They will then be discharged into the community as well. As I said earlier, we have a very focused discharge project that looks to improve those processes to make discharge even more effective.

Mr McCarthy: I back up what has been said already. You said that you would get a copy of the presentation that we had. It was very distressing to hear it. There are inconsistencies between what they said and what you said. That has to be sorted out. I appeal to you, as directors of the Belfast Trust, to ensure that nurses are better provided for. Otherwise, we will go from crisis to crisis.

Ms Creaney: As I said, we work very closely with our trades unions, including the Royal College of Nursing. In fact, I am meeting Janice Smyth on Friday to look at how we can do that at a support level for our staff and also for planning.

Mr McCarthy: That is very important. Forward work planning seems to have been non-existent for a long time. If that was overcome, it might help us to overcome the current problems.

Mr Brady: Thanks for the presentation. I will try to be as brief as possible. This follows on from what Kieran was saying: Dr Stevens mentioned the possibility of keeping 700 people out of the acute end

of it. The Royal College of Nursing said in their presentation that community services are not being developed. It is back to vision without action. That has to be worked on because, as you said, you are responsible for both.

The other thing is to do with A&E. In Daisy Hill, the out of hours is in the hospital. That seems to work quite well because people probably have confidence in going to the hospital initially. It takes some pressure off the A&E.

Mr Donaghy: That was my decision, by the way, Mickey.

Mr Brady: I am sure that it was. That is when you were in the Southern Trust.

It was interesting that you mentioned people first. That turned out to be a euphemism. Had it been put into operation as it was supposed to be, it might have alleviated the problems that you are now experiencing. I do not know whether you agree. I remember it well; there was fanfare at the time.

I spoke to a member of one of the families, or someone who had a connection to the family, involved in the serious adverse incidents here in Belfast. They were not happy; they felt let down. They had not been communicated with as they felt they should have. In fact, in one case, they felt as though they had not been communicated with at all by the Department or the trust. That may be something to address.

Mr Donaghy: I will start with an apology: it should not have happened. I would be happy to apologise to that family in meeting them.

Mickey mentioned community infrastructure. I assure you that we are looking at community infrastructure to support discharge. We have just invested in additional step-down beds: beds where people can step down from hospital for a period of rehabilitation and patient care outside the hospital in a non-acute setting. I mentioned acute care at home pilot. There are other proposals, which we can share with the Committee rather than go through them today, that also emphasise caring for people closer to their own home rather than requiring them to go into hospital.

I want to mention another thing about Transforming Your Care, although I am sorry to bring it in at this late stage. It covers more than just hospital services. Although we have talked today primarily about its impact on hospital services, it covers mental health, learning disability, older people, physical disability, and children's services, although not as much as perhaps it could have. It is much wider than just the hospital aspect.

Mr Brady: It is not all doom and gloom because the Belfast Trust has no statutory residentials as such. There was a furore in April or May. The Belfast Trust seems to have managed that without all that hype and furore and done so in a measured way. I know, from talking to some of our people in west Belfast, how that was done, and that seemed to have been managed in a constructive way.

Mr Donaghy: The principle in Belfast was about planning for the future and older people who do not want to go into institutional care but prefer to stay longer behind their own front door. That is the planning, and that is the supported housing that we are putting in place in those schemes. We also recognised that there was a need to respect the people who were in residential care and to assure them that they could remain in residential care for as long as they required. That was slightly controversial in the recent consultation, but, four years ago, we ensured that anybody who requires residential care gets it, but, with the statutory residential care, we ceased admissions to our homes. It has never been the case that anybody who has required a residential care place has not got it.

Mr Brady: It went reasonably well.

Mr Donaghy: There is no unmet need.

Mr Brady: Perhaps you should have passed on your expertise, if that is the right word, in that area, because it did not work in April and May.

Mr Donaghy: People are now looking at that way of ensuring that people who are in residential care have their place for as long as they want it and plan for the future, because those were the two aspects that needed to be addressed.

Mr Brady: It meant that TYC fell at the first hurdle, and that is part of the difficulty.

Mr McCarthy: Is Cherry Tree House not in Belfast?

Mr Donaghy: That is one of ours, yes.

Mr McCarthy: Is it not under threat? As far as I know —

The Chairperson: I need to take the conversation back, because we are not here to pat the trust on the back.

Mr Donaghy: It is one of the homes that no longer has admissions —

The Chairperson: I know that Fearghal has a question, but let me come in at this point because I have to leave, unfortunately. In bringing this to a conclusion, I will ask a direct question: do you think that emergency departments and emergency care is in crisis?

Mr Donaghy: No, I do not. I think that it is under tremendous pressure. We know the reasons for that, but I do not think that it is in crisis.

The Chairperson: What is the situation today in the Royal?

Mr Donaghy: I could look at my phone and tell you. The Royal ED has been under pressure for the past two or three days. When I came to this meeting, we had about 30 people in the department.

The Chairperson: On trolleys?

Ms Owens: No, in total.

Mr Donaghy: No, it was 30 people in the department in total. However, nine people had waited longer than 12 hours at that point.

The Chairperson: As we are having this conversation, I am being contacted by staff who are indicating that, effectively, ED has not stopped since Sunday, that there are patients who have been waiting over 25 hours for a bed and that patients have e-mailed the Minister. I am reflecting what I am being told; I am putting it straight back at you. If that is the situation, surely that is crisis that needs here-and-now interventions.

Mr Donaghy: There will be here-and-now interventions. However, you have information before you that has been texted to you; I do not. When I last looked at the ED, that was not the situation. However, as soon as we are finished here, we will certainly look at that.

The Chairperson: I ask that you respond urgently and come back to me on that because I am bringing it to your attention now. If it is the case, it is very serious.

Mr McKinney: Are the problems being experienced at the Royal also being experienced at the Mater?

Mr Donaghy: Not to the same degree, but there is pressure at the Mater as well, as there is in other hospitals in the Northern Ireland system.

Mr McKinney: Could the Mater be used to reduce the pressure on the Royal?

Mr Donaghy: Because of the pressure that it experiences, and given that it is a much smaller ED, we tend to allow the Mater, if you forgive the phrase, to consume its own smoke. However, if there was additional capacity at the Mater, we would use it, but the Mater tends to be able to deal with its own pressure. That means that we can concentrate on the Royal Victoria Hospital.

(The Deputy Chairperson [Mr Wells] in the Chair)

Mr McKinney: Will the City Hospital emergency department ever open again as an emergency department?

Mr Donaghy: I cannot answer that; it is for the Minister to make the final decision. Our advice to the Minister would be that it should not open again and that our preferred model is to continue to have two emergency departments, at the Mater and the Royal. However, the final decision is with the Minister.

The Deputy Chairperson: Thank you very much, Colm. This may be the last time that we see you before you go. I was joking when I said that we would raid Sussex for middle-grade doctors, but perhaps there will be a surplus available when you take over. This is a difficult issue for you and your colleagues. We thank you for being here and taking the pointed questions that we raised with you.