



Northern Ireland  
Assembly

Committee for Health, Social Services and  
Public Safety

# OFFICIAL REPORT (Hansard)

Accident and Emergency Improvement  
Action Group

21 November 2012

# NORTHERN IRELAND ASSEMBLY

## Committee for Health, Social Services and Public Safety

### Accident and Emergency Improvement Action Group

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**Members present for all or part of the proceedings:**

Ms Sue Ramsey (Chairperson)  
Mr Jim Wells (Deputy Chairperson)  
Mr Roy Beggs  
Ms Paula Bradley  
Mr Mickey Brady  
Mr Gordon Dunne  
Mr Samuel Gardiner  
Mr Kieran McCarthy  
Mr Conall McDevitt  
Ms Maeve McLaughlin

**Witnesses:**

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

**The Chairperson:** Good afternoon. I welcome Catherine, John and Mary to the meeting and thank them for their briefing paper. This is probably a good time to come before the Committee on the back of some of the material that has been in the media over the past number of weeks, especially the past number of days. I will hand over to you to make your presentation, after which we will open the meeting up for questions and comments from members.

**Ms Catherine Daly (Department of Health, Social Services and Public Safety):** Thank you very much, Chair. My colleagues and I are very grateful for the opportunity to update the Committee on the work of the improvement action group (IAG). Mary, John and I previously appeared before the Committee on 20 June this year to brief you on the work of the group. At that session, we detailed the background to, and the rationale for, the establishment of the improvement action group. We have provided the Committee with a briefing paper for today's session. Chair, if you and the members are content, I will not go over that paper in great detail again. However, it may be helpful for me to outline a summary of the key points and, following that, John and Mary will provide some further detail. We will be happy to take questions from members.

Members may recall that at the ward sister conference in Mossley Mill on 21 March, the Minister announced the development of an action plan to eliminate, as far as possible, waits of more than 12 hours in emergency departments (ED). That was part of a determined effort to improve the quality of care and patient experience. Prior to that, a number of issues had affected the timeliness and quality of care in some emergency departments on some occasions. The Minister was very concerned about the excessive waiting times that were being experienced by patients in those emergency departments.

He was very clear that he wanted a significant improvement in the performance of emergency departments through a broad approach that would involve the entire health service.

In response to the Minister's concerns, the improvement action group was established in April by the Health and Social Care Board (HSCB), working with the Public Health Agency (PHA). The primary objectives of the group were to secure a step change in improvement in the 12-hour and four-hour performance at emergency departments and the patient experience in those departments.

It was in that context that the key focus of the IAG's work has been on working with trusts to deliver on the Minister's targets and on addressing the patient experience issues. Although the 12-hour and four-hour targets are the most easily measurable, they attract the greatest attention. The primary focus has to be on the quality of service that patients receive.

Patients need to be examined, diagnosed, monitored, treated and informed regularly about what is happening to them. They need to know and understand why they are waiting. In that context, communication is absolutely essential. In taking forward the work, the improvement action group was asked to consider any actions that would improve emergency department service, including, for example, the 18 unscheduled care action points that had been agreed with the Department. The group has taken that into account in its work.

There is no doubt that there has been an improvement in waiting times in emergency departments since the group was set up. In some instances, those improvements have been significant. However, as members will note from our briefing paper, the good progress that was made up to the end of August has fallen slightly since then. Although the position is better than it was in March before the group was set up, there is absolutely no room for complacency. We are clear that there is a long way to go, and the Minister is determined to keep up the pressure to improve services.

As the briefing paper notes, there have been improvements. In that context, the Committee will be aware that the challenges that will be faced by the emergency department of the Royal Victoria Hospital (RVH) in the Belfast Health and Social Care Trust was one of the reasons why that trust was placed into special measures earlier this year. Under special measures, there were increased governance arrangements, and the trust was asked to put in place an action plan to address specific milestones.

The emergency department's performance was only one element of the action plan. The improvements that were made by the trust on the 12-hour unscheduled care target have seen a reduction in 12-hour breaches in A&E in the Belfast Trust from 171 in April to three in September. That is one example of the evidence-based improvement, which has led to the Minister announcing today that he is relaxing special measures at the Belfast Trust.

There will, of course, continue to be close monitoring of —

**The Chairperson:** I am sorry; did you say that he is relaxing special measures?

**Ms Daly:** He is relaxing special measures.

**Mr Wells:** Has that been announced?

**Ms Daly:** The Minister announced that this morning at the Belfast Trust leadership conference. That decision is based on the improvement against the trust's action plan. The Department and the board will, of course, continue to monitor the trust.

At the evidence session in June, we made the point that there is no standard set of changes that will improve emergency care across all hospitals. Each hospital has its own challenges and strengths, and improvements in emergency care will depend on changes to whole systems, not just to emergency departments. The improvement action group is building on those strengths and identifying measures that are working elsewhere. It is identifying the lessons that can be learned and shared across trusts. In addition to the IAG meeting individually with the trusts, the group held two shared learning events in June and October. They provided a formal setting in which health and social care staff were able to network and learn from one another. The October event included speakers from England so that we could see how other countries are dealing with similar challenges.

Improvements in the emergency care department go far beyond the emergency department. The emergency department can provide the best care in the world, but if other parts of the hospital system are not able to play their part, the emergency departments will inevitably be put under unsustainable pressure. We need to ensure that the flow of patients through hospitals and back to their homes is working effectively. That means prompt admission to wards from A&E, appropriate lengths of stays in hospitals, prompt discharge when the patient is medically fit, and primary and community care arrangements being in place to support the discharge. It also means looking at ways to prevent admission to hospital or other ways to get appropriate treatment in the first place. The strategic review of health and social care services, 'Transforming Your Care', which is out for consultation, includes a number of proposals that are designed to identify patients who are most at risk of needing unplanned care and putting in place measures to help to avoid that and to reduce unnecessary attendance at hospitals.

Other aspects include making people aware of alternatives to emergency departments, such as GPs, GP out-of-hours services or advice from a local pharmacist if appropriate. It is important that the issues that our emergency departments face are considered from a strategic as well as an operational perspective. That will be important work going forward.

The group was initially established for three months. However, it has been decided that its operation should be extended until at least March 2013. That is to allow the group to continue to support trusts and to work with them over the winter period when, traditionally, our services come under additional pressure.

That outlines the key issues and the overarching picture of the improvement action group. I will hand over to John and Mary to provide some more detail on the work that is being taken forward.

**Mr John Compton (Health and Social Care Board):** I do not propose to say very much at all. Mary has the details. I am sure that that is what the Committee wants to hear. We will be able to take questions after Mary talks about the work that has been ongoing for the past number of months.

**Ms Mary Hinds (Health and Social Care Board):** The approach that we have taken through the improvement action group is to use whatever evidence of action that makes a difference. We focused particularly on bottlenecks, which cause delays in the entire system of care. As Catherine said, ED is the symptom of the problem; it is not invariably the problem itself. We aim to provide practical support as well as challenge.

I acknowledge the significant effort and commitment of staff in the trusts to reducing delays and providing the best service for their patients. I have worked alongside them recently, and they are quite exceptional.

All trusts have engaged with the improvement action group in a positive manner. They have been willing to share good practice and have supported colleagues in other trusts. Again, that is to be commended, and it should continue. We get it right for most patients who come into our emergency care departments. Year on year, attendances have increased, but this year, they have recently decreased.

What makes some trusts achieve better results than others? There are some common themes. In the trusts that have better performances, there is a culture that values strong clinical and managerial leadership and empowerment. Patients in the emergency department are viewed as part of the integrated system of care. Attention is paid to other indicators, such as length of stay, occupancy and the patient experience. There is significant co-operation between a hospital and community services, and there are effective arrangements to divert and other good co-operative partnerships with primary care. All those things demonstrate that if the whole system works, the care will be good and patients will not be delayed.

I will talk members through some of major indicators, one of which is the 12-hour performance. The Western Health and Social Care Trust and the Southern Health and Social Care Trust have consistently demonstrated a sustained excellent performance in 12 hours, preventing 12-hour breaches in all their hospital sites. Both those trusts have developed clear ownership of the challenge throughout the whole system of care and visible leadership in acute hospital services and the community. The Belfast Trust has improved its 12-hour performance significantly, with a 64% reduction in the number of 12-hour breaches from April to October compared with the same period last year. I feel confident enough to say that a 12-hour breach in the Belfast Trust is now an exceptional

event. The trust team have promoted, introduced and led a range of initiatives. There is much more to do but they have improved performance significantly.

The South Eastern Trust's performance has improved, with a 43% reduction in the number of 12-hour breaches from April to October. It has demonstrated the same commitment to new ways of working and has specifically strengthened relationships between hospital and community. September, October and November have been very challenging for the trust, resulting in an increasing number of breaches. The trust has had to manage increasing attendances in its emergency department and an unusually increasing number of ambulance attendances. The volatility of that performance remains a concern, but we continue to work with the trust to try to address that.

The Northern Trust's performance has improved, with a 50% reduction in the number of 12-hour breaches from April to October compared with the same period last year. Although the urgent crisis of last winter may have receded and improvements clearly have been made, the current performance remains a concern, with approximately 100 breaches a month being commonplace.

In summary, all the trusts have demonstrated improvements, but the performance in the Northern Trust and, latterly, the South Eastern Trust continues to require some ongoing, escalated and supportive arrangements.

If you remember, the four-hour target is that 95% of patients will be seen, treated and discharged or admitted within four hours. As part of the improvement group, I know that this is a target that all our trusts have struggled with in Northern Ireland for some time. Trusts sometimes need a target that they can work towards, so we have given them an incremental step. It does not replace or dilute the Minister's target, but the incremental step is to improve their six-hour performance as well as their four-hour performance.

The Western Trust has maintained a relatively good four-hour performance, ranging from 81% to 88%. It has also demonstrated a sustained improvement in its six-hour performance, with an average of 94% of patients seen, treated and discharged within six hours.

The Southern Trust is the best-performing trust in Northern Ireland against the four-hour target, achieving 84% to 91%. Since April, its six-hour performance has also been improving, peaking in September at 98% of patients seen, treated and discharged within six hours. So those that are good are getting better.

The Belfast Trust performance against the four-hour target has been poor, with an average of 73%. The most significant challenge is on the Royal Victoria Hospital site, with its performance ranging between 69% and 75%. The performance is below an acceptable standard. The trust knows and acknowledges that, and it is working with us.

The South Eastern Trust has maintained its four-hour performance at between 82% and 86%, and there have been significant improvements in its six-hour performance, with an average of 93% and a peak of 95% in August being seen, treated and discharged.

Although the Northern Trust remains a poor performer against the four-hour target, with an average of 75%, there have been improvements in the six-hour performance, which is at 87%. Again, the most significant challenge is Antrim, where the monthly average has not exceeded 70% and, at times, has been as low as 60%. Again, that performance is below an acceptable level.

Although all trusts have not quite reached a performance that we would be proud of, which means hitting the 95% target, we have made improvements, and we can see a step change in improvements against the six-hour target.

The Royal Victoria Hospital and Antrim Area Hospital remain a concern, and we will continue working with those organisations.

As part of the group's work, each trust is required to complete an exception report on all patients breaching the 12-hour target, which they must bring to our members' attention. The trusts are required to have in place an internal review process to ensure that senior officers review those reports and take any necessary actions to prevent breaches. We in the team also review those reports. A number of recurrent themes have occurred, such as whether there are sufficient staff out of hours to match the peak times of demand, which would help to lead to more timely assessment and treatment, and, therefore, shorten the patient journey. In partnership with the trusts, we are, therefore,

conducting a demand/capacity exercise. We are looking at the capacity of staff in the system, the demand in the system and whether we can better match the two.

Exception reports submitted by trusts also indicated that some patients in the system of care were experiencing delays in accessing interventional and diagnostic cardiology. To help to ensure that the whole system understands the pressures that each one of us is under, we have facilitated a teleconference three times a week. That is held with all the trusts concerned, and it allows for shared information and shared understanding, and it smoothes the pathway for patients. There is still more work to do, but that has had an impact and reduced some of the delays.

We have also worked with trusts on internal hospital processes. Given the amount of time that we have today, I will pick out just a few. All trusts now implement daily walkabouts that bring hospital and community staff together to identify as early as possible patients who are ready to go home or ready to be cared for in another setting. We have also increased the number of senior reviewers in ward settings. A review of every patient should happen every day. Again, that is to shorten the patient journey.

Hospital pharmacists are implementing a range of innovative arrangements to improve patient flow, such as the preparation of medications earlier in the day or the day before a patient's discharge. I keep saying to people that if someone gave me a ticket to Paris, I would pack the night before, not wait until the morning that I was going. It is the same when someone is being discharged.

A number of trusts, including the Northern and Southern, allow same-day access and reporting on a number of diagnostic procedures. Again, those arrangements support the timely management of patients inside and outside hospitals.

Trusts have used a range of internal and external transport arrangements to ensure that patients are discharged safely and as early in the day as possible. Some trusts have taken forward escort-supported discharge so that patients are cared for and transported safely to their homes.

Nurse-led discharge has improved. The Royal Victoria Hospital now has the highest percentage of nurse-led discharges in Northern Ireland. The Northern Trust has put in place a system in which each ward has a target for nurse-led discharges, and that performance is scrutinised by the director of nursing.

Trusts have developed a range of escalation plans that focus on the whole system of hospital and community care. They are also working with us further to refine those so that we have emergency department-specific escalation plans. That was an outcome from one of our learning events. Matthew Cooke was the national clinical director in the Department of Health and targeted much of the work on unscheduled care in England. He came and shared some of his experiences with us.

So we look at the front door, the processes through the hospital and the back door. We also challenge some of the clinical practice surrounding patients who have been in hospital for over 20 days. We have a system in which we ask trusts to review patients who have been in hospital for over 20 days and have not been declared medically fit. That has resulted in a change, and we have seen a drop in the number of those patients. However, it is one of the issues that we have to constantly monitor and observe.

I mentioned the walkabouts on which hospital and community staff come together. Many trusts have also sought to reorganise their community services by creating step-up and step-down services. The South Eastern Trust, for example, has increased the capacity in its community nursing teams by creating rapid response nursing services to meet the needs of patients when they come out of hospital. Domiciliary or social care is just as important to discharge as the healthcare element. A number of trusts are undergoing a review of their domiciliary care services, particularly of their demand and capacity, and are negotiating with local providers where there are shortfalls in capacity. The Belfast Trust has increased the capacity of its community nursing beds to help to address the delays and specifically to improve the movement of patients over weekends. We have found that there is often a dip in discharges over the weekend.

Access to nursing homes can be delayed unnecessarily. A particular delay identified to us was that nursing home staff had to come into hospitals to review patients so that they could be safely discharged to their facilities. We have worked with the Regulation and Quality Improvement Authority to make sure that everybody understands the rules and regulations in order to ensure that we do not put any unnecessary delays into the system.

As I said, early interface with primary care is really important. Altnagelvin and Craigavon have led the way with very successful systems that encourage GPs to refer potential medical admissions directly to senior physicians in their medical assessment units. In the Western and Southern trust areas, experienced triage nurses can refer directly to their out-of-hours service as an alternative for assessment. Colleagues in other trusts have learnt from the Western Trust and the Southern Trust. More recently, the Belfast Trust opened a facility in Ward 5 North of the City Hospital to accept direct GP referrals for assessment and admission. It was a slow start. The service was relaunched in September, and it took time to undertake significant engagement with GPs. On one occasion, the trust ran an event that was attended by more than 60 practices. The initiative is increasingly successful and shows great promise, with more than 1,200 patients having been admitted to that facility. Initial feedback from patients and GPs is extremely positive. Staff in the Belfast Trust were very generous to our colleagues in the Northern Trust and allowed them to see, understand and participate in some of their work. In Antrim Area Hospital, a similar service, albeit on a slightly smaller scale, has opened. To promote the facility, local GPs and the primary care partnership are working with clinicians in the hospital to redirect certain patients there instead of to the emergency department. So far, the feedback from general practitioners has been positive. On average, they see about 10 patients a day.

I am conscious of time. The Northern Ireland Ambulance Service is the glue that holds it all together. It is really important, particularly as we change our services. We are working with the Ambulance Service on its non-urgent service, which is the service that takes patients to clinics and home, to ensure that it is more efficient. Our work focuses on a range of areas. One is the introduction of HALOs — they are not saintly or spiritual; they are hospital ambulance liaison officers, who are absolutely key, and we have found them effective. We have placed one in the Belfast Trust, one in the Northern Trust and one in the South Eastern Trust. We hope that they will ensure that we improve the performance of the Ambulance Service and get the most productive use of that very scarce and precious resource.

On ambulance turnover times, we are concentrating on delays at the front door. We have given the Ambulance Service a live link. Had I been allowed to bring my BlackBerry into the meeting, I could have shown you a live link, which allows us to see in real time what the pressure is like in every A&E department in Northern Ireland. That is really important because it means that we might be able to manage pressures across the system in a more coherent and joined-up way. We are also working further to refine the information that we collect on turnover times. It is not perfect. We should not draw too many conclusions from it at present, except to say that Craigavon Area Hospital is the best performer. The Royal struggles —

**Mr Gardiner:** Excuse me, but I agree with you.

**Ms Hinds:** Well, I thought that you would.

**Mr Gardiner:** Hear, hear.

**The Chairperson:** I have never seen him smile as much as this in a Committee meeting. Every time that you mention Craigavon, he smiles.

**Mr Gardiner:** That is because we are the tops.

**Ms Hinds:** I am cutting through some issues but not leaving Craigavon out. It is important that we acknowledge those that perform well. Sometimes, we concentrate on those that struggle a little.

In October and November, the Ulster Hospital particularly improved its performance. Perhaps you remember that the context was that it got more ambulances through the day in the past couple of months. It has also tested some internal escalation processes, which have shown interesting results.

The Ambulance Service also has limited options for what its staff do with patients when they meet them in their homes. We are working with the service to see whether there are other see-and-treat or see-and-talk options as opposed to always bringing patients to hospital. We have been monitoring the patient experience. A fuller report will go to the HSCB and PHA board meetings in December. Some of the issues will be no surprise to any members here: repeated interruptions; people not introducing themselves; patients being placed in areas where the level of privacy is not ideal, etc. All trusts have action plans to deal with all the issues highlighted.

As you know, winter comes every year, and we try to plan for it. We have been working with all six trusts and local commissioning offices to help to develop proposals that will support them through the winter. The board has identified a planned resource in the region of £2 million to support trusts over that period. In partnership with trusts, we are looking at admission avoidance, improving patient flow, improving discharge and enhancing community-supported discharge. Examples include supporting temporary increases in staffing to improve seven-day working; extending the hours of emergency-care nurse practitioners to midnight; supporting community services to be able to respond better; addressing specific areas of high admissions, such as rapid response to redirect certain conditions; increasing allied health professionals' capacity; and increasing the capacity of the Northern Ireland Ambulance Service.

Our colleagues in integrated care are working with general practitioners to increase the number of surgeries that can be made available during the winter period so that people have the choice to go to their GP. So for the future, we continue to work with colleagues and are looking to develop a range of quality indicators. We will not take our foot off the pedal; we will continue to press for the four-hour and 12-hour targets because we are not there yet, and that is the task that we have been charged with. We are looking at other issues, such as the time to initial assessment, time to treatment, unplanned re-attenders, and patients left waiting without being seen. Those are part of a suite that the emergency medicine section of the Royal Society of Medicine considers appropriate quality indicators.

We are working with trusts on workforce modernisation. As I said, we must match capacity to demand. We are looking at whether we can manage the pressures throughout the system of care in a better way. Integrated care colleagues are looking at whether we can develop any other models for urgent care. We are working with the Ambulance Service on the see-and-treat option.

In conclusion, there have been improvements and a reduction in the number of 12-hour breaches since April. The Southern Trust and the Western Trust should be congratulated on their sustained good progress and performance, and the Belfast Trust has made significant improvements. The South Eastern Trust is making huge progress but has had a number of challenging months that impacted on its performance, but it is totally engaged with the team. The Northern Trust's performance remains a concern, with significant levels of breaches consistently reported since April.

The trusts' staff are to be congratulated. There is not one member of staff in any trust who is not working very hard with us and for their patients to make the system better.

**The Chairperson:** Mary, thank you. That was a very comprehensive report. Let me say at the outset that no one is criticising any of the work that staff do. They work at the coalface and, unfortunately, have to deal with this. What has happened over recent days was, I think, a cry for help from staff.

I will go through some of the points. I asked the Committee Clerk to get a copy of this morning's press release on the Minister's statement and have just received that. The press release does not say that the Minister has taken the Belfast Trust off special measures.

**Ms Daly:** We had provided advice to the Minister on the basis of progress. As you know, the special measures were put in place —

**The Chairperson:** Did the Minister say that at the conference?

**Ms Daly:** Yes.

**The Chairperson:** May we have a copy of his speech? You would think that such an important announcement would be included in his press release.

**Ms Daly:** The Minister said that he is relaxing the special measures. There were a number of actions, and meetings took place in May, June, July, August and September. The Minister received a progress report against each of the milestones under the action plan, and that included a progress report from the Health and Social Care Board.

**The Chairperson:** What does he mean by "relaxing"?



**Ms Daly:** That means that the specific measures that were put in place — monthly accountability and governance meetings — will be stood down, but there will continue to be close monitoring —

**The Chairperson:** Is that the only difference?

**Ms Daly:** All the action points and milestones that were specifically identified have been addressed. So this means that the trust will be under the normal governance and accountability arrangements that are in place for all the arm's-length bodies under the Department. If there is any significant deterioration in performance, the Minister will be advised of it, and he will take action as appropriate.

**The Chairperson:** I will come back to that. A number of members want to ask questions, and I have questions that I want to ask. Let us try to keep the answers as succinct and clear as possible. I thought it important to let you finish, Mary, and give you the time to present your report. Let us try to get to the key issues.

In fairness, we need to congratulate the hospitals that are doing well. There is no criticism of the hospitals that are performing well. However, we visited a number of A&Es. One of the key issues was that some hospitals had increased the number of rounds, in parts of the hospital other than A&E, for discharging patients throughout the day. Has that changed in any hospitals other than those that have continued to do well? Have hospitals that continue not to do well increased the times when they can discharge patients?

**Ms Hinds:** Yes. There is a combination of factors: it is about the senior clinical decision-makers, who see every patient on a ward every day, making the decision to discharge, and about what we call an outcome-focused plan. If you come into hospital, there is a clear plan about what care you will get while you are there. If you have a clear outcome-focused plan, you can increase nurse-facilitated, or nurse-led, discharge, so there has been an increase in that across the board. There has also been an increase in the use of expected date of discharge. That is all tied in with the multidisciplinary walkabouts or "white board" rounds, which happen every single day, sometimes twice a day. Those are the rounds that hospital and community staff make together.

**The Chairperson:** So outside of the emergency department in the Royal, the doctors in the rest of the hospital have increased their ward rounds so that they can discharge people at 9.00 pm?

**Ms Hinds:** Yes. Not every department and not everywhere because it is a work in progress.

**The Chairperson:** I am glad that you clarified that. Is that a work in progress because there is an issue with contracts and things like that?

**Ms Hinds:** There is a job planning process, and a discussion that has to be had. There is also a practical consideration. We have consultants who work between sites, and they can be at only one site at a time, so there is still work to be done.

**The Chairperson:** In case I forget, I have a particular concern about waiting times. It is bad enough that adults have to wait for that length of time, but I am concerned that, in October, 355 children waited for between four and 12 hours in the Royal Belfast Hospital for Sick Children. It is very hard to explain to kids that they have to wait. I would appreciate you looking at that.

**Ms Hinds:** I am happy to do that.

**The Chairperson:** At least with adults, you can explain. They might not be happy, but you can explain it.

Is the staff ratio in all our A&Es OK or are there issues with staffing levels?

**Ms Hinds:** The staffing varies between A&E departments. I will start with nursing. There has never been a recognised tool for working out A&E staffing, so much of it is based on what happened historically and how services are developed, so there are a lot of emergency practitioners in one area and not in another. We are working with the Royal College of Nursing UK-wide to develop a workforce tool for A&E nursing. We have tested it in two sites. The initial feedback, which is reasonably positive, is that it is a reasonably sound tool. The message is that, in some areas — as we have not tested it everywhere, we do not know about everywhere yet — we may have enough staff but we may

not be rostering them according to when we know that the demand will hit the A&E department. I know that sometimes A&E departments look chaotic, but there is often a pattern to the demand, so we have further work to do there.

There has been an investment in consultant medical staff over the year. There is variability in the number of consultant medical staff, middle-tier registrars and juniors throughout the piece. Currently, the most significant number of consultant staff are based on the Royal Victoria Hospital site. There is work to be done in all the trusts to look at the numbers of medical staff and the demand. Are we matching the number of staff with the demand coming through the door? Recruiting to the middle tiers in A&E departments has been challenging, so the IAG is working with the medical staff. I have started to meet the senior medical staff in all A&E departments regularly because we all need to understand one another's demands. We will carry out a demand/capacity exercise for nursing and medicine in A&E departments.

**The Chairperson:** Explain what happens in this situation: 10 patients who need to be admitted are waiting in A&E, but there is a problem with the patient flow throughout the rest of the hospital because patients cannot be discharged. Correct me if I am wrong but, technically, once admitted, those 10 patients are no longer under A&E. However, they are still in A&E, so who is responsible for them? Are staff redirected from other parts of the hospital to look after them?

**Ms Hinds:** That is a very good point. The systems are slightly different, but the general system is that if you are recorded on the patient administration system as having been admitted, you will, for example, be under the care of a particular surgeon. Each trust has to have an internal escalation plan by which, if the risk is such that, for instance, the nursing staff cannot cope, extra nurses should come down to the A&E department.

**The Chairperson:** Has that happened, Mary?

**Ms Hinds:** That has happened in many trusts. If someone is telling you that that is not happening in their trust, they need to be telling me and their managers. We specifically ask those questions because the key factor is keeping patients safe. We do not want anyone waiting in A&E. In my career, I experienced ward rounds in A&E, which almost compound the problem rather than dealing with it. If patients are subject to delay in A&E, they are entitled to and should get care equivalent to what they would receive in a main ward of the hospital. Clinical teams should care for them, and there should be sufficient nurses to care for them. That is why we are looking at the patient experience. Much of what was said in the press about us this time last year was to do with some of the fundamentals of care. It is important that A&E departments have sufficient nursing staff to care for those patients.

**The Chairperson:** Let us go back to waiting times. One of the good things about local accountability and local democracy is that we all live and work in the constituencies that we represent, so we are probably more up to date with what is happening in our constituencies than you would like. I accept that there have been improvements in the number of waits between four and 12 hours in October, but that performance seems to be dipping. How many of those waits were close to the 12-hour mark? Have you figures for people who waited for over 8 hours and people who waited for slightly under 12 hours?

**Ms Hinds:** We thought of that, too. If you were to put a cynical hat on, you could ask whether there was a bit of gaming and whether everyone was being admitted after 11 hours and 55 minutes.

**Mr Wells:** No, 11 hours and 59 minutes.

**Ms Hinds:** You are even more cynical than me.

**The Chairperson:** I was going to say 11 hours and 58 minutes.

**Ms Hinds:** I have not got the figures with me, but I can get them. We monitor 12-hour breaches. We monitor waits between eight and 12 hours; those who are seen within six hours; and those seen within four hours. We have divided waiting times into four categories, always mindful that there could be no waits at the 12-hour mark but 12 in the next category. This is where we need to push right down incrementally so that 95% are seen, treated and discharged within four hours. We are very mindful of that.

**The Chairperson:** Will you get us those figures? That would be useful.

**Ms Hinds:** Yes, not a problem.

**Mr Compton:** I draw your attention to the very high percentage in the six-hour category. That is just for today, and we will get you the other numbers.

**The Chairperson:** If you are sitting there as a patient, waiting for six hours or eight hours —

**Ms Hinds:** Sue, the categories relate to the percentage of patients seen within four hours; the percentage seen within six hours; the percentage seen after a wait of between six and eight hours; the percentage seen after a wait of more than eight but less than 12 hours; and the percentage seen after waiting for over 12 hours. I get that information every day.

**The Chairperson:** OK.

The role of GPs has come up time and time again. What is the role of GPs in hospitals, especially in A&E settings?

**Ms Hinds:** There is variable evidence on putting a general practitioner into an A&E and on whether doing so has a positive impact on the basis of value for money. A test is ongoing in the Northern Trust because this issue has been raised before. I think that it was raised when I was in front of the Committee. At present, the numbers are small, and we will let that test run its course and then evaluate the impact. In the Southern Trust, Craigavon Area Hospital has its out-of-hours GP service quite close to the hospital, and, as I said earlier, nurses can refer patients to that.

GPs want to be able to access diagnostics, opinion, assessment and a bed for their patient, without necessarily going through the emergency department, where that is appropriate. The Western Trust, the Southern Trust, the Belfast Trust and the Northern Trust are already taking forward that work, which is showing very positive outcomes. So GPs have a role. There is a bigger piece of work, a review of unscheduled out-of-hours services, which my colleagues in integrated care are taking forward. If all the pieces of the jigsaw do not fit together, we will not get a pretty picture. It all needs to work, including the GPs.

**The Chairperson:** Finally from me for now because I want to bring other members in, has there been an increase in incident reports over the past year?

**Ms Hinds:** What do you mean by incident reports?

**The Chairperson:** The incident record (IR1) forms.

**Ms Hinds:** I do not get information on incident reports, and I could not tell you, off the top of my head, about the serious adverse incidents. I would be guessing.

**The Chairperson:** The incident reports are when staff raise issues of concern. Do you have access to those?

**Ms Hinds:** No, I do not get access to those. The incident reports are internal in the trust.

**The Chairperson:** Through you, Catherine, can we get information on that?

**Ms Daly:** Absolutely, yes.

**The Chairperson:** I am led to believe that there is an increase, which comes more from the staff raising issues of concern internally.

**Mr Compton:** There are two ways of looking at it. It could be because there is a genuine concern, and that is reasonable, but it is also because there is very strong encouragement now to —

**The Chairperson:** Whatever the reason, we need to look at it. We need to give staff at the coalface protection when they raise issues with their managers. For a while, there was criticism that people were not raising those points.

**Ms Hinds:** I have met staff-side organisations and have said that my door is always open. Only one member of staff has come to me, but I have taken time to work with that member of staff to deal with their concerns.

**The Chairperson:** Interestingly, given the stuff in the media over the past number of days, have you been in contact with the RVH?

**Ms Hinds:** No.

**Ms Daly:** The Minister has made very clear the importance of staff being able to raise issues, and we will make sure we get that information to you.

**Mr McDevitt:** Catherine, I want to make sure that I did not pick you up wrong. You mentioned some comparative figures between April and September this year for 12-hour breaches in the Royal. Did I hear you right?

**Ms Daly:** Yes.

**Mr McDevitt:** What were the figures?

**Ms Daly:** It was 171 in April and down to three in September.

**Mr McDevitt:** Those are not the figures that we have, Catherine. It is on page 19 of the departmental brief in the table under paragraph 5. The figure for the Royal in April is 107, not 171, and, for September, it is two, not three. In fact, the figure that we have for the Belfast Trust is 170, not 171, in April and four, not three, in September. Where did you get those figures, Catherine?

**Ms Daly:** The figures in my briefing are 171 in April in the Belfast Trust — that covers all sites — and three in October.

**Mr McDevitt:** The figure that we have is certainly not 171 in the Royal, but it definitely was not 171 in the Belfast Trust either.

**Ms Daly:** What paragraph is that in your briefing?

**Mr McDevitt:** It is in paragraph 5 of your briefing to us, which shows performance against 12-hour targets from April 2012 to October 2012. It shows that in April, in the Royal Victoria Hospital, there were 107 of what are colloquially called 12-hour breaches and 170 in the Belfast Trust in total. In September 2012, there were two in the Royal Victoria Hospital and four in the Belfast Trust.

**Ms Daly:** Yes, I see the figures. There is a difference. The figures that I am relaying are for the trust in its entirety, but there still is a difference of one. We seem to be out by one. I want to take the opportunity to convey my apologies for that difference; we will look into that. However, the materiality of the change remains, and there is no material difference.

**The Chairperson:** Can we have clarification on whether your information, or the information that Mary provided, is the most up to date?

**Mr McDevitt:** I heard you say the Royal, but I take your point about the trust.

**The Chairperson:** The 171 was for the Belfast Trust, but it is still one out.

**Mr McDevitt:** I will move on to the four-hour breach. I acknowledge the work that has been done on the 12-hour stuff. The Royal, Antrim, Ulster and Craigavon hospitals all have big accident and emergency departments, and every one of them reports more people breaching the four-hour wait in October 2012 than in April 2012.

**Ms Hinds:** There has been a growing number of attendances in the past number of weeks. Why have we not improved the target in general? In my opinion, a lot of the improvement that needs to happen on the four-hour target is about the internal workings in the ED as well as the external workings in the community and in other areas. It is a fair criticism. We have been concentrating very much on trying to deal with the sharper end of the 12-hour breaches, and that is why we put in a six-hour target. Some of the trusts were so far away from the four hours that it became almost something that they felt that they could never achieve. The six-hour target is a milestone for them to work towards, and if I remember rightly, all of them have improved — albeit some of them marginally — on that.

**Mr McDevitt:** If you look at trends in the Royal, for example, you start with 2,317 breaching four hours in April, it goes down to 2,253 in May, it goes down to 2,044 in June, and it goes down to 1,891 in July. However, from August to date, there has been a significant jump, and it has jumped to higher than it was in April. August comes in at 2,405, September comes in at 2,556 and October comes in at 2,475. I am not sure that you can argue that that is a positive trend. It says that there was improvement, and now we are back to where we were.

**Ms Hinds:** We struggle with the four-hour performance target, and I have not said anything different to you. We continue to work with the trusts. We have concentrated very much on the 12-hour target. I recognise that we need to do more on the four-hour one. We have given them an incremental, six-hour target to work towards. You are absolutely right: in some areas, it is drifting in the other direction. As I said, in the South Eastern Trust, the 12-hour time is drifting in the other direction but coming back down again.

**Mr McDevitt:** The four-hour standard is 95%. Is that correct?

**Ms Hinds:** It is, yes.

**Mr McDevitt:** We are only doing 72.7% in the Belfast Trust; 76.3% in the Northern Trust; 84.1% in the South Eastern Trust; 87.5% in the Southern Trust; and 85.8% in the Western Trust. The latter two are your star performers. We are miles off the target everywhere.

Maybe taking advantage of a little information is a dangerous thing, but I was curious to note that there seems to be a direct correlation between the size of the A&E and its ability to perform against the targets.

**Ms Hinds:** You mean that the bigger the A&E —

**Mr McDevitt:** The worse it does.

**Ms Hinds:** That is probably a little bit unfair. I do not know whether there is a direct correlation between the size of the A&E, its physical capacity and —

**Mr McDevitt:** If you look at the percentage of patients seen within four hours, the smaller A&Es are the ones that all meet the target.

**Ms Hinds:** The smaller A&Es will have a different acuity of patients going through them.

**Mr McDevitt:** They will have fewer staff as well.

**Ms Hinds:** There is no one thing that is the cause and effect of why the four-hour standard is drifting away from what it should be or why it has not been anywhere near what it should be. It is infinitely more complex than that. That is why we are doing the demand/capacity exercise. You may have more of one particular type of staff, and you may have consistent staff. Therefore, you get a consistent way of working. You could be working in a bigger unit that has been under pressure, and as a result, it has been difficult to recruit and, therefore, you get turnover of staff. When you get that type of environment, it is hard to maintain and sustain changes and improvements in services.

**Mr McDevitt:** Are we not led to believe that everyone wants to work in the bigger units and that it is impossible to get someone to go and work in a small unit? Was that not why we had to abandon the

prospect of the new Downe Hospital having an accident and emergency facility and why we have been told, in 'Transforming Your Care', that we need to consolidate into centres of excellence?

**Ms Hinds:** The recruitment issue in the bigger hospitals is certainly in and around the middle tiers. We struggle to retain middle tiers, and it is not just about the desire to work in a larger place, it is about the availability of a lot of those middle-tier staff. That is why we think that we need to look at the multidisciplinary team to see whether there is another way of doing it.

**Mr Compton:** There are a couple of other things. First, the hospital in Downpatrick has an accident and emergency department, which is working at this point in time. Secondly, if you have a situation where a hospital does not have general or emergency surgery, you skew dramatically the nature of the patients who come to it. Therefore, if you take, for example, Lagan Valley Hospital and Downpatrick, where there is no emergency surgery, no patient who would be designated or thought of as requiring emergency surgery would turn up at those hospitals in the first instance. Children would not turn up there, nor would you have people with a range of other very significant conditions turning up there. Those hospitals have, as it is sometimes referred to, a level-2 emergency department, and that largely explains why the performance is variable and different.

Just to be straight about it, it is another matter of fact that we concentrated on the 12 hours. Remember where we were last year. In one of the large units, we had 16% of patients waiting for 12 hours. The thing was in a very fragile position. So we had to get the 12-hour position into a much better place, which we have done — it is not perfect but we are at it. Then there is a second-order thing, which is the four hours. As Mary said, as only a stepping stone to get to the four hours, we have looked at what six hours means. Certainly, the first sign is that we are making some progress on the six hours. However, I would not sit here and pretend that this matter is resolved. It is clearly not, and it will clearly require us to continue to apply the same amount of energy and effort that we have applied over the past number of months.

**Mr McDevitt:** As we head into this winter, do you have confidence that the system is more resilient than it was this time last year?

**Mr Compton:** Yes.

**Ms Hinds:** Yes.

**Mr McDevitt:** We will see a better performance across all the variables this winter than we saw last year?

**Mr Compton:** Well, yes. That is the starting position. We have put a huge effort into this and have done a lot of planning for the winter. I cannot legislate for the fact that you may end up with some sort of massive norovirus outbreak or something like that across Northern Ireland. That would put real stresses and strains on us. However, in the normal course of events, we are in a much better place than we were at this time last year.

**Mr McDevitt:** OK, thank you.

**Ms Daly:** It is important from the departmental perspective to make very clear the Minister's position on this. He absolutely recognises that improvements have been made but there is a long way to go. That is why the momentum and this work will continue.

It is absolutely right to say that the number of four-hour breaches is higher in September than in April, but what is reflected there is the improvement in the proportion of patients who were seen within the four hours. That reflects that there were greater numbers in September, but the proportion that were seen within the four hours in September was higher than April but absolutely nowhere near where it needs to be, and that is fully recognised.

**Mr McDevitt:** Just to be pedantic, figures are figures. I think that is a brave and courageous statement. If you take the small level-2 facilities out of it, you do not see an improvement, at best, in percentage terms; you see a flatline and, generally speaking, deterioration. We need to put that on the record. There is no evidence here that the four-hour situation has significantly improved.

**Mr Compton:** I do not think we said that.

**Mr McDevitt:** The Department has — just.

**Ms Daly:** No, sorry, I was just trying to clarify.

**Mr McDevitt:** Oh, you did not say that? OK. I know it is a bad morning for you but —

**The Chairperson:** Clarify what was clarified what was clarified. The reality is that people are waiting more than four hours, some waiting more than 12 hours and some being sorted at eleven-and-a-half hours. That is not right, and we need to be dealing with that.

**Mr Beggs:** Thank you for your presentation. Before I start, I express my personal thanks to A&E staff who have treated me and members of my extended family recently.

**The Chairperson:** Will you get a free pass for the weekend, then, to get sorted? *[Laughter.]*

**Mr Beggs:** I have concerns about your briefing because you did not seem to have any realisation of winter pressures. Do you appreciate that there are winter pressures that cause peaks and troughs throughout the year?

**Mr Compton:** Absolutely.

**Mr Beggs:** The figures that you have presented to us are based on April onwards. Paragraph 10 refers to a 4.8% improvement.

**Mr Wells:** A 4.8 percentage point improvement.

**Mr Beggs:** Yes, a 4.8 percentage point improvement in the numbers being seen within the four-hour period. When you look at the figures from a year ago, however, it is a 0.4% improvement. Are you in danger of being complacent? Are you being disingenuous? Why did you highlight the figure of 4.8? When you compare the figures of a year ago, which are tucked in at the back of the document, where you mention the 8.3%, which is only 0.4% on a year ago? My point is are you being complacent by using the figure of 4.8% improvement and not recognising that there are winter pressures, and if you chose somewhere in the middle of the winter a year ago and used that as a starting point, you have made a very slight improvement on a year ago. It is probably just at the point of not being statistically significant, I do not know.`

**Ms Daly:** Those figures are highlighted because they are from when the improvement action group was put in place. You are absolutely right to say that certain volumes of patients will hit hospitals at specific times of the year. We are not being complacent. We are simply reflecting the period when the improvement group was set up.

**Ms Hinds:** I will give you a flavour of some of the winter pressures initiatives. There has been planning, and that happens every year to help the trusts through the winter. We are in a better position now in respect of the 12-hour breach. However, we accept that we are nowhere near where we wish to be in respect of the four-hour breach. We are in a much better position now than at this time last year. All the trusts have worked with us, and they are doing things, such as appointing additional social workers, allied health professionals, physiotherapists and occupational therapists, and providing extra beds in the community and access to extra domiciliary care. So, initiatives are happening in every trust and the Ambulance Service to help us through the winter.

**Mr Beggs:** What is wrong with our system, when so many people are working very hard and diligently, but the system is not producing results? I decided to go online to take a look at the English figures. The worst performing health trust in England is at 80.7%. So we are at the same level as the worst performing trust in England. There is only one other trust area in the 80% to 90% range. The rest of the trusts are over 90%, and the vast majority of them are over 95%. So what is fundamentally wrong with our system?

**Ms Hinds:** Perhaps you recall what I said at the start. You are absolutely right, and that is partly why we brought over colleagues from England to try to learn about what they did because they started the process with gusto a couple of years ago.

The creation of an improvement group by the Minister and the board has resulted in improvement, and it is the work of the trusts that is delivering that improvement. It is like a series of roundabouts. If somebody is driving around at 72 mph and somebody else is driving around at 50 mph, it will not work. However, if everybody is going at a reasonable speed — if everybody is doing their job and understands that everybody's 15 minutes counts — the system will work. At the minute, A&Es or EDs are under pressure.

In the best-performing hospitals in Northern Ireland — we accept that those are not where the hospitals in England are, but we are working with them — it is about having that interface between hospital and community; clear, clinical, senior ownership in the organisation; clear escalation; and developing alternatives. So, a menu of things has to happen in order to make the cake rise. If somebody decides not to do something until tomorrow morning, that makes a difference. Part of our job, in working with the trusts, is to get every single member of staff in the whole system of care, be they in a hospital or in the community, to understand that our patients are important to every single one of us and, therefore, everything we do matters. You should be in hospital for as long as required but no longer than is necessary, and you should be safely discharged to go home.

So, it is difficult to say. It is not about one or two things but a whole system of care, and we have not cracked that whole system of care yet. We have made improvements, which, I think, have been demonstrated by the reduction in 12-hour breaches, but we have not cracked it yet.

**Mr Beggs:** I am an East Antrim representative, and the primary hospitals serving my community and a much wider area are Antrim and, to a degree, the Royal. So I decided to take a closer look at those hospitals. When I looked at the figures for the number of patients being seen within four hours this year compared with those from a year ago, I found that, in the Royal, there was a worsening of 5.4%, from 74.8% to 69.4%, and in Antrim, there was, again, a worsening of 2%, from 69.1% to 67.1%. So how can you say that you are getting a grip on it? There are major problems, so what specifically is being done to bring about improvement? If that is not addressed, we will have more and more people waiting on trolleys, particularly as we approach the winter peak.

**Ms Hinds:** I am sorry; in respect of 12-hour breaches, the fact is that there has been improvement. You are absolutely right, and those were the two trusts that I highlighted in my presentation in respect of the four-hour performance. That is unacceptable, and it is not good enough. We are working with them to try to improve things, but it is not going to be easy. You asked whether we have a grip on it. We have a better grip on it than we did at this time last year.

**Mr Compton:** The conversation with the Committee at this time last year, when all this emerged, was all about the 12 hours. I am not saying that it is perfect, but I think that it is some degree of progress that we are talking about four hours, because it shows that we have made some improvement with regard to the 12 hours. The reporting period is the reporting period of the IAG, and it will clearly show what it turns out to be as it goes through a full calendar year, including the winter. It is a good place to be having the debate. I am not at all complacent about the fact that it is not where we want it to be. However, on this occasion, the nature and shape of the debate is different from what it was when we were talking about these matters a year ago. At that time, the entire discussion was around that. As referenced, at its worst, 16% of attendees had 12-hour breaches in the facilities in your constituency area.

**The Chairperson:** I appreciate what you are saying, John. I know all the work that has been done in the background and in the A&Es, but in October, almost 4,000 people waited for more than four hours in the Belfast Trust. It is an accident and emergency department, so, when you are attending with an accident or emergency, it is not right to be told that you have a waiting time of anything between five minutes and five minutes less than 12 hours. We are talking about human beings. I know about the work that has gone into the system so that people can be seen in four hours. Almost 2,500 people were not seen until the four- to 12-hour period in the Royal. That has a knock-on effect.

**Mr Compton:** Of course it does. I am not being complacent, in any shape or form, about the personal and individual stress that that causes. I am well aware of that. The point I am trying to make is that the debate has shifted to a different place. At this time last year, we were, I think, having a different debate. In fact, my recollection is that we were having a very different debate in Committee about the nature and shape of A&Es. That is the only point that I was making. I am not, in any shape or form, attempting to rationalise away or justify something that I do not think is acceptable.



**The Chairperson:** Sorry to butt in, but we are still at it a year later. Although there has been a slight improvement —

**Mr Compton:** We have been at it for six months now, with regard to where we are going with the IAG. We are here to say to you that we believe that we have made progress in the six months, and we are continuing to make that progress. We would like to come back in six months' time to say that we have made further progress, part of which is around the four-hour target. It is a journey.

There is no simple switching on or switching off of a light to solve this conundrum or difficulty. It is about grinding and putting continuous downward pressure on the things that we know that work and the things that are talked about, such as how people practise at the front door and how we work closer with general practitioners. I have an interesting observation. In the information that we gave you, you may have seen that with the introduction of the admission unit in the Belfast area, through the City Hospital, we have seen that the average length of stay for people admitted through the emergency department is now less than six days. In hospitals in which we do not have that admission unit working as successfully, the average length of stay is more than seven days. Clearly, that is telling us to get that type of system in place. This is about creating a capacity and doing all of that, but, frankly, it cannot be done within a number of weeks, because we have to do all sorts of things to get that in situ.

**Mr Beggs:** Can you assure me that you are learning lessons, particularly at Antrim and the Royal, from other hospitals that are producing much better results? Can you assure me that there are no sacred cows impeding change in practice so that the very best service is delivered to constituents?

**Mr Compton:** Absolutely. The learning event that we had recently was a no-holds-barred event. People were asked to talk about their experiences and difficulties right across Northern Ireland. There is a lot more engagement. I know that colleagues from the Antrim Area Hospital, for example, have been down to Craigavon Area Hospital to meet with the staff there to talk about their systems and processes and what that might mean for their introduction in Antrim.

When we had individuals across from Manchester and the Heart of England Trust to talk about how they handle things, a number of different learning issues arose. It is important that we lift our eyes and look outside Northern Ireland. If other people have fixed it, they have fixed it, and we should not go around trying to reinvent something that already exists for us to look at and to apply in a Northern Ireland context. All of that is clear.

I can assure you now that I believe that there is not a senior person working in the health service who does not understand that the touchstone of how our health and social care system is judged is the experience and publicity around emergency departments. I can give you a categorical assurance that that is absolutely crystal clear to everyone involved.

**Mr Wells:** I am a bit taken aback by the dramatic announcement that the special measures have been withdrawn. I was aware of what was going on this morning, but I did not pick up on the radar that that was going to happen. You have obviously taken the first opportunity to tell us, so I am not going to get onto my soapbox about that. I am slightly surprised, given the storm clouds that were gathering around the Royal and Tony Stevens having to go on the media to try to bolster public confidence in what was going on. Is there any chance that that may be a bit premature?

**Ms Daly:** I think you need to be very clear about the reasons for the special measures and why they were set up. They were set up in relation to specific issues that the Minister had concern about. That is why there were specific milestones that were to be addressed. I can go through what those issues were. There is absolutely no question about it, and we know from discussions here that the Belfast Trust is still facing significant challenges, but it is facing the same sort of challenges that apply across the entire system. The view is that those are issues that it should be possible to address through the Health and Social Care Board working with the trust on performance management. The issues that the trust faces are the same issues facing all other trusts. However, in relation to the very specific issues that the special measures had been set up for, the advice that we provided to the Minister was that the progress against those areas was sufficient for those to be relaxed. The Chairperson asked me earlier exactly what that means, and I said that it means that there will continue to be close scrutiny, in the same way that there is with all our arm's-length bodies.

I should also mention that the trust, as with other arm's-length bodies under the Department, will be asked to complete a board governance self-assessment exercise. That is something that will be rolled

out across all our arm's-length bodies. That is to test the effectiveness of the board's oversight of the risks facing the organisation and corporate issues that we would expect all board members to be on top of. That should identify weaknesses — as well as those areas of strength for the trust — and we will expect the trust to act in response to those. We expect that the Belfast Trust will be the first arm's-length body to undergo that process.

**Mr Wells:** It will be a bit of a PR disaster if, having removed them, suddenly you get a mid-winter pressure and you have to reinstate them, perhaps in December or January. Far be it from me to criticise the Department or the Minister. Of course it is a very wise decision, but it strikes me as an odd time to do it. I would have thought that you would have seen through the winter and waited until things settled in April before you removed them.

**Ms Daly:** Special measures are exceptional, and they were set up for those precise reasons. Another aspect would be to actually recognise the changes and the progress that has been made. It is important to assure the Committee that the trust is absolutely seized of the need to address those issues, and it has done that. It recognises areas where changes are needed, and it is working to deliver those. On the basis of our assessment and on the advice that we received from John at the board, the advice that we provided to the Minister was that they should be relaxed.

**Mr Wells:** We went to Craigavon Area Hospital a few months ago and had a presentation by the chief executive and her assistant. They had faced very similar problems in the Southern Trust, and they devised a series of tactics to address them, and address them they did, to the extent that, yet again — this is where the record needle has stuck — the Southern Trust is emerging — *[Interruption.]* It is a fact. It is not just Sam and me bleating on about it. It is a fact that, on almost every measure, the Southern Trust comes out on top. If we could get the rest of Northern Ireland up to the level of the Southern Trust, you would not be sitting here. That is a fact, because the Southern Trust's figures are extremely good. Why do you not borrow from its experience?

John, you were almost the Red Adair of the health service at one stage; you were a troubleshooter. Only the older people even know who I am talking about; we will explain to the under-40s who Red Adair was.

**The Chairperson:** I read about him in my history class.

**Mr Wells:** John, you were drafted in as an emergency firefighter and you turned trusts around. Surely, when we know what to do, as the Southern Trust has done, it is not rocket science to implement exactly the same measures throughout Northern Ireland. Is that being too simplistic?

**Mr Compton:** At one level, it is too simplistic, but at another it is correct. The 18 measures referred to, the evidence, and the things that Mary talked about — discharging people, the percentage of people who are discharged before lunchtime, how transport is handled, the pharmacy and discharge arrangements into the community, and how you engage with the clinical leadership — are all understood by everyone. There is considerable effort being applied to our organisations to do that.

People start from where they start from, and we have to get them all to the one place. As I pointed out, we have used the staff in Craigavon to talk to others about what worked for them and what was difficult, what was a problem, and how and why it worked or did not work. All that learning is there. At the event that we had, you would have been pleased, as I was, to see that no one was saying, "We know best and we are not listening to you." It was more about people asking others what they did and asking for their help, acknowledging good ideas and being determined to see how those ideas would work in their environment. A lot of that is going on at the moment.

In the end, we have to motivate a large number of people to get in step and move in the one direction, and that is what we are doing.

**Mr Wells:** One of the things that Mairead McAlinden told us that day was that all the staff had been issued with the ubiquitous BlackBerry. Three times a day, everyone at senior level in the trust got a message to say exactly how they were performing on that day — not on a weekly or monthly basis. If there was any sign of the targets being missed, there was an immediate alert. Is that not a best practice technique?

**Mr Compton:** Yes, and there is a live-time stream everywhere for that information to get through.

**Mr Wells:** I want to be fair to the other trusts. I visited the Northern Trust recently, and an accusation was made that the Southern Trust had an advantage over everyone else because it has much greater capacity and can decant patients to other hospitals very rapidly; out of A&E to Lurgan Hospital, South Tyrone Hospital and Armagh Community Hospital. Obviously, if you can get people out of A&E to a lower level of care to convalesce, there is less pressure on the four-hour and 12-hour rules.

When you were looking at this, did you find any evidence that it was true?

**Ms Hinds:** The Southern Trust would not have proportionately more than any other areas. Indeed, there are other areas that probably have proportionately higher numbers of beds to which they could decant patients. It does not matter how many beds you have or where you have them. If you are not managing all those beds efficiently, either in hospitals or in the community, your systems can still clog up.

What the Southern Trust does particularly well is to use intermediate care beds efficiently. It tries to reduce the number of patient movements. You could have a system in which you move someone out to one facility, after which they move to another and then, perhaps, they move home, or you could have a one-step move. The Southern Trust concentrates often on providing intermediate care in the patient's own home or as close to home as possible. It is about the system that is being used to manage those beds, it is not just about the numbers of beds.

**Mr Wells:** Does everyone in the other four trusts know that?

**Ms Hinds:** Yes, they do. We are working with them. My team works in the community as well as in the hospitals. We are specifically looking at intermediate care beds, and our colleagues in integrated care are working with general practice on the use of intermediate care beds. It is about whether we can step patients down out of a hospital to be cared for by general practitioners in another facility. We are looking at all those options.

**Mr Wells:** It is funny; I got the same answer from the Southern Trust, so there is consistency there. Thank you.

**Mr McCarthy:** I am disappointed about what you said about the Ulster Hospital because, for a long time, it had been in front. Why has that happened? Is it due to a knock-on effect from the closure of the City Hospital?

**Ms Hinds:** The Ulster Hospital was doing extremely well until we hit September. It had some increasing ED attendances. I would not say that it was, necessarily, cause and effect of the City Hospital because, if you look at the total trust, its numbers have gone down — if I recall that correctly. However, there seems to have been a movement of patients around the south-eastern area. Although the numbers in the A&E might be smaller, we are admitting more patients into the Ulster Hospital than would have been the case. The Ulster Hospital is a confined site and it has only a certain amount of capacity to manage that. We are working with the trust to try to understand what happened during September because something quite dramatic happened during September and October. Numbers are starting to come down again, which is good, and the trust is making every effort with alternatives to the community, etc. However, there is something going on as regards how we move patients around the system of care and how patients enter the system of care.

I am meeting all the clinical directors — the senior medics — in ED, and we are sharing information about population moves. With a whole lot of things going on, people are either choosing to go to different hospitals, or the Ambulance Service is sometimes choosing to send them to different hospitals and, in fairness to the Ulster Hospital, it dealt with a bit of a surge in ambulance patients over a period of time, which was during those past couple of months. The hospital has to be commended because, at the same time, it reduced its ambulance handover times. Therefore, it is working hard to manage that. It is disappointing, and I know that the staff are disappointed.

**Mr McCarthy:** Exactly. While we are on the topic of the City Hospital, it was a temporary closure. Is it still temporary? How long is temporary?

**Mr Compton:** It remains temporary. The Minister has just about cleared the consultation exercise and that will commence shortly. Again, just to be clear about this, we invested over £8.5 million to enable that transfer to take place. This is not about cash: that is the last thing that this is about.

**The Chairperson:** It is the first time in a long time that we have had a presentation and questions from members that have not referred to finance. People are well aware that, sometimes, it is the system that needs to change, and that is all systems from GPs to primary care to community.

**Mr Compton:** Specifically, there is a consultation exercise that the Minister is asking the board to lead on, and that has to be cleared. That will then go out and there will be a consultation exercise that will follow the normal consultation processes.

**Mr McCarthy:** So, it is still temporary.

**Mr Compton:** Yes, and that is the position. In the end, the Minister determined that he was the person who would make the final decision on the matter. Therefore, it has to go through a process.

**Mr McCarthy:** Catherine, you mentioned the difficulties that the Belfast Trust faced, and nobody can be in any doubt that there have been difficulties and that those difficulties continue. Dr Russell McLaughlin, who is a consultant there, has thrown in the towel. He said that he is concerned about patient safety. What do you say about that? How can we —

**The Chairperson:** We need to be careful. Dr McLaughlin has stepped aside. I would not say that he has thrown in the towel.

**Mr McCarthy:** Well, he has thrown in the towel as director of operations or whatever it is, which would seem that he is not content with what is going on at the Belfast City Hospital in the interests of safety of patients, and that is very concerning.

**The Chairperson:** In fairness, he has never said that. We need to be careful about the language that we are using.

**Mr Compton:** Without going into personal details here, I do not know that the way in which it has been presented in the public environs is accurate. That is all that I would say.

**Mr McCarthy:** OK, we will leave that.

Finally, you said something about the consultation between the staff and the bosses. When staff are under pressure, are you convinced that there is an avenue whereby they can go to somebody and tell them what is going on, and that they will act? Words are fine, but action is required.

**Ms Daly:** There is a very clearly established policy there. The Minister spoke earlier this year — I am sorry that I cannot remember the precise details of when that was — and the policy is very clear: if staff members have concerns, they can raise those concerns and they will be effectively addressed.

**Mr McCarthy:** I was just checking. That is the most important thing. Thanks.

**Mr Dunne:** Apologies for being late; I had other business on this afternoon. On the total attendances at A&Es across the Province, will you clarify that August had the highest attendance of 59,302 yet just 97 people waited for more than 12 hours? Is there any reason for that?

**Mr Compton:** A&E attendances are not easily predictable. You know, broadly speaking, where you are going to be but you can get a movement of 1,000 or 2,000 attendances across Northern Ireland in a month. That can happen.

**Mr Dunne:** That was the maximum attendance, yet it was the best figure in relation to the 12-hour wait.

**Mr Compton:** It could be to do with the nature of the problems, the acuity of the patient population that turned up. You may have had a bigger proportion of those issues that were at the lower end of

acuity. There may have been a larger proportion of minor injuries, which would have been people who were seen, treated and discharged from the A&E and not admitted.

**Mr Dunne:** More of a minor nature, perhaps.

**Mr Compton:** Yes.

**Mr Dunne:** The workload is fairly consistent, between 55,000 and 61,000. Is that figure increasing relatively or is it fairly steady?

**Mr Compton:** In the year, there has been a drop of 2% in the number of people attending emergency departments across Northern Ireland. That does not apply itself universally or even exactly in the same place everywhere. Some places will have dropped a little bit more and one or two places will be a little bit more busy. If you are looking at just the big header numbers, there is about a 2% reduction overall.

It is partly to do with people choosing not to use accident and emergency and getting their healthcare needs met in another way. The real issue for us is the proportion of people who come to emergency departments. We talk about the conversion rate. In other words, if you arrive at an emergency department, what is the percentage conversion when you become an in-patient? There are two distinct groups. There is the group of people who come, are seen and discharged, and the people who are seen, treated and admitted. The conversion rate at times can be volatile. A movement of 1% or 2% in the numbers we are talking about turns into largish numbers going through the system. Those are the things that drive our understanding.

**Mr Dunne:** I am picking up on Kieran's point about the Ulster Hospital. It now seems to be the subject of very heavy loading in relation to A&E. It is getting up nearly to the level of the Royal, roughly 1,000 off that. Obviously, it is the next major hospital after the Royal.

**Mr Compton:** Yes, the Ulster Hospital has a very busy emergency department and, for some time, it probably has been doing broadly an equivalent number to the Royal. If you speak to the staff there, they would be quite clear about that. That is because of its location and the interface between the north Down nexus and the east Belfast move-out in population. The facility is very well-regarded by its local community.

**Mr Dunne:** There is, obviously, a significant impact from the City Hospital closure. The Ulster must be getting more than its fair share of people from south Belfast.

**Mr Compton:** I do not think that that would be borne out if you look at the attendances. We have been tracking this all the way through and tracking all the BT numbers and the planning assumptions that we made regarding the movement of patients as a consequence of the City changes, and they are, broadly, pretty much in line with what was predicted. That is why we invested so much money, and the lion's share went to the Ulster Hospital because we felt that the South Eastern Trust area was likely to bear the brunt, so it got a £6 million-plus investment package as far as that was concerned.

We are talking to them all the time about that, and if it turns out not to be the case and if those figures are not accurate and if we have not quite responded correctly in financial terms, we will adjust that side of things. However, the numbers in our planning assumptions across the system were reasonably accurate. What turned out to be different in the Ulster Hospital was the acuity rate, not necessarily from the move from the City Hospital but just the people who were turning up at the Ulster Hospital. That happened from mid-year onwards. So, some months after the change in the City Hospital, the Ulster went through a period when it had a bigger conversion rate for admissions than other hospitals. We are looking at that.

**Mr Dunne:** Finally, are the figures for over 12 hours still an issue of concern? That is the time from when a patient goes into A&E until they leave it. Could people be lying on trolleys, if you still use trolleys, and be in those statistics?

**Mr Compton:** When anyone is in an A&E Department and it is recorded, the clock starts when they come in. Wherever they are at the 12-hour point, whether they are on a bed in A&E, a trolley, or a chair — and they could be in any of those locations — all of that is counted and recorded for 12 hours. There is no differentiation. It is the total group of people.

**Mr Dunne:** From when they come in until they leave?

**Mr Compton:** Yes.

**Mr Dunne:** So, the people that we are all concerned about will have had some treatment.

**Mr Compton:** Yes.

**Mr Dunne:** Treatment is in progress, perhaps.

**Mr Compton:** Yes. I think that that is the other thing. Again, nothing that I am saying here should be seen as a defence or an excuse, but anybody who is unwell enough to be in hospital for a 12-hour period will have been seen and the appropriate treatment will have been offered to the individual in that regard.

**The Chairperson:** In the paper you provided, although one or two of the figures were out and we are going to get them updated, the table on emergency care performance information has the following categories: within four hours; four hours to 12 hours, and over 12 hours. We are going to get a breakdown on that. Mary, did you say that you monitor four to six hours, six to eight hours and eight to 12 hours?

**Ms Hinds:** Yes, we monitor the percentage of people seen within four hours, the percentage seen within six hours, the numbers waiting for six to eight hours, the numbers waiting for eight to 12 hours, and the numbers waiting over 12 hours.

**The Chairperson:** Do you not monitor the eight to 10 hours?

**Ms Hinds:** No, we do not, actually.

**The Chairperson:** Can we get that information?

**Ms Hinds:** Yes. I get the information. The reason we monitored those waiting from eight hours to 12 hours is because of your very concerns that we would not have a rump of patients who are sitting for 11 hours.

**The Chairperson:** I appreciate that, but if you are looking at four to six hours and six to eight hours, then eight to 10 hours would seem natural, so could we have that?

**Ms Hinds:** No problem.

**The Chairperson:** The paper states:

*"Time from date/time of arrival to date and time when the patient leaves the Emergency Care Department".*

The point I made earlier was about when a patient is due to be admitted. Does that apply when there is no bed and they are admitted to the main part of the hospital within that 12-hour period, or are they handed over to another department and are still in —

**Ms Hinds:** No, they have to have left the A&E department.

**The Chairperson:** Completely?

**Ms Hinds:** Yes.

**Mr Compton:** There is no gaming going on, if that is the question.

**The Chairperson:** I would not suggest for one minute that there is gaming going on, but they physically leave the emergency department?

**Ms Hinds:** Yes.

**The Chairperson:** OK. Again, I know that you have not got the information with you, but can we have a breakdown of how many staff our A&Es, as they stand, should have at every level?

**Ms Hinds:** Remember that we are working on some of those workforce tools at the moment. We can certainly give you a breakdown of what is there and give you a commentary on what we think.

**The Chairperson:** Will you comment on the high level of locums as well? There seems to be an issue that we are still depending on locums in some of our A&Es.

**Ms Hinds:** Yes.

**The Chairperson:** I have two final points. What happens when a hospital goes into divert — when patients are diverted to another hospital?

**Mr Compton:** Usually, "divert" is an ambulance divert. It is important to understand why that is important. If someone arrives in the back of an ambulance, they are likely to be sicker than if they had walked in. That is not always the case, but they are likely to be sicker. Secondly, that will divert senior time and senior assessments. It may take 45 minutes for those receiving the individual from the ambulance to make an assessment and do whatever they have to do, or maybe longer, depending on the nature of the situation.

If you place a divert for three or four hours, and a department is receiving two or three ambulances an hour, you are diverting nine or 10 people. The number is not the issue; the issue is the time that you are —

**The Chairperson:** I appreciate all that. I am not trying to be clever, but if the Mater Hospital puts on a divert to the Royal, it means that the Royal is getting additional patients to its normal walk-ins. It might only be for a couple of hours, but are additional measures put in to allow the Royal to deal with the additionality, based on the Mater having to place a divert? Or is it just a case of, "Deal with it."

**Mr Compton:** A divert is not a particularly usual event, but it is not unknown. If you were organising one, you would not divert from the Mater to the Royal, as you did in your example, if the Royal was exceptionally busy and under major pressure. The divers come when there is an ability to respond to the divert on the other side.

**The Chairperson:** It has happened, John. The Royal has been under extreme pressure, other hospitals have been under extreme pressure, and ambulances have been diverted to the Royal, but there does not seem to have been any additionality.

**Mr Compton:** Remember, the only time that that might be an issue for the Royal is if the divert is from an outside organisation, such as the South Eastern Trust. In the end, our expectation of the Belfast Trust is that will provide emergency services for the population in two locations. Therefore, it organises itself to do that. If it is doing it internally, it is doing so because it is deeming that to be the best way to handle it. The point would be different, if we were diverting many patients from external organisations, such as the South Eastern Trust or parts of the Antrim area, as it spills back into Belfast. We certainly know that; that is why we put the live stream into the ambulance department. The first people who will understand where the pressure is in any system will be the ambulance department, because it will know where it is deploying its ambulances to, and it will know where the difficulties are. It is very much an early warning system for us. The best way of solving divers is to solve them before you have to get anywhere near a divert, and that is to understand the flow.

**The Chairperson:** Are you due to go in to look at any of the hospitals, based on the information that came out over the past number of days?

**Ms Hinds:** My colleagues are meeting in Belfast, as we speak. I have already gone in to spend some time. The team and I have tried to spend some time on the floor with the staff because, invariably, that is a far better way of finding out what is going on and how the systems work. Over a couple of

weeks, I spent an evening in the Royal casualty and some time with the bed managers, and we will go back.

**The Chairperson:** Finally, Catherine, I know this discussion is not about money, but did you say in your presentation that the board was given £2 million. Maybe Mary said it.

**Ms Daly:** John mentioned that.

**Mr Compton:** We mentioned that. It is our normal winter planning.

**The Chairperson:** Is it additional to what they got last year?

**Mr Compton:** It is on top of what is in their system now. Yes.

**The Chairperson:** There was a presentation earlier about not knowing where the pound goes, so have you a breakdown of where that £2 million is going to go? Could we have that as well?

**Mr Compton:** Yes. We know, absolutely, where every penny of it is going to.

**Mr McCarthy:** During the conversation, you mentioned domiciliary care. We all accept the importance of that, but are you aware of the pressures that the providers of domiciliary care are under, in that they are under pressure to reduce the time that people have to give the care to the patient, out in the countryside, for instance?

**Mr Compton:** There are two issues there: the delivery of domiciliary care and the quality of the delivery of domiciliary care. We are aware of where there are issues in that regard. We are quite clear about that. We want the quality of domiciliary care to be appropriate to the individual's needs, and we are aware, more particularly to this debate, of the need for domiciliary care. Therefore, in our discussions on winter planning, there are issues about domiciliary care and some level of additional.

**The Chairperson:** OK. I know that this presentation was planned, but it fell at a good time. On behalf of the Committee, I want to again thank you for your papers. I think that this has been useful. As I said earlier, we are all constituency MLAs, and we all have family and friends who use the services provided by the health service. I want to end by saying that nobody is more aware of the pressure staff are under than us. They are doing a fantastic job at the coalface, given the multitude of issues there. It is important that we can continue to raise these issues, so if we had a mechanism whereby we could pick up information and feed that either directly to Mary or John, or to Catherine in the Department, that would be useful.

I wish you all the best. I hope that this time next year, we are not saying, "We talked about that last year and the year before and the year before that." On behalf of the Committee, thanks very much. I know that you have man flu, John, so thanks very much for coming up today.

**Mr Compton:** Thank you.